BMO

# Dental Summary Plan Description (SPD)

**BMO U.S. Health and Welfare Benefit Plan**

# Contents

# *About this Summary Plan Description*

This document is the Summary Plan Description ("SPD") for the dental benefits portion of the BMO U.S. Health and Welfare Benefit Plan (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 dental 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, 2024. 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 and the legal Plan document, the Plan document controls.

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 dental 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 different-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; and
- your children under age 26, defined as:
  - your biological children;
  - your adopted children or children place with you for adoption;
  - your stepchildren, regardless of where they live;
  - 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 who 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 105(b) of the Internal Revenue Code ("Code").

## Verifying eligibility

The Company shares in the investment of you and your family's health and well-being; it's a partnership, and together we can work to help keep our plan sustainable for the future. To keep the health plan competitive and affordable, we verify that Dependents enrolled in a medical, dental and/or vision plan meet the eligibility requirements. You may also be required to provide documentation to demonstrate any other matters required by the Plan (not just for verifying Dependents).

**We recognize that you may need to spend time gathering documentation, and we thank you for your cooperation in completing this important activity.**

## 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 Plan if certain conditions are met. The Plan will cover the adult dependent child, as long as:

- the child is permanently and totally disabled, as defined by Code section 22(e)(3);
- the child's disability began before the child attained the age of 26;
- the child has the same principal place of abode as you for more than half of the year;
- the child has not provided over half of their own support;
- the child is considered your tax dependent;
- the child is unmarried;
- 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, if 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.

## Dependent Verification

After you choose to enroll your Dependent(s) on your medical, dental and/or vision Plans for the first time, you will be mailed your personalized verification request notice by Dependent Verification Services. To ensure that your Dependents remain covered, you must submit all documentation by the deadline listed in the verification status section of the letter.

You can access your Verification Center dashboard by going to **Workday**, **My Benefits & Retirement** app, and select **Dependent Verification Process** under **Quick Actions**.

If you do not complete the verification process by the deadline, any unverified dependents will be removed from your coverage the 1st of the month following the date your final determination letter is sent from Dependent Verification Services. Any dependent that loses coverage because they were not verified will not be eligible for COBRA. 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**<br>(1 document from each category required) | • Government-issued Marriage Certificate; or<br>• Notarized Affidavit of common law marriage | • Joint federal tax return filed within prior 2 years; or<br>• Proof of joint ownership within last 6 months |

| *Dependent Type* | *Required Documentation Category 1* | *Required Documentation Category 2* |
|---|---|---|
| **Domestic partner** (1 document from each category required) | • Certificate of Domestic Partner registration; or<br>• Notarized Affidavit of Domestic Partnership; or<br>• Government-issued certificate of Civil Union Partnership | • Joint tax return filed within prior 2 years; or<br>• 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<br>• Adoption Certificate; or<br>• 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<br>• Biological parent's Government-issued Birth certificate including parent's names | • Federal tax return filed within prior 2 years claiming grandchild as tax Dependent |
| **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<br>• Proof of disability document | • Federal tax return filed within prior 2 years claiming disabled adult child as tax Dependent |

## *Domestic Partner Eligibility Requirements*

**Criteria of Domestic Partnership:**

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

- you share your principal place of residence;
- you are both at least eighteen (18) years of age and mentally competent to consent to a contract;
- 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;
- neither of you is currently married to or legally separated from another person, nor has any other domestic partner, civil union partner, spouse or equivalent of the same or opposite gender;
- 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.

The following documentation that demonstrates your domestic partner meets the eligibility requirements is required. Two of the items listed must be provided. Additional documentation may be requested if necessary to determine eligibility:

- federal and state tax returns
- domestic partnership agreement
- joint, unexpired mortgage, lease agreement or ownership of real estate property (issued within last 6 months)
- 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 bank checking or credit card account
- joint responsibility for debts
- other document stating common residency

## *Tax Implications Affecting Domestic Partnership Benefits*

Employees are responsible for reporting to the Company if their domestic partner or child(ren) of a domestic partner are a tax-qualified dependent. If you choose to cover your domestic partner under the dental plan, the IRS requires that the amount the Company pays to cover your domestic partner be added to your taxable earnings, called imputed income, unless your partner qualifies as your dependent under section 105(b) of the Code. This means that your taxable pay will be increased by the cost of your domestic partner's coverage minus the amount your pay on an after-tax basis for their coverage. The amount of your imputed income will be taxed as part of your regular income and reported to the IRS on your W-2.

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 105(b) of the Code.

### Qualifying for tax-dependent status

Your domestic partner is a Dependent under Section 105(b) of the Code if they meet all the following criteria:

1. Your domestic partner has the same principal place of abode as you for the full taxable year and is a member of your household (and the relationship is not in violation of local law);

2. Your domestic partner is a citizen, national, or resident of the United States or a resident of Canada or Mexico;
3. Your domestic partner is not a qualifying child of anyone; and
4. Your domestic partner receives more than half of their support from you.

It can be complex determining whether an individual satisfies the definition of a tax dependent under the Code. You should consult a tax professional for advice on your personal situation before you declare tax status.

The following chart summarizes the differences between *tax dependent* and *non-tax dependent* status.

| | ***Tax-dependent status*** | ***Non-tax dependent status*** |
|---|---|---|
| **How premiums are deducted** | Domestic partner's and employer's portion of the premium are deducted from your pay before taxes, just like your own premium. | Domestic partner's and employer's portion of the premium are deducted from your pay after taxes. |
| **BMO's portion of the premium** | BMO's portion of the premium is not taxed, just like for your own coverage. | BMO's portion of the premium is taxed. |

### Certification of Federal Tax Dependent Status

When you enroll your domestic partner for the first time in the benefits system, you'll be asked to certify whether your domestic partner qualifies as a tax Dependent, with a link to the Domestic Partner Tax Certification System. If you have a domestic partner on file already and experienced a change in tax status, you must submit an updated form found on the bmousbenefits.com site by navigating to Forms/Docs.

## 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 QMCSO. If BMO is notified that any of your children are covered by a QMCSO, you will be required to remain enrolled in BMO's medical, dental or vision plans, covering the applicable children, until the QMCSO is no longer valid. You may call the Human Resources Centre at 1-888-927-7700 for information regarding the procedures governing QMCSOs.

# Enrolling & changes

## When coverage begins

Coverage under the Plan is not automatic; you must enroll, go to **Workday**, click on the **My Benefits & Retirement** application. 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. **Please note**: 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.

**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.**

Once made, you generally cannot change your elections during the year, however, you can do so only in limited situations; refer to Mid-year election changes for more information.

### Coverage levels

The following coverage levels are available under the Plan:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

**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.

## 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

Annual enrollment occurs once a year (usually in October) and is your chance to re-evaluate what benefits coverage you need in place to best support you and your family. **Annual enrollment requires your active participation.** During annual enrollment 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. 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.

## *Mid-year election changes*

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. Coverage will be effective as of the date of the event, but you only have 31 calendar days (includes the event date) to make changes to your coverage. Benefit changes that you make during a qualifying life event must be consistent with the change in status. You may need supporting documentation, but not when initiating the event.

### Change in Status Events (Pre-Tax Benefits)

You may change certain elections mid-year if you experience a change in status event listed below. You must notify BMO of the change. **Where applicable, the changes you make to your coverage must be consistent with and "on account of and correspond with" the event.** For example, if your child no longer is eligible for medical benefits, you may cancel medical coverage only for that child, not yourself or your spouse.

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.
- **Number of eligible Dependents:** Any event that changes your number of eligible Dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status:** Any event that changes your or your eligible Dependents' employment status that results in gaining or losing eligibility for coverage.
- **Dependent Status:** Any event that causes your eligible Dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.
- **Residence:** A change in the place of residence for you or your eligible Dependents if the change results in you or your eligible Dependents living outside the network service area of your medical coverage.
- **Change Under Another Employer's Plan**: If you experience a change in medical, dental, and/or vision coverage under another employer's plan (e.g., loss of coverage or a change associated with a different open enrollment period) (note: the election change must be permitted under both plans).
- **Loss of Coverage Under a Governmental or Educational Institution Group Health Plan**: If you or your eligible Dependents lose coverage under a plan sponsored by a governmental or educational institution (e.g., CHIP, an Indian Health Service program, a state health benefits risk pool, or a foreign government group health plan).
- **Significant Change in Coverage**: If the cost of coverage is significantly increased or decreased, or if benefits are significantly improved or curtailed.

## *How to change, add or cancel coverage*

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

1. Go to **Workday**, click on the **My Benefits & Retirement** app;
2. Select your network status (on or off the BMO network);
3. Click on **Change Your Coverage** from the top menu or 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 change, add, or cancel coverage is during annual enrollment, unless another qualifying life event occurs that would allow a change.

### *Accessing Workday outside the BMO network*

To access Workday outside the BMO network through an internet browser or the Workday app available on the App Store or Google Play you will first need to set up a series of security challenge questions in Workday from a computer or device connected to the BMO network.

1. On the Workday home page, select your Profile icon in the upper-right corner. The icon will be either your photo or a generic cloud image.
2. Select My Account under your name.
3. Select Manage Password Challenge Questions.
4. Select three security challenge questions and provide answers. Then, select OK.

To set up your Workday Password – outside the BMO network – for the first-time launch Workday from your internet browner (https://wd3.myworkday.com/bmo/login.htmld) or the Workday app.

1. On the Login screen, select Outside the BMO network.
2. On the Outside the BMO network screen, select Forgot Password?.
3. Enter your Employee Identification Number (EIN) in the Username field, then select Continue.
4. Answer the three Workday security challenge questions that you set up in Workday previously, then select Submit.

## *Family and Medical Leave of Absence*

You may be able to continue Plan coverage for up to 12 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 you receive pay during your FMLA leave, 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 16 weeks of paid maternity/parental leave. Premiums will continue to be deducted from your pay.
- If you choose to take additional 8 weeks of 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 dental 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 dental 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 benefits or loss of all eligibility for the Plan.

## Claims and appeals

There are different types of appeals under this benefit program and the process differs depending on which type is involved.

The Claim Administrator will receive and review claims for benefits and will process claims consistent with administrative practices and procedures. Benefit claims and appeals are handled by the Claims Administrator as described under Claiming benefits under the dental plan.

An eligibility appeal relates to enrollment in the Plan, eligibility for coverage in the Plan, or in situations where you think an error was made.

If one or more of your Dependents was discontinued from the Plan because Dependent Verification wasn't completed or information wasn't sufficient to prove the eligibility you are entitled to have the decision reviewed by initiating a claim.

## Procedure for filing an eligibility appeal

Contact the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concerns. If the HRC was not able to resolve the issue to your satisfaction, you may file an eligibility appeal. You must provide written explanation and provide any documents to demonstrate there was an extenuating circumstance which prevented you from being able to complete the process within the required timeframe or that an error occurred.

The eligibility administrator will respond to your appeal within 30 days. If the eligibility administrator requests additional information to properly review your appeal, you will be notified of any additional information needed. If you do not provide the requested information within 30 days, your appeal will be considered invalid.

To constitute a valid appeal, it must be in writing, and it must include your name, employee ID, and be delivered, along with supporting documentation to:

**Mail:** BMO Financial Corp.
C/O Appeals
DEPT 14613
PO Box 64050
The Woodlands, TX 77387-4050

**Fax:** 1-866-894-6684

## Procedure for filing a second-level eligibility appeal

If your eligibility appeal is denied, you or your authorized representative may appeal that decision by submitting a second level appeal in writing within 60 days of receiving the eligibility appeal denial.

For a second level appeal, you must be able to demonstrate that your claim falls outside the Plan rules. If your appeal relates to a request to change your election outside of annual enrollment or a qualifying life event (as described in the Enrolling and changes section), per IRS rules, BMO can only allow changes in very limited circumstances. You should provide any evidence of extenuating circumstances related to your eligibility appeal with your request.

The Benefit Administration Committee will respond the final decision regarding your appeal within 60 days (or 120 days if an extension is required) of the date the appeal was received. If the Benefits Administration Committee needs additional information to accurately review your appeal, you will be notified. If you do not provide the requested information within 30 days, your appeal will be considered invalid.

Upon request, you will be provided with copies of all documents and information relevant to your appeal free of charge. You may also submit additional information about your claim to the Committee to consider upon reviewing your appeal.

To constitute a valid second level appeal, it must be in writing and include your name and employee ID, and be delivered, along with any supporting documentation not previously submitted to:

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

**Email:** usbenefits@bmo.com

## Procedure for filing an appeal involving dependent verification

If one or more of your Dependent's coverage under the Plan was terminated due to unsuccessful completion of the dependent verification process, you may start a claim with the Dependent Verification Services team.

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 appeal is received. If claims and appeals management needs additional information to determine whether to grant your appeal, they will notify you of the additional information needed. If you do not provide that information within 30 days, your appeal will be considered invalid.

Please note that submitting an Appeal does not guarantee that your Dependent(s) will be reinstated on your coverage. 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.

To constitute a valid appeal, include your name and employee ID, along with any supporting comments, documents, records, and other information to:

**Dependent Verification Claims and Appeals Team**
PO Box 299102
Lewisville, TX 75029-9102

## Limitation of action

You cannot bring any legal action against BMO Financial Corp., the Benefits Administration Committee (or any other Claims 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 twelve (12) months 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

The Company pays a significant portion of the cost for coverage under the Dental 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. 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. For more information, refer to Tax Issues Affecting Domestic Partnership Benefits.

### Additional savings opportunities

Not all your expenses are covered by the Dental Plan. Some of these extra expenses can be reimbursed tax-free if you make contributions to the Health Care Flexible Spending Account (HCFSA) and/or a Health Savings Account (HSA). To learn more about the HCFSA, review the Summary Plan Description or Plan details found on www.bmousbenefits.com.

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, select your network option (on or off the BMO network),click on **Reimbursement Accounts**.

# Dental Plan

The Company's Dental Plan provides dental care for you and your eligible Dependents, including preventive care (e.g., cleanings), basic and major services (e.g., fillings, crowns, etc.), oral surgery and orthodontia.

The Company offers you the Delta Dental Plan. The Plan is designed to encourage preventive care while also helping you and your Dependents handle the cost of major dental expenses.

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

## Dental Plan at a glance

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

| *Features* | *Delta Dental* |
|---|---|
| **Choice of Dentists** | You may go to any Dentist you choose |
| **Deductible** | • $50 per person<br>• $150 family maximum (three individual Deductibles per family)<br>• Applies to basic and major services |
| **Coinsurance** | |
| Preventive services | 100% |
| Basic services | 80% |
| Major services | 50% |
| Annual maximum benefit | $2,000 |
| Orthodontia benefit (Dependent children age 19 or younger) | 50% |
| **Lifetime orthodontia maximum** | 50% of reduced fee subject to separate $2,000 lifetime maximum |
| **Temporomandibular Joint (TMJ)** | Separate $1,000 lifetime maximum |

## Meeting the Annual Deductible

Under the Delta Dental Plan, an Annual Deductible per person applies for all covered services except preventive and orthodontia. The Deductible will not exceed the equivalent of three individual family members' Deductible.

# How the Dental Plan works

The Dental Plan provides in-network and out-of-network benefits for eligible employees and Dependents, including preventive care (e.g., cleanings), restorative care (e.g., fillings), oral surgery and orthodontia. You may choose to receive care from any Dentist, even if he or she is not part of the network. However, your out-of-pocket costs may be higher when you receive care from an out-of-network provider since he or she may bill you for fees exceeding the Maximum Plan Allowance.

In some situations, a rebate, refund or other similar payment may be paid by an insurance company which provides coverage under the Plan or a third-party administrator that provides administrative services under the Plan. In addition, in some situations, an insurance company or third-party administrator may withhold payment to a health care provider or provide an incentive or other additional payments to a provider based on satisfaction of certain standards. Any such payment or withholding of payment will not affect the amount of Deductible, Copayment, coinsurance or out-of-pocket amounts that you pay for any service under the Plan.

## Finding a dental provider

The Dental Plan provides in-network benefits and out-of-network benefits. You may obtain dental services from the Dentist 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. You always have the choice of what dental services you receive and who provides them, regardless of what the Dental Plan covers or pays.

### Network providers

You have the freedom to choose any Dentist and still receive dental benefits, but you can save money and avoid claim forms by choosing Dentists in either of Delta Dental's two participating provider networks:

- **Delta Dental PPO network.** The Delta Dental PPO network is smaller than the Delta Dental Premier network, but Delta Dental PPO Dentists accept the deepest discounts on covered services, saving you the most on your out-of-pocket costs and stretching your annual maximum benefit dollars.
- **Delta Dental Premier network.** The Delta Dental Premier network is a larger Dentist network when you can't find a Delta Dental PPO Dentist. A Delta Dental Premier Dentist will usually save you more money than if you visit a Non-Delta Dental Dentist. While Premier Dentists' contracted fees are often slightly higher than Delta Dental PPO Dentists' fees, Premier Dentists cannot bill you above Delta Dental's approved amount.

To locate a network Dentist near you, visit www.deltadentalil.com, or call 1-800-323-1743.

**Out-of-network provider**

Out-of-network Dentists usually charge more than Delta Dental's contracted fees, so you'll reach your annual maximum benefit sooner. Plus, you will be responsible for all charges in excess of the Maximum Plan Allowance as determined by Delta Dental for specific services in a geographic area. Out-of-network Dentists could charge you up to their full fees. You may be required to pay the Dentist the full amount at the time of service and then submit a claim form to Delta Dental for reimbursement.

### *Pretreatment estimate*

If you and/or your Dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed $200, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your Dentist to submit the claim form in advance of performing the proposed services, including your dental needs and a description of procedures and services the Dentist plans to perform, (including the actual fees to be charged for each procedure).

Pretreatment estimate requests are not required but may be submitted for more complicated and expensive procedures, such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pretreatment estimate to you and the attending Dentist with non-binding verification of the level of payment under this Plan. The pretreatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate. This may be due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

## *What's covered under the Delta Dental Plan*

The Dental Plan covers charges for diagnostic and preventive services at 100%, up to the annual maximum. You pay nothing (the Annual Deductible is waived), except for charges above the Maximum Plan Allowance for out-of-network care.

Diagnostic and preventive care is important to maintain your dental well-being. If you maintain your dental health by regularly receiving dental care, you may avoid more costly dental expenses. Following are covered services under the Delta Dental Plan.

### *Diagnostic Services*

- Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused): two per calendar year.
- Comprehensive oral evaluations – new or established patient: *once per Dentist.*
- Detailed and extensive oral evaluation – problem focused, by report: *once per Dentist.*
- Comprehensive periodontal evaluation: new or established patient: *once per Dentist.*
- Periodic oral evaluations: *twice per calendar year.*
- Intra-oral periapical radiographs.
- Bitewing x-rays (not including vertical bitewings): *one per calendar year.*
- Complete full mouth x-rays: *once per 36-month interval.* A full mouth x-ray includes bitewing x-rays. Panoramic x-ray in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full-mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.
- Diagnostic casts: when rendered more than 30 days prior to definitive treatment.
- Pulp vitality tests: *once per visit.*
- Screening or assessment of a patient: *once in a 12-month interval.*

*Detailed or comprehensive oral evaluations count toward the calendar year maximum of two oral evaluations.*

## *Preventive Services*

- Dental prophylaxis (cleaning): *twice per calendar year. **
- Topical fluoride applications: twice per calendar year for covered Dependents under age 19.
- Space maintainers: covered when they replace prematurely lost teeth for covered Dependents under age 19.
- Recementation of space maintainers: once per lifetime for covered persons under age 19.
- Sealants: applied once per tooth to the occlusal surface of molars that are free of decay and restorations; for covered Dependents under age 19.

*With an indicator of surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit ear for periodontal maintenance or adult prophylaxis.*

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per Benefit Year.*

**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per Benefit Year and for topical application of fluoride at the frequency stated.*

**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per Benefit Year and for topical application of fluoride at the frequency stated.*

**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

## *Basic restorative services*

You pay 20% coinsurance after your Annual Deductible for basic restorative services, plus charges above the Maximum Plan Allowance for out-of-network care.

**Following are basic restorative services covered under the Delta Dental Plan:**

**Restorative Services**

- Fillings, including amalgam and resin-based composite fillings: *once per surface in a 12-month interval.*
- Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.
- Crown repair.
- Additional procedures to construct a new crown under an existing partial denture framework.
- When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.

*When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.*

**Endodontic Services**

- Pulpal and root canal therapy.

*When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.*

*Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.*

*When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.*

*Pulpal therapy (resorbable filling) is a covered dental benefit once per tooth per lifetime.*

**Surgical Periodontic Services**

- Gingivectomy or gingivoplasty, gingival flap procedure.
- Clinical crown lengthening – hard tissue.
- Osseous surgery (including flap entry and closure).
- Guided tissue regeneration, per site: only when performed in association with natural teeth.
- Bone replacement and soft tissue grafts.

*Surgical periodontics is allowed once every 3 years.*

**Non-Surgical Periodontic Services**

- Periodontal scaling and root planning.
- Full mouth debridement to enable comprehensive evaluation and diagnosis*: once per lifetime.*
- Periodontal maintenance: *twice per calendar year.*

*Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.*

*With an indicator or surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a Benefit Year for periodontal maintenance or adult prophylaxis.*

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per Benefit Year.*

**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per Benefit Year and for topical application of fluoride at the frequency stated.*

**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per Benefit Year and for topical application of fluoride at the frequency stated.*

**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

**Removeable Prosthodontic Services**

- Adjustments and repairs to complete and partial dentures, *twice every 12-months.*
- Repairs to complete and partial dentures, *once every 24-months.*

- Replace missing or broken teeth.
- Add tooth or clasp to existing partial denture, *once per lifetime.*
- Replace all teeth and acrylic on cast metal framework, *once per lifetime.*
- Denture rebase or reline: *once in a 3-year period.*
- Tissue conditioning: *once in a 12-month interval.*

**Fixed Prosthodontic Services (Bridges)**

- Recement fixed partial denture, *once per lifetime*
- Fixed partial denture (bridge) repair, *once per lifetime*

*When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 96 months following placement of the initial appliance is not a covered benefit.*

*When the edentulous between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.*

*When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.*

*If, in the construction of a prosthodontic appliance, personalized or special techniques including but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.*

*When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.*

**Adjunctive General Services**

- Palliative (emergency) treatment of dental pain minor procedure.
- Deep sedation/general anesthesia: when provided by a Dentist in conjunction with oral surgery other than simple extractions.
- Intravenous conscious sedation/analgesia: when medically necessary and provided in conjunction with oral surgery other than simple extractions.
- Consultations (100% paid).

**Other**

- Treatment of factures of facial bones.

## *Major restorative services*

You pay 50% coinsurance after your Annual Deductible for major services, plus charges above the Maximum Plan Allowance for out-of-network care.

**Following are major restorative services covered under the Delta Dental Plan:**

**Restorative Services**

- Onlays: permanent teeth only.
- Crowns and ceramic restorations (permanent teeth only): *once every eight years.*
- Prefabricated stainless steel crowns.
- Sedative filling: once per tooth per lifetime.
- Pin retention.
- Cast or prefabricated post and core; core build-up.

*When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.*

**Removeable Prosthodontic Services**

- Complete and partial dentures.
- Stayplate, once in a 5-year interval.

**Fixed Prosthodontic Services (Bridges)**

- Pontics.
- Fixed partial denture retainers – inlays/onlays/crowns (placed as abutments, i.e., to retain or support fixed partial dentures).
- Cast or prefabricated post and core; core build up.

*When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 96 months following placement of the initial appliance is not a covered benefit.*

*When the edentulous between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.*

*When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.*

*If, in the construction of a prosthodontic appliance, personalized or special techniques including but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.*

*When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.*

**Other**

- Implants once every 8-years for covered persons age 16 and older.
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction (includes occlusal guards.

## *Oral surgery*

You pay 20% coinsurance after your Annual Deductible for oral surgery services, plus charges above the

Maximum Plan Allowance for out-of-network care.

**Following are oral surgery services covered under the Delta Dental Plan:**

- Simple extractions.
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
- Removal of impacted tooth – soft tissue, partially bony, completely bony.
- Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.
- Surgical access of an unerupted tooth.
- Biopsy of oral tissue; brush biopsy.
- Alveoloplasty – per quadrant.
- Surgical excision of soft tissue lesions.
- Surgical excision of intra-osseous lesions.
- Other surgical/repair procedures: removal of exostosis, torus palatinus or totus mandibularis, incision and drainage of abscess – intraoral soft tissue, frenulectomy or frenuloplasty, excision of hyperplastic tissue or pericoronal gingiva, surgical reduction of osseous or fibrous tuberosity, dilation of salivary duct.

*Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a Dentist's office.*

## *Orthodontic Services*

Orthodontic services are treatments performed by a licensed Dentist for the proper alignment of teeth. Dependent children are eligible for orthodontic services until age 19. You pay 50% coinsurance, plus charges above the Maximum Plan Allowance for out-of-network care and lifetime maximum orthodontic benefit limit of $2,000 per covered person.

If specialized techniques (for example, clear or "Invisalign" braces) are elected, a Delta Dental PPO Dentist is not obligated to accept the scheduled fee as full payment and may charge the patient any difference in cost between the optional method and a conventional appliance in addition to scheduled Copayment amounts.

## *Enhanced Benefits Program*

Delta Dental of Illinois' Smile Smart Enhanced Benefits Program allows additional frequency for some treatments. This program enhances coverage for individuals who have specific health conditions.
Those eligible for the Enhanced Benefits Program include the following:

- People with periodontal (gum disease)
- People with diabetes
- Pregnant women
- People with high-risk cardiac conditions
- People with kidney failure or who are undergoing dialysis
- People undergoing cancer-related chemotherapy and/or radiation
- People with suppressed immune systems due to HIV positive status, organ transplant, and/or stem cell (bone marrow) transplant
- People with special healthcare needs

These enhancements are based on scientific evidence that shows treating and preventing oral disease in these situations can improve overall health. To enroll, visit the subscriber section of www.deltadentalil.com, or call 1-800-323-1743.

## *What's not covered by the Delta Dental Plan*

Dental benefits are not provided for any of the following charges:

**EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES**:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

**EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES**:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

**EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES**:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.
- Replacement of a stainless-steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.
- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.
- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.
- The repair of any component of a cast restoration is not a covered benefit.
- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.
- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.
- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

**EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES**:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

**EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES**:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.
- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.
- Periodontal splinting to restore occlusion is not a covered benefit.

**EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES**:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 96 months following initial placement of existing appliance is not a covered benefit.
- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.
- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.
- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.
- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

**EXCLUSIONS THAT APPLY TO ORAL SURGERY**:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

**GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES**:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and congenitally missing teeth. This exclusion does not apply to *newborn infants.*
- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement and a Subscriber elects Family Unit coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.
- Charges for services completed prior to the date the person became covered under this program.
- Services for anesthetists or anesthesiologists.
- Temporary procedures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.
- Drugs or the administration of drugs, except for general anesthesia and intravenous sedation.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Surgical services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the *Covered Individual's Effective Date of Coverage* as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

- Services and supplies received from either a *Covered Individual's* or *Covered Individual's* spouse's relative, any individual who ordinarily resides in the *Covered Individual's* home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plaque control programs.
- Services or supplies to correct harmful habits.

## *Claiming benefits under the Delta Dental Plan*

If you're covered under the Delta Dental Plan and another dental plan, see Coordination of Benefits.

For care received from in-network providers, you do not have to submit a claim. In-network providers will submit claims directly to the Claims Administrator.

For care received from out-of-network providers, you may be required to file a claim for reimbursement with the Claims Administrator. Simply pay the out-of-network provider in full at the time you receive service and obtain an itemized receipt. Mail the itemized receipt to the Claims Administrator, along with the claim form, within 90 days of service. All claims must include:

- A proper claim form; and
- An itemized bill for the services or supplies provided.

For a claim form, visit www.deltadentalil.com. Properly completed claim forms should be submitted to the Claims Administrator at the following address:

Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

### *Disputed claims procedure under the Delta Dental Plan*

**Prior approval of benefits**
This group Dental Plan does not require prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the Plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this Plan and is subject to any applicable Deductible, waiting periods, annual and lifetime coverage limits as well as this Plan's payment policies.

**Notice of adverse benefit determination**
If a claim is denied in whole or in part, Delta Dental of Illinois (DDIL) shall notify the enrollee of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not

exceeding 15 days, for processing. DDIL will notify the treating Dentist as well by issuing an Explanation of Payment. If an extension is necessary, DDIL shall notify the enrollee and the treating Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the enrollee or the treating Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

**Explanation of Benefits form**
This form includes the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific Plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary.
- A description of DDIL's Appeal process and the time limits applicable to the process, including a statement of the enrollee's right to bring a civil action under the Employee Retirement Income Security Act ("ERISA") following an adverse benefit determination.
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination.
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

**Request for appeal of adverse benefit determination**
If the enrollee disagrees with DDIL's adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of DDIL within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that DDIL's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, DDIL will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

**Reevaluation committee's review**
The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a Dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

**Notice of review decision**
The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific Plan provisions upon which the determination is based.
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request.
- A statement of the claimant's right, to bring a civil action under ERISA.
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination.
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

**Employer's review of claims for eligibility reasons**
Notwithstanding the above procedures, employer has the right to review and override all claim determinations related to eligibility or loss of eligibility, whether said claims are approved or denied.

If you have a question about a dental claim, call the Claims Administrator at 1-800-323-1743.

## 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 twelve (12) months 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.

# Coordination of benefits

Coordination of Benefits (COB) applies when you have coverage through more than one group program. The purpose of COB is to ensure that you receive all 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 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.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If you are thinking about carrying dual coverage for yourself and your family, it's important to understand the way the dental plan coordinates coverage with other group plans.

The dental plan has a coordination of benefits provision that prevents duplication of benefit payments when you or your Dependent also has other coverage through another group plan. Coordination of benefits procedures also determine which plan pays your claim first.

## How coordination of benefits works

Here's how the coordination of benefits provision works: When you have a claim, determine which plan will be your primary plan (see Determining your primary plan). Then, send your claim to the primary plan, which pays benefits up to its plan limits, without regard to any other plans. After the primary plan processes your claim, send copies of the same medical bills and the primary plan's explanation of benefits (EOB) to the secondary plan.

Under the Dental Plan, when another plan is primary Delta Dental is the secondary plan. Depending on the benefit you have already received and what your other plan covers, you may receive up to 100% of your benefit between the two plans, but not more than that.

As the secondary plan, Delta Dental calculates your benefit as if there were no other plan. Then they subtract what the other plan paid, taking Deductibles and Copayment levels for the benefit into consideration. The difference between what Delta pays as the secondary plan and what Delta would have paid as the primary plan is available to pay for allowable expenses incurred but not paid in a calendar year for the person making the claim.

## Determining your primary plan

If a Covered Individual is entitled to coverage under two or more policies or prepaid health care plans, then the covered dental benefits are paid as follows:

1. The benefits of the plan which covers the person directly as the employee and not as a Dependent will be determined before those of the plan which covers the person as a Dependent.

2. Except as set forth in paragraph 3, when two or more plans cover the same child as a Dependent of different parents:

    - The benefits of the plan of the parent whose birthday, excluding year of birth, falls earlier in a year will be determined before those of the plan of the parent whose birthday, excluding year of birth, falls later in that year; but

    - If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time will be determined before those of the plan which covered the parent for a shorter period of time.

    However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state plan which has a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. If two or more plans cover a Dependent child of divorced or separated parents, benefits of the child are determined in this order:

    - **First**, the plan of the parent with custody of the child;
    - **Second**, the plan of the spouse of the parent with custody of the child; and
    - **Third**, the plan of the parent not having custody of the child.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before that entity has that actual knowledge.

    But if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules as set forth in paragraph 2.

4. The benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's Dependent, will be determined before those of a plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan is not subject to this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.

5. If none of the rules in paragraphs 1, 2, 3 or 4 determine the order of benefits, the benefits of the plan which covered an employee for a longer period of time will be determined before those of the plan which covered that person for the shorter period of time.

If this Dental Plan provides only secondary coverage, it shall not be obligated to make payment until Delta Dental of IL receives a copy of the primary carrier's proof of payment and calculation of benefits.

Where an individual has dual coverage, this Dental Plan shall not be charged with a greater amount than the amount for which it would be liable if such dual coverage did not exist. In any event, the benefits under both plans shall not total more than the Dentist's billed fees.

If you are uncertain whether your plan is primary, call your plan's Member Services.

## *Right of recovery*

This Plan reserves the right to recover benefit payments made for an allowable expense under this Plan in the amount which exceeds the maximum amount this Plan is required to pay under these provisions. This right of recovery applies to this Plan against:

1. any persons to, for or with respect to whom, such payments were made; or
2. any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

This Plan alone will determine against whom this right of recovery will be exercised.

# *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 through COBRA*

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Dental Plan ends, you, or your covered spouse/domestic partner and Dependent children may be eligible to

temporarily continue coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your covered spouse/domestic partner or dependent children to lose coverage under the Plan. Depending on the type of qualifying event, qualified beneficiaries can include the employee covered under the group health plan, the covered employee's spouse, and dependent children of the covered employee. Domestic partners are not qualified beneficiaries, but the Plan treats them as qualified beneficiaries.

## 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, /domestic partner, your covered children** | • A reduction in your work hours (scheduled to work less than 20 hours a week)<br>• Your termination of employment (except in cases of gross misconduct) | 18 months* |
| **Your spouse/domestic partner** | • Your death<br>• Divorce or legal separation/termination of domestic partnership<br>• Employee's entitlement to Medicare (Part A, B, or both)** | 36 months |
| **Your covered children** | • Your death<br>• Divorce or legal separation<br>• Employee's entitlement to Medicare (Part A, B, or both)**<br>• Children no longer meet the eligibility criteria under the Plan | 36 months |

**Coverage can continue for an additional 11 months if a qualified beneficiary 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 because 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 COBRA, 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 spouse/domestic partner and dependent children 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.**

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated through the month you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Inspira Financial to confirm the correct amount of your first payment.

The claims administrator will be notified to retroactively reinstate coverage once Inspira Financial receives both the COBRA Continuation Enrollment Form and the premium payment. It may take the claims administrator approximately 7-10 business days for coverage to be reinstated and for providers to verify benefits.

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. Should some but not all of your Dependents wish to continue coverage, you are welcome to call Inspira Financial to obtain information about specific premium amounts due. COBRA premium amounts will also be listed in the COBRA election notice.

### Notification requirements

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

- The date of the divorce, legal separation, termination of domestic partnership, 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, your spouse, domestic partner, or your dependent children 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 COBRA, you must notify the COBRA Administrator within 60 days of the birth or adoption of a child.

### Extended continuation coverage

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 Inspira Financial of a disability or a second qualifying event 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:**

Inspira Financial Health, Inc.
BENEFITS BILLING DEPARTMENT
P.O. BOX 953374

ST. LOUIS, MO 63195-3374
1-888-678-7835

## Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled during the first 60 days of COBRA coverage. You must notify Inspira Financial 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. All the qualified beneficiaries indicated within this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Inspira Financial of that fact within 30 days of SSA's determination. Coverage exceeding the first 18-month continuation ends when the individual is no longer Social Security-disabled.

## Second qualifying event

An 18-month extension of coverage will be available to spouses/domestic partners and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee; divorce, or separation, or termination of domestic partnership 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 Inspira Financial 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.**

## When COBRA coverage ends

COBRA continuation coverage will end before the maximum continuation period if:

- any required premium is not paid on time;
- if a qualified beneficiary becomes covered under another group health plan;
- if a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;
- if the Company ceases to provide any group Plan for its employees;
- the Company would terminate coverage for a participant or beneficiary not receiving continuation coverage (such as fraud); or
- 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 consider 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 dental coverage under the BMO Retiree Medical and Life Insurance Plan ("Retiree Plan")** and you elect COBRA under this Dental Plan at the time of your retirement, you will forfeit your right to participate in dental coverage under the Retiree Plan.

**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 will pay second. Certain COBRA continuation coverage 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.

**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/domestic partner, 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.

You can voluntarily drop your COBRA coverage or stop paying premiums, but you will not be eligible for a special enrollment opportunity, **and this is generally not a qualifying event for you to end COBRA and elect coverage elsewhere**. Only exhaustion of your COBRA coverage triggers a special enrollment opportunity.

**Keep Your Plan Informed of Address Changes**
To protect your family's rights, you should keep the COBRA 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 COBRA Administrator.

# Administrative information

## Plan identification

**Plan name**
This Summary Plan Description describes the Dental Plan portion of the Plan. The Plan, a group health plan subject to ERISA, provides medical, prescription drug, employee assistance, life, disability, dental, vision, and Health Care Flexible Spending Account benefits.

Separate Summary Plan Descriptions describe the Medical, Vision, Flexible Spending Accounts, Employee Assistance Program and Life and Disability portions of the Plan.

**Plan number**
507

**Employer Identification Number**
51-0275712

**Plan year**
January 1 – December 31

**Plan sponsor**
BMO Financial Corp.

**Plan administrator**
Benefits Administration Committee

The Plan sponsor and Plan administrator can be contacted at:

BMO Financial Corp.
Benefits Administration Committee
320 South Canal Street, Floor 8
Chicago, IL 60606
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 Claims 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 Claims Administrator, as applicable, determines in its discretion that the claimant is entitled to them.

**Plan trustee**

The Plan trustee for the Plan is:

BNY Mellon Client Service Center
500 Ross Street, 8th Floor
Pittsburgh, PA 15262-0001

**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**

The Plan is funded by the employer's general assets and a trust.

## Claims administrators and service providers

| Claims Administrator | For | Address for filing claims |
|---|---|---|
| **Delta Dental of Illinois**<br><br>www.deltadentalil.com<br>**Member Services:** 1-800-323-1743 | Dental benefits | Delta Dental of Illinois<br>PO Box 5402<br>Lisle, IL 60532 |

| Service provider | For | Address |
|---|---|---|
| **Alight Solutions –HR Benefits**<br><br>**Human Resources Centre (HRC):** 1-888-927-7700 | Processes eligibility and provides customer service to Covered Individuals | Alight Solutions –HR Benefits<br>DEPT 14613<br>PO Box 64050<br>The Woodlands, TX 77387-4050 |
| **Dependent Verification Center** | Submitting initial Dependent Verification documents | Dependent Verification Center<br>PO Box 299109<br>Lewisville, TX 75029-9109 |

| COBRA administrator | For |
|---|---|
| **Inspira Financial Health, Inc**<br>Benefits Billing Department<br>PO Box 953374<br>St. Louis, MO 63195-3374<br><br>**Member Services:** 1-888-678-7835 | COBRA continuation coverage<br><br>www.inspirafinancial.com<br>Employer ID: 139888 |

## Uncashed checks

Benefit payment or reimbursement checks under the Plan that relate to benefits that are paid from the bank's or the company's general assets and that remain uncashed after 180 days (or, if later, the expiration date set forth on the reimbursement check) shall be returned to the bank or the company, as applicable. Benefit payment or reimbursement checks under the Plan that relate to benefits that are paid from the trust fund and that remain uncashed after 180 days (or, if later, the expiration date set forth on the reimbursement check) shall be returned to the trust fund. The treatment of uncashed checks relating to benefits under the Plan that are paid by an insurer shall be determined by the insurer.

## Future of the Plan

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 encounter 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, Head, U.S. Benefits, by emailing usbenefits@bmo.com.

## *Your rights under ERISA*

As a participant in the Plan, you are entitled to certain rights and protections under 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 because 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 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 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. a

# *Glossary of terms*

Capitalized terms have the meaning listed below unless the context clearly indicates otherwise. If you have any questions about the Glossary of Terms, please contact Member Services for Delta Dental.

**Annual Deductible (or Deductible)**
The amount you must pay for covered health services in a calendar year before the Plan will begin paying benefits in that calendar year.

**Benefit Year**
The reference period specified in the Dental Plan Specifications for purposes of determining the application of Deductibles, waiting periods and coverage limits for each Covered Individual.

**Covered Individual**
Any employee or any Dependent of that employee who enrolls in this Group Dental Plan and who is entitled to receive Dental Benefits, unless and until coverage terminates as provided herein.

**Covered Individual's Effective Date of Coverage**
The date an individual meets the required conditions of eligibility and becomes enrolled in this Group Dental Plan.

**Claim(s) Administrator**
Means Delta Dental of Illinois

**Copayment (or Copay)**
A copay is the flat dollar amount that you pay for a specific covered service before the Plan pays any benefits.

**Delta Dental PPO Dentist**
A Dentist who, by written agreement with DDIL, will provide dental services to Covered Individuals in accordance with DDIL's negotiated fee schedules and has agreed to abide by the bylaws, rules and regulations established by DDIL.

**Dependent**
An individual who meets the eligibility requirements specified in the Plan.

**Dentist**
A licensed dentist or physician legally entitled to practice dentistry at the time and in the place services are provided.

**Maximum Plan Allowance**
The amount that a Delta Dental Premier Dentist agrees contractually to accept as full payment for covered procedures. The Maximum Plan Allowance is calculated as a percentile of billed fees.

**Non-Delta Dental Dentist**
A dentist who has not agreed to be a Delta Dental PPO dentist. There are two categories of Non-Delta Dental Dentists:

- Delta Dental Premier dentists are bound to accept DDIL's approved fee as full reimbursement for their services after application of any deductibles and DDIL's benefit payment.
- Non-Dental Dental Premier dentists have not agreed to accept DDIL's approved fee as full payment of their services. Non-Delta Dental Premier dentists may bill the patient the difference between his/her fee and DDIL's benefit payment.