Summary Plan Description

BMO U.S. Health and Welfare Benefit Plan for Retirees

Plan 508

Effective January 1, 2026

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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 for Retirees** (the "Plan") for eligible BMO U.S. retirees.

This document serves as a consolidated, Employee Retirement Income Security Act of 1974 ("ERISA")-compliant SPD that "wraps" the various health and welfare component plans 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 component plans include:

- Medical (Pre-Medicare coverage)
- Medicare Secondary Health Reimbursement Arrangement (HRA) Plan
- Dental (Closed Group)
- Vision (Closed Group)
- Basic Life Insurance (former Bank of the West retirees only)
- Accidental Death and Dismemberment Insurance Plan (Closed Group)

This SPD is intended to satisfy the disclosure requirements of ERISA, as amended. For detailed information about specific benefits - such as coverage levels, deductibles, copayments, exclusions, and limitations - please refer to the applicable benefit booklets or insurance certificates.

The terms and conditions of the Plan are set forth in this SPD and the Welfare Program Documents related to the benefits under the Plan. Together, the SPD and the Welfare Program Documents constitute 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 and Cost for Benefits

You and your eligible dependents may be able to participate in the Retiree Medical Program if you meet the eligibility criteria listed below. Eligibility to participate in the Retiree Medical Program generally differs depending on whether you are eligible under:

- **BMO,**
- **Marshall & Ilsley Corporation ("M&I"), or**
- **Bank of the West**

(Together, the "Companies"). Eligibility criteria for retirees of each group is outlined below.

You are not eligible to participate in the Retiree Medical Program if, while an employee, you performed services for the Companies under an agreement or arrangement between the Companies and a third party that designated you as an independent contractor or consultant or that excluded you from Plan participation. You are not eligible for retiree medical coverage if your employment with the Companies was terminated due to misconduct, including but not limited to, dishonesty, theft, embezzlement, disclosure of trade secrets, commission of a felony, or inappropriate behavior or if you voluntarily terminated your employment after having committed such acts.

1.1 Eligibility Provisions for BMO Retirees

Qualifications for Coverage

You are eligible for the Retiree Medical Program if:

- you retire at age 55 or older with at least 10 years of service with any BMO entity; and
- you are working as a U.S. employee immediately preceding your retirement; and
- you are enrolled in a BMO-sponsored medical plan immediately preceding your retirement.

Different eligibility requirements and contribution percentages may apply if you were hired through one of the acquisitions or mergers as stated under Companies Acquired by BMO Financial Group U.S.

Coverage under the BMO U.S. Health and Welfare Benefit Plan for Retirees Health Reimbursement Arrangement ("Retiree HRA") when you become Medicare eligible

(because of age or disability) is not available if you were hired or rehired on or after January 1, 2008, or younger than age 35 as of December 31, 2007.

Special Eligibility Rule for Employees of Divested Companies

If your employment with BMO ends in connection with a sale or other divestiture that occurs on or after June 1, 2015 and all of the conditions set forth below are met, you will be eligible to participate in the Retiree Medical Program on the date that you would have first become eligible to participate in the Retiree Medical Program had your employment with BMO not ended:

- You are employed by the successor company immediately following the sale or other divestiture;
- You would have been eligible to participate in the Retiree Medical Program within two years of the date of the sale or other divestiture had you remained an employee of BMO; and
- The sale agreement or other document authorizing such sale or divestiture provides for special Retiree Medical Program eligibility as described in this section.

Companies Acquired by BMO Financial Group U.S.

You are eligible for retiree medical coverage if you meet the requirements described above. Generally, your eligibility for the Retiree Medical Program starts on the later of the actual (closing) date your company was acquired or the date your company joined the Plan, whichever is later.

For certain acquisitions (which are asterisked in the chart below) your period of employment going back to your latest hire date with the acquired company may be recognized for purposes of determining eligibility in the Retiree Medical Program.

Acquired Company	**Acquisition Date**
Argo State Bank*	July 31, 1982
Chemical Bank	January 3, 1984
National Westminster Bank USA	January 18, 1985
Bank of Montreal*	January 1, 1986
Derivative Markets	March 20, 1986
Wilmette	January 1, 1987
Marine Midland National Bank	September 20, 1985
Naperville	January 1, 1988
Barrington*	January 1, 1989

Roselle*	January 1, 1989
Batavia	January 1, 1989
Glencoe-Northbrook	January 1, 1989
Hinsdale	January 1, 1989
St. Charles	January 1, 1989
Winnetka	January 1, 1989
Libertyville*	May 1, 1990
Frankfort	October 1, 1990
Nesbitt Thompson Securities*	April 1, 1992
Suburban	January 1, 1995
Household	June 29, 1996
Burns Fry*	January 1, 1997
KeyCorp*	January 2, 1997
Burke, Christensen & Lewis (BCL)	January 1, 2000
Village Bank of Naples	July 3, 2000
Freeman Welwood	October 1, 2000
Century Bank	December 15, 2000
First National Bank of Joliet	July 13, 2001
CSFB Direct	February 1, 2002
Northwestern Trust	April 1, 2002
MyCFO	November 1, 2002
Sullivan, Bruyette, Speros and Blayney (SBS)	January 16, 2003
Gerard Klauer Mattison (GKM)	July 3, 2003
Lakeland Community Bank	February 27, 2004
New Lenox State Bank	June 1, 2004
Mercantile National Bank	December 30, 2004
Villa Park Trust and Savings Bank	January 1, 2006

First National Bank & Trust (FNBT)	January 4, 2007
Fidelity Information Services	January 1, 2007 or on employee hire date with Harris N.A., whichever is later
Merchants & Manufacturers Bancorporation, Inc.	March 1, 2008
Ozaukee Bank	March 1, 2008
Griffin, Kubik, Stephens & Thompson	July 1, 2008
Pierce, Givens & Associates, LLC	February 13, 2009
Stoker Ostler Wealth Advisors	September 9, 2009
Citicorp Diners Club Inc.	January 1, 2010
Amcore N.A.	April 24, 2010
Marshall & Ilsley Corporation (M&I)	July 6, 2011
CTC Consulting LLC	June 1, 2012
General Electric Transportation Finance	December 1, 2015 *(Service date varies depending on hire date.)*
Greene, Holcomb, Fisher, LLC	August 1, 2016
FIS	April 8, 2017
KGS Alpha	September 1, 2018
Clearpool Group Inc.	April 6, 2020
PeopleScout	July 1, 2020
Radical	December 1, 2022
Bank of the West	February 1, 2023

Rehired employees

If you are rehired on or after January 1, 2008, you will become part of eligibility group 4 for the Retiree Medical Program. Your prior service time will be counted for Retiree Medical Program eligibility; however, the timeframe you were not employed with BMO is considered a “break-in-service” and will not be counted in your service time calculation. Please note, your prior service time will not count towards eligibility for BMO funding.

Individuals participating in the Retiree Medical Program immediately prior to the date of rehire are considered active participants of the waiver program and will maintain their current BMO

contribution, if any, and current retiree group classification based on their initial retirement date. No additional service time is gained.

The Retiree Medical Program was redesigned effective January 1, 2008, and employees were classified into eligibility groups to determine what benefits and funding would be offered to them and their dependents during retirement. Your age and years of service, as of December 31, 2007, were used to determine your eligibility group. See How BMO Contributes for more information.

Eligibility for Dependent of BMO Retirees – Pre-Medicare Coverage

At the time of your retirement, your eligible dependents can enroll in the Retiree Medical Program, regardless of whether they were enrolled in the active medical plan. However, if they were not enrolled in the active medical plan, then they need to have a loss of other group coverage in order to enroll, and they must enroll within 31 days of the loss of coverage. The only exception to this is a birth or adoption, in which case, the new child may be added to coverage within 90 days of the event. Children are allowed to stay on coverage until the end of the month in which they turn age 26, at which time they will be offered COBRA (qualified disabled adult children may be able to stay on after age 26).

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless of whether you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring your eligible dependents, you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the Retiree Medical Program in the future, except for new biological or adopted children.

Your dependents do not need to be enrolled in BMO's active medical plan when you retire. The dependent must meet the definition of an eligible dependent at the time of your retirement and at the time you request to enroll them in coverage. You are only able to add the following members to your medical coverage later if they continue to meet the dependent definition, as applicable:

- Your legal spouse or your qualified domestic partner at the time of your retirement date;
- Your existing eligible dependent children at the time of your retirement.

Plan cost for BMO Retirees

You and BMO share in the cost of the Retiree Medical Program. Your share of the premium (and the premium for any eligible dependents you enroll) depends on:

- your years of service with BMO;
- your age;
- the medical plan coverage option you select.

Costs for the Retiree Medical Program are based on coverage and administrative fees for the retiree group and are different from the active employee rates. Once you or your spouse/domestic partner/dependent child are Medicare eligible, your coverage under the Retiree Medical Program will change to the HRA. To be covered under the Retiree HRA, you are required to enroll in a medical plan through Via Benefits. For information regarding BMO's contribution to your/your spouse's/domestic partner's/dependent child's HRA, see the chart Your Plan Options/How BMO Contributes below.

How BMO Contributes

BMO made changes to the retiree medical benefits effective January 1, 2008, and your age and years of service (in months and years) as of December 31, 2007 will be used to determine the group you are classified under. The group will determine your access and BMO contribution for retiree medical benefits.

How to Determine Your Years of Benefit Service

In general, your service begins on your hire date with BMO, however, some employees will need to know their vesting service, while others will need to know their benefit service. Generally, benefit service begins on the actual date your company was acquired or the date your company joined the Plan, whichever is later. See Companies Acquired by BMO Financial Group U.S. for more information.

You have the flexibility to view your service dates at any time by accessing your job details in Workday.

How to Determine Your Retiree Group

In addition to meeting the eligibility and qualifications criteria to be eligible for retiree benefits, the following special rules apply:

Group 1 and Group 2	Employees who on 12/31/2007 were age 55 or older with at least 10 years of benefit service* or age 45 or older with at least 60 points (your points are your age plus years of benefit service) will pay a percentage of the medical premium. BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%. Your spouse/domestic partner and child(ren) will pay an additional 25% of the premium. See the Contribution schedule for more details. * *Generally, your hire date with BMO can be used to determine your benefit service.*

Example: A retiree with 25 years of benefit service will pay 45% of the monthly premium. The full monthly premium for the BCBSIL HDHP is $$1,382.40, the retiree will pay 45% or $622.08 per month. The spouse pays an additional 25% of the full monthly premium, which means the cost for spouse coverage is 70% (45% + 25%) or $967.68. The total cost for retiree + spouse is $1,589.76 per month.	
Group 3	Employees who on 12/31/2007 were age 35 or older, who are not in Groups 1 or 2, for coverage before age Medicare eligibility, will pay a percentage of the medical premium. Beginning at the age of 65 (or when you are otherwise Medicare-eligible), you will receive an HRA contribution from BMO to cover the cost of eligible medical expenses (as defined in the HRA summary plan description). You will receive a capped annual subsidy of $70, times years of benefit service, up to a maximum of $2,450 per year (An aggregate of $600 less for your Medicare-eligible spouse/domestic partner/child(ren)). The value of your contribution will be fixed when you reach age 65/Medicare eligibility – with no future increase. The subsidy will continue for your lifetime. In the event of your death, your Medicare-eligible spouse/domestic partner/child(ren) contribution would also continue for his or her lifetime.
Example: If you retire from BMO with 25 years of benefit service, BMO will pay $70 x 25, or $1,750 per year toward the cost of your retiree medical coverage once you are Medicare eligible because of age or disability. Your spouse’s subsidy would be $1,150 per year.	
Group 4	Employees who on 12/31/2007 were under age 35 and who retire before age 65 will have to pay the full cost of coverage. BMO does not offer retiree medical coverage or the HRA contribution once you reach age 65. You would be responsible for your own coverage, which can be through Medicare and/or an individual insurance plan.

Contribution Schedule

Years of service	You Pay	Spouse Pays	Years of service	You Pay	Spouse Pays
10	75%	100%	**23**	49%	74%
11	73%	98%	**24**	47%	72%

12	71%	96%	**25**	45%	70%
13	69%	94%	**26**	43%	68%
14	67%	92%	**27**	41%	66%
15	65%	90%	**28**	39%	64%
16	63%	88%	**29**	37%	62%
17	61%	86%	**30**	35%	60%
18	59%	84%	**31**	33%	58%
19	57%	82%	**32**	31%	56%
20	55%	80%	**33**	29%	54%
21	53%	78%	**34**	27%	52%
22	51%	76%	**35 or more**	25%	50%

BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%.

Your spouse/domestic partner and child(ren) pay an additional 25% of the premium.

Retiree Group	Your Plan Options		How BMO Contributes	
Employees who by 12/31/2007 were:	**Pre-Medicare**	**Post-Medicare**	**Pre-Medicare**	**Post-Medicare**
1 Age 55 or older with at least 10 years of benefit service*	You have access to the same plan options as active employees.	You will have access to the Retiree HRA.	BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%. The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	BMO HRA contribution: The full monthly cost of the post-Medicare coverage ($272[1]) times the percentage that BMO contributes based on the provision of the retiree medical program. For Medicare-eligible spouses/domestic partners/dependent children, the contribution is 25% less than the contribution for the retiree.
2 Age 45 or older with at least 60 points (your points are your age plus years of benefit service)*	You have access to the same plan options as active employees.	You will have access to the Retiree HRA.	BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%.	BMO HRA contribution: The full monthly cost of the post-Medicare coverage ($272[1]) times the percentage that BMO contributes based on the provision of the retiree medical program. For Medicare-eligible spouses/domestic partners/dependent children, the

			The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	contribution is 25% less than the contribution for the retiree.
3 Age 35 or older (but not in either group above)**	You have access to the same plan options as active employees.	You will have access to the Retiree HRA.	BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%. The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	BMO will provide an annual HRA contribution that will begin at age 65 (or, if earlier, once you are eligible for Medicare) and equal $70 times years of benefit service (up to 35 years) earned in the Plan. Your Medicare-eligible spouse/domestic partner/child(ren) will receive an aggregate of $600 less.
4 Under age 35**	You have access to the same plan options as active employees.	No coverage available through BMO.	You pay the full cost of coverage.	N/A

* Generally, your hire date with BMO can be used to determine your benefit service.
** Employees hired or rehired on or after January 1, 2008 will be part of Group 4.

[1] $272 is the actuarial value of the previous BMO Medicare Supplement Plan based on current individual market rates.

Pre-65 Plan Option (Not Medicare Eligible)	How to calculate your share of the premium		
Retiree Only	Total premium = *Retiree Only* premium x Retiree Pays % ***Example with 20 years of service:*** $1,382.40 x 55% = $760.32		
Spouse Only	Total premium = *Spouse Only* premium x Dependent Pays %		
Retiree+Spouse Determine the share of the premium for the retiree versus the spouse and apply applicable percentages	Step 1 Retiree share of premium = *Retiree Only* premium x Retiree Pays %	Step 2 Spouse share of premium = (*Retiree+Spouse* premium - *Retiree Only* premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Spouse share of premium
EXAMPLE **Retiree+Spouse**: 14 years of benefit service	Retiree share of premium = $1,382.40 x 67% = $926.21	Spouse share of premium = ($2,764.80 - $1,382.70) x 92% = $1,271.81	Total premium = $926.21 + $1,271.81 = $2,198.02
Retiree+Child(ren) Determine the share of the premium for the retiree versus the child(ren) and apply applicable percentages	Step 1 Retiree share of premium = *Retiree Only* premium x Retiree Pays %	Step 2 Children share of premium = (*Retiree+Child(ren)* premium - *Retiree Only* premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Child(ren) share of premium
Spouse+Child(ren)	Total premium = *Spouse+Child(ren)* premium x Dependent Pays %		
Child(ren) Only	Total premium = *Child(ren) Only* premium x Dependent Pays %		
Family Determine the share of the premium for the retiree versus the spouse & child(ren) and apply	Step 1 Retiree share of premium = *Retiree Only* premium x Retiree Pays %	Step 2 Spouse & Child(ren) share of premium = (*Family* premium -	Step 3 Total premium = Retiree share of premium + Spouse &

applicable percentages		*Retiree Only* premium) x Dependent Pays %	Child(ren) share of premium
EXAMPLE **Family**: 23 years of benefit service	Retiree share of premium = $1,382.40 x 49% = $677.38	Family share of premium = ($3,456.00 - $1,382.40) x 74% = $1,534.46	Total premium = $677.38 + $1,534.46= $2,211.84

How to Determine Your Share of the Monthly Premium

To calculate your share of the premium you will need the full monthly retiree medical premiums and your contribution percentages.

2026 **Pre-65/Not Medicare Eligible Plan Option**	**Retiree Only or Spouse Only**	**Retiree + Spouse**	**Retiree + Child(ren) or Spouse + Child(ren)**	**Child(ren) Only**	**Family**
BCBSIL HDHP	$1,382.40	$2,764.80	$2,073.60	$691.20	$3,456.00
Kaiser (N. CA) HDHP	$1,545.29	$3,399.85	$2,735.44	-	$4,589.69
Kaiser (S. CA) HDHP	$1,202.22	$2,645.12	$2,128.22	-	$3,570.48
Kaiser (CO) HDHP	$1,189.78	$2,498.37	$2,259.99	-	$3,568.18
Kaiser (OR) HDHP	$967.01	$2,127.65	$1,885.57	-	$4,020.11
BCBSIL PPO	$1,493.10	$2,986.20	$2,240.10	$747.00	$3,733.20
Kaiser (N. CA) HMO	$1,902.18	$4,185.01	$3,367.14		$5,649.33
Kaiser (S. CA) HMO	$1,479.79	$3,255.75	$2,619.51		$4,394.83
Kaiser (CO) HMO	$1,464.43	$2,618.55	$2,320.69		$4,948.35
Kaiser (OR) HMO	$1,190.15	$2,618.55	$2,320.69		$4,948.35

Paying for Retiree Premiums

Retiree medical premium billing for any pre-Medicare individuals is administered by Inspira Financial Health, Inc. If you would like to pay for your retiree medical premiums via automatic deduction from a checking or savings account, you must complete the Inspira Financial Depositor Authorization Form and return as directed on the form. If you do not enroll in the automatic payment option and wish to pay your premiums by sending a check, you will receive coupons from Inspira Financial. Payments are due the first of each month and must be made within the 30-day grace period or coverage will be cancelled and cannot be reinstated.

You can view your account online by visiting www.inspirafinancial.com and completing the registration. Once you register you can manage your account online, view your payment history, and set up account alerts.

The portion that BMO pays toward the cost of retiree medical coverage, if any, for qualified domestic partners and domestic partner children (if they are a tax dependent) is considered taxable. Retirees covering a domestic partner under the Retiree Medical Program will receive a tax form each year reflecting this amount. In addition, you will be responsible for applicable income taxes.

Special Eligibility Provisions

Certain retirees are eligible for different benefits than those described above, including:

- 100% funding in the HRA based on medical plan enrollment with Via
- Dental coverage at full rate
- Dental coverage at active rate
- Dental coverage at no cost

You should have received written correspondence from BMO confirming that you are eligible for one or more of the benefits listed above.

1.2 Eligibility Provisions for Marshall & Ilsley Corporation Acquisition

This section applies if you were an employee of M&I.

If you were rehired after M&I's acquisition (closing) date with BMO and were not retiree medical eligible when you terminated the first time, see How BMO Contributes above for more information.

Your Retiree Medical Program eligibility is based off the provisions of the legacy M&I Retiree Medical Program if you were on staff as of July 5, 2011 and have not had a break in service after July 5, 2011. If you experienced a break in service after July 5, 2011 and were rehired, you need to satisfy the eligibility requirements of the BMO Retiree Medical Program provisions from your rehire date, unless you were eligible when you first terminated.

The Retiree Medical Program is available to eligible retirees and their eligible dependents based on the guidelines indicated below.

Eligibility and Qualifications for Pre-Medicare Coverage

Different eligibility requirements and funding levels may apply if you were hired through one of the acquisitions or mergers as stated under the *Acquisitions/Mergers* section below.

Access to Pre-Medicare retiree medical coverage is available to employees ages 55 to 64 (who are not otherwise eligible for Medicare) who at retirement meet the following requirements:

- are at least 55 years old;
- have at least 10 years of vesting service* with M&I and/or BMO; and
- have participated in any M&I and/or BMO medical coverage for at least 10 consecutive years immediately prior to retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).

Retirees who meet the qualifications for the Retiree Medical Program who are eligible for Medicare will have access to coverage through VIA Benefits.

* *In order to earn one year of vesting service, you must be actively employed and work at least 1,000 hours during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.

Special Eligibility for Retirees who were Employed by Metavante Corporation at the time Metavante Split from M&I Corporation on November 2, 2007: Retirees who met the above eligibility guidelines as of November 2, 2007 are eligible for the Retiree Medical Program as of the date they retire from Metavante Corporation. Funding level is based off of eligibility for the program as of November 2, 2007.

Eligibility for Dependent of M&I Retirees – Pre-Medicare Coverage

At the time of your retirement, your eligible dependents can enroll in the Retiree Medical Program, regardless of whether they were enrolled in your active medical coverage. However, if they were not enrolled in the active medical coverage, then they need to have a loss of other group coverage in order to enroll, and they must enroll within 31 days of the loss of coverage. The only exception to this is a birth or adoption, in which case, the new child may be added to coverage within 31 days of the event. Children are allowed to stay on coverage until the end of the month in which they turn age 26, at which time they will be offered COBRA (qualified disabled adult children may be able to stay on after age 26).

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless of whether you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring your eligible dependents, you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the Retiree Medical Program in the future, except for new biological or adopted children.

Your dependents do not need to be enrolled in your active medical plan when you retire. The dependent must meet the definition of an eligible dependent at the time of your retirement and at the time you request to enroll them in coverage. You are only able to add the following members to your medical coverage later if they continue to meet the dependent definition, as applicable:

- Your legal spouse or your qualified domestic partner at the time of your retirement date;
- Your existing eligible dependent children at the time of your retirement.

Eligibility and Qualifications for Post-Medicare Coverage

Different eligibility requirements and funding levels may apply if you were hired by M&I through one of the acquisitions or mergers as stated under the *Acquisitions/Mergers* section below.

Access to post-Medicare coverage is available through VIA Benefits to employees ages 65 and older or who are otherwise eligible for Medicare and who, at retirement, meet the following requirements:

- are at least 55 years old;
- have at least 10 years of vesting service* with M&I and/or BMO; and
- have participated in any M&I and/or BMO medical coverage** for at least 10 consecutive years immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).

Retirees who meet the qualifications for the Retiree Medical Program who are eligible for Medicare will have access to coverage through VIA Benefits..

In order to receive the funds from your HRA (if eligible), you must enroll in a medical plan through Via Benefits.

* *In order to earn one year of vesting service, you must be actively employed and work at least 1,000 hours during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

Special Eligibility for Retirees who were Employed by Metavante Corporation at the time Metavante Split from M&I Corporation on November 2, 2007*: Retirees who met the above eligibility guidelines as of November 2, 2007 are eligible for the Retiree Medical Program as of the date they retire from Metavante Corporation (or its successor). Funding level is based off of eligibility for the program as of November 2, 2007.*

Plan Cost for Legacy M&I Retirees

Funding

Employer Group **(Employees must also meet the requirements as stated under "Qualifications for Pre-Medicare Coverage" above)**	**Employer Subsidy towards the retiree group rate**
Active employees on staff prior to 9/1/97 (without a break in employment of more than 30 days on or after 9/1/97)	**60%**
Employees hired or acquired on or after 9/1/97	**0%** (Retiree pays 100% of the cost)

Funding

The following chart applies to active employees on staff prior to September 1, 1997 (without a break in employment of more than 30 days on or after September 1, 1997):

Employee Group	**HRA Contribution**

(Employees must meet the requirements as stated under "Qualifications for Post-Medicare Coverage" in addition to the requirements listed below)	
Employees age 60 or older as of 8/31/02 Who, at the time of retirement: meet the "Rule of 75" (age + years of vested service = 75)	BMO HRA contribution: The full monthly cost of the post-Medicare coverage ($272[2]) times 60%. For Medicare-eligible spouses/domestic partners/dependent children, the contribution is 25% less than for the retiree.
Employees age 55 to 59 as of 8/31/02 Who, at the time of retirement: meet the "Rule of 75" (age + years of vested service = 75)	BMO HRA contribution: The full monthly cost of the post-Medicare coverage ($272[2]) times 40%. For Medicare-eligible spouses/domestic partners/dependent children, the contribution is 25% less than for the retiree.
Employees under age 55 as of 8/31/02	No HRA contribution
Employees over age 54 as of 8/31/02 Who at the time of retirement: do not meet the "Rule of 75" (age + years of vested service = 75)	No HRA contribution

***Employees hired on or after September 1, 1997* who meet the eligibility requirements as stated under "Qualifications for Post-Medicare Coverage" are eligible for access to retiree medical coverage (the retiree pays 100% of the cost).**

Waiver Provision Prior to Retirement

After December 31, 2006, if you are age 55 or older, have 10 or more years of vested service, and have participated in a BMO-sponsored health plan for 10 or more consecutive years, you may waive your medical coverage as an active employee **without** losing your eligibility for retiree coverage. As long as you meet these requirements at the time of the waiver, you do not have to meet the 10-year participation requirement immediately prior to retirement. If you

[2] $272 is the actuarial value of the previous BMO Medicare Supplement Plan based on current individual market rates.

waived your M&I medical coverage prior to January 1, 2007 when this provision was implemented, this provision does not apply.

If you choose to waive your medical coverage as an active employee, you may do so during the annual enrollment period or as the result of a qualifying event by making your changes via the online benefits portal. You may re-enroll in coverage during the annual enrollment period (effective the following January 1st); as the result of a qualifying event (effective based on rules under Qualifying Life Event); or at retirement (effective the day following your last working day).

Please note: Enrollment rules vary by health plan and all current options may not be available at the time you request re-enrollment.

Acquisitions/Mergers

The following guidelines apply to both pre- and post- Medicare coverage.

Employees who were hired by M&I through an acquisition or merger *prior to September 1, 1997** fall under the guidelines indicated in the above sections. The 10-year participation in an M&I and/or BMO health plan requirement will be waived, provided you meet the following guidelines:

- You enrolled in any M&I or/or BMO health plan at the time of the acquisition/merger and have been continuously enrolled immediately before your retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).
- You have not had a break in service of more than 30 days since the acquisition/merger date. You meet the other requirements as stated in the above sections: you are at least age 55 at the time of your retirement, and you have at least 10 years of vested service (vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I & BMO and/or the previous employer; any time after 2004 during which you receive severance pay is treated the same as full-time active employment). *Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

Additional qualifications for eligibility and employer funding may apply if you were hired by M&I through a merger or acquisition on or after September 1, 1997* as indicated below.

** Former employees of Valley Bancorporation fall under the guidelines as indicated below.*

Eligibility/Funding

If you were hired by M&I through one of the acquisitions or mergers indicated below, you are eligible for access to retiree medical coverage if at retirement:

- you are at least 55 years old; and
- you meet the requirements as indicated by the categories below.

The guidelines below apply to former employees of Valley Bancorporation – Acquired by M&I 6/1/94:

- Eligible employees who retired *prior to January 1, 1995*, are eligible for employer funding based on years of vested service*:

Years of Service	Employer Funding
0 – 9	0%
10– 14	20%
15 – 19	30%
20 – 24	40%
25+	50%

- Employees who retire *on or after January 1, 1995*, are eligible for the following:

Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by the acquired company and/or M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.

10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by Valley Bancorporation and/or M&I** and/or BMO immediately before retirement: pre-Medicare retiree medical coverage is available at 100% of the retiree group rate; no post-Medicare coverage is available (i.e., no HRA contribution).

10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan** following the acquisition and immediately before retirement: retiree medical coverage is available based on the guidelines as described under the *Qualifications for Pre-Medicare Coverage* and *Qualifications for Post-Medicare Coverage* sections above.

* *Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or Valley Bancorporation. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of the following acquired companies:

Central Fidelity Bank – Acquired by M&I 9/1/97
Security Bank – Acquired by M&I 10/1/97
Citizens Bank – Acquired by M&I 11/1/97
Advantage Bank – Acquired by M&I 4/1/98
Fifth Third Bank – Acquired by M&I 9/8/01

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO ** immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): pre-Medicare retiree medical coverage is available at 100% of the retiree group rate; no post-Medicare coverage is available (i.e., no HRA contribution).

* *Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I & BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

** *Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of National City Bank (NCB) – Acquired by M&I 8/1/01:

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO ** immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): pre-Medicare retiree medical coverage is available at 100% of the retiree group rate; no post-Medicare coverage is available (i.e., no HRA contribution).

Grandfathered Employees: Employees at least age 55 with 10 or more years of vesting service* at the earlier of June 30, 2002 or the date of retirement, and 10 or more consecutive years of participation in a health plan sponsored by NCB or M&I or BMO as of the date of retirement are eligible for pre- Medicare funding based on the declining scale below:

Year	Employer Funding
2004	35%
2005	30%
2006	25%
2007	20%
2008	15%
2009	10%
2010+	0%

* *Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

** *Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of the following acquired companies:

First Indiana Bank Trust Company – Acquired by M&I 1/1/06

First Indiana Bank – Acquired by M&I 1/1/08:

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by acquired company and/or M&I and/or BMO *** before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO *** before

retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): pre-Medicare retiree medical coverage is available at 100% of the retiree group rate; no post-Medicare coverage is available (i.e., no HRA contribution).

First Indiana Bank Grandfathered Employees: Employees who meet the Rule of 75 (age + years of vested service is equal to or greater than 75*) as of December 31, 2007, are eligible for pre-age Medicare employer subsidy based on the following declining schedule in place at the time of retirement provided they meet the eligibility guidelines as described above at the time of retirement:

Year	Employer Subsidy**
2008	75%
2009	50%
2010	25%
2011+	0%

The subsidy is applied to the portion of the premium which is equal to the difference between the adjusted 2007 First Indiana plan rate and the current retiree group rate. Any remaining portion of the premium is not subsidized. (Employer funding is* ***not *provided to former employees of First Indiana Bank Trust Company.)*

Pre-Medicare retiree medical coverage is available at 100% of the retiree group rate to former employees of First Indiana Bank and First Indiana Bank Trust Company; no post-Medicare coverage is available (i.e., no HRA contribution).

**Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Any time after 2004 during which you receive severance pay is treated the same as full-time active employment.*

***Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of the following M&I acquired companies:

Acquired Company	Acquisition Date
CardPro	April 1, 1999
Traveler's Express	April 9, 1999

HUBCO	November 13, 1999
Derivion Corporation	June 1, 2001
CyberBills	June 21, 2001
Brokat	September 8, 2001
401k Services.Com	December 20, 2001
Century Bank	March 1, 2002
Richfield Bank	March 1, 2002
TrustStar Retirement Services – Glendale location	April 8, 2002
– San Mateo location	April 15, 2002
Beneplan	May 1, 2002
Paytrust, Inc.	July 22, 2002
Southwest Bank	October 1, 2002
Printing for Systems, Inc. (PSI)	November 15, 2003
AmerUs Home Lending Inc	January 1, 2004
United Missouri Bank	Various acquisition dates by individual
Kirchman Corporation	May 28, 2004
Advanced Financial Solutions (AFS)	July 1, 2004
NYCE Corporation	July 30, 2004
Response Data Corporation (RDC)	September 8, 2004
NuEdge	October 20, 2004
VECTORsgi Holdings Inc.	November 22, 2004
Prime Associates, Inc.	February 9, 2005
MBI Benefits, Inc.	July 22, 2005
TREEV	August 8, 2005
GHR	August 11, 2005
Brasfield Technology, LLC	October 6, 2005
Link2Gov	November 30, 2005

AdminiSource Communications	January 3, 2006
Gold Banc Corporation, Inc.	April 1, 2006
Trustcorp Financial, Inc. (Missouri State Bank and Trust Company)	April 1, 2006
VICOR, Inc.	September 2, 2006
Valutec Card Solutions, LLC	January 17, 2007
United Heritage Bank	April 1, 2007
North Star Financial Corporation	April 21, 2007
Excel Bank Corporation	July 1, 2007
Citizens Bank (asset purchase)	January 1, 2008
Taplin, Canida & Habacht, Inc. (TCH, LLC)	January 1, 2009
U.S. Bank (asset purchase)	May 3, 2010

- Less than 10 years of vesting service with M&I and/or BMO * following the acquisition, and less than 10 consecutive years of participation in any health plan sponsored by M&I and/or BMO ** immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service with M&I and /or BMO * following the acquisition, and 10 or more consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): pre-Medicare retiree medical coverage is available at 100% of the retiree group rate; no post-Medicare coverage is available (i.e., no HRA contribution).

** To earn one year of vesting service, you must be actively employed and work at least 1,000 hours with M&I and/or BMO during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

***Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

How to Determine Your Share of the Monthly Premium

To calculate your share of the premium you will need the retiree medical rate to determine your amount. To calculate your share of the premium:

- **Step 1:** Determine the full premium amount for the option you are choosing.
- **Step 2:** Apply your applicable (pre-Medicare coverage) contribution percentage.

Example: You and your spouse are both under 65 and not otherwise eligible for Medicare: Total premium = *Retiree+Spouse* premium x your contribution % for pre-Medicare coverage. Eligible dependents will receive the same contribution percentages that the retiree is eligible for. Refer to How to Determine Your Share of the Monthly Premium for the full retiree rates.

Enrolling & Changes Under the Retiree Medical Program (for BMO and M&I Retirees)

Coverage Options for Pre-Medicare Coverage

Retirees are eligible to enroll in the following tiers: Retiree Only or Spouse/Domestic Partner Only, Retiree + Spouse/Domestic Partner, Retiree + Child(ren) or Spouse/Domestic Partner + Child(ren), Child(ren) Only, or Family.

You decide which coverage option best meets your and your family's needs. In cases where both the retiree and their eligible dependents are under age 65 and not otherwise Medicare eligible, all must enroll in the Family coverage level in the same coverage option under the retiree. You are not able to choose a separate coverage option for yourself and each of your eligible family members.

In cases where the retiree or eligible dependent(s) is Medicare eligible because of age, disability, or ESRD, but the other individual(s) is under 65 and not Medicare eligible, coverage will be split. The individual that is Medicare eligible will have access to enroll in a plan through VIA Benefits and the individual not Medicare eligible will enroll in a Pre-Medicare eligible option. Any non-Medicare eligible children will be covered with the individual who is not Medicare eligible or enrolled in the Child(ren) Only tier.

For BMO and M&I retirees, if both the retiree and their eligible spouse/domestic partner are Medicare eligible because of age, disability, or end-stage renal disease, both individuals will have access to enroll in a plan through VIA Benefits, each with their own HRA account (if eligible). If there are remaining eligible children, the children will be enrolled in a Pre-Medicare eligible option, if the child is not also Medicare Eligible (if the child is eligible for Medicare, he/she will have access to enroll in a plan through VIA Benefitswith his/her own HRA account, if eligible for funding).

In cases where the retiree no longer qualifies for coverage, any dependent(s) enrolled in coverage will also be ineligible for coverage.

In the event a retiree actively elects to cancel their retiree medical coverage, any dependent(s) enrolled in coverage will also be cancelled and no longer eligible for coverage.

Medical Coverage When You and Your Spouse/Domestic Partner Both Work at the Company

In situations where you and your spouse/domestic partner are employees of the Company, there may be different alternatives for continuing medical coverage at retirement. Here are some examples of the options that may be available to dual employed couples.

- If both employees retire from the Company and both are eligible for retiree medical coverage (age 55 or older with 10 or more years of benefit service), each may enroll for single retiree medical coverage with premiums based on his or her own years of service. Or, one retiree may choose to enroll as the dependent of the other, provided at least one retiree qualifies for retiree medical.
- If one employee retires while the spouse continues working at the Company, the working spouse may remain in the active plan and enroll the retiree as a dependent. If the working spouse leaves or retires from the Company, they may be enrolled as the dependent of the retiree within 31 days from the last day of work.

Becoming Medicare Eligible

If you or your dependent(s) become Medicare eligible as a result of a disability or ESRD prior to turning age 65, it is your responsibility to inform BMO.

Retirees and eligible dependents that are considered Medicare eligible, because of age, disability, or ESRD will have access to enroll in a plan through VIA Benefits. If there are individuals under the age of 65 or who are otherwise not eligible for Medicare that were covered on your pre-Medicare coverage, they will remain covered on their current pre-Medicare plan until becoming Medicare eligible or no longer meeting the criteria of an eligible dependent.

If you and/or your dependents choose to waive or cancel your coverage, please complete and return the Retiree Medical Program Election/Waiver form indicating your election. You are encouraged to return your forms as soon as possible to expedite the set-up of your retiree coverage or to update your status if you are waiving coverage.

If you Enroll in Coverage

When you complete and return the Retiree Medical Program Election/Waiver form indicating your medical plan election, your retiree coverage will be effective the first of the month following the month you retired.

The form must be returned within 31 days of when active coverage ends, or when the packet is mailed, whichever is later. This will expedite the set-up of your retiree medical coverage and avoid a delay of coverage or receiving new ID cards.

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless if you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring

your eligible dependents you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the Retiree Medical Program in the future, except for new biological or adopted children. (You will need to notify the Human Resources Centre at 1-888-927-7700 within 31 days of the birth or adoption).

Coordination of benefits

The medical plans have a coordination of benefits provision that prevents duplication of benefit payments when you or your dependent also has other health coverage through another group plan. Coordination of benefits procedures also determine which plan pays your claim first. Refer to the Coordination of Benefits section in this SPD for more information.

If You Decline, Cancel, or Waive Coverage

You have the option to waive your coverage under the Retiree Medical Plan through BMO and retain your Retiree Medical Program eligibility status (under certain circumstances) through the Retiree Medical Waiver Provision by completing the Retiree Medical Program Election/Waiver form**.**

Your coverage will be cancelled effective the last day of the month in which your completed paperwork is received (or at the end of a future month if you indicate that on your form).

Permanent Cancellation

You will forfeit your eligibility for the Retiree Medical Program, or your coverage may result in permanent cancellation if you do not follow the provisions of the Retiree Medical Program. Any of the following events would result in permanent cancellation of your retiree medical coverage through BMO:

- You elect COBRA continuation coverage at the time of your retirement.
- You do not return the Retiree Medical Program Election/Waiver form within 31 days of your retirement date indicating your intention to elect or waive coverage.
- You do not request re-enrollment in the Retiree HRA within 31 days of turning age 65, becoming Medicare eligible, or experiencing another qualifying event*. (Exception: You continue to be enrolled in other group coverage.)*
- You are Medicare eligible because of age, disability, or ESRD and have not been enrolled in other group coverage continuously during your waiver period from the time you became Medicare eligible.
- You voluntarily choose to permanently cancel your coverage.

Retiree Medical Waiver Provision

You and/or your eligible dependents have the option to waive your retiree medical coverage

through BMO under the Retiree Medical Waiver Provision. This option allows you to retain your retiree medical eligibility status and re-enroll when certain qualifying conditions are met. To enroll in the waiver program, indicate your intent to waive on the Retiree Medical Program Election/Waiver form**.**

This option may be beneficial to you if you are eligible for other employer group medical coverage through a spouse/domestic partner or other employer. If you choose to waive coverage, please carefully read through the provisions to understand your options. If you elect COBRA health insurance coverage at the time of your retirement, you will forfeit your right to participate in the Retiree Medical Program and therefore this waiver provision does not apply.

Eligibility for Waiver Provision

Please refer to the Retiree Waiver Options Chart for rules that apply based on your age and/or Medicare status and how your election impacts your dependents.

If you are under the age of 65 and not Medicare eligible and decide to waive enrollment, your eligible dependent(s) enrollment is automatically waived. You can only re-enroll when certain conditions are met or at the time you are newly eligible for Medicare because of age or disability.

If you are under age 65 and decide to waive enrollment, your spouse/domestic partner who is eligible for coverage through VIA Benefits may continue enrollment with VIA Benefits.

<table>
<tr><th colspan="4">Retiree Waiver Options Chart</th></tr>
<tr><th>Retiree Age Status</th><th>Retiree Action</th><th>Spouse /Domestic Partner/Dependent Child Medicare Status</th><th>Allowable Spouse/Domestic Partner/Dependent Child Action</th></tr>
<tr><td rowspan="5">Retiree is under 65 or not Medicare Eligible</td><td rowspan="3">Enrolls in a Pre-Medicare Eligible option – BCBSIL or Kaiser</td><td rowspan="2">Spouse/Domestic Partner/Dependent Child is under 65 or not Medicare Eligible</td><td>Enroll on the Retiree’s medical coverage</td></tr>
<tr><td>Waive coverage**</td></tr>
<tr><td rowspan="2">Spouse/Domestic Partner/Dependent Child is over 65 or Medicare Eligible</td><td>Enroll in coverage through VIA Benefits</td></tr>
<tr><td>Waive coverage**</td></tr>
<tr><td rowspan="2">Waives Retiree Medical pre-Medicare coverage*</td><td>Spouse/Domestic Partner/Dependent Child is under 65 or not Medicare Eligible</td><td>Coverage is automatically waived*</td></tr>
<tr><td>Spouse/Domestic Partner/Dependent</td><td>Enroll in coverage through VIA Benefits</td></tr>
</table>

		Child is over 65 or Medicare eligible	Waive coverage**
Retiree is over 65 or Medicare Eligible	Enrolls in coverage through VIA Benefits	Spouse/Domestic Partner/Dependent Child is under 65 or not Medicare Eligible	Enroll in a Pre-Medicare Eligible option – BCBS or Kaiser
			Waive coverage*
		Spouse/Domestic Partner/Dependent Child is over 65 or Medicare Eligible	Enroll in coverage through VIA Benefits
			Waive coverage**
	Waives coverage through VIA Benefits due to enrollment in other group coverage**	Spouse/Domestic Partner/Dependent Child is under 65 or not Medicare Eligible	Coverage is automatically waived*
		Spouse/Domestic Partner/Dependent Child is over 65 or Medicare Eligible	Enroll in coverage through VIA Benefits
			Waive coverage**
	Waives coverage through VIA Benefits. Does not enroll in other group coverage (Permanent Cancellation)	Spouse/Domestic Partner/Dependent Child is under 65 or not Medicare Eligible	Permanently Cancelled
		Spouse/Domestic Partner/Dependent Child is over 65 or Medicare Eligible	

Requesting Re-Enrollment

To request re-enrollment in the Retiree Medical Program you will need to submit a Retiree Medical Program Election/Waiver form to elect coverage.

It will be necessary to provide supporting documentation of the qualified life event within 31 days from the qualifying event to enroll in the Retiree Medical Program.

The following reasons are **NOT considered qualifying events** that would allow re-enrollment in the Retiree Medical Program:

- Annual enrollment;
- You discontinue coverage under an individual medical policy;

- You voluntarily discontinue other group medical coverage;
- You enroll in COBRA continuation coverage through BMO;
- You discontinue COBRA continuation coverage through another employer before the full COBRA period is exhausted for a reason other than an increase in cost or coverage curtailment as described above;
- You did not request re-enrollment within 31 days of when Medicare became your primary payer of your health coverage or within 31 days of a qualifying event.

*** Pre-Medicare Waiver**	You have the option to waive your pre-Medicare coverage at any time with the opportunity to re-enroll once you meet one of the following guidelines. **You have 31 days from the date of the qualifying event to enroll in the Retiree Medical Program.** • You become Medicare Eligible because of age, disability, or ESRD you have 31 days from the date of becoming eligible for Medicare to enroll in coverage through VIA Benefits, unless Medicare enrollment can be postponed due to enrollment in other group medical coverage. *Refer to the post-Medicare waiver provision for additional information on eligibility when you become Medicare Eligible.* • You lose other group or state-provided medical coverage as a result of one of the qualifying events: - a change in legal marital status or qualified domestic partner relationship; - a change in employment status of the individual that carried the other employer group coverage; - a change in benefit's eligibility status of the individual that carried the other group coverage; - a change in residence. • You experience a significant cost increase or significant coverage curtailment under your other employer group or state provided medical coverage. The cost must exceed the cost of what you would be paying for your BMO retiree medical coverage.

	• An eligible spouse/domestic partner/dependent child would be allowed to enroll in the retiree medical coverage in the event of the retiree's death if otherwise eligible under the Plan. The spouse/domestic partner/dependent child must have a qualifying event consistent with re-enrolling in coverage as outlined above at the time enrollment is requested.
****Post-65 Waiver**	You may waive or continue to waive your coverage after age 65 with the chance to re-enroll only if you have been continuously enrolled in other group medical coverage from the date the age 65/Medicare eligible waiver was effective until the time you are requesting re-enrollment in the Retiree Medical Program. • It will be necessary to provide supporting documentation of continuous enrollment in other group medical coverage within 31 days of when you lose your other group coverage and Medicare becomes your primary payer.

Death

In the event of the death of a retiree, the retiree's covered dependents may continue coverage under the Plan. If the spouse/domestic partner of the deceased retiree remarries or enters into another domestic partner relationship, the new spouse/domestic partner and any dependents of the new spouse/domestic partner are not eligible for coverage. Call the Human Resources Centre at 1-888-927-7700 to report any changes in status.

1.3 Eligibility Provisions for Bank of the West Retirees

This section applies if you were an employee of Bank of the West.

An eligible retiree is a former employee of Bank of the West, Essex Credit Corporation, or Trinity Capital Corporation who meets all of the following requirements:

- he or she is age 55 or older as of December 31, 2016;

- he or she retires from Bank of the West, Essex Credit Corporation, or Trinity Capital Corporation effective after July 1, 2004;
- he or she has been credited with at least 10 years of eligibility service as of December 31, 2016;
- he or she was covered by a medical benefits option under the Bank of the West Group Health and Welfare Plan (or the BMO Health and Welfare Benefit Plan, if applicable) for at least one full year immediately preceding retirement (this does not apply to a former employee whose employment was terminated as a result of his or her layoff);
- he or she commences participation in the Retiree Medical Program or its predecessor effective as of his or her retirement date (however, an individual who meets all of the other requirements listed in this section and who has received a severance package from Bank of the West, Essex Credit Corporation, or Trinity Capital Corporation as a result of his or her termination of employment will be eligible to participate in the Retiree Medical Program if the individual commences participation in the Retiree Medical Program or its predecessor effective as of the date he or she ceases to be covered by a medical benefits option under the severance package);
- he or she is not entitled to receive medical or health benefits under any plan, program, policy, agreement, contract, or other arrangement that is entered into, established, sponsored, or maintained by Bank of the West (or its successor) other than this Retiree Medical Program or its predecessor; and
- he or she is not a current employee of Bank of the West, Essex Credit Corporation, or Trinity Capital Corporation.

If a former employee of Bank of the West, Essex Credit Corporation, or Trinity Capital Corporation does not elect to participate in the Retiree Medical Program or its predecessor effective as of his or her retirement date at the time and in accordance with rules established by the plan administrator, he or she will not be eligible to participate in the Retiree Medical Program at a further date.

These provisions apply to former employees of Union Safe Deposit Bank effective only for the period of January 1, 2005 – January 20, 2005. For purposes of determining whether the individual was covered by a medical benefits option for at least one full year immediately preceding retirement, coverage under a medical benefits plan sponsored by Union Safe Deposit Bank or Community First Bankshares, Inc. or Commercial Federal Bank that immediately preceded coverage under the Bank of the West Group Health and Welfare Plan will be counted for the purpose of determining whether he or she has been covered under the Bank of the West Group Health and Welfare Plan for at least one full year immediately preceding retirement.

For an employer who was eligible, on or before December 2, 2006, to receive medical or health benefits under a plan, program, policy, agreement, contract, or other arrangement that was sponsored by Commercial Federal Bank prior to December 2, 2005, if he or she otherwise meets the requirements above, he or she will be eligible to participate in the Retiree Medical

Program if he or she makes an irrevocable election not to participate in the Commercial Federal Bank Retiree Medical Plan, in such form and at such time as required by Bank of the West.

Each eligible retiree or family member covered under the Retiree Medical Program or its predecessor has the opportunity to opt-out and waive future participation in and reimbursements from the Retiree Medical Program on an annual basis during the annual open enrollment period for the Retiree Medical Program.

Eligibility for retiree medical coverage was frozen effective January 1, 2017. Persons who are eligible retirees (as outlined herein) on January 1, 2017 will continue to receive retiree medical coverage in accordance with the terms outlined herein. Each employee who, as of December 31, 2016, has reached age 55 and been credited with 10 years of eligibility service may become eligible for coverage if he or she otherwise meets the requirements outlined herein. However, such employee will not earn or be entitled to earn additional years of credited service for employment on or after January 1, 2017. Except as described in the preceding sentence, no person may become an eligible retiree on or after January 1, 2017.

Dependent Eligibility for Bank of the West Retirees

Your spouse or domestic partner, child(ren) under age 26, disabled child of any age (if the disability commenced prior to age 18), or a child eligible for coverage pursuant to a Qualified Medical Child Support Order is eligible for coverage under the Retiree Medical Program if he or she is not yet Medicare eligible and covered by the Bank of the West Group Health and Welfare Plan (or the BMO Health and Welfare Benefit Plan, if applicable) immediately preceding your retirement date ("Eligible Family Member").

At retirement, you may elect to cover an Eligible Family Member under a medical benefits option. If you do not elect to cover an Eligible Family Member at the time of retirement (under rules and procedures established by BMO), that Eligible Family Member may not be covered by a medical benefits option in the future.

If an individual becomes a new Eligible Family Member (as a result of a change in family status (marriage, establishment of domestic partnership, birth, or adoption of a child), they are eligible for coverage under a medical benefits option if you elect coverage for them within 30 days of the date of the change in family status.

Subsequent to retirement, if you fail to pay required medical premiums or elect to discontinue coverage for an Eligible Family Member, then he or she will be ineligible for coverage under a medical benefits option in the future.

Once you are eligible for Medicare, you will be covered under the Retiree HRA. You can use the HRA to reimburse your eligible expenses (as defined in the Retiree HRA summary plan description) and the eligible expenses of your Code section 105(b) dependents.

RETIREE MEDICAL CREDITS – Bank of the West Retirees

<u>Allocation of Retiree Medical Credits</u>

Upon retirement, a one-time allocation of retiree medical credits from the Bank of the West (or its successor) will be made as follows:

Retiree	**Credits**
Eligible Bank of the West retirees, except for certain former United California Bank Employees, as described below.	500 credits per year of credited service at retirement

All retiree medical credits are recorded in an unfunded account for each eligible retiree. Retiree medical credits may be used for the sole purpose of paying a designated percentage of the monthly premium charged for coverage under a medical benefits option for an eligible pre-Medicare retiree or Eligible Family Member. Once the retiree is eligible for Medicare, the credit will be a contribution to the Retiree HRA that the retiree can use to pay for the eligible expenses (as defined in the Retiree HRA summary plan description) of the retiree and his or her Code section 105(b) dependents.

Definition of Year of Credited Service

Year of credited service means each full year of employment before January 1, 2017, beginning on: (i) the date of original hire as an employee of the Bank of the West and anniversaries of that date; or (ii) the date or original hire with a Related Employer (Trinity Capital Corporation and Essex Credit Corporation) and anniversaries of that date.

For Eligible Retirees who, before July 1, 2004, were employed by the Bank of the West or a Related Employer, year of credited service means a full year of employment as an employee with the Bank of the West or the Related Employer or a predecessor of the Bank of the West or Related Employer, as determined in the sole discretion of the Bank of the West (or its successor). Each of these eligible retirees is credited with one year of credited service for each full year of employment, commencing on his or her date of original hire or date of adjusted service, if applicable, as determined in the sole discretion of the Bank of the West (or its successor), and anniversaries of that date.

A year of credited service will also be credited to an eligible retiree who was an employee of Commercial Federal Bank if it would have been credited if the eligible retiree were a Bank of the West employee.

A year of eligibility service is credited to an employee for each full year of employment with Union Safe Deposit Bank, Community First Bankshares, Inc., or Commercial Federal Bank.

No years of credited service will be counted for periods of employment (1) of less than a full year, or (2) on or after January 1, 2017.

Division of Retiree Medical Credits

If the spouse or domestic partner of an eligible retiree is covered by the Retiree Medical Program as an eligible family member and one person is Medicare eligible while the other person is not Medicare eligible, the credits can be divided between the couple.

USE OF RETIREE MEDICAL CREDITS

Medical Benefits Options: Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Family Members

At retirement, an eligible pre-Medicare retiree and Eligible Family Member who enrolls for coverage under a medical benefits option will pay 25% of the total cost, and their credits will pay 75% of the cost until their credits are exhausted. Once credits are exhausted, then the retiree is responsible for 100% of the cost. Each retiree medical credit is used to reduce one month's premium by one dollar.

Eligible Medical Expenses: Eligible Post-Medicare Retirees and Eligible Post-Medicare Family Members

Once the retiree is eligible for Medicare, the remaining credits will be a converted to an HRA that the retiree can use to pay for the eligible expenses (as defined in the Retiree HRA summary plan description) of the retiree and his or her Code section 105(b) dependents. If the retiree exhausts his/her credits before he/she is Medicare eligible, then he/she will not be eligible for the Retiree HRA.

Forfeiture of Retiree Medical Credits

Retiree medical credits in an eligible retiree's account will be forfeited, in whole or in part, as appropriate, and will not be restored, if: (i) an eligible pre-Medicare retiree or eligible pre-Medicare family member fails to pay required monthly premiums under a medical benefits option on a timely basis; or (ii) an eligible retiree dies leaving no surviving spouse or domestic partner who is covered by the Retiree Medical Program.

Effect of Death of Eligible Retiree

Except as provided below, upon the death of an eligible retiree:

(a) An eligible pre-Medicare family member may use any remaining retiree medical credits and continue coverage under his or her medical benefits option until he or she reaches age Medicare. After all retiree medical credits have been exhausted, an eligible pre-Medicare family member may continue coverage under his or her medical benefits option until he or she reaches age 65 (or otherwise becomes eligible for Medicare) if he or she pays the full cost of required premiums, as determined by the Bank of the West (or its successor.

(b) If he or she was an eligible post-Medicare retiree on the date of death, retiree medical credits may be used to pay for eligible medical expenses of eligible family members.

(c) After all retiree medical credits have been exhausted, eligible family members who used Extend Health (or other health care coverage advisor designated by the Bank of the

West (or its successor)) to enroll for medical coverage (e.g., a Medicare Supplement or Medicare Advantage plan) at the time the eligible retiree first became covered under the Retiree Medical Program (or, if later, at the time the eligible family member ceased to be covered by a medical benefits option under the Retiree Medical Program), may continue to consult with Extend Health (or other health care coverage advisor designated by the Bank of the West (or its successor)) regarding their health care coverage options.

If an eligible retiree dies leaving behind no surviving spouse or domestic partner, any remaining retiree medical credits will be forfeited, as described above.

Allocation of Retiree Medical Credits to Certain Former United California Bank Employees

Former United California Bank ("UCB") employees whose age plus years of credited service totaled 65 or more as of September 30, 1995 and who are eligible to participate in the Retiree Medical Program will receive an allocation to their accounts at retirement equal to the greater of:

(a) 500 credits per year of credited service, or

(b) 300 credits per year of credited service; plus 400 credits per year of credited service as of September 30, 1995; or, for a former UCB employee who elects to cover family members at the time of his or her retirement, 300 credits per year of credited service plus 750 credits per year of credited service prior to September 30, 1995.

The special allocation under this section will not be made to the account of a former UCB employee who was allocated retiree medical credits under another retiree medical plan or program sponsored by the Bank of the West or UCB.

Related Employers

The following are Related Employers under the Program. Each Related Employer is considered an "Employer" under this Summary Plan Description.

<u>Related Employer</u>

Trinity Capital Corporation

Essex Credit Corporation

<u>Years of Credited Service</u>

A year of credited service will also be credited to an Eligible Retiree who was an employee of Commercial Federal Bank if it would have been credited if the Eligible Retiree were a Bank of the West employee.

<u>Years of Eligibility Service</u>

A year of eligibility service is credited to an employee for each full year of employment with Union Safe Deposit Bank, Community First Bankshares, Inc. or Commercial Federal Bank.

Special Eligibility Provisions

Certain retirees are eligible for different benefits than those described above, including:

- Annual funding to the HRA based on the annual indexed amount determined by the Plan's actuary
- Annual funding in the HRA in the amount of the Medicare Part B premium for that year
- Annual funding in the HRA in the amount of $600
- Dental coverage at the full rate
- Dental coverage at the active rate
- Pre-Medicare medical coverage at the active rate until you turn 65

You should have received written correspondence from BMO/BOTW confirming that you are eligible for one or more of the benefits listed above. Please contact the Human Resources Centre at 1-888-927-7700 with any questions.

2.0 Health and Welfare Benefit Plans Offered

Health and Welfare Benefit plans offered to eligible retirees may include:

- Medical (Pre-Medicare)
- Medicare Secondary HRA Plan
- Dental (Closed group)
- Vision (Closed group)
- Basic Life Insurance (former Bank of the West retirees only)
- Accidental Death and Dismemberment Insurance Plan (Closed group)

These plans are not offered automatically and you must meet the specific requirements for each plan.

2.1 Medical (Pre-Medicare)

BMO offers different medical plan designs to provide retirees and dependents not eligible for Medicare yet with flexibility in managing their healthcare needs. Through Blue Cross Blue Shield of Illinois (BCBSIL), all individuals can choose between a High Deductible Health Plan (HDHP) and a Preferred Provider Organization (PPO) plan.

For individuals 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 individuals, nationwide		Only individuals 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

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 (copay waived if admitted)	$300 copay (copay waived if admitted)	$100 copay and 20% coinsurance after deductible (copay waived if admitted)	$300 copay (copay waived if admitted)

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

***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.*

**** 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 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 Home Delivery: $25 copay		Retail: $10 copay Mail order: $20 copay	
Preferred Brand	30% coinsurance		Slight variances based on region, see SBC for details:	

	Retail Pharmacy: $25 minimum; $100 maximum Home Delivery: $62.50 minimum; $250 maximum	Review your regional Kaiser SBC: • Kaiser HDHP California • Kaiser HDHP Colorado • Kaiser HDHP Northwest • Kaiser DHMO California • Kaiser DHMO Colorado • 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		

This a high-level overview of **in-network benefits** for the BMO medical plans. For more detailed information, review the BCBSIL HDHP Booklet, BCBSIL PPO Booklet and the BCBSIL/Kaiser Summaries of Benefits and Coverage.

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

2.2 Medical (Retiree Health Reimbursement Arrangement Plan)

Eligible retirees and dependents who are Medicare eligible can enroll in coverage through Via Benefits, a private Medicare marketplace.

Via Benefits can help you understand and navigate your Medicare plan options, giving you access to Medigap, Medicare Advantage, and Medicare Part D Prescription Drug plan from the nation's leading health insurance carriers. Via Benefits has experienced, unbiased, licensed benefit advisors who will help you and your covered dependents select and enroll in plans from

the Medicare marketplace. Via Benefits offers advice and guidance throughout your retiree medical insurance experience at no cost.

If you are eligible for subsidized coverage, it will be provided through an HRA administered by Via Benefits.

For more detailed information, review the BMO Retiree HRA Plan Details.

2.3 Dental (Only for Select Individuals as referenced in the Eligibility Section)

BMO offers comprehensive dental benefits through Delta Dental of Illinois, offering flexibility and cost-saving opportunities. There are two plan options to choose from, the High Plan and Low Plan, giving you flexibility to select the coverage that best fits your needs and budget. 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	
	High Plan	**Low Plan**
Annual deductible	Individual: $50 Family coverage: $150 (three individual deductibles per family)	
Annual benefit maximum	$2,000 per person	$1,000 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	

Dental: At-a-glance		
Orthodontia services	50% coinsurance (maximum of $2,000 for children up to age 19)	Not covered

This a high-level overview of **in-network benefits** for the BMO dental plan. For more detailed information, review the Delta Dental High Plan Booklet and Delta Dental Low Plan Booklet.

2.4 Vision (Only for Select Individuals as referenced in the Eligibility Section)

BMO offers a vision plan option through VSP that allow individuals 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**
WellVision exam (every year)	$10 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 • Lined bifocal • Lined trifocal	Included with prescription glasses

Vision: At-a-glance	
Lens Enhancements (every calendar year) • Progressive lenses • Tinted lenses • Scratch-resistant coating • Ultraviolet coating	You pay nothing
Premium and custom progressive lenses	$50
Retail frame	$150 allowance, every other calendar year
Featured frame brand	$200 allowance, every other calendar year
Frame discount	20% savings on amount over allowance, every other calendar year
Contact lens exam (every calendar year)	Up to $40
Contact lenses (every calendar year)	$150 allowance, copay does not apply
VSP EasyOptions	Not included
VSP Lightcare	Not Included
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.	

This a high-level overview of **in-network benefits** for the BMO vision plan. For more detailed information, review the VSP Vision Certificate of Coverage (Base Plan Only).

2.5 Basic Life Insurance (former Bank of the West retirees only)

Retiree life insurance benefits are available to former Bank of the West retiring employees who were at least age 55 with at least 10 years of service as of December 31, 2016. Life insurance coverage through MetLife in the amount of $10,000 is provided to you by the Bank as part of your retiree benefits. This coverage is paid for by the Bank and will remain in force for the remainder of your lifetime. Certificate of coverage available upon request to the U.S. Benefits Team.

2.6 Accidental Death and Dismemberment Insurance Plan

Retiree Accident insurance coverage of $10,000 was available to you through age 70 if your retired before January 1, 2021 and were enrolled in the Accidental Death & Dismemberment Plan immediately prior to retirement. This is a closed group with no individuals eligible in the future. Certificate of coverage available upon request to the U.S. Benefits Team.

3.0 Enrolling in Retiree Medical Coverage

A packet will be sent to you upon your retirement that will include your enrollment materials.

4.0 Paying for benefits

Retiree medical premium billing for the pre-Medicare eligible plans is administered by Inspira Financial, Inc. If you elect coverage, you will receive a separate mailing from Inspira with details about how to make your payments.

You can view your account online by visiting www.inspirafinancial.com and completing the registration. Once you register you can manage your account online, view your payment history, and set up account alerts. You will find detailed instructions included on how you can use this site. You may reach out to Inspira Financial at 888-678-7835 for assistance.

Medical premium billing for Medicare plan enrollments with Via Benefits is handled directly with Via Benefits and the carrier selected.

5.0 Administrative Information about the Plan

This SPD outlines the provisions of the Plan. The Plan offers a comprehensive suite of benefits to eligible participants, including medical, prescription drug, life insurance, dental, vision, and a Health Reimbursement Arrangement (HRA).

5.1 Plan Identification

Plan Number: 508

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 eligible participants. Unless delegated to another named fiduciary, claims administrator, on insurer, 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 administrator or insurer, 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, claims administrator, or insurer as applicable, determines in its discretion that the claimant is entitled to them.

Plan trustees:

Midwest Institutional Trust Company
10700 Research Drive, Suite 205
Wauwatosa, WI 53226-3460

BNY Mellon Client Service Center
500 Ross Street, 8th Floor
AIM # 154-0800
Pittsburgh PA 15262-0001

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 Retiree Medical Program is partially funded by the employer's general assets and partially funded by a trust.

5.2 Claims Administrators, Third Party Administrators, and Service Providers

The Plan relies on a number of claims administrators, insurers, and service providers to deliver health and welfare benefits.

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
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 • S. California: #102000: 1-800-464-4000 • Oregon: #3992: 1-800-813-2000 • Colorado: #22343: 1-800-632-9700
VIA Benefits	Medicare Secondary Health Reimbursement	10975 South Sterling View Drive South Jordan, UT 84905 800-849-7016

	Arrangement Plan Claims Administrator	My.ViaBenefits.com/funds
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
MetLife	Fully-Insured Basic Life Insurer	
SunLife	Fully-Insured Accidental Death and Dismemberment Insurer	

5.3 Appeal 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) and 5.3.2 (Eligibility Appeal). BMO and its delegates will administer the Plan in a fair, consistent, and compliant manner. As such, the BMO will 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 three types of appeals available under the Plan:

- Coverage Appeal
- Eligibility Appeal
- Claims Appeals

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 retiree
- You do not take action during annual enrollment

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 1.0 Eligibility for Benefits.

- You attempt to enroll a dependent who does not meet the criteria outlined in Section 1.0 Eligibility for Benefits.

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 Claims Appeal

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/Insurer	Where to find Appeal Procedures

Blue Cross Blue Shield of Illinois	• HDHP: BCBSIL HDHP Booklet • PPO: BCBSIL PPO Booklet
Express Scripts	• 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	Delta Dental High Plan Booklet and Delta Dental Low Plan Booklet.
VSP Vision	• VSP Vision Certificate of Coverage
VIA Benefits (HRA)	• BMO Retiree HRA Plan Details.

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*** 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	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. 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.

treatment that is the subject of the claim.	
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	You must submit your appeal within 60 days of the date of your initial denial notice.

Indemnity Insurance, and/or Legal	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).

5.3.4 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 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. **Retiree vs. Dependent**: The plan covering the individual as a retiree 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 the 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

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Retiree Medical Program ends due to one of the events listed below, you or your covered spouse/domestic partner and dependent children may be eligible to continue your/their coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your covered spouse/domestic partner or dependent children to lose coverage under the Plan. Depending on the type of qualifying event, qualified beneficiaries can include the retiree covered under the Retiree Medical Program the covered retiree's spouse, and the covered retiree's dependent children. Domestic partners are not qualified beneficiaries, but the Plan treats them as qualified beneficiaries.

COBRA Covered Plans

The extension of coverage through COBRA applies to Medical, Dental, Vision, and HRA.

Qualifying events for continuation coverage under COBRA

The following table outlines situations in which a Qualified Beneficiary may elect to continue coverage under COBRA, and the maximum length of time that COBRA coverage is available. These situations are considered qualifying events.

COBRA qualifying event	Who can elect COBRA coverage (Qualified Beneficiaries)	Maximum continuation period
Divorce or legal separation from your spouse	Your spouse and your covered children	36 months
End of relationship status with your domestic partner	Your domestic partner and their children covered on your plan(s)	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
BMO files for bankruptcy under Title 11 of the United States Code	You, your spouse/domestic partner, and your covered children	You are entitled to coverage for life; your spouse/domestic partner and/or children can continue coverage

		for 36 months following your death
** Medicare entitlement is only a qualifying event if it results in loss of coverage.*		

Getting started

You will be notified by mail if you become eligible for COBRA coverage because of the Company's bankruptcy. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. The benefits provided under COBRA are the same as those provided to other participants; however, the Company no longer shares the cost with you. You pay the full health care premium plus a 2% administrative fee.

Under COBRA, you have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. **If this election period is missed, you and your spouse/domestic partner and dependent children will lose the opportunity to continue coverage under COBRA.**

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

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

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

Each Qualified Beneficiary has a separate right to elect continuation coverage. For example, your spouse may elect continuation coverage even if you do not. COBRA premium amounts will be listed in the COBRA election notice.

Notification requirements

You, your spouse/domestic partner, or your dependent children must notify the COBRA Administrator when certain qualifying events occur. If your covered spouse/domestic partner or dependent children lose coverage due to divorce, legal separation, termination of domestic partnership, or loss of dependent status, you, your spouse/domestic partner, or your dependent children must notify the plan administrator within 60 days of the latest of:

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

If you, your spouse/domestic partner, or your dependent children fail to notify the plan administrator of these events within the 60-day period, the affected Qualified Beneficiary **will lose the opportunity to continue coverage under COBRA**. If you are continuing coverage under COBRA, you must notify the COBRA Administrator within 60 days of the birth or adoption of a child.

When COBRA coverage ends

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

- any required premium is not paid on time;
- a qualified beneficiary becomes covered under another group health plan;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage (unless the qualifying event is bankruptcy);
- the Company ceases to provide any group health plan for its employees; or
- the Company would terminate coverage for a participant or beneficiary not receiving continuation coverage (such as fraud).

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group

health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

What is the COBRA premium?

When you choose COBRA coverage, you must pay the full monthly premium amount (the total of what you and the Company were paying for your coverage), plus a 2% administration fee.

5.8 Other Important Legal Notices Governing the Plan

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

- COBRA Continuation of Rights
- Creditable Coverage Notice
- HIPAA Notice of Privacy Practices
- 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 and claims administrators 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.