BMO

Retiree Health Reimbursement Arrangement Summary Plan Description (SPD)

BMO Retiree Medical & Life Insurance Plan

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Retiree Health Reimbursement Arrangement
Summary Plan Description

Effective January 1, 2024

Table of Contents

Introduction

This Health Reimbursement Arrangement Summary Plan Description ("HRA SPD") describes the Health Reimbursement Arrangement Plan ("HRA Plan"), a component benefit of the BMO Retiree Medical and Life Insurance Plan ("Retiree Plan"). This summary is intended to meet the requirements for a Summary Plan Description ("SPD") under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The purpose of the HRA Plan is to reimburse eligible retirees for Eligible Medical Expenses that are not otherwise reimbursed. The HRA Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Internal Revenue Code ("Code") Sections 105 and 106, as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. The Retiree Plan (including the HRA Plan) is intended to be exempt from certain requirements otherwise applicable to group health plans as a "retiree-only" plan pursuant to ERISA Section 732(a) and Code Section 9831(a)(2).

Read this summary carefully so you understand the provisions of the HRA Plan and how you can use the HRA Plan to your advantage.

The HRA Plan is subject to federal laws, such as the Code, ERISA, and other federal laws that may affect your rights. The provisions of the HRA Plan are subject to revision due to changes in laws or due to pronouncements by the Internal Revenue Service ("IRS") or other federal agencies. BMO Financial Corp. ("BMO" or "Company") may also amend or terminate the HRA Plan. If the provisions of the HRA Plan described in this SPD change, you will be notified.

Note that this SPD is only a summary. If there are any differences between the information in this SPD and in the legal plan document, the plan document will control. If the plan document is silent, the language in this SPD will control.

Note that terms used in this SPD are defined the first time they are used. Please note that "you," "your," and "my" when used in this SPD refer to you, the retiree.

How the HRA Works

A Health Reimbursement Account ("HRA") is a nominal reimbursement account the Company establishes on you and your eligible dependent's behalf. For BMO or Marshall & Ilsley Corporation ("M&I") retirees, unless stated otherwise in the Eligibility and Cost Appendix, the Company will credit a specific dollar amount to the HRA each year to help cover the cost of the accountholder's Eligible Medical Expenses. For Bank of the West ("BOTW") retirees, unless stated otherwise in the Eligibility and Cost Appendix, any remaining retiree medical credits from your pre-Medicare coverage will be converted in to a one-time credit to your HRA to help cover the cost of your and your eligible dependent's Eligible Medical Expenses. If you are a

Medicare-eligible BOTW retiree who was participating in the HRA under the Bank of the West Retiree Medical Program, any balance in your HRA under that program will transfer to the HRA Plan effective January 1, 2024. These expenses must be incurred while the HRA Plan remains in effect and you are eligible and participate in the HRA.

Only the Company can contribute to your HRA. The HRA is a bookkeeping account on the Company's records only, with reimbursements being paid from the Company's general assets or a trust. The IRS does not permit you to contribute your own money to an HRA.

You do not pay taxes on the HRA contributions or the amounts you are reimbursed from the HRA for Eligible Medical Expenses. However, you will be taxed on the value of your domestic partner's HRA coverage if your domestic partner is not a tax dependent under Code Section 105(b).

Eligibility

You are eligible to participate in the HRA Plan if you are a Medicare-eligible former employee of BMO, M&I, or BOTW (or a related entity) who has satisfied the requirements in the applicable Eligibility and Cost Appendix. In addition, if you are a BMO or an M&I retiree, the Company will establish an HRA for your dependents (as defined in the applicable Eligibility and Cost Appendix) once they become Medicare-eligible.

When Participation Begins – BMO and M&I Retirees

An eligible retiree or eligible dependent becomes a Participant in the HRA Plan on the later of the effective date of the HRA Plan, as provided in the Plan Information Appendix, or the date that he/she has satisfied all of the following requirements:

- He/she is eligible for Medicare.
- He/she has obtained an individual health insurance policy through Via Benefits (or any of its affiliates).
- He/she has completed any enrollment forms or procedures required by the Plan Administrator.

When Participation Begins – BOTW Retirees

An eligible retiree becomes a Participant in the HRA Plan on the later of the effective date of the HRA Plan, as provided in the Plan Information Appendix, or the date that he/she has satisfied all of the following requirements:

- He/she is eligible for Medicare.
- He/she has obtained an individual health insurance policy through Via Benefits (or any of its affiliates) or he/she has provided satisfactory evidence to the Plan Administrator that he/she has other coverage permissible to the Plan Administrator.

- He/she has completed any enrollment forms or procedures required by the Plan Administrator.

Contributions – BMO and M&I Retirees

A separate HRA will be established for you and your eligible dependents and notional contributions for each participant in the HRA Plan will be credited to his or her own HRA, as described in the applicable Eligibility and Cost Appendix.

Your HRA balance will be reduced by the amount of any Eligible Medical Expenses for which you are reimbursed under the HRA Plan. Note that retirees are not permitted to make any contributions to their HRA.

Unused contributions remaining in your HRA at the end of the plan year's runout period will be forfeited.

You may opt out of future contributions to the HRA at least annually. Remaining HRA contributions cannot be paid in cash or other form of distribution, other than through reimbursement of Eligible Medical Expenses incurred while you are enrolled in the HRA Plan.

Contributions – BOTW Retirees

Once you are Medicare-eligible, any remaining retiree medical credits (as described in the Eligibility and Cost Appendix) will be converted to a one-time contribution to an HRA. Your HRA balance will be reduced by the amount of any Eligible Medical Expenses for which you are reimbursed under the HRA Plan. Note that retirees are not permitted to make any contributions to their HRA. Your participation in the HRA Plan will terminate once your HRA balance is exhausted. Unused contributions remaining in your HRA at the end of the plan year roll over to the next plan year and are available for use in future plan years to reimburse Participants for Eligible Medical Expenses incurred during subsequent plan years.

You may opt out of the HRA at least annually. Amounts remaining in your HRA cannot be paid in cash or other form of distribution, other than through reimbursement of Eligible Medical Expenses incurred while you are enrolled in the HRA Plan.

Eligible Medical Expenses – BMO and M&I Retirees

Eligible Medical Expenses are premium expenses that the Participant paid for medical and prescription drug insurance and Medicare Part B for him or herself. Any other expense is ineligible under the HRA Plan.

Eligible and Ineligible Expenses – BOTW Retirees

When you or your eligible dependent has a medical expense that is not paid by another medical plan, you may submit a claim for reimbursement from your HRA.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid even if the covered individual paid the premium for the coverage prior to the first day of the plan year.

The federal government permits you to take a deduction on your income tax return for certain health care expenses. You should remember that you cannot claim the same expense twice, once through the HRA and as a tax deduction. For specific advice about your situation, you may want to consult a tax advisor. The Company cannot advise you regarding tax, investment, or legal considerations relating to the HRA.

You may not submit a claim for an amount that was incurred prior to the time the HRA became effective. In addition, you cannot submit a claim for any expenses that have been paid in-full through any other health insurance plan, Section 125 "cafeteria" plan or other similar health care expense reimbursement arrangement.

Eligible Medical Expenses

Premium expenses for: medical, prescription drug, dental, vision, Medicare Part B, and long-term care incurred while you are enrolled in the HRA.

Out of Pocket expenses for: medical care under Code Section 213(d) (except for prescription and over-the-counter drugs) incurred while you are enrolled in the HRA.

The following are examples of Eligible Medical Expenses when they are incurred by you or your eligible dependents and are not reimbursed under another health plan:

- Acupuncture services related to the diagnosis, cure, mitigation, treatment, or prevention of disease.
- Ambulance expenses
- Chiropractor fees
- Dental care
- Diagnostic services, including laboratory and X-ray services
- Eyeglasses and contact lenses

- Inpatient and outpatient hospital fees
- Medical appliances, such as artificial teeth or limbs, crutches, elastic stockings and hearing aids
- Nurse fees
- Oxygen equipment and oxygen
- Physician fees
- Psychiatric care
- Psychologist fees
- Surgical fees
- Certain travel related to your health care

Ineligible Expenses

Eligible Medical Expenses do not include the following types of expenses:

- Prescription and over-the-counter drugs
- The cost of most types of cosmetic surgery, including breast augmentation, face lifts, hair transplants, hair removal (electrolysis) and liposuction (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease)
- Certain vitamins
- Health spas, health club dues and exercise classes
- Weight reduction classes
- Babysitting expenses to enable you to get to a doctor’s appointment
- Controlled substances (such as marijuana, laetrile, etc.) that aren't legal under federal law, even if such substances are legalized by state law
- Massage therapy
- Funeral or burial expenses

- Household and domestic help
- Cosmetics, toiletries, toothpaste, etc.

Some expenses may be covered if you provide a Letter of Medical Necessity from your doctor or health care provider, that verifies the services or items you are purchasing are for the diagnosis, treatment, mitigation, or prevention of a disease or medical condition and you show that you would not have incurred the expense but for the disease or medical condition.

If you need more information regarding whether an expense is an Eligible Medical Expense under the HRA Plan, contact the Via Benefits. Via Benefits solely determines what qualifies as an Eligible Medical Expense.

Eligible Medical Expenses are incurred when the covered individual is provided the health care that gives rise to the expense, and not when the amount is billed or paid. An expense that has been paid but not incurred (e.g., pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid even if the covered individual paid the premium for the coverage prior to the first day of the plan year.

The federal government permits you to take a deduction on your income tax return for certain health care expenses. You should remember that you cannot claim the same expense twice, once through the HRA and as a tax deduction. For specific advice about your situation, you may want to consult a tax advisor. The Company cannot advise you regarding tax, investment, or legal considerations relating to the HRA.

You may not submit a claim for an amount that was incurred prior to the time the HRA became effective (typically the first day of the plan year or the first day your election for HRA coverage is effective, if later). In addition, you cannot submit a claim for any expenses that have been paid in-full through any other health insurance plan, Section 125 “cafeteria” plan or other similar health care expense reimbursement arrangement.

How to Use the HRA

When you pay for an Eligible Medical Expense, you want to put your HRA to work right away. Via Benefits gives you several options to use your money the way you choose.

Using Your Smartphone or Mobile Device

Using the Via Benefits mobile app, you can submit claims, upload, and submit receipts, and check your account balance any time.

To use the Via Benefits mobile app:

- Visit iTunes or Google Play Store to download the Via Benefits Accounts mobile app.
- Log in to your account. If you normally access the website through the Company (using single sign-on), you'll need to create a login ID and password to use the mobile app.
- Check your balance, request reimbursement, upload receipts and check claim status, among other activities. All activities are easily accessible from the app home screen.

Using the Via Benefits Website

Using the Via Benefits website means you will never need to fill out a paper claim form again. It's quick, easy, secure, and available 24/7/365.

Once you've logged in:

- You'll be asked to provide details about the claim, including date of service, reimbursement/payment amount, and provider. You'll also choose whether to reimburse yourself or pay the provider and you'll upload/attach your receipt or EOB.

Paper Claim

You can also download the Via Benefits claim form from viabenefitsaccounts.com and fax or mail your claim to the address on the form.

What to Include in a Claim

Regardless of the method you choose to submit a claim, for Eligible Medical Expenses that are not premiums, make sure your documentation includes the following:

- Date of service or purchase
- Patient name
- Detailed description
- Patient portion or amount owed
- Provider or merchant name

For premium expenses, make sure your supporting documents show:

- Insurance carrier (the name of your medical insurance provider)
- Premium type (e.g., medical, prescription drug)

- Premium amount (proof of total amount you paid for premiums)
- Your name and, for BOTW retirees, names of the eligible dependent(s))
- Premium coverage period (e.g., January 1-January 31 for January premiums)

For BMO and M&I retirees and eligible dependents, you may submit a claim for reimbursement for an Eligible Medical Expense arising during the plan year at any time during the year and for a runout period after the plan year ends. For BOTW retirees, you may submit a claim for reimbursement for an Eligible Medical Expense arising during the plan year at any time.

If you lose eligibility under the HRA Plan, you must submit a claim for any expenses incurred while you were a participant within 6 months of the date of loss of eligibility. Upon the death of a BMO and M&I retiree or eligible dependent, claims incurred for his or her Eligible Medical Expenses must be submitted within 14 months of the date of his or her death. Upon the death of a BOTW retiree, claims incurred for himself/herself or his/her eligible dependents prior to the death of the retiree must be submitted within 6 months of the retiree's death. In the case of divorce for BOTW retirees, claims that were incurred by the spouse during the period when the spouse was an eligible dependent must be submitted within 6 months of the divorce, unless the spouse elects COBRA continuation coverage.

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

Via Benefits may establish an automatic premium reimbursement process for the payment of certain health insurance premiums. In establishing and operating any automatic premium reimbursement process, the Via Benefits may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements will not be considered to be claims for benefits and will not be subject to the procedures described in the "Claims and Appeals Procedures" section of this SPD.

MORE ABOUT CLAIMS

Via Benefits will process your claim, and if the request is for an Eligible Medical Expense, Via Benefits will deduct the money from your HRA and pay you via direct deposit or check. If your claim request is denied, you will be notified of this denial under procedures described below. If you have a question regarding your eligibility for an HRA or the amount of your HRA contribution, contact the U.S. Benefits Team.

For BMO and M&I retirees and eligible dependents, you must submit requests for reimbursement of Eligible Medical Expenses by March 31 following the plan year in which the expense is incurred (the "runout period"). Any claims submitted after that date will not be

reimbursed. BOTW retirees can submit requests for reimbursement of Eligible Medical Expenses at any time.

Initial Claims Process and Timing

For non-premium expenses, claims for expenses covered under a group health plan must be submitted to that group health plan first, and then submitted to the HRA after the group health plan has determined whether the claim is payable.

If you make a claim for reimbursement of expenses under the HRA, the following timetable for claims decisions applies (references to "days" below indicate calendar days):

Notification of whether claim is denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim	15 days
Notification to Participant	15 days
Response by Participant	45 days
Response to claim upon receipt of additional information	15 days

If a claim under the HRA is denied in whole or in part, the participant will receive a notice that includes the following information:

- The specific reason(s) for the denial;
- Reference to the specific plan provisions on which the denial was based;
- A description of any additional material or information needed to further process the claim, and an explanation of why such material or information is necessary;
- A description of the Plan's internal review procedures, and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
- A description of any internal rule, guideline, protocol, or similar criteria used in the decision OR statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon request; and
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided upon request, free of charge.

Claims Appeals Process

If you receive a claim denial, you will have 180 days following the receipt of the notification in which to appeal the decision, by making a written request for consideration to Via Benefits. You have the right to:

- Submit written comments, documents, records, and other information relating to the reimbursement claim for benefits;
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim request if it:
    - Was relied upon in making the benefit determination;
    - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination;
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination;
- A review that takes into account, all comments, documents, records, and other information related to the claim that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination;
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate;
- If the appeal involves a denial based on a medical judgment, a review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental); and
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

If sufficient information is available to decide the first level appeal, Via Benefits will resolve your first level appeal within a reasonable period of time but not later than 30 days from receipt of the first level appeal request.

If you are not satisfied with the determination after your first level of appeal, you may file for a second level of appeal with the Benefits Administration Committee within 180 days of receipt of the notification regarding your first level of appeal. Second level appeals should be sent to 395 N. Executive Dr., Brookfield, WI 53005. The Benefits Administration Committee will resolve your second level appeal within a reasonable period of time but not later than 30 days from receipt of the second level appeal request.

Notice of an adverse benefit determination on appeals will contain all of the following information:

- The specific reasons for the denial;
- The specific HRA Plan provisions on which the decision is based;
- A statement describing any voluntary appeal procedures offered by the HRA Plan and your right to obtain the information about such procedures, including your right to bring a civil action in federal court following a claims denial on review;
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material, will be provided upon request, free of charge;
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge; and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

If you have any questions about a denied claim, you should contact Via Benefits. Via Benefits' decisions are conclusive and binding unless determined by a court to be arbitrary and capricious.

You cannot bring any legal action relating to this HRA against the Retiree Plan, plan administrator, or Via Benefits for any reason unless you first complete all non-voluntary steps in the appeal process as described in this "Claims Appeals Process" section. (However, you may be treated as having completed all these steps with respect to a claim if the plan fails to comply with its obligations at any point in the claims and appeals process, unless the plan's failure to comply is de minimis, non-prejudicial, attributable to good cause, or matters beyond the plan's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern

or practice of non-compliance.) After completing the claims and appeals process, if you want to bring such a legal action you must do so within 12-months of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

Overpayments

If it is later determined that you and/or your covered eligible dependent(s) received an overpayment or a payment was made in error, you (or your covered eligible dependents) will be required to refund the overpayment or erroneous reimbursement to the HRA Plan. An example of an overpayment is being reimbursed for an expense under the HRA that is later determined to be ineligible.

If you do not refund the overpayment or erroneous payment, the HRA Plan reserves the right to offset future reimbursements from the HRA equal to the overpayment or erroneous payment. In addition, the HRA Plan has a right to engage an outside collection agency to recover overpayments on the HRA Plan's behalf if the HRA Plan's collection effort is not successful. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Company may include the amount on a Form W-2 as wages. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under the HRA.

Unclaimed payments

Any HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit 180 days from the date set forth on the check (or, if later, the expiration date set forth on the reimbursement check).

If the participant or other authorized person does not contact Via Benefits prior to the 180 day forfeiture time frame, the unclaimed reimbursement will be voided, and the amount of the voided check will be returned to the Company.

If the participant or other authorized person contacts Via Benefits within six months of the check cancellation, Via Benefits may cancel and void the original check or payment and re-issue a new check or as otherwise determined by Via Benefits.

If the participant or other authorized person contacts Via Benefits after six months of the check cancellation, Via Benefits will cancel and void the original check or payment and shall re-issue the payment by direct deposit, or as otherwise determined by Via Benefits.

Continuation of Coverage under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the HRA Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered spouse/domestic partner and dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the HRA Plan. It can also become available to your spouse/domestic partner and dependent children who are covered under the HRA Plan when they would otherwise lose such coverage due to certain events.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of HRA Plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your covered spouse/domestic partner or dependent child could become qualified beneficiaries if covered under the HRA Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the HRA Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Events

If you are a covered retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are the covered spouse/domestic partner of a retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because any of the following qualifying events happens:

- Your spouse/domestic partner dies (BOTW retirees only).
- You become divorced or legally separated from your spouse/you terminate your domestic partnership (BOTW retirees only).
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are the covered dependent child of a retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because any of the following qualifying events happens:

- Your retiree parent dies (BOTW retirees only).

- Your retiree parent becomes divorced or legally separated from his or her spouse/terminates his or her domestic partnership (BOTW retirees only).
- You no longer meet the definition of dependent child under the HRA Plan (BOTW retirees only).
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

Giving Notice that a COBRA Qualifying Event Has Occurred

The HRA Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the retiree's death or the employer's bankruptcy filing, the employer must notify the Plan administrator of the qualifying events.

For all other qualifying events (divorce or legal separation/termination of domestic partnership and a dependent child losing eligibility under the HRA Plan), you are responsible to notify the plan administrator in writing within 60 days after the later of: 1) the date of qualifying event or 2) the date the qualified beneficiary loses (or would lose) coverage under the HRA Plan as a result of the qualifying event. You must provide this notice in writing to the COBRA Administrator listed in the Plan Information Appendix below.

Once the plan administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation on behalf of their covered spouses/domestic partners or covered dependent children, but covered retirees cannot reject COBRA continuation on behalf of their covered spouses/domestic partners or covered dependent children.

If coverage under the HRA Plan is changed for retirees, the same changes will apply to individuals receiving COBRA continuation coverage.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of HRA coverage.

When the qualifying event is the death of the retiree, loss of dependent status under the HRA Plan, or divorce/termination of domestic partnership, COBRA continuation coverage for the retiree's covered spouse/domestic partner or covered dependent child(ren) (but not the retiree) under the HRA Plan lasts for up to a total of 36 months from the date of the qualifying event.

When the qualifying event is the bankruptcy of the Company, you can continue your retiree health coverage under the HRA Plan for yourself and your covered spouse/domestic partner/dependent children for the rest of your (the retiree's) life. After your death (including if

you have already died when the bankruptcy proceeding begins), your surviving covered spouse and/or surviving covered dependent children may continue HRA Plan coverage for an additional 36 months.

The table below provides a summary of the COBRA provisions outlined in this section.

	Maximum Continuation Period	
Qualifying Events That Result in Loss of Coverage	**Retiree**	**Spouse/domestic partner/dependent**
Retiree dies	N/A	36 months
Retiree and spouse/domestic partner divorce/terminate domestic partnership	N/A	36 months
Dependent loses eligibility	N/A	36 months
The Company commences bankruptcy proceedings under Title 11 of the United States Code	Death	36 months[1]

[1] 36-month period is counted from the date of retiree's death.

Electing COBRA Continuation Coverage

You, your covered spouse/domestic partner, or your covered dependent child(ren) must choose to continue coverage under the HRA Plan within 60 days after the later of the following dates:

- The date you, your covered spouse/domestic partner or covered dependent child would lose coverage under the HRA Plan as a result of the qualifying event, or
- The date the Company notifies you and/or your covered spouse/domestic partner and/or covered dependent child (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost of HRA Plan coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45

days after the date of your election, you will lose all COBRA continuation coverage rights under the HRA Plan. Payment is considered made on the date it is sent to the HRA Plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the HRA Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:

- The applicable 36-month COBRA continuation coverage period ends.
- Any required premium is not paid on time.
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as a retiree or otherwise) under another group health plan (not offered by the Company).
- The date the Company ceases to provide any group health plan for its employees and retirees.

COBRA continuation coverage may also be terminated for any reason the HRA Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your Health Reimbursement Account under COBRA

If you elect to continue your HRA under COBRA, the HRA will provide for continuation of the maximum reimbursement available at the time of the qualifying event reduced by any claims reimbursed during the period of coverage.

If you continue your HRA under COBRA, any amounts that would otherwise have been contributed by the Company into the HRA will continue.

Marketplace Coverage as an Alternative to COBRA.

As explained above, when you lose your coverage under the HRA Plan by reason of a COBRA qualifying event, you temporarily can elect to continue that coverage under the applicable health plan at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan (such as your spouse's employer plan). You also have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace ("Public Marketplace") or through other commercial insurance issuers outside of the Public Marketplace. The Public Marketplace may offer you less expensive premiums and out-of-pocket costs than any other health care coverage options, including COBRA coverage, especially in the event that you qualify for governmental subsidies (i.e., tax credits) that help you pay for your coverage purchased from the Public Marketplace.

You should carefully and timely review all of your coverage options before making a final decision. If you decide to purchase other health coverage (e.g., through your spouse or through the Public Marketplace or other commercial insurance) and do not elect COBRA within the 60-day election period, you will no longer have the right to elect COBRA coverage under the health plans.

If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy. For example, if you enroll in COBRA medical coverage under the plan but decide mid-year that you want to drop that coverage because it is not affordable to you, most insurance carriers will not permit you to enroll in an individual health insurance policy until the next open enrollment period. This restriction applies even though COBRA is no longer affordable to you (e.g., when your financial situation changes or a COBRA subsidy, if any, from the Company or another source ends).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the plan administrator. Additional information regarding Public Marketplace coverage is available by visiting www.healthcare.gov and also in the health plans' COBRA Notices.

If You Have Questions

Questions concerning your plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website.)

Additional Information

Keep Your Plan Informed of Address and Contact Changes

In order to protect your rights, as well as the rights of your eligible dependents, you should keep the Service Center informed of any changes in the addresses of your spouse/domestic partner and/or dependent children. You should also keep a copy for your records of any notices you send to the Service Center. You can reach the Service Center at 800-849-7016.

Plan Accounting

VIA Benefits will periodically furnish you with a statement of your HRA balance and reimbursements so you can track your account balance during the year. This will also help you budget for expense reimbursement needs in future plan years. You may also submit a written request to the plan administrator to receive a copy of your account information at any time.

Your Rights

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations such as work sites, 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 Description. 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 group health coverage for yourself, your spouse, or your dependents if there is 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 SPD for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for HRA Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the HRA Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and

other HRA 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 an HRA 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 HRA 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 the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the HRA Plan's claims and appeals procedure as described in this SPD. In addition, if you disagree with the HRA Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and 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.

Qualified Medical Child Support Order

The HRA Plan will comply with all the terms of a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under a health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact:

Director – U.S. Benefits
BMO

395 N. Executive Dr.
Brookfield, WI 53005

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HRA Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The Company is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting:

Director – U.S. Benefits
BMO
395 N. Executive Dr.
Brookfield, WI 53005

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 (EBSA), 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 Ave. N.W. Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-EBSA (1-866-444-3272), logging on to www.dol.gov or by contacting the EBSA Field office nearest you.

Plan Information Appendix

Details About Plan Administration	
Plan Administrator	BMO Financial Corp. Benefits Administration Committee 320 South Canal Street, Floor 8 Chicago, IL 60606
Plan Sponsor	Name: BMO Financial Corp. Address: 320 South Canal Street, Floor 8, Chicago, IL 60606 Phone Number: 888-927-7700
COBRA Administrator	Name: BMO U.S. Benefits Address: 395 N. Executive Dr. Brookfield, WI 53005 Phone Number: 888-927-7700
Employer Identification Number	51-0275712
Official Plan Name and Number	BMO Retiree Medical and Life Insurance Plan Plan Number: 508
Plan Year	January 1 through December 31
Type of Plan	Welfare benefit plan providing health care reimbursements under ERISA.
Agent for Service of Legal Process	The plan administrator is the agent for service of legal process.
Third Party Administrator	Via Benefits 10975 South Sterling View Drive South Jordan, UT 84905 800-849-7016 My.ViaBenefits.com/funds

Claims Submission Information	Name: Via Benefits Mobile App: Search for Via Benefits Accounts where you download apps URL VIAbenefits.com Mail: P.O. Box 981156 El Paso, TX 79998-1156 Fax: 1-844-930-0236
Plan Funding	The Company contributes to the participants' HRAs as described in this SPD. The HRAs are notional accounts and reimbursements of Eligible Medical Expenses are made from the Company's general assets and the trusts.
Plan Trustees	Midwest Institutional Trust Company 10700 Research Drive, Suite 205 Wauwatosa, WI 53226-3460 BNY Mellon Client Service Center 500 Ross Street 8th Floor AIM # 154-0800 Pittsburgh PA 15262-0001

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of the HRA Plan will be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator will have the exclusive discretionary authority to determine all matters relating to the HRA Plan, including eligibility, coverage, and benefits.

The plan administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the HRA Plan. The plan administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the plan administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Plan Document

This SPD is intended to help you understand the main features of the HRA Plan. It should not be considered a substitute for the official legal HRA plan document that governs the operation of the HRA Plan. That document sets forth the provisions concerning the HRA Plan and is subject to amendment. To request a copy of the plan document, contact BMO U.S. Benefits, 395 N. Executive Dr. Brookfield, WI 53005, 888-927-7700.

The Company's Right to Amend or Terminate the Plan

Any part or all of the HRA Plan may be amended by the Company or its delegate at any time or from time to time except that no such amendment will permit the return or reversion to the employers of any part of the trust, nor permit the use or application of the trust fund for the benefit of anyone other than eligible individuals under the HRA Plan (including any successor plan). Any action to amend the HRA Plan will be taken by the Company or its delegate pursuant to procedures established hereunder for actions by employers.

The HRA Plan may be terminated at any time by action of the Company or its delegate. The HRA Plan as applied to any single employer may be terminated at any time by such employer. Any action to terminate the HRA Plan will be taken by the Company or, when applied to a single employer, by such employer, pursuant to procedures established hereunder for actions by employers.

Upon termination of the HRA Plan, the assets of the trust may be disposed of in a manner consistent with ERISA and the Code.

Limitation on Assignment

Your rights under the HRA Plan cannot be assigned, sold, or transferred to your creditors, health care providers, or anyone else. Any attempt to assign your rights hereunder will be void.