BMO

# Vision Summary Plan Description (SPD)

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

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# About this Summary Plan Description

This document is the Summary Plan Description ("SPD") for the vision 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 vision benefits portion of the Plan. Other portions of the Plan discuss other benefits. Those other portions are not covered by this SPD.

The information in this SPD is current as of January 1, 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 vision benefits portion of the Plan if you are a:

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

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

## Eligible Dependents

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

- your legal spouse unless you are legally separated or divorced. A legal spouse includes a same-sex or 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 BMO Plan if certain conditions are met. The Plan will cover the adult dependent child, as long as:

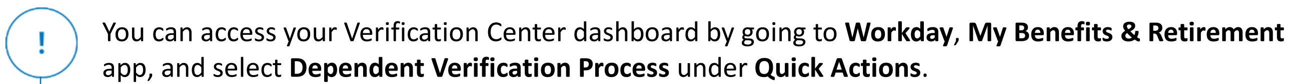
- the child is permanently and totally disabled, as defined by Code section 22(e)(3);
- the child's disability existed prior to the child reaching age 26;
- the child has the same principal place of abode as you for more than half of the year;
- the child has not provided over half of their own support;
- 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**<br>(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**<br>(document from category 1 required) | • Government-issued Birth certificate including parent's names | |
| **Adopted child**<br>(1 document from category 1 required) | • Government-issued Birth certificate; or<br>• Adoption Certificate; or<br>• Placement Agreement | |
| **Step-child**<br>(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**<br>(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**<br>(documents from both categories required) | • Government-issued Birth certificate including parent's names | • Court ordered document of legal guardianship |
| **Grandchild**<br>(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**<br>(documents from both categories required) | • Government-issued Birth certificate | • Foster care letter of placement |
| **Disabled adult child**<br>(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

### 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, as outlined below. **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.
- **HIPAA Special Enrollment Event**: The events listed above as HIPAA Special Enrollment events.
- **Entitlement to Medicare or Medicaid**: If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid.
- **Judgment, Decree, or Order**: If a judgment, decree, or order, such as a QMCSO, requires your dependent child to be covered under this Plan (or another plan).
- **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 the 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 vision coverage while you are on an approved leave of absence. If you are on a paid leave, your premium is deducted from your pay as usual. If any portion of your leave is unpaid, your benefits coverage will continue, and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume, and any accumulated arrears will be collected at a rate of one additional deduction per pay until your arrears balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums. Your contribution amount is the same as when you were actively working and is subject to change each January 1.

## If you become disabled

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

## Retroactive cancellation of coverage

The Plan expects that you will provide complete and accurate information. If you or your Dependents commit fraud against the Plan or make a misrepresentation, the Plan may take appropriate actions in response to such fraud or misrepresentation. The actions can include a loss of 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 Claim Administrator as described under Claiming benefits under the vision 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.<br>C/O Appeals<br>DEPT 14613<br>PO Box 64050<br>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 appeal 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 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.

# *Plan cost*

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

## *Tax-saving advantage*

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

If you enroll a tax dependent domestic partner, the additional premium is equal to that for a spouse. However, if you enroll a non-tax dependent partner, you pay the premium on an after-tax basis, and it creates imputed income. 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 Vision 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**.

# *Vision Plan*

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

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

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

## *Vision Plan at a glance*

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

| *Features* | *VSP Base Plan (In Network)* | *VSP Premier Plan (In Network)* | *Out-of-network (non-VSP provider)* |
|---|---|---|---|
| **Deductible** | N/A | N/A | N/A |
| **Eye exam every calendar year** | Wellness Exam: $10 copay<br>Routine Retinal Exam: $20 | Wellness Exam: $0<br>Routine Retinal Exam: $20 | $45 allowance |
| **Eyeglass lenses (covered every 12 months)** | Included in Prescription Glasses<br>• Single vision, lined bifocal, and lined trifocal lenses<br>• Impact-resistant lenses for dependent children | Included in Prescription Glasses<br>• Single vision, lined bifocal, and lined trifocal lenses<br>• Impact-resistant lenses for dependent children | Single vision: $30 allowance<br>Lined bifocals: $60 allowance<br>Lined trifocal: $80 allowance |
| **Lens enhancements** | • $0 copay for standard progressive lenses, tinted lenses, scratch-resistant coating, UV protection<br>• $50 copay for premium progressive lenses, custom progressive lenses<br>• Average savings of 30% on other lens enhancements | • $0 copay for standard progressive lenses, tinted lenses, scratch-resistant coating, UV protection<br>• $195 - $105 copay for premium progressive lenses (see EasyOptions for more benefits)<br>• $150 - $175 custom progressive lenses (see EasyOptions for more benefits) | Not covered except for $60 progressive lenses allowance |

| | | | |
|---|---|---|---|
| | | • Average savings of 30% on other lens enhancements | |
| **Eyeglass frames (covered every 24 months)** | • $150 frame allowance<br>• $170 featured frame brands allowance<br>• 20% savings on the amount over your allowance<br>• $80 Walmart®/Sam's Club®/Costco® frame allowance | • $ 175 frame allowance<br>• $ 225 featured frame brands allowance<br>• 20% savings on the amount over your allowance<br>• $95 Walmart®/Sam's Club®/Costco® frame allowance | $70 allowance |
| **Contacts lens exam (fitting & evaluation)** | Up to $40 copay | Up to $40 copay | $ 210 combined allowance for Necessary Contact Lenses<br><br>$105 combined allowance for Elective Contact Lens |
| **Contact lenses every calendar year (instead of glasses)** | $150 allowance for Elective Contact Lens<br><br>Necessary Contact Lenses are covered in full, less any applicable Copayment | $175 allowance for Elective Contact Lenses<br><br>Necessary Contact Lenses covered in full, less any applicable Copayment | |
| **EasyOptions Upgrades every calendar year** | N/A | Members can choose one of these upgrades:<br>• Additional $75 frame allowance<br>• Fully covered premium or custom progressive lenses<br>• Fully covered light-reactive glasses<br>• Fully covered anti-glare coating<br>• Additional $75 contact lens allowance | N/A |
| **LightCare every calendar year** | N/A | $225 allowance for ready-made nonprescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts | $70 allowance<br>(only available for VSP Premier) |

## *Extra savings and discounts*

- **Glasses and sunglasses:** 20% off additional glasses and sunglasses, including lens enhancements from any VSP provider within 12 months of your last eye exam.
- **Retinal screening:** Guaranteed pricing on retinal screening as an enhancement to your eye exam.
- **Laser vision correction:** Average of 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.
- **TruHearing:** Save up to 60% on digital hearing aids

## *VSP Primary EyeCare Plan℠*

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

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

### *Finding a vision provider*

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

#### Network providers

Network providers are a group of optometrists or ophthalmologists organized to deliver vision care to members at reduced (discounted) rates. While you can use any provider you wish, you generally pay less if you use network providers because services are covered at a higher level.
For the most up-to-date listings of VSP providers in your area, visit www.vsp.com or call 1-800-877-7195.

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

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

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

### Out-of-network providers

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

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

## What's covered under the Vision Plan

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

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

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

## What's not covered by the Vision Plan

Services and material not covered under the vision benefits include:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter)
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

## Claiming benefits under the Vision Plan

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

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

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

The address for claim submission is:

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

### Requests for appeals

You have the right to appeal if:

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

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

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

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

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

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

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

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

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

## 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.

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

# When coverage ends

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

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

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

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

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

## Continuing coverage under COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Vision Plan ends, you or your covered spouse/domestic partner and dependent child(ren) 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 carrier 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 carrier 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.
BENEFIT 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, 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; or
- the Company would terminate coverage for a participant or beneficiary not receiving continuation coverage (such as fraud).
- 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 vision coverage under the BMO Retiree Medical and Life Insurance Plan ("Retiree Plan")** and you elect COBRA under this Vision Plan at the time of your retirement, you will forfeit your right to participate in vision 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 Vision 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, Dental, 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 claim administrator, the Committee shall have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. The Committee shall have discretionary and final authority to interpret the terms of the Medical Plan regarding matters for which it is responsible as set forth above and its decisions shall be final and binding on all parties. The Plan Administrator has delegated to the Claim Administrator the discretionary authority to make decisions regarding the interpretation and application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan and to make claims and final appeals determinations under the Plan. Benefits under the Plan will only be paid if the Plan Administrator or the Claim Administrator, as applicable, determines in its discretion that the claimant is entitled to them.

**Plan trustee**

The Plan trustee for the 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 Vision Plan is considered fully insured. Vision Plan contributions are made by participating employees. Company and employee contributions are made to the trust and used to pay the premiums to VSP Vision Care. VSP Vision Care pays all benefit claims.

## Claims administrators and service providers

| Claims Administrator | For | Address for filing claims |
| --- | --- | --- |
| **VSP Vision Care**<br><br>**Member Services:** 1-800-877-7195 | Vision benefits | Send completed VSP Member Reimbursement Form and a legible copy of your itemized receipt(s) to:<br>VSP Vision Care<br>PO Box 385018<br>Birmingham, AL 35238-5018 |

| 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 |

## 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, Director of US Benefits, by emailing usbenefits@bmo.com

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

## *Your rights under ERISA*

As a participant in the 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 as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### Prudent actions by plan fiduciaries

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

### Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide all 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.

# 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 VSP.

**CLAIM ADMINISTRATOR**
Means VSP

**CLIENT**
Means BMO Financial Corp.

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

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

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

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

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

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

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