Summary Plan Description

BMO U.S. Health and Welfare Benefit Plan for Active Employees

Plan 507

Effective January 1, 2025

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About this Summary Plan Description

This Summary Plan Description (SPD) provides an overview of benefits available under the **BMO U.S. Health and Welfare Benefit Plan** (the "Plan") for eligible U.S. Active Employees. This document describes multiple benefit options. All of the benefits are governed by the Employee Retirement Income Security Act of 1974 (ERISA) except for the HSA, DCFSA, commuter benefits, and STD benefits. Those are not part of the Plan and are described in this SPD for convenience only.

This document serves as a consolidated, ERISA-compliant SPD that "wraps" the various health and welfare component benefits into a single, comprehensive resource. It incorporates by reference the benefit booklets, plan details and certificates issued by claims administrators and insurance carriers. Together, this SPD and the referenced materials constitute the official Summary Plan Description. When the term "SPD" is used, it refers collectively to this document and the incorporated booklets, plan details and certificates.

The ERISA-governed component benefits are:

- Medical (including prescription drug)
- Dental
- Vision
- Health Care Flexible Spending Account (HCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Basic Life Insurance
- Supplemental Life Insurance
- Family Life Insurance
- Business Travel Accident Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Group Legal Plan
- Long-Term Disability (LTD)
- Employee Assistance Program (EAP)

For convenience, this SPD also includes descriptions of non-ERISA benefits, which are not subject to ERISA requirements. These are:

- Health Savings Account (HSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Commuter Benefits
- Short-Term Disability (STD)

This SPD is intended to satisfy the disclosure requirements of ERISA. For detailed information about specific benefits - such as coverage levels, deductibles, copayments, exclusions, and limitations - please refer to the applicable benefit booklets, plan details or certificates ("Welfare Program Documents").

The terms and conditions of the Plan are set forth in this document SPD and the Welfare Program Documents related to the benefits under the Plan. Together, the SPD and the Welfare Program Documents constitute the summary plan description. An amendment to one of these documents constitutes an amendment to the Plan.

This SPD should be read in connection with the applicable Welfare Program Documents. Unless otherwise noted, if there is a conflict between a specific provision under the plan document and a Welfare Program Document or this SPD, the plan document controls. If the plan document is silent on a specific issue, then the SPD controls on that issue, except where the SPD refers to a Welfare Program Document, in which case the Welfare Program Document controls. If both the plan document and the SPD are silent, the terms of the applicable Welfare Program Document control. However, with respect to fully insured benefits, the terms of the certificate of coverage/insurance policy control when describing specific benefits that are covered or insurance-related terms. See below to determine whether a particular benefit is self-insured by BMO or fully insured by the insurer.

BMO reserves the right, in its sole discretion, to modify, amend, or terminate any part of the Plan at any time and for any reason, with or without prior notice. Receipt of this SPD does not guarantee eligibility for benefits. To receive benefits, you must meet all applicable eligibility and enrollment requirements.

1.0 Eligibility for Benefits

You and your dependents are eligible to participate in the Plan if you meet the eligibility requirements outlined in Sections 1.1 and 1.2 of this SPD. Some component benefits may have additional requirements, which are detailed in the applicable Welfare Program Documents linked to throughout this SPD and at www.bmousbenefits.com.

1.1 Employee Eligibility Requirements

Full-time and part-time employees scheduled to work at least 20 hours per week are eligible for the Plan and the component benefits described in this SPD.

You are considered an "employee" only if you are specifically treated or classified as a regular employee on BMO records for payroll purposes of withholding federal employment and income taxes. If BMO classifies you as an independent contractor, consultant, leased employee, temporary agency 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.

1.2 Dependent Eligibility Requirements

Certain benefit options also allow you to cover eligible dependents, provided they meet the applicable requirements and are verified through the Dependent Verification Process (if applicable). These dependents may include:

Your Legal Spouse (same- or opposite-gender)

- Must be recognized as your spouse for federal tax purposes
- Must not be legally separated or divorced from you
- May be a common-law spouse if the marriage is legally recognized in a state that permits common-law marriages

Your Domestic Partner (same- or opposite-gender)

- Must meet all of the specific eligibility requirements, including:
  - Be in a sole, committed relationship with you for at least one year, with the expectation that the relationship will continue indefinitely
  - Share a principal place of residence with you
  - Be at least 18 years old and legally competent to enter into a contract (applies to both of you)
  - Not be related by blood to you in a way that would prohibit legal marriage in the state of residence
  - Not be married to, legally separated from, or in a relationship with another person (applies to both of you)
  - Jointly share responsibility for each other's welfare and financial obligations
- May qualify as a tax-dependent or non-tax dependent (see section 1.2.2 Considerations when covering a Domestic Partner and their Children)

Your Dependent Children may be covered through the end of the month they turn 26. These Include:

- Your biological children
- Your legally adopted children or children placed with you for adoption
- Stepchildren, regardless of where they live
- Children for whom you have legal custody (these children need to qualify as Code section 105(b) dependents in order to have tax-free coverage)
- Foster children living with you
- Your domestic partner's children (these children need to qualify as Code section 105(b) dependents in order to have coverage, see section 1.2.2 Considerations when covering a Domestic Partner and their Children)
- Any other child for whom you are the legal guardian and support in a parent-child relationship (these children need to qualify as Code section 105(b) dependents in order to have tax-free coverage)

Your Disabled Adult Dependent Children age 26 or older who are physically or mentally incapable of self-support.

- Must meet all of the specific eligibility requirements, including:
  - The child is permanently and totally disabled, as defined by Code Section 22(e)(3)
  - The disability began before the child reached age 26
  - The child has the same principal place of residence as you for more than half of the year
  - The child has not provided more than half of their own financial support
  - The child is unmarried
  - The child is a U.S. citizen, resident, or national or a resident of Canada or Mexico
  - You provide proof of your child's disability and dependency within 31 days of the date coverage would have otherwise ended due to age
  - You provide ongoing proof, upon request by the Plan, that the child continues to meet the above conditions

Proof of disabled dependent status may include medical records, a formal determination of disability, and copies of federal tax returns.

1.2.1 Dependent Verification Requirement

To ensure compliance and maintain the integrity of the Plan, all dependents enrolled in BMO's medical, dental, or vision coverage must be verified. The Dependent Verification Process typically occurs when you first enroll a dependent in the Plan, but you may also be asked to recertify eligibility periodically. When verification is required, you will receive a packet from **Dependent Verification Services** with detailed instructions on what documentation to submit, how to submit it, and the applicable deadlines. If you do not provide the required documentation by the deadline or if the documentation shows that the dependents are no eligible, coverage for unverified/ineligible dependents will be canceled the 1st of the month following the date your final determination letter is sent from Dependent Verification Services.

Once removed, dependents cannot be re-added during the plan year unless you experience a qualified life event or wait until annual enrollment - and verification will still be required at that time. Any dependent removed from your coverage due to lack of verification is not eligible for COBRA coverage.

Dependent Type	Required Documentation
Legal Spouse	• Government Issued marriage certificate including date of marriage **AND** Federal Tax Return issued within last 2 years listing Spouse **OR** • Government Issued marriage certificate including date of marriage **AND** Proof of Financial Partnership issued within last 6 months **OR** • Government Issued marriage certificate only including date of marriage (if married within the last 12 months)
Domestic Partner	• Notarized Affidavit of Domestic Partnership **AND** Proof of Financial Partnership issued within last 6 months **OR** • Certificate of Domestic Partner registration **AND** Proof of Financial Partnership issued within last 6 months **OR** • Certificate of Domestic Partner registration **AND** Federal Tax Return issued within last 2 years listing partner
Common Law Spouse	• Notarized Affidavit of common law marriage **AND** Proof of Financial Partnership issued within last 6 months **OR** • Notarized Affidavit of common law marriage **AND** Federal Tax Return issued within last 2 years listing Spouse
Civil Union partner	• Government Issued of civil union partnership **AND** Federal Tax Return issued within last 2 years listing Partner **OR** • Government Issued of civil union partnership **AND** Proof of Financial Partnership issued within last 6 months
Biological Child	• Government Issued Birth certificate including parent's names
Adopted Child	• Adoption placement agreement (including child's date of birth) **OR** • Petition for adoption (including child's date of birth) **OR** • Adoption certificate (including child's date of birth)

Dependent Type	Required Documentation
Stepchild/Domestic partner Child/Civil Union Partner	• Government Issued Birth Certificate (including spouse or partner's name as a parent) **AND** Both documents to verify Spouse or Partner
Legal Ward	• Government Issued Birth Certificate (including parent's names) **AND** Court ordered document of legal guardianship
Grandchild	• Dependent Government Issued Birth Certificate (including parent's names), Parent Government Issued Birth Certificate (including parent's names), **AND** Federal Tax Return issued within last 2 years claiming Grandchild
Foster Child	• Government Issued Birth certificate **AND** Foster care letter of placement
Disabled Child	Documentation listed above to prove child relationship status **AND** Federal Tax Return issued within last 2 years claiming child **Note:** Disabled adopted child cannot verify with a placement agreement or petition.

Glossary

Term	Definition/Description
Birth Certificate	• Must include names of parents. Certificates that do not include parent's names will not be accepted. • Hospital-issued birth certificates are only accepted for children who are less than 3 months of age.
Government Issued	• An official government record printed on security paper and includes an official raised, embossed, impressed, or multicolor seal.
Proof of Financial Partnership	• May include mortgage statements, bank statements, credit card statements, current rental/lease agreements (including start and end dates and cannot be month to month) or property tax statements with both parties' names as co-owners. • Proof of Financial Partnership includes separate documents in participant's name and spouse or partner's name, both showing the same address. • Proof of Financial Partnership cannot be delinquent or past due.

Term	Definition/Description
Federal Tax Return	• Send only the **first page** of your recent Federal Tax Return (Form 1040) that shows your dependent.

1.2.2 Considerations When Covering a Domestic Partner and Their Children

If you choose to cover a domestic partner or their eligible children under BMO's medical, dental or vision plans, it's important to understand the potential tax implications. The IRS treats employee and employer-paid premiums for a domestic partner and their children differently than for a legal spouse or tax-qualified dependents.

Tax Treatment

Under federal law, coverage for domestic partners and their children is not automatically tax-free. To receive pre-tax benefits:

- The enrolled individual must qualify as the employee's federal tax dependent for health coverage purposes.
- If they do not qualify, the value of coverage (including employer-paid premiums) will be treated as taxable income, subject to withholding and reported on the employee's W-2.

State Tax Treatment: State tax rules may differ. You should consult a tax advisor for guidance on your state's rules.

Tax-Qualified vs. Non-Tax-Qualified Dependents: You are responsible for notifying BMO whether your domestic partner and/or their children qualify as your tax dependents under Code Section 105(b). This determination affects how premiums are taxed and reported.

Tax Status	Tax-Qualified Dependent	Non-Tax Qualified Dependent
Employee paid Premiums	Employee premiums are deducted pre-tax	Employee paid premiums for the domestic partner/domestic partner's child's portion are after-tax
Employer paid Premiums	Not taxable	Employer paid premiums are treated as imputed income and added to your taxable wages
W-2 Reporting	No additional income reported	Imputed income is reported as taxable wages on your Form W-2

Criteria for Tax-Qualified Dependent Status

Your domestic partner and/or the domestic partner's child may qualify as a tax-dependent under Code Section 105(b) if all of the following are true with respect to the person:

1. They share your principal place of residence for the entire taxable year and are a member of your household (not in violation of local law);
2. They are a U.S. citizen, national, or resident, or a resident of Canada or Mexico;
3. They are not a qualifying child of another taxpayer; and
4. You provide more than half of their financial support during the year.

Important: Determining tax-dependent status can be complex. You are encouraged to consult a tax advisor to understand how these rules apply to your personal situation.

Domestic Partner and Child Tax Certification Requirement

You must complete a Domestic Partner Tax Certification Form for your domestic partner and each of their children to declare their tax-dependent status the first time you enroll them under your coverage.

If your domestic partner or their child's tax status changes in the future such that they are no longer a tax dependent, you will need to notify BMO by completing a new Domestic Partner Tax Certification Form.

If no Domestic Partner Tax Certification Form is received from you, BMO will assume that the enrolled individual does not qualify as your federal tax dependent for health coverage purposes for that year and treat the coverage as taxable.

1.2.3 Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a legal judgment, decree, or order issued by a court or authorized state agency under domestic relations law. A QMCSO requires an employee to provide health care coverage for a child under the employer's group health plan.

BMO will comply with all valid QMCSOs and ensure that affected children are enrolled in the applicable medical, dental, or vision plans as required. If BMO is notified that one of your children is subject to a QMCSO, you will be required to remain enrolled in the relevant benefit plans and maintain coverage for the child(ren) named in the order until the QMCSO is no longer in effect.

For more information about the procedures governing QMCSOs, or to request a copy of the Plan's QMCSO procedures, please contact the Human Resources Centre at 1-888-927-7700.

1.2.4 Non-duplication of Coverage

If your spouse, domestic partner, or eligible dependent child is also employed by BMO and eligible to participate in the Plan, the following rules apply:

- An individual may be covered under the component plans as either an employee or a dependent, but not both.

- You and your spouse or domestic partner may each elect your own coverage under any of the component plans, or one of you may elect coverage and enroll the other as a dependent.
- If both you and your spouse or domestic partner elect your own coverage under any of the component plans, only one of you may enroll your eligible children as dependents on that same plan.
- You and your spouse or domestic partner may choose to split enrollment across component plans and cover each other as dependents. For example, one of you may enroll the family in medical coverage, while the other enrolls the family in dental coverage.
- If your eligible child is also employed by BMO and qualifies for coverage under the Plan as an employee, they may elect own coverage. In that case, they cannot also be covered as a dependent under another employee's Plan enrollment.

2.0 Health and Welfare Benefits

BMO is committed to supporting the health, well-being, and financial security of our employees by offering a comprehensive suite of health and welfare benefits. These benefits are a key part of your total rewards package and reflect our investment in your overall well-being. Some benefits are provided automatically, while others require you to actively enroll based on your personal needs. BMO also provides generous employer contributions and subsidies to help make coverage more affordable and accessible for you and your family.

2.0.1 List of Health & Welfare Benefit Plans Offered

BMO's health and welfare benefits include:

- Medical
- Dental
- Vision
- Health Savings Account (HSA)
- Health Care Flexible Spending Account (HCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Basic Life Insurance
- Supplemental Life Insurance
- Family Life Insurance
- Business Travel Accident Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Group Legal Plan
- Commuter Benefits
- Short term Disability
- Long term Disability
- Employee Assistance Program (EAP)

2.0.2 Earnings Used for Benefits

Some of BMO's component plans rely on compensation elements to calculate your premiums or coverage amounts.

Compensation Element	Definition	What it is used for
Annual Base Salary This amount is viewable in your Workday profile > Compensation > Total Base Pay	Your salary used to calculate your bi-weekly paycheck amounts.	Calculation of your: • Short Term Disability pay Maternity Leave pay • Parental Leave pay • Business Travel Accident coverage
Base Benefit Rate (BBR)	Your BBR is the greater of: • Your base pay/draw plus average of two previous	Calculation of your: • Short Term Disability pay • Maternity Leave pay

Compensation Element	Definition	What it is used for
Used for certain commissioned employees only This amount is viewable in your Workday profile > Actions > Benefits > View Benefits Annual Rate	calendar years' commissions (incentive pay is excluded unless otherwise noted); or • The midpoint of your salary range Note: IRS Annual Compensation Limits may apply The BBR is recalculated annually in February.	• Parental Leave pay
Total Compensation Base Benefit Rate (TCBBR) This amount is viewable in your Workday profile > Actions > Benefits > View Benefits Annual Rate	Your TCBBR is an accumulation of your base salary, overtime, shift differential and any variable pay that is related to work performance that is paid to you between October 1 and September 30 of the prior year. The TCBBR is recalculated annually in October.	Calculation of your: • Medical Premium Tier • Life Insurance coverage and premium amounts • Long Term Disability pay • Supplemental Long Term Disability premiums

2.1 Medical

BMO offers different medical benefit designs to provide employees with flexibility in managing their healthcare needs. Through Blue Cross Blue Shield of Illinois (BCBSIL), all employees can choose between a High Deductible Health Plan (HDHP) and a Preferred Provider Organization (PPO) plan.

For employees in regions (California, Colorado, and Oregon) served by Kaiser Permanente, BMO also provides an additional HDHP and a Deductible Health Maintenance Organization (DHMO) plan to choose from.

Medical: At-a-glance				
In-Network Plan Features	**BCBSIL**		**Kaiser Permanente**	
	HDHP	**PPO**	**HDHP**	**DHMO**
Eligibility based on location	All employees, nationwide		Only employees in CA, CO, & OR	
Provider Network	You can see any provider you choose, but you'll get higher benefits and pay less when you see in-network providers.		The plan uses a provider network; most benefits are *only* covered when you see Kaiser providers.	
HSA Eligible Plan	Yes	No	Yes	No
Annual Deductible*	Individual: $1,750	Individual: $750	Individual: $1,750	Individual: $750

Medical: At-a-glance				
HDHPs: includes medical and prescription drugs **PPO/DHMO:** includes medical only (separate Rx deductible)	Family: $3,500**	Family: $1,500 ***	Family: $3,500**	Family: $1,500 ***
Annual Out-Of-Pocket Maximum* Includes deductible, copays, and coinsurance for medical and prescription drugs	Individual: $3,425 Family: $6,850	Individual: $3,000 Family: $6,000	Individual: $3,425 Family: $6,850	Individual: $3,000 Family: $6,000
Annual Benefit Maximum	None		None	
Lifetime Benefit Maximum	None		None	
What you pay				
Office Visit	20% after deductible	Copay: $25 PCP, $40 specialist	20% after deductible	Copay: $25 PCP, $40 specialist
Well Care/ Preventive Care	You pay nothing			
Lab Test and X-rays	20% after deductible			
Inpatient Care	20% after deductible			
Urgent Care	20% after deductible	$150 copay	20% after deductible	$150 copay
Emergency Room	$100 copay and 20% coinsurance after deductible	$300 copay (copay waived if admitted)	$100 copay and 20% coinsurance after deductible	$300 copay (copay waived if admitted)

Medical: At-a-glance				
	(copay waived if admitted)		(copay waived if admitted)	

** Annual deductibles and out-of-pocket limits for in-network and out-of-network must be met separately.*

***Under the HDHPs, the entire family deductible must be met before the plan will pay benefits for any covered family members. If combined expenses for the family meet the family deductible, the deductible is met for the entire family.*

**** Under the PPO/DHMO, each covered person has an individual deductible. Once the individual deductible is met, the plan begins to pay benefits for that person. Once the total family deductible is reached, the plan starts to pay benefits for all covered family members, even if some members still need to meet their individual deductible.*

Prescription coverage included with BMO Medical Plans

When you enroll in a BMO medical plan, prescription drug coverage is automatically included.

- **BCBSIL Plans**: Prescription benefits are managed by **Express Scripts**.
- **Kaiser Plans**: Prescription services are provided directly through the **Kaiser plan.**

Prescription: At-a-glance				
In-Network Plan Features	**BCBSIL**		**Kaiser Permanente**	
	HDHP	**PPO**	**HDHP**	**DHMO**
Prescription Drug Coverage	Provided by Express Scripts		Provided by Kaiser	
Annual Deductible	Combined with Medical	Individual: $250 Family: $500	Combined with Medical	Individual: $250 Family: $500
Annual Out-Of-Pocket Maximum	Combined with Medical			
What you pay (post-deductible)				
Generic	Retail Pharmacy: $10 copay		Retail: $10 copay	

Prescription: At-a-glance		
	Home Delivery: $25 copay	Mail order: $20 copay
Preferred Brand	30% coinsurance Retail Pharmacy: $25 minimum; $100 maximum Home Delivery: $62.50 minimum; $250 maximum	Slight variances based on region, see SBC for details: Review your regional Kaiser SBC: • 2025 Kaiser HDHP California • 2025 Kaiser HDHP Colorado • 2025 Kaiser HDHP Northwest • 2025 Kaiser DHMO California • 2025 Kaiser DHMO Colorado • 2025 Kaiser DHMO Northwest
Non-Preferred Brand	40% coinsurance Retail Pharmacy: $50 minimum; no maximum Home Delivery: $125 minimum; no maximum	
Specialty Drugs	Based on category (generic, formulary, non-formulary). Must be filled through Express Script's specialty home delivery pharmacy, **Accredo,** which provides 24/7 access to speciality-trained pharmacists and nurses who understand your condition.	
Express Scripts: Retail Pharmacy: Up to 30 day supply; Home Delivery: Up to 90 day supply *Kaiser: Retail: Up to 30 day supply, Mail order: Up to 100 day supply*		

Medical Plan Coverage Levels

You may choose to enroll yourself and any eligible dependents in the medical plan. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

This a high-level overview of **in-network benefits** for the BMO medical plans. For more detailed information including how out-of-network claims are covered, review the following:

2025 BCBSIL HDHP Booklet, 2025 BCBSIL PPO Booklet,

Kaiser-CO-HSA, Kaiser-S.CA-HSA, Kaiser-N.CA-HSA, Kaiser-NW-HSA,

Kaiser-CO-DHMO, Kaiser-S.CA-DHMO, Kaiser-N.CA-DHMO, Kaiser-NW-DHMO

BCBSIL/Kaiser Summaries of Benefits and Coverage.

For more information on the prescription drug coverage for the BCBSIL plans, review the 2025 Prescription Drug Plan Details

2.2 Dental

BMO offers comprehensive dental benefits through Delta Dental of Illinois, offering flexibility and cost-saving opportunities. Employees may visit any licensed dental provider; however, greater savings are available by choosing a provider within the Delta Dental's PPO or Premier networks.

Dental: At-a-glance	
Provider Networks	• **Delta Dental PPO**: Lowest out-of-pocket costs and network protection • **Delta Dental Premier:** Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection • **Non-network**: You may have the highest out-of- pocket costs
Annual deductible	Individual: $50 Family coverage: $150 (three individual deductibles per family)
Annual benefit maximum	$2,000 per person
Lifetime non-surgical TMJ Maximum	$1,000 per person
What you pay (post-deductible)	
Preventive services	You pay nothing
Basic services	20% coinsurance
Major services	50% coinsurance
Orthodontia services	50% coinsurance (maximum of $2,000 for children up to age 19)

Dental Plan Coverage Levels

You may choose to enroll yourself and any eligible dependents in the dental plan. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

This a high-level overview of **in-network benefits** for the BMO dental plan. For more detailed information including how out-of-network claims are treated, review the 2025 Delta Dental Benefits Booklet.

2.3 Vision

BMO offers two vision plan options through VSP: the Base Plan and the Premier Plan. Both plans allow employees to visit any licensed vision care provider; however, using an in-network VSP provider offers enhanced value, including higher reimbursement rates, lower out-of-pocket costs, and simplified claims processing. These options are designed to support varying needs for routine eye care and eyewear.

Vision: At-a-glance		
In Network Features	**VSP Base Plan**	**VSP Premier Plan**
WellVision exam (every year)	$10 copay	$0 copay
Retinal imaging/screening	$20 copay	
Additional exams as needed	$20 copay	
Treatment of eye conditions (e.g., pink eye, vision loss, cataracts)	$20 copay	
Lenses (every calendar year) • Single vision	Included with prescription glasses	

Vision: At-a-glance		
• Lined bifocal • Lined trifocal		
Lens Enhancements (every calendar year) • Progressive lenses • Tinted lenses • Scratch-resistant coating • Ultraviolet coating	You pay nothing	
Premium and custom progressive lenses	$50	$95 – $175
Retail frame	$150 allowance, every other calendar year	$175 allowance, every calendar year
Featured frame brand	$200 allowance, every other calendar year	$225 allowance, every calendar year
Frame discount	20% savings on amount over allowance, every other calendar year	20% savings on amount over allowance, every calendar year
Contact lens exam (every calendar year)	Up to $40	
Contact lenses (every calendar year)	$150 allowance, copay does not apply	$175 allowance, copay does not apply
VSP EasyOptions	Not included	Choose one of the following upgrades when purchasing glasses or contact lenses*: • Additional $75 frame allowance • Fully covered premium or custom progressive lenses • Fully covered light-reactive lenses • Fully covered anti-glare coating

Vision: At-a-glance		
		• Additional $75 contact lens allowance *Upgrade is available every calendar year. Copay is included in prescription glasses
VSP Lightcare	Not Included	$250 allowance for ready-made non-prescription sunglasses or non-prescription blue light filtering glasses (instead of prescription glasses or contacts)* *Allowance available every calendar year. $0 copay
VSP also offers extra savings on additional glasses and sunglasses, laser vision correction and frames, lens enhancements and more. *If you see a non-VSP provider, services are either paid based on an allowance or not covered.*		

Vision Plan Coverage Levels

You may choose to enroll yourself and any eligible dependents in the vision plan. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

This a high-level overview of **in-network benefits** for the BMO vision plan. For more detailed information including how out-of-network claims are treated, review the VSP Vision Certificate of Coverage.

2.4 Health Savings Account (HSA)

If you enroll in one of BMO's HDHPs, you may be eligible to open and contribute to a Health Savings Account (HSA). BMO contributes, and allows you to contribute pre-tax through payroll, to an HSA administered by Alight Smart-Choice Accounts. An HSA lets you use pre-tax dollars to pay for qualified medical, prescription, dental, and vision expenses, reducing your out-of-pocket burden and taxable income.

Employer Contribution: BMO provides a lump-sum **core contribution** to your HSA - regardless of whether you choose to contribute yourself (unless you are ineligible to contribute to an HSA). You'll receive:

- **$500** if you're enrolled in **Employee-only** coverage
- **$1,000** if you're enrolled in **Family** coverage

This upfront contribution gives you a head start in covering healthcare expenses and maximizing the benefits of your HSA paired with your HDHP.

Each year, the IRS sets contribution limits based on your HDHP coverage level. The 2025 IRS Limits are as follows:

HDHP Coverage Level	BMO Core Contribution	Maximum Employee Contributions	IRS Limits
Employee Only	$500	Under Age 55: $3,800	Under Age 55: **$4,300**
		55 or Older: $4,800	55 or Older: **$5,300**
Family	$1,000	Under Age 55: $7,550	Under Age 55: **$8,550**
		55 or Older: $8,550	55 or Older: **$9,550**

This a high-level overview of BMO's HSA plan. For more detailed information, review the Health Savings Account Plan Details.

2.5 Health Care Flexible Spending Account (HCFSA)

BMO offers a Health Care Flexible Spending Account (HCFSA) administered by Alight Smart-Choice Accounts that allows you to set aside pre-tax dollars to pay for eligible **health care** expenses for you and your Code Section 105(b) dependents. These out-of-pocket expenses include deductibles, coinsurance, and copays from your medical, dental, or vision plans.

Each year, the IRS sets annual contribution and carryover limits for the HCFSA, and it's important to plan carefully - any unused funds above the carryover limit will be forfeited if you do not submit eligible claims by the plan's deadline. This "use it or lose it" feature makes thoughtful budgeting essential. If you elect the HDHP for the following plan year, your carryover will be to the Limited Purpose Flexible Spending Account.

The 2025 IRS annual pre-tax limits for HCFSA are:

Annual Contributions		Allowable Carryover
Minimum:	$100	$660
Maximum:	$3,300*	

*See Health Care and Limited Purpose Flexible Spending Account Plan Details for certain limitations.

You have until April 30 of the following year to submit any HCFSA claims incurred in the previous calendar year while you were actively participating.

This benefit is especially beneficial if you are not enrolled in BMO's HDHP or are ineligible to contribute to an HSA.

Important: You are unable to enroll in the HCFSA and contribute to an HSA. Instead, you may enroll in the Limited Purpose Flexible Spending Account (LPFSA) to maximize your tax savings.

This a high-level overview of BMO's HCFSA plan. For more detailed information and how to submit claims, review the Health Care and Limited Purpose Flexible Spending Account Plan Details.

2.6 Limited Purpose Flexible Spending Account (LPFSA)

BMO offers a Limited Purpose Flexible Spending Account (LPFSA) administered by Alight Smart-Choice Accounts that allows you to set aside pre-tax dollars to pay for eligible **dental and vision expenses** for you and your Code Section 105(b) dependents. You can use LPFSA funds before meeting your HDHP deductible, making it a smart way to manage out-of-pocket dental and vision costs while preserving your HSA for broader medical needs.

Once you've met your HDHP deductible, you can then use the LPFSA to cover a wider range of qualified medical, dental, prescription, vision, and Code Section 213(d) expenses. You need to contact SmartChoice to allow for these additional expenses once you've met your deductible.

Each year, the IRS sets annual contribution limits for the LPFSA, and it's important to plan carefully—any unused funds above the carryover limit will be forfeited if you do not submit eligible claims by the plan's deadline. This "use it or lose it" feature makes thoughtful budgeting essential. If you elect the HDHP for the following plan year, your carryover will be to the Limited Purpose Flexible Spending Account.

The 2025 IRS annual pre-tax limits for the LPFSA are:

Annual Contributions		Allowable Carryover
Minimum:	$100	$660
Maximum:	$3,300*	

*

See Health Care and Limited Purpose Flexible Spending Account Plan Details for certain limitations.

You have until April 30 of the following year to submit any LPFSA claims incurred in the previous calendar year while you were actively participating.

This a high-level overview of BMO's LPFSA plan. For more detailed information and how to submit claims, review the Health Care and Limited Purpose Flexible Spending Account Plan Details.

2.7 Dependent Care Flexible Spending Account (DCFSA)

BMO offers a Dependent Care Flexible Spending Account (DCFSA) administered by Alight Smart-Choice Accounts that allows you to set aside pre-tax dollars to pay for eligible **child care and elder care expenses** that enable you (and your spouse, if applicable) to work, look for work, or attend school full-time. Eligible expenses may include daycare, preschool, before- and after-school programs, and adult day care services.

The Code contains annual contribution limits for the DCFSA, and it's important to plan carefully - any unused funds will be forfeited if you do not submit eligible claims by the applicable deadline. This "use it or lose it" feature makes thoughtful budgeting essential.

The 2025 annual pre-tax limits for the DCFSA are:

Annual Contributions		Allowable Carryover
Minimum:	$100	$0
Maximum:	$5,000 if single or married and filing jointly* or $2,500 if married and filing separately*	

*See Dependent Care Flexible Spending Account Details for certain limitations for highly compensated employees.

You have until April 30 of the following year to submit any DCFSA claims incurred in the previous calendar year while you were actively participating.

This a high-level overview of BMO's DCFSA plan. For more detailed information and how to submit claims, review the Dependent Care Flexible Spending Account Plan Details.

2.8 Basic Life Insurance

BMO provides employer-paid Basic Life Insurance coverage equal to two times your Total Compensation Benefits Base Rate (TCBBR), up to $500,000. This coverage is administered by Voya under a group policy issued by ReliaStar Life Insurance Company.

Under the Code, employer-paid life insurance coverage over $50,000 is considered taxable imputed income. To avoid this tax impact, you have the option to cap your coverage at $50,000.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your TCBBR calculation.

You will want to **assign and regularly review your beneficiaries** for this benefit to ensure benefits are paid according to your wishes.

This a high-level overview of BMO's Basic Life Insurance benefit. For more detailed information, review the Life Insurance Schedule of Benefits.

2.9 Supplemental Life Insurance

To increase your life insurance coverage, you can purchase one to eight times your TCBBR through the Supplemental Life Insurance benefit, up to a combined maximum of $3 million (including your employer-paid Basic Life Insurance). Rates are based on your tobacco user status, with lower premiums available to non-tobacco users. This coverage is administered by Voya under a group policy issued by ReliaStar Life Insurance Company.

If you elect Supplemental Life Insurance when you are first eligible, you are not required to provide Evidence of Insurability (EOI). However, EOI is required if you enroll in or increase coverage later - such as during annual enrollment or following a qualifying life event.

Limit without proof: You may elect up to $1 million or five times your TCBBR, whichever is less, without providing EOI during your initial eligibility period.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your TCBBR calculation.

You will want to **assign and regularly review your beneficiaries** for this benefit to ensure benefits are paid according to your wishes.

This a high-level overview of BMO's Supplemental Life Insurance plan. For more detailed information, review the Life Insurance Schedule of Benefits.

2.10 Family Life Insurance

BMO offers optional Family Life Insurance to provide financial protection for your loved ones in the event of an unexpected loss. Electing coverage for your spouse/domestic partner and child(ren) can help ease the financial burden of final expenses and provide peace of mind during a difficult time. This benefit allows you to extend life insurance protection beyond

yourself, ensuring you and your family has added support when needed most. This coverage is administered by Voya under a group policy issued by ReliaStar Life Insurance Company.

- **Spouse/Domestic Partner Life Insurance**: You can purchase coverage in the amount of $25,000, $50,000, $100,000, or $150,000.

  If you elect this coverage when you are first eligible for benefits, no EOI is required. However, EOI is required for coverage amounts of $100,000 or $150,000, or if you enroll or increase coverage later- such as during annual enrollment or following a qualifying life event.

- **Child Life Insurance**: You can purchase coverage in the amount of $10,000, $15,000, $20,000, or $25,000. EOI is not required for child life insurance coverage.

You are automatically the beneficiary of your Family Life Insurance policies, meaning the benefit is paid to you if a covered family member passes away.

This a high-level overview of BMO's Family Life Insurance plan. For more detailed information, review the Life Insurance Schedule of Benefits.

2.11 Business Travel Accident Insurance

BMO provides Business Travel Accident Insurance insured by AIG Insurance Company of Canada to help protect you in the event of a serious injury or accident while traveling for work. This coverage reflects BMO's commitment to employee safety and well-being, recognizing that business travel - whether across the country or around the globe - can carry unexpected risks. The insurance offers financial protection and peace of mind, ensuring that you and your loved ones are supported if an accident occurs while you're away on business.

Coverage is automatic from your first day of employment, and no enrollment is required.

It begins when you leave your home, office, or other location to start a business trip and ends when you return or begin a personal side trip. This benefit is in addition to any personal accident coverage you may have elected through employee, spouse, or child accident insurance plans.

Note: This benefit does not cover your regular commute to and from work.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your annual base pay calculation for purposes of this benefit.

This a high-level overview of BMO's Business Travel Accident Insurance plan. For more detailed information, review the AIG Business Travel Accident Insurance Policy and the AIG Business Travel Accident Insurance Policy Schedule.

2.12 Accident Insurance

BMO offers Accident Insurance to provide financial support when you or a covered family member experiences an unexpected injury. Offered by Voya and insured by Reliastar Life Insurance Company, this coverage pays benefits for specific, covered accidents and related treatments that occur on or after your coverage effective date. It's designed to help offset out-of-pocket costs such as emergency care, hospital stays, and follow-up visits - helping to reduce the financial stress that often comes with accidental injuries.

You may choose to enroll yourself and any eligible dependents in the Accident Insurance benefit. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

Covered accidents include:

- Injuries such as fractures, burns, lacerations, and dislocations (e.g., hip, knee, shoulder).
- Treatment-related expenses including emergency room visits, ambulance services, surgery, doctor visits, and hospital admission.
- A Sports Accident Benefit: If your injury occurs during an organized sporting activity, your benefit is increased by 25%, up to an additional $1,000.

Benefit payments can be used however you choose - whether for everyday expenses, lost income, child care, deductibles, or copays - and are paid in addition to any other coverage you may already have.

Benefit amounts vary based on:

- The nature and severity of the injury
- The type of treatment received
- The plan level you select- **Low Plan** or **High Plan**

Note: This plan includes a **Wellness Benefit**. If you or your spouse/domestic partner complete a health screening, you will each receive $50, payable once a year from Voya. Each child who completes a health screening will also receive $50.

This benefit is portable when you leave or retire from BMO.

This a high-level overview of BMO's Accident Insurance benefit. For more detailed information, review the Accident Insurance Certificate of Coverage or visit Voya's site: www.presents.voya.com/EBRC/BMO.

2.13 Critical Illness Insurance

BMO offers Critical Illness Insurance to provide financial support if you or a covered family member is diagnosed with a serious medical condition. Offered by Voya and insured by Reliastar Life Insurance Company, this coverage pays a lump-sum benefit for specific, covered illnesses that occur on or after your coverage effective date. It's designed to help offset the financial impact of a major health event - such as a heart attack, stroke, or cancer- by providing funds you can use however you choose.

You may choose to enroll yourself and any eligible dependents in the Critical Illness Insurance benefit. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

Covered illnesses and conditions include:

- Heart attack, stroke, cancer, organ transplant, infectious disease, paralysis, advanced Alzheimer's, and more.

Benefit payments can be used however you choose - whether for everyday expenses, lost income, child care, deductibles, or copays - and are paid in addition to any other coverage you may already have.

Benefit amounts vary based on:

- The nature and severity of the illness or condition
- The plan level you select - **Low Plan** or **High Plan**

Low Plan:

- You and your spouse/domestic partner: Up to $10,000
- Your children: Up to $5,000

High Plan:

- You and your spouse/domestic partner: Up to $20,000
- Your children: Up to $10,000

Note: This plan includes a **Wellness Benefit**. If you or your spouse/domestic partner complete a health screening, you will each receive $50, payable once a year from Voya. Each child who completes a health screening will also receive $50.

This benefit is portable if you leave or retire from BMO.

This is a high-level overview of BMO's Critical Illness Insurance benefit. For more detailed information, review the Critical Illness Insurance Certificate of Coverage or visit Voya's site: www.presents.voya.com/EBRC/BMO.

2.14 Hospital Indemnity Insurance

BMO offers Hospital Indemnity Insurance to complement your medical coverage by providing additional financial support if you or a covered family member needs to stay in the hospital. Offered by Voya and insured by Reliastar Life Insurance Company, this voluntary benefit pays daily cash benefits for hospital-related stays that occur on or after your coverage effective date. It's designed to help offset out-of-pocket costs such as deductibles, copays, and lost income - helping to reduce the financial stress that often comes with inpatient care.

You may choose to enroll yourself and any eligible dependents in the Hospital Indemnity Insurance benefit. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

Covered situations include:

- Hospital admission and confinement
- Critical care unit admission and confinement
- Rehabilitation facility confinement
- Daily benefit for observation unit stays

Benefit payments can be used however you choose—whether for everyday expenses, child care, travel costs, or medical bills—and are paid in addition to any other coverage you may already have.

Benefit amounts vary based on:

- The type of facility and length of stay
- The plan level you select - **Low Plan** or **High Plan**

Note: This plan includes a **Wellness Benefit**. If you or your spouse/domestic partner complete a health screening, you will each receive $50, payable once a year from Voya. Each child who completes a health screening will also receive $50.

This benefit is portable if you leave or retire from BMO.

This is a high-level overview of BMO's Hospital Indemnity Insurance benefit. For more detailed information, review the Hospital Indemnity Insurance Certificate of Coverage or visit Voya's site: www.presents.voya.com/EBRC/BMO.

2.15 Group Legal Plan

BMO offers the UltimateAdvisor® Legal Plan to provide access to legal experts and self-help resources for a wide range of personal legal matters. Administered by ARAG, this voluntary benefit helps you navigate everyday legal situations with confidence and support.

You may cover yourself, your spouse/domestic partner, and/or dependent children.

Covered legal matters include:

- Wills and trusts
- Divorce and family law
- Traffic violations
- Sale or purchase of a home
- Consumer protection
- Bankruptcy and civil damage defense
- Property issues
- Identity theft resolution
- Caregiving support
- Tax services
- Immigration assistance

Benefit payments and discounts:

- When you work with a network attorney, fees for covered services are 100% paid-in-full.
- For legal matters not covered under the plan, you receive at least 25% off the network attorney's normal rate.

This is a high-level overview of BMO's Group Legal Plan. For more detailed information, review the ARAG Legal Certificate or visit ARAG's website and enter the access code: 18694bmo.

2.16 Commuter Benefits

BMO offers Commuter Benefits to allow employees to pay for commuting expenses using pre-tax dollars, helping you save money on your annual taxes. Commuter Benefits are administered by Alight and EdenRed Benefits. The 2025 IRS monthly pre-tax limits for Commuter Benefits are:

Commuter Benefits Type	Monthly pre-tax limits
Mass transit	$325
Parking	$325

Your Commuter Benefits contributions are deducted once a month, taken from your first paycheck of the month.

Eligible Expenses Include:

- **Public Transit**: Train, Bus, Subway, Ferry, Trolley, Water Taxi, and Vanpools.
- **Parking**: Near your workplace or near your transit location; Discounts available through SpotHero (where applicable).

This is a high-level overview of BMO's Commuter Benefits. For more detailed information including how to enroll and make changes to your Commuter Benefits, review the Commuter Benefits Plan Details.

2.17 Short-Term Disability

BMO automatically provides Short-Term Disability (STD) income replacement benefits to support you when you're unable to work due to a non-work-related illness or injury lasting more than 10 consecutive business days. The STD plan is administered by Reliance Matrix Absence Management.

- **Benefit Duration**: Up to 100 business days.
- **Income Replacement**: 70% to 100% of your base salary (or Benefits Base Rate for eligible commissioned employees), based on your years of service.
- **Waiting Period**: 10 business days unpaid, unless you elect to use available paid sick or vacation time during the waiting period.
- **When Benefits Begin**: On the 11th business day of disability, if approved.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your base salary (or Benefits Base Rate) calculation.

This is a high-level overview of BMO's STD plan. For more detailed information including how to apply for STD, review the Short-Term Disability Plan Details.

2.18 Long-Term Disability

BMO automatically provides Long-Term Disability (LTD) income replacement benefits to support you if your illness or injury prevents you from returning to work after your Short-Term Disability period ends. The LTD plan is administered by Matrix Absence Management.

- **Benefit Start:** After STD benefits are exhausted and your LTD claim is approved.
- **Income Replacement**: Typically, 60% of your Total Compensation Base Benefits Rate (TCBBR) is automatically provided to you by BMO.

- **Maximum Monthly Benefit**: The total LTD benefit (basic + supplemental) is capped at $20,000 per month.
- **Duration**: As long as you remain eligible under the plan terms, up to age 65 or Social Security Normal Retirement Age.

2.18.1 Supplemental Long-Term Disability

You can elect to purchase Supplemental LTD coverage to increase your income protection while on Long Term Disability. This optional coverage enhances your total LTD benefit to **75%** of your TCBBR.

- **Income Replacement**: Combined basic and supplemental LTD coverage provides up to 75% of your TCBBR.
- **Maximum Monthly Benefit**: The total LTD benefit (basic + supplemental) is capped at $20,000 per month.
- **Coverage Limitations**:
    - If your TCBBR is **$400,000 or more**, you will not receive any additional benefit from electing Supplemental LTD.
    - If your TCBBR is between **$320,000 and $399,999**, you may elect coverage, but will receive less than the full 15% supplemental benefit due to the monthly cap.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your TCBBR calculation.

This is a high-level overview of BMO's LTD benefit. For more detailed information including how to apply for LTD, review the Long-Term Disability Plan Details.

2.19 Employee Assistance Program

BMO offers a free and confidential Employee Assistance Program (EAP), administered by TELUS Health, to support you and your immediate family with personal challenges that may affect your well-being or work. Available 24/7 - the EAP provides short-term counseling online, in-person, or by phone, and can help with:

- Stress, anxiety, and depression
- Relationship and parenting issues
- Financial concerns
- Addiction support
- Child and elder care
- Work-related conflicts
- Coping with change

The EAP is intended to short-term needs. Longer-term counseling may be covered under your medical plan.

This is a high-level overview of BMO's Employee Assistance Program. For more detailed information on the resources available to you, review the Employee Assistance Program Plan Details.

3.0 Enrolling and changes

Some benefits are provided to eligible employees **automatically**, without the need for enrollment:

- Basic Life Insurance
- Business Travel Accident Insurance
- Short-Term Disability (STD)
- Basic Long-Term Disability (LTD)
- Employee Assistance Program (EAP)

Other benefits require **active enrollment** during your initial eligibility period, newly enrolling during annual enrollment or during a qualifying life event to participate:

- Medical (including prescription drug)
- Dental
- Vision
- Health Savings Account (HSA)
- Health Care Flexible Spending Account (HCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Supplemental Life Insurance
- Family Life Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Group Legal Plan
- Supplemental Long-Term Disability

You may enroll in or make changes to your health and welfare benefit plans during the following events:

- **Initial Eligibility**: When you first become eligible for benefits, such as upon hire or a change in employment status that grants eligibility.
- **Rehire**: If you are rehired and meet the eligibility criteria.
- **Qualifying Life Event (QLE)**: When you experience a life event that qualifies for a mid-year change (e.g., marriage, birth of a child, loss of other coverage).
- **Annual Enrollment**: During the designated annual enrollment period, when you may review and update your benefit elections for the upcoming plan year.

3.1 Enrollment Deadlines and Coverage Effective Dates

Event	Enrollment Deadline	Effective Date of Coverage
New hire	31 days from hire date	1st of the month following 30 days from your hire date
Newly eligible for benefits status change	31 days from your status change date	1st of the month following 30 days from your status change date
Rehire within 30 days	Not applicable, your benefit elections in effect on the date of your termination are automatically reinstated.	Reinstated back to the benefit end date (no break in coverage).
Rehire greater than 30 days, but within 13 weeks of termination	31 days from rehire date	1st of the month from your rehire date
Rehire greater than 13 weeks of termination	31 days from rehire date	1st of the month following 30 days from your rehire date
QLE – excluding birth/adoptions	31 days from the QLE date	On the QLE date
Birth or Adoption QLE	90 days from the child's birth or adoption date*	On the child's birth or adoption date
Annual Enrollment (AE)	Varies but elections must be made during the communicated AE window	January 1st following AE
** For the critical illness, your child must be added within 60 days of the birth/adoption date.*		

For Commuter Benefits: Commuter Benefits are unique in that enrollment occurs outside of the standard health and welfare benefits enrollment process. You may enroll, change, or cancel your Commuter Benefits at any time, based on your commuting needs.

Enrollment Deadlines for Commuter Benefits:

- For most transit and parking options, changes must be submitted by the 10th of the month to be effective the following month.
- If you are using the Long Island Railroad or Metro-North Railroad in New York, changes must be submitted by the 4th of the month for benefits to be effective the following month.

3.2 How to Enroll

You will enroll and make changes to your health and welfare benefits through the My Benefits & Retirement app via Workday.

To access the *My Benefits & Retirement* homepage:

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app

3. Select your network status (on or off BMO network*)

**You can access Workday from outside the BMO firewall using a standard internet browser or the Workday mobile app. Before doing so, you must first complete your initial setup while connected to the BMO network. This setup includes logging in with your Employee Identification Number (EIN) as your username; creating a password; and setting up your security challenge questions. Once this setup is complete, you'll be able to securely access Workday from any location.*

3.2.1 Enrollment as a New Hire, Rehire or Newly Eligible Employee

When you initially become eligible for BMO's benefits, you will have the opportunity to enroll in the coverage you and your family needs. An enrollment event in *My Benefits & Retirement* will automatically appear for you to make changes and you have 31 days from your hire, rehire or status change date to enroll in your health and welfare benefits.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Enroll in your benefits** tile
5. Click **Go to Enrollment** and follow the prompts to navigate through the benefits election process

3.2.2 Mid-year Changes Due to a Qualifying Life Event

In most cases, the benefits you choose during enrollment stay the same all year. However, certain life events - like getting married or having a baby - may allow you to make changes mid-year. You will log your QLE and make changes to your health and welfare benefits through the My Benefits & Retirement app via Workday.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Change Your Coverage** tab
5. Select the life event type from the list that fits your QLE
6. Enter the event date and click **Continue**
7. Click **Go to Enrollment** and follow the prompts to navigate through the benefits election process

Important: Your QLE must be entered AND any changes to your benefits must be completed within 31 days of the event (or 90 days for a birth or adoption). For HIPAA special enrollment events related to CHIP or Medicaid, you have 60 days to request enrollment. If you miss the deadline, you won't be able to make changes until the next open enrollment period (unless another QLE occurs).

You can make changes due to a QLE if you or your dependent(s) experience a:

Change in	QLE types
Legal Marital Status	Marriage, divorce, legal separation, annulment, or death of a spouse
Number of Eligible Dependents	Birth, adoption, placement for adoption, legal guardianship, or death
Employment Status	Gaining or losing eligibility due to a job change (you or your dependents)
Dependent Status	Changes in eligibility due to age, disability, or similar factors
Residence Change	Moving outside your medical plan's network service area
HIPAA Special Enrollment Event	Loss of other coverage; gaining a new dependent through marriage, birth, adoption, or placement for adoption; gaining eligibility for Medicaid or CHIP coverage or a state premium assistance program under Medicaid or CHIP
Entitlement to Medicare or Medicaid	Gaining or losing eligibility to Medicare or Medicaid
Judgment, Decree, or Order	A judgment, decree, or order (such as a QMCSO) requires you to cover your dependent child under the Plan
Change Under Another Employer's Plan	Loss or gain of coverage due to another employer's plan (e.g., loss of coverage or a change associated with a different open enrollment period) (must be allowed under both plans)
Loss of Coverage Under Government/Educational Plan	Includes CHIP, Indian Health Service, state risk pools, or foreign government plans
Significant Change in Coverage	If the cost of coverage is significantly increase or decreased, or if benefits are significantly improved or curtailed (this event does not apply to the HCFSA or LPFSA)

Note: Under Code Section 125 rules, changes to your benefits must be consistent with the QLE and limited to the affected individual(s).

For example, if you child loses eligibility for coverage due to age or other reasons, you can remove coverage for that child only and cannot remove coverage for yourself or any other covered dependents, unless they are also affected by the same event.

Note about HSA mid-year changes: Unlike most other benefits, you can start, change or end your HSA contributions at any point during the year - as long as you're enrolled in the HDHP. See the Health Savings Account Plan Details for details on how to make mid-year changes.

3.2.3 Changes During Annual Enrollment

Each fall, you'll have a chance to review and update your benefit elections for the upcoming calendar year. During the two-week Annual Enrollment (AE) window, an enrollment event in *My Benefits & Retirement* will automatically appear for you to make changes.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Enroll in your benefits** tile
5. Click **Go to Enrollment** and follow the prompts to navigate through the benefits election process

Once the window closes, your elections are locked in for the year - unless you experience a QLE.

Passive vs. Active Elections during Annual Enrollment

For your convenience, most benefits will **automatically renew** during Annual Enrollment unless you make changes. Flexible Spending Account (FSA) benefits do not automatically renew and **require you to re-enroll** each year.

Passive (Automatically renew)	Active (Require re-enrollment)
• Medical • Dental • Vision • Health Savings Account • Supplemental Life Insurance • Family Life Insurance • Accident Insurance • Critical Illness Insurance • Hospital Indemnity Insurance • Group Legal Plan • Supplemental Long-Term Disability	• Health Care FSA • Limited Purpose FSA • Dependent Care FSA

If you do not take any action during AE, your current elections for benefits that are passive will carry over at the **new plan year rates**. Your current elections for FSA benefits that require active re-enrollment will be waived for the new plan year.

3.2.4 Enrolling and Making Changes to Commuter Benefits

You may enroll, change, or cancel your Commuter Benefits at any time, based on your commuting needs through the *My Benefits & Retirement* app in Workday.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Reimbursement Accounts** tab
5. Click **Commuter Account** and **Manage my commuter benefits** to navigate through the election process

3.3 When Coverage Ends

Your coverage under the Plan (and most component plans) ends on the **last day of the month** in which any of the following occur:

- Your employment with BMO ends for any reason*
- You become ineligible to participate* (see 1.1 Employee Eligibility Requirements)
- You fail to pay premiums when due
- The Plan terminates coverage for employees

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

- Your employment with BMO ends for any reason*
- You or your covered dependents become ineligible to participate* (see 1.2 Dependent Eligibility Requirements)
- 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 terminates coverage for employees, dependents, or domestic partners
- Your dependent fails the verification process

***Note:** Coverage will end on your termination date or the date you became ineligible for benefits for the DCFSA, life insurance benefits, Business Travel Accident, Accident Insurance, Group Legal benefit, disability benefits, and Commuter Benefits.

In most cases, you and your dependents may be eligible to continue coverage through **COBRA** when coverage ends. It is your responsibility to notify BMO of any change in your or your dependent's status that affects eligibility (e.g., a divorce, legal separation, end of domestic partnership, or a dependent child aging out) within **60 days** of the change in order for COBRA coverage to be offered.

Retroactive Cancellation of Coverage
BMO relies on the accuracy and completeness of the information you provide. If you or your dependents engage in fraud or make material misrepresentations in connection with the Plan, the Plan reserves the right to take appropriate corrective actions. These actions may include the denial or reversal of benefits, retroactive cancellation of coverage, and/or termination of eligibility under the Plan.

3.4 What Happens to Benefits During a Leave of Absence

Approved Leave

If your leave is approved (e.g., FMLA, Short Term Disability, Maternity, Parental, Military), your benefits coverage generally continues. Here's how it works:

- **Paid Leave**:
  Coverage continues uninterrupted. Premiums and contributions are deducted from your pay as usual.

- **Unpaid Leave**:
  Coverage continues, and you are responsible for payments for any premiums and contributions missed during your leave. Missed deductions will accumulate in arrears and be collected when you return (typically one extra deduction per pay period until paid in full).

  For extended unpaid leave, you may be contacted to arrange direct payment to maintain your coverage.

- **Military Leave**:
  Coverage continues at active employee rates for the full duration of your approved military leave.

  - During your one year of paid military leave, premiums and contributions are deducted from your pay as usual.
  - If you continue to be on military leave longer than one year, you are responsible for payments for any premiums and contributions missed during your unpaid military leave. Missed deductions will accumulate in arrears and be collected when you return (typically one extra deduction per pay period until paid in full).

    For an extended military leave, you may be set-up to make direct payments through our Billing Administrator to maintain your coverage.

  At the onset of your military leave you may also choose to waive your coverage. When you return to work following your leave, your coverage will be reinstated without a waiting period as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Unapproved Leave

If your leave is not approved or you do not return as expected:

- Coverage ends on the last day of the month in which your employment ends.

Long-Term Disability Leave

If you are on an approved Long-Term Disability (LTD) leave, your medical, dental, and vision coverage will continue for 3 years from the date you are approved for LTD income replacement benefits. At the end of the 3 years of coverage, you will be offered COBRA continuation coverage and/or Retiree Medical, if eligible.

4.0 Paying for Benefits

Some benefits under the Plan are paid entirely by BMO, some are paid entirely by employees, and others are shared between BMO and employees.

If you're responsible for part of the cost, your contributions will be deducted from your **bi-weekly paycheck**, either **pre-tax or after-tax**, depending on IRS rules.

Most BMO-paid contributions are **non-taxable**, but there are a few exceptions where IRS regulations require the value of employer-paid premiums or coverage to be treated as **taxable income**.

Component plan	Type of Plan	Who contributes	Tax Treatment of Premiums
Medical	Self Insured (BCBSIL/ESI) Fully-Insured (Kaiser)	You & BMO	Pre-tax & Non-taxable*
Dental	Self Insured	You & BMO	Pre-tax & Non-taxable*
Vision	Fully Insured	You	Pre-tax*
Health Savings Account	Not Applicable	You & BMO	Pre-tax & Non-taxable
Health Care Flexible Spending Account	Self Insured	You	Pre-tax
Limited Purpose Flexible Spending Account	Self Insured	You	Pre-tax
Dependent Care Flexible Spending Account	Not Applicable	You	Pre-tax
Basic Life Insurance	Fully Insured	BMO	Non-taxable & taxable**
Supplemental Life Insurance	Fully Insured	You	After-tax
Family Life Insurance	Fully Insured	You	After-tax
Business Travel Accident Insurance	Fully Insured	BMO	Non-taxable
Accident Insurance	Fully Insured	You	After-tax
Critical Illness Insurance	Fully Insured	You	After-tax
Hospital Indemnity Insurance	Fully Insured	You	After-tax
Group Legal Plan	Not Applicable	You	After-tax
Commuter Benefits	Not Applicable	You	Pre-tax & After-tax***
Short term Disability	Self Insured	BMO	Non-taxable
Long term Disability	Self Insured	BMO	Non-taxable
Supplemental Long term Disability	Self Insured	You	Pre-tax
Employee Assistance Program	Fully Insured	BMO	Non-taxable

** If you elect to cover a Non-Tax Dependent Domestic Partner under your Medical, Dental, or Vision plans, the portion of premiums attributed to their coverage will be treated as after-tax and taxable income.*
*** The first $50,000 of Basic Life Insurance coverage is non-taxable. Any coverage amounts exceeding $50,000 are treated as taxable income in accordance with IRS regulations.*
**** Contributions toward commuter benefits are considered pre-tax up to the applicable IRS limits. If you choose to exceed these limits for certain products, the excess amounts will be treated as after-tax.*

Missed Contributions during a Leave, during a Suspension without pay, or due to Low Earnings

If you miss a paycheck due to a leave of absence or a suspension without pay, or don't have enough earnings to cover your benefit deductions, you're still responsible for paying your share of premiums.

Your missed deductions for the following benefits will be tracked and collected in **arrears** and repayments will be added to future paychecks (at a rate of one additional deduction per payroll until your arrears balance is zero) along with your regular deductions for the following benefits:

- Medical, Dental, Vision
- Supplemental Life Insurance & Family Life Insurance
- Accident, Critical Illness & Hospital Indemnity Insurance
- Group Legal Plan
- Supplemental Long-Term Disability
- Commuter Benefits

If your arrears balance reaches a certain threshold, you may receive a notification from Inspira, our billing vendor, with instructions to make payments outside of payroll to resolve the owed premiums.

Your HSA and FSA contributions will automatically recalculate and adjust based on the number of remaining pay periods in the year. This ensures your total deductions align with your annual election amount.

5.0 Administrative Information about the Plan

This SPD outlines the provisions of the Plan, a group health plan governed by ERISA. The Plan offers a comprehensive suite of benefits to eligible employees, including medical, prescription drug, dental, vision, employee assistance program, life insurance, disability coverage, and health flexible spending accounts. These benefits are administered in accordance with applicable federal regulations and internal policies to ensure consistent, equitable, and compliant delivery of services.

5.1 Plan Identification

Plan number: 507

Employer Identification Number: 51-0275712

Plan year: January 1 – December 31

Plan sponsor: BMO Financial Corp.

Plan administrator: Benefits Administration Committee ("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
Email: usbenefits@bmo.com

Plan Administration and Discretionary Authority: The Plan Administrator has full discretionary authority to interpret and apply the terms of the Plan, including making determinations regarding eligibility for benefits and resolving factual questions. This authority extends to interpreting Plan provisions and ensuring that the Plan is administered in accordance with its terms and applicable laws.

Oversight of the Plan is entrusted to the Committee, whose principal duty is to ensure the Plan is carried out for the exclusive benefit of Plan participants. Unless delegated to another named fiduciary or claims administrator, the Committee retains full discretionary power to administer the Plan in all respects. The Committee's decisions regarding the interpretation of the Plan and related matters are final and binding on all parties.

The Plan administrator has delegated certain responsibilities to the claims administrators and insurers, including the authority to interpret and apply Plan provisions, make factual determinations, and decide claims and appeals. Benefits under the Plan will only be paid if the

Plan administrator or claims administrator, or insurer, as applicable, determines in its discretion that the claimant is entitled to them.

Plan trustee: The Plan trustee for the Plan is BNY Mellon and can be reached at:

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

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

Type of funding: The Plan is funded by the employer's general assets, employee contributions, and a trust.

Future of the Plan Statement: BMO reserves the right to amend, modify, replace, or terminate the Plan or any part of it at any time, for any reason. Such actions may be taken by the Board of Directors, an authorized administrative committee, or other designated individuals.

If changes occur, you will be properly notified.

Please note:

- Health and welfare benefits do not vest like retirement benefits.
- If the Plan is terminated, you will only receive benefits for covered expenses incurred before the Plan termination date.

5.2 Claims Administrators, Third Party Administrators, and Service Providers

The applicable claims administrators, insurers, and service providers are listed below.

Company	Services Provided	Contact Information
Alight Solutions	Benefits System and Human Resources Center (HRC) System Service Provider and Benefits Administrator	Alight Solutions – HR Benefits Dept 14613 PO Box 64050 The Woodlands, TX 77387-4050 HRC: 1-888- 927-7700
Strada	HR System (Workday) and Payroll Processing Service Provider	HRC: 1-888- 927-7700
Inspira Financial Health, Inc	COBRA & Direct Billing Administrator	Inspira Financial Health, Inc Benefits Billing Department PO Box 953374 St. Louis, MO 63195-3374 www.inspirafinancial.com Member Services: 1-888-678-7835 BMO Employer ID: 139888
Blue Cross Blue Shield of Illinois (BCBSIL)	Self-Insured Medical Plan Claims Administrator	bcbsil.com Member Services: 1-888-979-4516 Network Information: • **FL residents:** Blue, Group #266889 (HDHP), #323728 (PPO) • **WI residents:** Blue Preferred POS (Wisconsin), Group #266820 (HDHP), #323729 (PPO) • **NJ residents:** Horizon Managed Care Network Group #323722 (HDHP), #323733 (PPO) • **All other state residents:** Participating Provider Organization (PPO), Group #190565 (HDHP), #323725 (PPO)
Express Scripts	Prescription Benefit Manager for Self-Insured Medical Plan	express-scripts.com/bmofinancialgroup Member Services: 1-877-795-2926 Group #: BMOFGRX; BIN#610014
Kaiser Permanente	Fully Insured Medical Plan Provider and Prescription Coverage	kp.org Member Services by region: • N. California: #1932: 1-800-464-4000

Company	Services Provided	Contact Information
		• S. California: #102000: 1-800-464-4000 • Oregon: #3992: 1-800-813-2000 • Colorado: #22343: 1-800-632-9700
GeoBlue	Fully Insured Medical and Dental Plan Provider for U.S. Expatriates	Member Services: Outside the U.S.: 1-610-230-2406 Within the U.S.: 1-888-304-8898 customerservice@geo-blue.com
Delta Dental of Illinois	Self-Insured Dental Plan Claims Administrator	Delta Dental of Illinois PO Box 5402 Lisle, IL 60532 www.deltadentalil.com Member Services: 1-800-323-1743 Group #: 20246
VSP Vision	Fully Insured Vision Insurer	bmo.vspforme.com Member Services: 1-800-877-7195 Group #: 30028445
Alight Dependent Verification Center	Dependent Verification Service Provider	Dependent Verification Center PO Box 299109 Lewisville, TX 75029-9109 HRC: 1-888- 927-7700
Alight SmartChoice Accounts	HSA trustee & FSA Claims Administrator	HRC: 1-888- 927-7700
EdenRed Benefits	Commuter Benefits Service Provider	HRC: 1-888- 927-7700
AIG Insurance Company of Canada	Business Travel Accident Plan Insurer	AIG Insurance Company of Canada 2000 McGill College Ave, Suite #920 Montreal, Quebec H3A 3H3 AHClaimsCan@aig.com Policy #: 9906-96-62 For BMO Internal Support on Business Travel Accident Claims contact Corporate Risk at: CorporateRisk.Insurance@bmo.com
Voya (Reliastar Life Insurance Company)	Life Insurance & Voluntary Benefits (Accident Insurance, Critical Illness Insurance, & Hospital	voya.com Member Services for: • Life Insurance: 1-800-955-7736 • Voluntary Benefits: 1-877-236-7564

Company	Services Provided	Contact Information
	Indemnity Insurance) Insurer	Group #: 29316-4
ARAG Legal	Group Legal Plan Service Provider	araglegal.com/account/login Member Services: 1-800-247-4184
Reliance Matrix Absence Management	Leave of Absence and Disability Claims Administrator	Matrix Absence Management, Inc. 2421 W. Peoria Avenue, Suite 200 Phoenix, AZ 85029 matrixabsence.com Member Services: 1-888-295-7862
ALLSUP	SSDI Advocacy & Coordination Service Provider	www.allsup.com Customer Service (SSDI Benefits): 1-800-405-8339
TELUS Health	Employee Assistance Program Service Provider	one.telushealth.com User ID: BMO_US Password: Wellness@BMO EAP Member Support: 1-800-757-0327

5.3 Claims and Appeals Procedures

Claims for benefits (e.g., group health plan or other ERISA benefit claims/appeals) under the Plan are governed by ERISA. Other claims and appeals (e.g., eligibility and enrollment requests without a claim for benefits, dependent verification appeals) are governed by the rules in 5.3.1 (Coverage Appeal), 5.3.2 (Eligibility Appeal), and 5.3.3 (Dependent Verification Denial Appeal). BMO and its delegates will administer the Plan in a fair, consistent, and compliant manner. As such, the Plan must adhere strictly to the rules and criteria outlined in this SPD and related plan documents. **Exceptions to these rules are not permitted.**

However, you have the right to appeal a decision made by the Plan or its delegate if you believe an error occurred or if there were extenuating circumstances that impacted the outcome. The Plan provides a formal appeals process to ensure that all decisions are reviewed fairly and consistently.

There are four types of appeals available under the Plan:

- Coverage Appeal
- Eligibility Appeal
- Dependent Verification Denial Appeal
- Claim Denial Appeal

5.3.1 Coverage Appeal

A Coverage Appeal applies when you are denied the opportunity to enroll in the Plan or any of the component benefits. This may occur if:

- You miss your initial enrollment deadline as a newly eligible employee
- You do not take action during AE
- You fail to act within the required timeframe following a QLE
- You do not have a valid QLE that would allow you to enroll or make changes
- You made an unintentional change/omission during an enrollment event

Filing a First Level Coverage Appeal

1. Initial Contact
    - Call the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concern.
    - If the issue is not resolved to your satisfaction, proceed to file a formal appeal.
2. Prepare Your Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue
        - Any supporting documents showing:
            - Extenuating circumstances that prevented timely action
            - Evidence of an error
3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          BMO Financial Corp.
          C/O Appeals DEPT 14613
          PO Box 64050
          The Woodlands, TX 77387-4050
        - By Fax: 1-866-894-6684
4. Review Process
    - The Benefits Administrator (Alight) will respond to your appeal within 30 days.
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

Filing a Second Level Coverage Appeal

If your first level coverage appeal is denied by the Benefits Administrator, you have the right to receive a secondary review by the Plan Administrator, BMO's Benefits Administration Committee.

1. Timing
    - You must submit your second level appeal **within 60 days** of receiving the denial of your first-level coverage appeal.
2. Prepare Your Second Level Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue including why your coverage denial should be reconsidered
        - Any supporting documents showing:
            - Extenuating circumstances that prevented timely action or justification why your situation falls outside of Plan rules
            - Evidence of an error
            - Any additional supporting documentation not submitted during the first level appeal that you feel helps your case
    - Upon request, you can receive copies of all documents and information relevant to your appeal free of charge by contacting usbenefits@bmo.com.
3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          BMO Financial Corp.
          Benefits Administration Committee
          C/O BMO U.S. Benefits Team
          395 N. Executive Drive, 3rd Floor - HR
          Brookfield, WI 53005
        - By Email: usbenefits@bmo.com
4. Review Process
    - The Benefits Administration Committee will respond with a **final and binding decision** within:
        - 60 days, or
        - 120 days if an extension is required
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

5.3.2 Eligibility Appeal

An eligibility appeal applies when you or your dependents are denied eligibility to participate in the Plan or any of the component benefits. This may occur if:

- You do not meet the employee eligibility criteria outlined in Section 1.1 Employee eligibility requirements.
- You attempt to enroll a dependent who does not meet the criteria outlined in Section 1.2 Dependent eligibility requirements.

Filing a First Level Eligibility Appeal

1. Initial Contact
    - Call the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concern.
    - If the issue is not resolved to your satisfaction, proceed to file a formal appeal.
2. Prepare Your Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue
        - Any supporting documents showing:
            - Extenuating circumstances that justify your case falls outside Plan rules
            - Evidence of an error
3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          BMO Financial Corp.
          C/O Appeals DEPT 14613
          PO Box 64050
          The Woodlands, TX 77387-4050
        - By Fax: 1-866-894-6684
4. Review Process
    - The Benefits Administrator (Alight) will respond to your appeal within 30 days.
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

Filing a Second Level Eligibility Appeal

If your first level eligibility appeal is denied by the Benefits Administrator, you have the right to receive a secondary review by the Plan Administrator, BMO's Benefits Administration Committee.

1. Timing
    - You must submit your second level appeal **within 60 days** of receiving the denial of your first-level eligibility appeal.
2. Prepare Your Second Level Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue including why your eligibility denial should be reconsidered

        - Any supporting documents showing:
            - Extenuating circumstances that justify why your situation falls outside of Plan rules
            - Evidence of an error
            - Any additional supporting documentation not submitted during the first level appeal that you feel helps your case
    - Upon request, you can receive copies of all documents and information relevant to your appeal free of charge by contacting usbenefits@bmo.com.

3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
            BMO Financial Corp.
            Benefits Administration Committee
            C/O BMO U.S. Benefits Team
            395 N. Executive Drive, 3rd Floor - HR
            Brookfield, WI 53005
        - By Email: usbenefits@bmo.com

4. Review Process
    - The Benefits Administration Committee will respond with a **final and binding decision** within:
        - 60 days, or
        - 120 days if an extension is required
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

5.3.3 Dependent Verification Denial Appeal

A dependent verification denial appeal applies when one or more of your dependents are denied coverage during the dependent verification process (see Section 1.2.1 Dependent Verification Requirement). This may occur if:

- All of the required documentation is not submitted by the deadline
- Submitted documentation does not clearly demonstrate the dependent's eligibility
- You dependent has been determined to be ineligible based on the criteria outlined in Section 1.2 Dependent eligibility requirements

Filing a First Level Dependent Verification Denial Appeal

1. Initial Contact
    - Call the Dependent Verification Center via the HRC at 1-888-927-7700 to discuss your concern.
    - If the issue is not resolved to your satisfaction, proceed to file a formal appeal.

2. Timing

- You must submit your appeal **within 60 days** from the later of:
    - The coverage termination date, or
    - The eligibility enrollment date

3. Prepare Your Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue
        - Any supporting documents showing:
            - The required documentation has been/is now being provided
            - Comments or records
            - Evidence of extenuating circumstances that prevented timely completion of the verification process
            - Evidence of an error

Note: Submitting an appeal does **not guarantee reinstatement** of your dependent(s). You must demonstrate a valid reason for missing the verification deadline.

4. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          Dependent Verification Claims and Appeals Team
          PO Box 299102
          Lewisville, TX 75029-9102

5. Review Process
    - The Dependent Verification Claims and Appeals Team will respond to your appeal within 30 days of receiving your appeal.
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

Filing a Second Level Dependent Verification Denial Appeal

If your first level dependent verification denial appeal is denied by the Dependent Verification Claims and Appeals Team, you have the right to receive a secondary review by the Plan Administrator, BMO's Benefits Administration Committee.

5. Timing
    - You must submit your second level appeal **within 60 days** of receiving the denial of your first level dependent verification denial appeal.

6. Prepare Your Second Level Appeal
    - Your appeal must be submitted in writing and include:
        - Your name

        - Your employee ID
        - A clearly written explanation of the issue including why your dependent verification denial should be reconsidered
        - Any supporting documents showing:
            - Extenuating circumstances that justify why your situation falls outside of Plan rules
            - Evidence of an error
            - Evidence that all required documentation has been/is being submitted now
            - Any additional supporting documentation not submitted during the first level appeal that you feel helps your case
    - Upon request, you can receive copies of all documents and information relevant to your appeal free of charge by contacting usbenefits@bmo.com.

7. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
            BMO Financial Corp.
            Benefits Administration Committee
            C/O BMO U.S. Benefits Team
            395 N. Executive Drive, 3rd Floor - HR
            Brookfield, WI 53005
        - By Email: usbenefits@bmo.com

8. Review Process
    - The Benefits Administration Committee will respond with a **final and binding decision** within:
        - 60 days, or
        - 120 days if an extension is required
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

5.3.4 Claim Denial Appeals

Claims for Benefits: Deadline to File Claims

Unless otherwise provided in the applicable Welfare Program Document, you must file a claim for benefits within 365 days following the date the service was rendered. For details regarding the claims submission process of a specific component benefit, see the applicable Welfare Program Document listed in the chart below.

Claims Administrator	Where to find Appeal Procedures
Blue Cross Blue Shield of Illinois	• HDHP: 2025 BCBSIL HDHP Booklet • PPO: 2025 BCBSIL PPO Booklet

Claims Administrator	Where to find Appeal Procedures
Express Scripts	2025 Prescription Drug Plan Details
Kaiser Permanente	HDHPs: • Kaiser Permanente Colorado HSA Evidence of Coverage • Kaiser Permanente S. California HSA Evidence of Coverage • Kaiser Permanente N. California HSA Evidence of Coverage • Kaiser Permanente Northwest HSA Evidence of Coverage DHMOs: • Kaiser Permanente Colorado DHMO Evidence of Coverage • Kaiser Permanente S. California DHMO Evidence of Coverage • Kaiser Permanente N. California DHMO Evidence of Coverage • Kaiser Permanente Northwest DHMO Evidence of Coverage
Delta Dental of Illinois	2025 Delta Dental Benefits Booklet
VSP Vision	VSP Vision Certificate of Coverage
Smart-Choice Accounts (FSAs)	HCFSA and LPFSA Plan Details
Voya	• Life Insurance: Life Insurance Schedule of Benefits • Accident Insurance: Accident Insurance Certificate of Coverage • Critical Illness Insurance: Critical Illness Insurance Certificate of Coverage • Hospital Indemnity Insurance: Hospital Indemnity Insurance Certificate of Coverage
AIG Insurance Company of Canada (Business Travel Accident Insurance)	To appeal a decision about a denied claim, contact AIG at (416) 596-4005 or 1-877-317-8060. If you need to further appeal your denied claim, follow the "Standard Claim for Benefits procedure – Appeals".
ARAG Legal	To appeal a decision about a denied or uncovered claim or service, contact ARAG Legal at 1-800-247-4184. If you need to further appeal your denied claim, follow the "Standard Claim for Benefits procedure - Appeals".
Matrix Absence Management	STD: 2025 Short-Term Disability Plan Details LTD: 2025 Long-Term Disability Plan Details
TELUS Health	For Appeals related to denied EAP services, contact EAP Member Support: 1-800-757-0327. If you need to further appeal your denied claim, follow the "Standard Claim for Benefits procedure – Appeals".

Standard Claims for Benefits procedure: Initial Claims

Unless otherwise provided in the applicable Welfare Program Document, your claim for benefits will be processed under the procedures described below. ****Note: the procedures listed below are default claims procedures and apply only when the applicable Welfare Program Document does not provide for a specific claims procedure (Where it does, you must follow the specific claims procedure provided there).****

Medical, Dental, and/or Vision ***Urgent Claims***	Notice of the Plan's determination will be sent as soon as possible considering the medical exigencies, and in no case later than 72 hours after receipt of the claim.

Any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.	You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Medical, Dental, and/or Vision ***Pre-Service Claims*** A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is improperly filed, you will be notified within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the insurer or claims administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the insurer or claims administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Medical, Dental, Vision, Employee Assistance Program, and/or Health FSAs ***Post-Service Claims*** A claim for services that already have been rendered, or where the Plan does not require prior authorization.	Notice of the Plan's determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the insurer or claims administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the insurer or claims administrator expects to render a determination. If the extension is necessary to request additional information,

	the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Disability Claims	Notice of the Plan's determination will be sent within a reasonable time period, but not longer than 45 days from receipt of the claim. If the insurer or claims administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended for two additional 30-day periods. You will receive notice prior to each extension that indicates the circumstances requiring the extension, the date by which the insurer or claims administrator expects to render a determination, the standards on which entitlement to a benefit is based, and the unresolved issues that prevent a decision on the claim. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 30 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Life, AD&D, Business Travel Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, and/or Legal	Notice of the Plan's determination will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If the insurer determines that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the insurer expects to render a determination.

Standard Claims for Benefits procedure: Appeals

Refer to the Welfare Program Document for procedures to file claim for benefits or related appeal.

Unless otherwise stated in the applicable Welfare Program Document, you must file your appeal related to a specific coverage, treatment, eligibility determination, or benefit within the deadline set out in the chart below. Requests for appeals should be sent to the address specified in the denial notice.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the insurer or claims administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the insurer or claims administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified below.

****Note: the procedures listed below are default appeal procedures and apply only when the applicable Welfare Program Document does not provide for a specific appeal procedure (Where it does, you <u>must</u> follow the specific appeal procedure provided there).****

Medical, Dental, and/or Vision ***Urgent Claims***	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). You will be notified of the determination as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
Medical, Dental, and/or Vision **Pre-Service Claims**	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal of a Pre-Service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received (30 days if there is only one level of appeal).
Medical, Dental, Vision, Employee Assistance Program, and/or Health FSAs **Post-Service Claims**	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal of a Post-Service claim, you will be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received (60 days from the date if there is only one level of review).
Disability Claims	You must submit your appeal within 180 days of the date of your initial denial notice.

	You will be notified of the determination within a reasonable time, but not later than 45 days from receipt of the request for review. If the insurer or claims administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 45 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the insurer or claims administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 45 days from the date it receives your information, or, if earlier, the deadline to submit your information.
Life, AD&D, Business Travel Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, and/or Legal	You must submit your appeal within 60 days of the date of your initial denial notice. You will be notified of the determination within a reasonable time, but not later than 60 days from receipt of the request for review. If the insurer determines that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the insurer expects to render a determination.

Concurrent Care

If an ongoing course of treatment was previously approved for a specific period or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated.

If the claim is a request for an urgent extension of concurrent care and the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, you will be notified of the decision, whether adverse or not, as soon as possible but no later than 24 hours after receipt of the claim. If your request for extended treatment is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the

request will be treated as an urgent care claim and decided according to the urgent care time frames listed above.

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Plan does not involve urgent care, your request will be considered a new claim and will be decided according to pre-service or post-service timeframes, whichever applies.

Appeals of concurrent care claims will be governed according to applicable timeframes (urgent care, pre-service, or post-service) listed in the tables above.

Standard Claims for Benefits procedure: Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will, where applicable:

- State specific reason(s) for the adverse determination;
- Reference specific Plan provision(s) on which the benefit determination is based;
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim);
- Describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim);
- Include a statement of your right to bring a civil action under ERISA section 502(a) following appeal. For appeals of claims for disability benefits, this statement will also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action and the calendar date on which the contractual limitations period expires for the claim;
- State that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (all appeals and disability claims);
- Describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (all appeals);
- Disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request) (group health plan claims and appeals);
- If the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or state that such information will be provided free of charge upon request (group health plan claims and appeals and disability claims and appeals);
- Include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." (group health plan appeals);

- Include a description of an expedited review process for group health plans concerning a claim involving urgent care;
- Include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount (medical claims and appeals);
- Include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning (medical claims and appeals);
- Include the denial code and its corresponding meaning and a description of the Claims Administrator's or Insurer's standard, if any, that was used in denying the claim (medical claims and appeals);
- Describe any internal appeals and the external review process, if applicable, including information regarding how to initiate an appeal (medical claims and appeals);
- Include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (medical claims and appeals);
- Include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration regarding the claimant (disability claims and appeals); and
- Include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist (disability claims and appeals).

5.3.5 Limitation of Legal Action

You may not bring legal action against BMO Financial Corp., the Benefits Administration Committee, any Claims Administrator, or the Plan unless you have completed the full appeal process. Legal action must be filed within **12 months** of the final appeal decision; otherwise, your right to sue is waived.

Mandatory Venue
All lawsuits related to the Plan - including claim disputes - must be filed in **federal court in Cook County, Illinois**, which has exclusive jurisdiction over the Plan.

5.4 Coordination of Benefits

Coordination of Benefits (COB) applies when you or your covered dependents are enrolled in more than one group health plan, including medical, dental, or vision coverage. The purpose of COB is to ensure that you receive the full benefits to which you are entitled without exceeding the actual cost of care. Total payments from all plans combined will not exceed the provider's billed charges.

It is your responsibility to notify the claims administrator/insurer of any other group coverage that may apply.

Plans Subject to COB

COB applies if you are covered by more than one health benefits plan, including but not limited to:

- Another employer-sponsored medical, dental, or vision plan
- A medical component of a group long-term care plan (e.g., skilled nursing care)
- No-fault or fault-based auto insurance medical benefits
- Medical payment benefits under premises liability or other liability coverage
- Medicare or other government-sponsored health benefits

How COB Works

When you have a claim, determine which plan is your **primary plan** (see *Determining Your Primary Plan* below). Submit your claim to the primary plan first. Once processed, send the Explanation of Benefits (EOB) and itemized bills to the **secondary plan**, which will consider payment for any remaining eligible expenses.

Determining Your Primary Plan

The following rules determine which plan pays first:

1. **Employee vs. Dependent**: The plan covering the individual as an employee pays before a plan covering the individual as a dependent.
2. **Dependent Children (Birthday Rule)**:
    - The plan of the parent whose birthday (month and day only) falls earlier in the year pays first.
    - If both parents share the same birthday, the plan covering the parent for the longer period pays first.
    - If one plan uses a gender-based rule and the other uses the birthday rule, the gender-based rule applies.
3. **Divorced or Separated Parents**:
    - First: Plan of the parent with custody
    - Second: Plan of the custodial parent's spouse
    - Third: Plan of the non-custodial parent

- If a court decree assigns responsibility for health coverage, that parent's plan pays first (if the plan is aware of the decree).
- If joint custody is assigned without specifying responsibility, the birthday rule applies.

4. **Active vs. Retired/Laid Off**: The plan of an active employee pays before that of a retired or laid-off employee.
5. **Length of Coverage**: If none of the above rules apply, the plan that has covered the individual for the longest time pays first.

Claims Processing

If your BMO plan provides **secondary coverage**, the claims administrator/insurer is not obligated to pay until it receives proof of payment and benefit calculation from the **primary carrier**.

In all cases, the combined benefits from both plans will not exceed the provider's billed fees. The Plans will not be liable for more than they would have paid if no other coverage existed.

Right of Recovery

This Plan reserves the right to recover benefit payments made for an allowable expense that exceed the maximum amount the Plan is required to pay under the COB provisions. This right of recovery may be exercised against:

1. Any person to, for, or with respect to whom such payments were made; or
2. Any other insurance company or organization that, under these provisions, owes benefits for the same allowable expense under another plan.

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

5.5 Subrogation and Reimbursement

This section applies to the Blue Cross Blue Shield of Illinois self-insured medical plans only.

The Plan has rights to subrogation and reimbursement when benefits are paid for an illness or injury caused by a third party. References to "you" and "your" include any covered person (including spouses, domestic partners, and dependents) and their estate, heirs, and beneficiaries unless otherwise noted.

Subrogation

If the Plan pays benefits for an illness or injury caused by a third party, it may pursue recovery from that party in your name.

> **Example:**
> You're injured in a car accident caused by another driver. The Plan may seek reimbursement from that driver or their insurer for the cost of your treatment.

Reimbursement

If you receive a settlement, judgment, or other recovery from a third party for an illness or injury for which the Plan paid benefits, you must repay the Plan 100% of those benefits.

> **Example:**
> You're injured in a boating accident and receive a settlement. You must use those funds to reimburse the Plan for any benefits paid related to that injury.

Third Parties Include:

- Individuals or entities responsible for your illness or injury
- Their insurers or indemnifiers
- Workers' compensation carriers
- Auto, homeowners', or other insurers (including underinsured/uninsured motorist coverage)
- Parties liable under legal or equitable theories
- Those involved in malpractice claims related to your illness or injury

Subrogation and Reimbursement Obligations

By participating in the Plan, you agree to support the Plan's rights to recover costs from third parties responsible for your illness or injury. This includes:

Your Responsibilities

- Cooperate fully with the Plan, including:
  - Notifying the Plan of potential third-party claims
  - Providing requested information
  - Signing documents to secure recovery rights
  - Responding to inquiries and attending legal proceedings
  - Obtaining Plan consent before releasing liability or settling claims
- Hold recovered funds in trust until the Plan is reimbursed
- Assign rights to the Plan for any applicable insurance benefits (e.g., auto, no-fault, PIP)
- Do not accept settlements that fail to fully reimburse the Plan without written approval

Enforcement Actions

If you fail to comply with these terms, the Plan may:

- Terminate or deny future benefits for you, your dependents, or the subscriber
- Take legal action and recover attorneys' fees, costs, and interest
- Offset future benefits equal to unrecovered amounts

Plan's Recovery Rights

- The Plan has a first-priority right to recover 100% of benefits paid, before any other claims (including provider liens)
- Recovery applies to all types of damages, regardless of how proceeds are labeled

- The Plan's rights are not limited by doctrines such as "made whole," "common fund," or "collateral source"
- These rights apply even if:
    - You are no longer covered under the Plan
    - You or your estate receive funds after death
    - A dependent child is involved

Administrative Authority

The Plan and its administrators have full discretionary authority to:

- Interpret and enforce subrogation and reimbursement provisions
- Determine amounts owed to the Plan

Legal Enforcement

- The Plan may take legal action, including filing suit in your name or your estate's name
- You and your representative are considered fiduciaries under ERISA for any recovered amounts

5.6 Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under **ERISA**. These include:

Access to Plan Information

- Review, at no cost, Plan documents (including insurance contracts and the latest annual report) at the Plan administrator's office or designated locations.
- Request copies of Plan documents and reports in writing; reasonable fees may apply.
- Receive a summary of the Plan's annual financial report.

Continuation of Coverage

- Elect COBRA continuation coverage for yourself, your spouse, or dependents following a COBRA qualifying event. You may be required to pay for this coverage. Refer to section 5.7 Information about COBRA Continuation for details.

Fiduciary Responsibilities

- Plan fiduciaries must act prudently and in your best interest.
- No one may interfere with your rights under the Plan or ERISA, including through discrimination or termination.

Enforcing Your Rights

- If your request for documents is ignored for more than 30 days, you may file suit in federal court. The court may impose penalties unless the delay was beyond the Plan administrator's control.

- If your benefit claim is denied or ignored, you may file suit after exhausting the Plan's claims process.
- You may also take legal action if:
    - You disagree with decisions about domestic relations or medical child support orders.
    - Plan fiduciaries misuse Plan assets.
    - You are retaliated against for asserting your rights.

ERISA Assistance and Questions

For help with ERISA rights or obtaining documents, contact the Employee Benefits Security Administration (EBSA) at:

- **U.S. Department of Labor**
  Division of Technical Assistance and Inquiries
  200 Constitution Avenue, N.W.
  Washington, D.C. 20210
- Phone: 1-866-444-3272
- Website: www.dol.gov/ebsa

5.7 Information about COBRA Continuation

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows employees and their covered spouses and dependent children ("qualified beneficiaries") to temporarily continue their group health coverage after it would otherwise end due to certain life events.

COBRA Covered Plans

The extension of coverage through COBRA applies to medical, dental, vision, HCFSA, LPFSA, and the EAP.

COBRA continuation coverage for medical, dental, vision, HCFSA, and LPFSA is offered at the qualified beneficiary's expense and is designed to help bridge the gap in coverage during transitions, such as employment changes or other qualifying circumstances.

COBRA coverage for the HCFSA or LPFSA is only available if the account is "underspent" (i.e., the maximum benefit available for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the plan year) at the time of the qualifying event. COBRA continuation for the HCFSA or LPFSA is limited to the end of the plan year in which the COBRA qualifying event occurred; however, any carryover amount is available for the maximum COBRA continuation period (as outlined below). If COBRA is elected, the qualified beneficiary must pay the remaining HCFSA/LPFSA contributions on an after-tax basis, plus a 2% administrative fee. This allows access to the full annual election amount for eligible expenses incurred through the end of the plan year (plus carryover amounts for the maximum COBRA continuation period).

COBRA continuation for the Employee Assistance Program is provided automatically and at no cost to qualified beneficiaries for the duration of the COBRA continuation period. To access EAP services during your COBRA continuation period, contact **TELUS Health** directly.

COBRA Qualifying Events

COBRA qualifying events include job loss, reduction in work hours, divorce, or a dependent child aging out of coverage. The following table outlines COBRA qualifying events and the maximum duration of COBRA coverage.

COBRA qualifying event	Who can elect COBRA coverage (Qualified Beneficiaries)	Maximum continuation period
Loss of benefits eligibility: your work schedule is reduced below 20 hours per week***	You and any of your covered dependents	18 months*
Termination of your employment (except in the case of gross misconduct)***	You and any of your covered dependents	18 months*
Your death	Your covered dependents	36 months
Divorce or legal separation from your spouse	Your spouse and your covered children (if they lose eligibility under the Plan due to the divorce or legal separation)	36 months
End of relationship status with your domestic partner	Your domestic partner and their covered children	36 months
Your entitlement to Medicare (Parts A, B, or both)	Your covered dependents**	36 months
Your child no longer meets the criteria to be a dependent under the Plan (due to age, child's disability status or other loss of dependency)	Your child that lost eligibility under the Plan	36 months

** Coverage may be extended by an additional 11 months if a qualified beneficiary is deemed disabled by the Social Security Administration within the first 60 days of COBRA coverage. Coverage for covered dependents who elect COBRA can also be extended for 18 additional months if the qualified beneficiary experiences a second qualifying event. See section above regarding the maximum continuation period for the HCFSA and LPFSA.*

*** Medicare entitlement is only a qualifying event if it results in loss of coverage.*

****If, within 18 months after becoming entitled to Medicare, you subsequently lose coverage under the Plan due to your termination of employment or reduction in hours, your spouse/domestic partner and dependent child become entitled to COBRA coverage for a maximum period that ends 36 months after you become entitled to Medicare. You remain entitled to a maximum period that ends 18 months after the termination of employment or reduction of hours.*

Note: While domestic partners are not federally recognized as qualified beneficiaries under COBRA, BMO and the Plan treats them as such.

COBRA Coverage Notification and Election

If you or any of your covered dependents lose coverage under the Plan (for the benefit options outlined above), and you timely provide notice of the qualifying event (if required), a COBRA election notice packet will be sent via mail. This notice includes instructions for enrolling and outlines the monthly premium cost. COBRA benefits match those offered to active employees, but you pay the full premium (both employee and employer portion) plus a 2% administrative fee.

Qualified COBRA beneficiaries have **60 days** from the later of the date COBRA election notice packet is received or the date the coverage ends to elect COBRA coverage. If the election deadline is missed, you and/or your dependents will lose the right to continue coverage.

Payment and Coverage Activation

Your first COBRA payment is due within **45 days** of your election and must cover the period from the date your coverage ended through the current month. Coverage is retroactive once both the enrollment form and payment are received by Inspira Financial and may take 7–10 business days to be reinstated by the claims administrator or insurer.

Each qualified beneficiary has the right to elect coverage independently. For example, a spouse may elect COBRA even if the employee does not.

COBRA Notification Requirements

You or your dependents must notify the BMO within **60 days** of the following qualifying events:

- Divorce or legal separation
- End of a relationship with a domestic partner
- A dependent losing eligibility

Failure to notify within 60 days will result in loss of COBRA continuation rights for those covered dependents (qualified beneficiaries). They will be removed from your active coverage backdated to the event date (the date they no longer meet the criteria to be a covered dependent) but will not be offered extended coverage through COBRA.

Special Circumstances for COBRA Coverage Extension

COBRA continuation coverage generally lasts 18 or 36 months but may be extended in certain cases. You must notify Inspira Financial of these events within required timeframes to qualify.

Disability Extension

If a qualified beneficiary is deemed disabled by the Social Security Administration (SSA) within the first 60 days of COBRA coverage, an **11-month extension** may apply. Notify Inspira within **60 days** of the latest of:

1. SSA's disability determination
2. The qualifying event
3. Loss of coverage
4. Receipt of COBRA notice

Notice must be submitted before the initial 18-month period ends. If SSA later determines the individual is no longer disabled, notify Inspira within 30 days. Coverage ends when SSA disability status ends.

Second Qualifying Event

Spouses/domestic partners and dependent children may receive an **additional 18 months** (up to 36 months total) if a second qualifying event occurs during the initial 18-month period. Events include:

- Death of the covered employee
- Divorce/separation or end of domestic partnership
- Employee's Medicare entitlement (but only if this would have caused the loss of active coverage)
- Dependent child losing eligibility

Notify Inspira within **60 days** of the second event. Late notice may result in loss of your extended coverage opportunity.

Send all extension notices to:

Inspira Financial Health, Inc.
Benefits Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374
Phone: 1-888-678-7835

COBRA Continuation Coverage Termination

COBRA coverage will automatically end when the maximum continuation period is reached but may end sooner if:

- A qualified beneficiary chooses to cancel COBRA coverage sooner
- Required premiums are not paid on time
- A qualified beneficiary becomes covered under another group health plan
- A qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA
- BMO stops offering group health coverage
- Coverage would have ended for reasons such as fraud or other disqualifying actions
- SSA determines the individual is no longer disabled (if receiving the 11-month disability extension)

Once COBRA coverage is canceled, re-enrollment is not allowed.

Special Enrollment Rights under other group plans

When you are deciding whether to enroll in COBRA continuation coverage, you should consider that you may qualify for special enrollment in another group health plan (e.g., through a

spouse's employer), Medicaid, or the Health Insurance Marketplace (www.healthcare.gov) within 30 days of losing coverage due to a qualifying event. These options may be more affordable than COBRA.

- More information is available in the COBRA Continuation of Rights legal notice on www.bmousbenefits.com.

COBRA Implications if you are Eligible for BMO's Retiree Plan

If you are eligible for coverage under the BMO U.S. Health and Welfare Benefit Plan for Retirees ("The Retiree Plan") and you elect COBRA continuation coverage for medical at retirement, you will permanently forfeit your right to enroll in the Retiree Plan.

However, you may elect COBRA continuation coverage for your dental, vision, HCFSA or LPFSA at retirement without impacting your eligibility for the Retiree Plan.

Medicare and COBRA: What You Need to Know

If you delay enrolling in Medicare Part A or B because you're still employed, you'll have an 8-month special enrollment period to sign up beginning on the earlier of:

- The month after your employment ends.
- The month after your active employer-based group health coverage ends.

Important Considerations:

- If you elect COBRA instead of enrolling in Medicare, you may face a late enrollment penalty and a gap in coverage if you later decide to enroll.
- If you enroll in Medicare Part A or B after electing COBRA, your COBRA coverage may be terminated early.
- However, if Medicare Part A or B is effective before your COBRA election, COBRA coverage cannot be terminated due to Medicare entitlement.

Coordination of Benefits:

- If you are enrolled in COBRA and are eligible for Medicare, Medicare pays first (primary), and COBRA pays second (secondary). Therefore, if you do not enroll in Medicare, you will be responsible for the costs that Medicare would have paid.

For more details about Medicare, visit www.medicare.gov/medicare-and-you.

5.7.1 Subsidized COBRA for Survivors

Survivors of deceased employees may continue medical coverage for up to 36 months by applying for continuation coverage under COBRA. During the 36-month period, covered dependents will pay the active medical employee premiums. In a mailing from Inspira, you will receive information regarding COBRA including monthly premiums and enrollment forms. If the employee met the requirements for medical coverage under the Retiree Medical Plan at the time of their death and both the employee and the survivors were enrolled in the medical plan

immediately before the employee's death; surviving dependents have the option to enroll in the Retiree Medical Plan or elect continuation coverage under COBRA.

It is important to know that if you choose to enroll in subsidized COBRA coverage for medical instead of Retiree Medical Plan coverage, your rights to enroll in Retiree Medical Plan coverage in the future are forfeited.

5.8 Other Important Legal Notices

BMO and the Plan are required to provide certain legal notices, including:

- COBRA Continuation of Rights
- Creditable Coverage Notice
- Employee Rights Under FMLA
- HIPAA Notice of Privacy Practices
- Marketplace Health Insurance Coverage Options Notice
- Notice of Special Enrollment Rights
- Medicaid and the Children's Health Insurance Program (CHIP)
- Women's Health and Cancer Act of 1998
- Notice for Illinois Employees

These notices will be provided to you in October of each year and are also available at any time on www.bmousbenefits.com. You may also contact the HRC at 1-888-927-7700 to request paper copies of these notices or this SPD at any time.

5.9 Privacy and Protected Health Information

During the administration of the Plan, certain BMO personnel, claims administrators, and insurers may have access to information classified as "protected health information" (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To support our compliance with HIPAA, the Plan annually provides employees with a HIPAA Notice of Privacy Practices outlining how PHI may be used and disclosed, as well as your rights and protections under the law. This Privacy Notice is also available online at any time on www.bmousbenefits.com.

If you would like to request a paper copy of the Privacy Notice, have questions about how your PHI is handled or have concerns, please contact the HIPAA Privacy Officer:

Head of U.S. Benefits
395 N. Executive Drive, 3rd Floor-HR
Brookfield, WI 53005
usbenefits@bmo.com

5.10 Uncashed Claims Reimbursement Checks

If a benefit payment or reimbursement check remains uncashed after **180 days** (or the expiration date printed on the check, if later), it will be handled as follows:

- **Paid from BMO Assets**:
  The funds will be returned to the bank or BMO.
- **Paid from a Trust Fund**:
  The funds will be returned to the trust fund.
- **Paid by an Insurer**:
  Treatment of uncashed checks will follow the insurer's policies.

5.11 Employment Disclaimer

Participation in this Plan does not create a contract of employment between BMO Financial Corp. and any employee.

Being a Plan participant does not grant current or future employment rights, and Plan participation is not a condition of employment.