BMO

Disability Leave
Summary Plan Description (SPD)

BMO U.S. Health and Welfare Benefit Plan

Contents

About this Summary Plan Description

This document is the summary plan description (SPD) for the BMO U.S. Long Term Disability Income Plan (the "LTD Plan"). This SPD also describes the Company's Short Term Disability Operating Procedure and Sick Pay Operating Procedure. Unlike the Short Term Disability and Sick Pay Operating Procedures, the LTD Plan is subject to ERISA and is governed by a separate LTD Plan document. The LTD Plan is a part of the BMO U.S. Health and Welfare Benefit Plan. No long-term income benefits will be provided based on the terms of this summary, unless such benefits are provided for under the terms of the LTD Plan.

If you have questions about the LTD Plan, the Short Term Disability Operating Procedure, the Sick Pay Operating Procedure or you would like a complete copy of the LTD Plan document, contact the Human Resources Centre (HRC) at 1-888-927-7700.

Important notice

The information in this Summary Plan Description is based on the BMO U.S. Long Term Disability Income Plan in effect as of January 1, 2024. The official LTD Plan document contains the full LTD Plan details. If the SPD or any oral representation differs from the LTD Plan document, the LTD Plan document prevails.

While this Summary Plan Description summarizes the major provisions of this Plan, it does not provide you with every Plan detail. The Plan documents, which govern this Plan, provide full details. If there are any discrepancies between this Summary Plan Description and the legal Plan documents, the Plan documents rule.

Eligibility

Who is eligible

You are eligible to participate in the disability program if you are a:

- full-time employee, or
- part-time employee who is scheduled to work 20 or more hours a week (unless otherwise stated in this SPD).

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

Your dependents are not eligible for this program.

How and when to enroll

When coverage begins

The Company automatically provides you with sick pay, STD pay, and basic LTD coverage as shown below – all at no cost to you.

Plan	*When coverage begins*
Sick Pay	On your first day of work
Short Term Disability	On your first day of work
Long Term Disability (60% of coverage)	On your first day of work

Pre-existing conditions

Special rules govern disabilities resulting from illnesses or injuries that began before your disability coverage takes effect. If you have a disability in your first six months of employment that was caused by a pre-existing condition for which you received medical care during the three-month period prior to your coverage effective date, Long Term Disability benefits will not be paid for that condition.

If you did not enroll in supplemental LTD coverage when you were first eligible and enrolled as a result of Annual Enrollment or a Qualifying Life Event, and have a disability in the first six months of coverage due to a pre-existing condition for which you received medical care within three months before your supplemental coverage effective date, supplemental LTD benefits will not be paid for that condition.

Enrolling for supplemental LTD benefits

You can elect to purchase supplemental LTD coverage of an additional 15% of your Total Compensation BBR, providing you with a total of 75% of your Total Compensation BBR while you are disabled

Coverage under the Plan is not automatic; you must enroll, go to **Workday**, click on the **My Benefits & Retirement** application. As a new employee or an employee who changes to benefit-eligible status, you have 31 calendar days (includes your hire date* or newly benefit-eligible date) to make your benefit elections. **Please note**: the benefit effective date for employees hired as part of an acquisition and/or merger may be different based upon the terms of the purchase agreement.

Coverage begins on the first day of the month following 30 days from your date of hire or change in benefit eligible status date if you enroll within this 31-day period.

Once made, you generally cannot change your elections during the year except in the event of a qualifying life event. A qualifying life event is an event that affects your coverage needs such as a marriage, divorce, or the birth of a child. If you have a qualifying event, you have 31 days from the date of the event to make coverage changes. You will be required to provide proof of the qualifying event, and your change must be consistent with that event. If you fail to apply within 31 days of the qualifying event, you must wait until the next annual enrollment with an effective date of January 1st. For details on the election changes you may make based on the specific life event you experience, go to the **BMO U.S. Benefits site**. Select **Life Events** and then click on **Benefit Changes**. Retroactive changes to benefits and deductions may be necessary in a few situations, such as late entry of a benefit change or missed payroll cutoff, therefore any missed benefit deductions from the benefit effective date will be caught up on future payrolls.

Annual enrollment

You can change your LTD coverage during the annual enrollment period held each fall. At that time, you can increase your 60% coverage to 75%, or reduce your coverage to the basic 60% Company-provided level. Activation of your supplemental LTD coverage or election to drop supplemental LTD coverage becomes effective on January 1st following annual enrollment or the date the claims administrator approves the application, if later.

Plan cost

The Company pays the full cost of your sick pay, STD pay, and basic LTD benefit. You pay the full cost of supplemental LTD coverage with pre-tax dollars. If you elect supplemental LTD coverage, you pay only for the cost of the 15% difference between the basic 60% LTD coverage and the supplemental 75% LTD coverage.

Disability program

The Company's disability program provides you with a source of income when you cannot work because of your own illness or accidental bodily injury.

The disability program is made up of the following three parts, which offer you financial protection during brief absences as well as during longer, more serious disabilities:

- Sick pay provides benefits for an illness or injury that lasts up to 10 business days.
- Short Term Disability (STD) pay replaces all or a portion of your base pay (or applicable Benefits Base Rate (BBR) for certain commissioned employees) beginning on the 11th business day of your leave for the next 100 business days.
- After your STD pay ends, the Long Term Disability (LTD) Plan provides you with 60% of your Total Compensation Benefits Base Rate (TCBBR). If you choose, you can elect to purchase an additional 15% of supplemental LTD benefits which will provide you with a total of 75% of your Total Compensation Benefits Base Rate (TCBBR).

The maximum monthly benefit is capped at $20,000, which includes basic and supplemental coverage. This means if your TCBBR is $400,000 or more, you will not receive any benefit from electing the Supplemental LTD plan. If your TCBBR is between $320,000 – $399,999, you can still elect coverage, but you will not get the full 15% of supplemental coverage due to the $20,000 per month maximum.

Sick Pay Operating Procedure

How the Sick Pay Operating Procedure works

Under the Sick Pay Operating Procedure, the Company provides you with a specified amount of sick time each year based on your employment status and how long you have worked at the Company, as described in the Payment Schedule below. Using this sick time, the Company provides you with 100% of your base pay when you cannot be at work because of:

- personal illness (physical or mental),
- accidental personal injury,
- medical care of your own, or
- illness, injury, or medical care of a covered family member

A covered family member includes your legal, common law or civil union spouse, same or opposite gender domestic partner, children, parent, legal guardian, spouse's parent, domestic partner's parent, spouse of your child, domestic partner of your child, sibling, grandparent and any other individual related by affinity whose close association is the equivalent of a familial relationship. A child is defined as your biological child, adopted child, foster child, stepchild, domestic partner's child, grandchild, legal ward, or a child for whom you stand in loco parentis. Any sick time you use to care for a family member is part of your allotted sick time for the year.

Payment schedule

Full-time employees are granted 80 paid sick hours each calendar year. Part-time employees are granted a prorated number of paid sick hours each calendar year based on their standard hours.

Example: If a part-time employee is scheduled to work 24 standard hours each week, the prorated number of hours would be calculated as: 80 hours x (24/40) = 48. The employee in this example will receive 48 paid sick hours.

During your first year of employment, the number of paid sick hours you are granted depends on the month in which you are hired, as outlined below:

Month of hire	*Number of paid sick hours*	
	Full-time employees 40 hours/week	*Part-time employees 1-39.99 hours/week*
January – June	80 hours	80 hours prorated by standard hours
July – September	40 hours	40 hours prorated by standard hours
October – December	24 hours	24 hours prorated by standard hours

After you work for the Company for one year, you receive 80 paid sick hours each January 1st, or a prorated number of paid sick hours if you are a part-time employee, scheduled to work 1-39.99 hours per week.

Changes in standard hours during the year
If you experience an increase in your standard hours during the year, you will receive an adjustment to your sick time entitlement reflective of the new standard hours you will work for the remainder of the year. Employees with a reduction in scheduled hours will maintain their current sick time hours through the remainder of the year.

Unused sick time
If you have unused sick time from the previous year, you are permitted to carryover the unused sick time, up to the cap of 200 hours, with no limit on usage in a calendar year. At no time can your carryover balance and annual entitlement exceed 280 hours.

For example, an employee who is eligible for 60 hours of sick time on January 1st with 40 hours of unused time at the end of the previous year would be allowed to carryover 40 hours of sick time, making the combination of carryover and annual entitlement equal 100 hours of sick time.

Please note: Unused sick time is not paid out at year end or at termination of employment.

Short Term Disability (STD) Operating Procedure

How the STD Operating Procedure works

Short Term Disability (STD) pay replaces either 100% or 70% of your base pay (or applicable BBR for certain commissioned employees) depending on your years of service.

To qualify for STD benefits:

- your standard hours must be a minimum of 20 hours per week,
- you must be under the care of a qualified physician and undergoing appropriate medical treatment for the illness or injury,
- the claims administrator must approve your claim for benefits, and
- you must be unable to perform the necessary duties of your job or a similar job.

While receiving STD benefits, an employee is not permitted to work in a paid or unpaid capacity by another employer, an employee or family-owned business, or as a volunteer.

If your claim is approved, STD benefits begin on the 11th consecutive business day of your disability. During the first 10 consecutive business days of your illness or injury, the unpaid waiting period, you may use your paid sick time. If you have insufficient sick time, you may choose to use vacation days to receive 100% of your pay. You are not required to use sick time or vacation pay to cover the unpaid waiting period.

Partial return to work

A partial return to work allows you to work reduced hours and ease back into work, as part of your recovery process. While on a partial return to work, you will continue to receive STD benefits until you can resume your regularly scheduled hours. Any number of hours of STD used in each day are counted as one day of your available 100 days of STD.

You will be paid for your hours worked in addition to your STD benefits, up to your standard weekly hours. Employees will need to enter their actual hours worked into Workday. This is required for both Exempt and Non-Exempt employees. At the end of each week, it is the managers responsibility to approve the time entered so that Payroll may pay the hours worked. Please also note that time entered is paid 2 weeks in arrears.

Coordination with state plans

If you live in a state that provides paid leave benefits, you will be required to apply for those benefits. BMO offsets your disability pay by the amount you receive from your state. If your benefit from the state is less than what STD would pay, STD pays you the difference so your benefit equals 100% or 70% of your base pay. **The claims administrator will assume and apply the maximum state benefit to your offset**. Be sure to submit your state award letter to the claims administrator to ensure your STD benefits are offset accurately.

Paying for your benefits while on leave

While receiving STD, the coverage for your elected benefits will continue and you will continue to pay your share of the costs through payroll deductions. If for any reason during your time on STD your payroll amount is insufficient to cover the cost of your elected benefits, your premiums will accumulate in arrears subject to the terms of the BMO U.S. Health and Welfare Benefit Plan. When you return from leave, your regular deductions will resume, and any arrears will be collected at a rate of one additional deduction per pay until your arrears balance is zero.

You may be billed directly for missed premiums depending on the amount you owe and expected length of your leave.

Payment schedule

STD benefits are paid with the same frequency as your regular paycheck. STD benefits continue as long as you are disabled, as determined by the claims administrator, or through the 100th business day of your disability, whichever comes first.

Your STD benefit is calculated using your base pay (or applicable BBR for certain commissioned employees) divided by 26, which is the number of pay periods per calendar year. This base pay amount will be slightly higher than your usual bi-weekly pay as BMO divides annual salary by 26.0714286 to calculate bi-weekly pay. This base pay amount then has the 100% or 70% benefit amount applied.

The percentage of base pay (or applicable BBR for certain commissioned employees) you receive is based on your years of service as of the last business day before your disability began, and the number of days you are absent due to the disability, as shown in the table below.

Years of service	*Percentage of base pay you receive*	
	Number of days at 100% of pay	*Number of days at 70% of pay*
Less than 1	0	100
1	10	90
2	20	80
3	30	70
4	40	60
5	50	50
6	60	40
7	70	30
8	80	20
9	90	10
10 or more	100	0

Maternity leave benefit

Birth mothers are eligible to receive 100% salary continuation starting on the date of the child's birth, or the next scheduled working day should the birth mother work her entire scheduled shift on the day of birth, and will run through 16 continuous weeks of leave. The maternity leave benefit is calculated using your standard hours and base salary (or applicable BBR for certain commissioned employees.) You may choose to return to work prior to 16 weeks of leave but will not be able to resume receiving paid benefits at a later date.

To qualify for the maternity leave benefit, you must be under the care of a qualified physician and undergoing appropriate medical treatment. All births occurring on or after the 24th week of pregnancy will qualify for the maternity leave benefit. The maternity leave benefit will run concurrently with the STD payment schedule. This means that you will get the maternity leave benefit in lieu of STD pay. There is no waiting period for maternity leave.

You will not qualify for the maternity leave benefit if at the time of your child's birth you are on approved LTD for a disabling condition not related to your pregnancy. Your LTD benefit will continue according to the LTD payment schedule.

Maternity complications

If you experience complications during pregnancy that require a leave of absence to start before the birth of your child, you will need to apply for STD benefits.

- You will be required to fulfill the unpaid 10-day waiting period required under the STD Operating Procedure.
- Available sick or vacation time can be used to provide salary continuation during the unpaid 10-day waiting period.
- You will be required to provide medical documentation from the treating physician to the claims administrator.
- If approved by the claims administrator, you will receive salary continuation under the STD Operating Procedure until the birth of the child, starting on the 11th consecutive day of disability.
- Upon delivery of the child, you will switch to the maternity leave benefit and receive up to 16 weeks of salary continuation.

If you experience complications after the delivery of a child that requires a leave of absence to extend past the 16 weeks of maternity leave benefit, you will need to apply for STD benefits to continue receiving pay.

- In this case, your maternity leave time counts towards satisfying the unpaid 10-day waiting period required under the STD Operating Procedure. You will not have another unpaid 10-day waiting period to satisfy.
- You will be required to provide medical documentation from the treating physician, which will be approved by the claims administrator. You are encouraged to submit your STD application, and all required medical documentation from the physician to the claims administrator as soon as possible in order to avoid a delay of pay continuation.
- After the 16 weeks of maternity leave benefit is paid and the approval is received from the claims administrator, you will receive salary continuation under the STD Operating Procedure.
- The 16 weeks of maternity leave benefit will count towards your STD time on the STD payment schedule. For the portion of your leave extending past the 16 week maternity leave benefit, the number of days you receive at 100% or 70% depends on where you fall in the payment schedule (minus the unpaid 10-day waiting period) based on your years of service and length of leave.

Recurring disability

If you experience a second disability or a series of disabilities, your STD benefits either continue or start over again according to the following rules:

If you return to work and become disabled again

If you become disabled from the same or related illness or injury within six months after you return to work:

- your second disability is considered a continuation of your first one, and you do not have to satisfy the waiting period again before your STD benefits begin. This disability will be included in your original 100 covered business days of STD.

If you become disabled from the same or related illness or injury more than six months after you return to work:

- your second disability is considered a new disability. Your STD benefits begin again on the 11th consecutive business day of your disability. You may use any remaining sick time pay or vacation pay during the 10-day waiting period. Your 100 covered business days of STD coverage will start over.

If your second disability is caused by an illness or injury that is unrelated to your first, it is considered a new disability no matter how long you've been back at work. Your STD benefits begin on the 11th consecutive business day of your disability and your coverage will continue for 100 business days. You may use any remaining sick time pay or vacation pay during the unpaid 10 day waiting period.

While you are on disability leave

If you are receiving disability benefits for one condition, but suffer a second or series of disabilities, whether the conditions are related or unrelated, your second disability is considered a continuation of the first disability.

Long Term Disability (LTD) Plan

How the LTD Plan works

If your disability is due to an illness or an accidental injury that lasts more than 110 business days, the LTD Plan continues to provide you with a part of your Total Compensation BBR while you are disabled. To qualify for LTD benefits:

- you must be under a physician's care and undergoing appropriate medical treatment for the illness or injury, and
- your condition must meet the following definition:

Definition of long term disability	
First 24 months	You are unable to perform the necessary duties of your job or a similar job.
After 24 months	You are unable to perform the necessary duties of any occupation for which you are, or may reasonably become, qualified based on your education, training, and experience.

You must provide proof of your disability to the claims administrator at the time you apply for benefits. You also may need to provide proof of continued disability from time to time to maintain benefits.

While receiving LTD benefits, an employee is not permitted to work in a paid or unpaid capacity by another employer, an employee or family-owned business, or as a volunteer, except with respect to rehabilitation employment.

Payment schedule

LTD benefits begin on the 111th business day of your disability, which is the date your STD benefits end. If you were disabled prior to January 1, 2024, your LTD benefits equal 60% (75% if you elect supplemental LTD coverage) of your pre-disability base pay (or applicable BBR for certain commissioned employees) as of the last business day before your disability began.

If you were disabled on or after January 1, 2024, your LTD benefits equal 60% (75% if you elect supplemental LTD coverage) of your Total Compensation Benefits Base Rate (TCBBR) as of the last business day before your disability began. The maximum monthly benefit is capped at $20,000.

An employee's eligible total compensation is base salary, overtime, shift differential and any variable pay that is related to work performance that is received between October 1 and September 30 of the prior year. For example, for 2024, total compensation is based on eligible pay paid from October 1, 2022, to September 30, 2023.

Variable pay includes team-based plans (based on company, corporate, department or unit performance, managerial plans, sales, incentive, and commission-based plans, business referral plans, and ad hoc cash awards related to performance.

You can view your Total Compensation BBR in Workday. In your worker profile, select "Actions"- "Benefits" – "View Benefits Annual Rate".

You will receive a monthly disability payment, payable on the 20th of each month. If you are eligible for a disability payment for any length of time that is less than a full month, the payment will be pro-rated for the number of days you are considered disabled for that month.

The amount of time you receive disability payments depends on your age when your disability begins, as shown in the table below:

Age when disability begins	*Benefits are paid up to:*
Before age 60	Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 through 74	12 months
75 or older	6 months

If your disability ends and you have reached retirement age, you may be eligible for retiree benefits under a retirement plan in accordance with the terms and conditions of that retirement plan.

Disability due to alcohol, drug or substance abuse or addiction

You can receive up to a total of 24 months of LTD benefits during your lifetime for a disability due to alcohol, drug or substance abuse or addiction. You are required to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a physician in order to be considered to have a disability. Disability benefits will end at the earliest of the date you receive 24 months of disability benefit payments or the date your benefits otherwise end (as described below under the "When Coverage Ends"), whichever is earlier; the date you cease or refuse to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a physician: or the date you complete a recovery program.

Disability due to mental or nervous disorders or diseases

The provisions under this section apply to Participants who incurred a disability prior to January 1, 2024.

You can receive up to a total of 24 months of LTD benefits during your lifetime for a disability due to mental or nervous disorders or diseases, even if the periods of disability are not continuous; and/or not related. Disability benefits will end at the earliest of the date you receive 24 months of disability benefit payments or

the date your benefits otherwise end (as described below under "When Coverage Ends"), whichever is earlier. If you are confined in a hospital or institution, this limit does not apply. Any time period during which you are confined in a hospital will not count toward this 24-month limit. Disability benefits will be limited as stated above for a mental or nervous disorder or disease, which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders as of the date of your disability, regardless of its cause, except for:

- schizophrenia;
- dementia; or
- organic brain disease.

Disability due to subjective disorders and related conditions

You can receive up to a total of 24 months of LTD benefits during your lifetime for a disability due to subjective disorders and related conditions, even if the periods of disability are not continuous; and/or not related. Disability benefits will end at the earliest of the date you receive 24 months of disability benefit payments or the date your benefits otherwise end (as described below under "When Coverage Ends"), whichever is earlier. If you are confined in a hospital, this limit does not apply. Any time period during which you are confined in a hospital will not count toward this 24-month limit. Disability benefits will be limited as stated above for a subjective disorder and related conditions, including but not limited to neuro-musculoskeletal and soft tissue disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue, including sprains and strains of joints and adjacent muscles; Chronic Fatigue Syndrome; Fibromyalgia; Fibrositis; Chronic Pain; or Environmental Sensitivity Disorder, unless the Disability has objective evidence of:

- Seropositive Arthritis (inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease);
- Spinal Tumors (malignant or benign abnormal growths on the bony spine or spinal cord), malignancy, or Vascular Malformations (abnormal development of blood vessels);
- Radiculopathies (disease of the peripheral nerve roots supported by objective clinical finding of nerve pathology);
- Traumatic Spinal Cord Necrosis (injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis); or
- Musculopathies (disease of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG)).

Coordination with other plans

The benefits paid by LTD are reduced by any payments you receive from:

- Federal Social Security Act on your own behalf,
- Any state or federal government disability plan,
- Worker's compensation or
- Retirement or group disability plan paid for by another employer.

If your benefit from these sources is less than what the LTD Plan would pay, the LTD Plan pays you the difference, so your benefit equals 60% (or 75% if you elect supplemental LTD coverage) of your Total Compensation BBR.

Social Security and Medicare benefits during your disability

If you are disabled and qualify for LTD benefits, you must apply for Social Security benefits and enroll in Medicare Parts A and B as follows:

Social Security Disability benefits

If your disability is expected to last 12 months or longer and you have not reached full retirement age, you may be eligible for Social Security Disability benefits. You must apply for Social Security Disability benefits; they are not automatic.

The Social Security approval process takes several months to complete and may involve denials before your disability is approved and the award is received. You are required to file all levels of appeal. The claims administrator will engage the services of Allsup, Inc. to provide Social Security Disability Income (SSDI) advocacy services to you, including but not limited to assistance with the initial application process with the Social Security Administration for SSDI benefits. This service is at no cost to you

If Allsup, Inc. reports that they have accepted your case and will be aiding in your efforts to apply for SSDI benefits, the Company will continue to pay the full LTD benefit during the SSDI process. Once you receive your SSDI award, your monthly LTD benefit will be reduced by the offset. Any retroactive SSDI will be subject to the offset and you may owe money back to the Company. You will be required to sign and return a Repayment Agreement when you apply for LTD.

If you do not apply for Social Security benefits or file all levels of appeal, your LTD benefit will be offset by an estimated Social Security amount six months from your LTD date.

Medicare benefits

After 24 months on SSDI you are automatically enrolled in Medicare Part A. You are eligible for Medicare Part B, but you must enroll. Medicare Part A provides Hospital Insurance and Medicare Part B provides Medical Insurance. There is a cost to you for Medicare Part B coverage. You will receive a packet from the Social Security Office with information related to Medicare. Included in the packet will be a red, white, and blue Medicare card which will be used as your insurance card for all hospital and medical bills. Under the terms of the LTD Plan, you are required to be enrolled in Medicare Parts A&B in order to continue coverage in the BMO Financial Corp. medical plan. Medicare will automatically become the primary payer, and your BMO Financial Corp. medical plan will be the secondary payer, twenty-four months from your SSDI date. The Company will engage the services of Allsup, Inc. to assess your situation and advise you when to submit claims to Medicare. This service is provided at no cost to you.

You must notify the Human Resources Centre to provide proof of Medicare enrollment. This notification will allow you to receive a credit toward your Medicare Part B premium. This credit is applied to your LTD benefit check for as long as you qualify for the LTD benefit and the Company offers this benefit.

Rehabilitation employment

Rehabilitation employment encourages you to return to gainful employment as soon as possible following a period of total disability for which you received LTD benefits. When it is appropriate, as recommended by your doctor and approved by the claims administrator, you may continue to receive partial LTD benefits for up to 24 months while participating in a Company approved rehabilitation program.

While you are participating in the rehabilitation program, your LTD benefit is reduced by 70% of your outside earnings. Your reduced disability benefit and rehabilitation earnings may not equal more than 100% of your pre-disability base pay.

Successive disabilities

If you experience a second disability or series of disabilities, your LTD benefits either continue or start again according to the following rules:

If you return to work and become disabled again

If, after receiving LTD benefits, you return to full-time work and become disabled again from the same or related illness or injury within six months, your second disability is considered a continuation of the first disability. Your LTD benefits resume, and the 60% (or 75%, if you elect supplemental LTD coverage) benefit amount payable during your original disability continues, regardless of any pay changes you may have received after you returned to work.

If, after you return to work for more than six months, you suffer a relapse from the same or related disability your disability is considered a new disability. Your LTD benefits begin again after you've been disabled for more than 110 business days.

Successive disabilities resulting from unrelated causes will be considered a continuation of the first disability unless separated by your return to active service for at least one day. Your LTD benefits begin again after you've been disabled for more than 110 business days.

While you are on disability leave

If you are receiving disability benefits for one condition, but suffer a second or series of disabilities, whether the conditions are related or unrelated, your second disability is considered a continuation of the first disability.

Example: How disability program benefits work together

This example shows how the disability program benefits work together. Let's assume:

- Eva is age 45 and has been a full-time employee of the Company for three years,
- they elected supplemental LTD coverage when they were first eligible,
- Eva gets into a serious car accident, is under a doctor's care, and is unable to report to work,
- when disability began, they had already used three of their 10 paid sick days for the year,
- after 24 months, Eva is still unable to perform the duties of their job or a similar job, and
- the claims administrator approves both STD and LTD benefits.

The chart below shows how Eva's benefits are paid under the program.

Disability period	*Benefits paid*
Days 1 - 10 (Unpaid waiting period)	7 days paid at 100% of base pay* 3 days paid at 0%**
Days 11 - 110 (Short Term Disability period)	30 days at 100% of base pay 70 days at 70% of base pay
Days 111 until he recovers or reaches age 65, whichever occurs first*** (Long Term Disability period)	75% of base pay
*Eva was not required to use paid sick days during the unpaid waiting period but chose to use seven days. ** Eva could have used three vacation days instead of unpaid days to receive full pay during the 10-day waiting period. *** Eva must show continued proof of disability to continue receiving benefits.	

What the plans do not cover

The plans do not pay STD or LTD benefits for conditions that result from any of the following:

- intentionally self-inflicted injuries or attempted suicide while sane or insane,
- service in the armed forces of any country or international authority,
- war or an act of war, whether declared or undeclared,
- committing or attempting to commit a felony; and
- any disability that begins while on Special Service Leave.

The LTD Plan does not pay LTD benefits for pre-existing conditions for a disability that began during your first six months of coverage and was caused by a pre-existing condition for which you received medical care or advice during the three months prior to your coverage effective date.

If you did not enroll in supplemental LTD coverage when you were first eligible and enrolled as a result of Annual Enrollment or a Qualifying Life Event, and have a disability in the first six months of coverage due to a pre-existing condition for which you received medical care within three months before your supplemental coverage effective date, supplemental LTD benefits will not be paid for that condition.

Pre-existing condition means:

- any accidental bodily injury, sickness, mental illness, pregnancy, episode of substance abuse; or
- any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, mental illness, pregnancy, or substance abuse.

Benefits while you are on Long Term Disability

Health / Dental / Vision

While you are on LTD, you will be billed directly for your benefits by Inspira Financial. Inspira will be responsible for collecting your monthly premiums for any health, dental, or vision insurance you are enrolled in. You may continue these benefits at the active employee rate as long as you continue to pay the required premiums and remain eligible for the plan. Failure to pay the premiums on time or to enroll in Medicare Parts A&B will result in the cancellation of your benefits.

Effective January 1, 2025, employees on LTD can continue their health, dental, and vision insurances at the active rate for 36 months. After 36 months, your active benefits will end. You and your dependents may be able to continue coverage through COBRA and/or retiree medical, if eligible.

Supplemental LTD

While you are on LTD, you will not be required to pay for your supplemental LTD premium.

Life Insurance

Once you are approved for LTD you will be automatically enrolled for Waiver of Premium (WOP), which allows you to continue your elected Supplemental Life and/or Basic Life Insurance provided by the Company. To be eligible, you must be approved for LTD prior to your sixtieth birthday and satisfy all conditions according to the life insurance plan definition. When you are enrolled in WOP your coverage will remain in place until the earlier of age 65 or when you are no longer disabled according to the life insurance plan definition. You will not have to pay the premium for your elected Supplemental Life Insurance. Your Basic Life Insurance provided by the Company and your Supplemental Life Insurance will continue at no cost to you. WOP does not apply to Family Life Insurance. All Dependent Life Insurance will be cancelled upon WOP enrollment and conversion paperwork will be mailed to your home address.

Health Care and Dependent Care Spending Accounts

If you are enrolled in a Health Care Spending Account under the Cafeteria Plan of Bank of Montreal/Harris, coverage under that plan will terminate at the end of the month in which your STD ends. If you have a balance in your Health Care Spending Account when your coverage ends, you may claim qualified expenses incurred while you were a participant in that plan, up to the amount you elected less any prior reimbursements. You may be eligible for COBRA coverage for the remaining portion of the plan year. COBRA paperwork will be sent directly to your home. Your Dependent Care Spending Account will end on the first day following the last day of your STD leave. If you have a balance in your Dependent Care Spending Account when your coverage ends, you may claim qualified expenses incurred for the remainder of the calendar year. Expenses will be reimbursed up to the total amount of unused funds remaining in your account. COBRA coverage is not available for the Dependent Care Spending Account.

Voluntary Benefits

If you are enrolled in Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, or the Legal Plan under the BMO U.S. Health and Welfare Benefit Plan, coverage under those insurances will terminate at the end of the month in which your STD ends.

Commuter

You are not eligible to continue the commuter program while on LTD. You are responsible for discontinuing your deduction while on STD and reinstating it, if desired, when you return to work. While you are on STD you must terminate your commuter election by the 10th of the month (or the 4th for Long Island and Metro North Railroad users in New York) in order to cancel for the following month's order.

Employee Stock Purchase Plan (ESPP)

While you are receiving LTD benefits, your contributions to the ESPP will stop. Any unused contributions will be applied to purchase shares on the first quarter purchase date following your approval for leave. If you return to work your ESPP contributions will begin at the same payroll deduction rate as you had when you went out on leave.

Retirement and Savings Plans

If you are a participant in the BMO U.S. Pension Plan (hired before April 1, 2016), the benefits you have earned in the pension will be maintained and available for payment to you in the future. Benefits become available for payment after your coverage under LTD ends and you retire, or otherwise choose not to return to work.

Any non-vested portion of your BMO 401(k) Savings Plan account will become immediately, 100% vested upon approval for LTD. If you previously elected to participate in the 401(k) Savings Plan, your contributions will not be deducted from pay you receive directly from the LTD plan, and you will not earn the BMO Match or Core contributions while on LTD. If your LTD ends and you are able to return to work at BMO, you will be eligible to participate in the 401(k) Savings Plan on a go-forward basis.

If you have an outstanding loan from the BMO 401K Savings Plan, the loan payments will not be deducted from your LTD benefit payment. You must continue to comply with the terms of your loan agreement, and continue to make your loan payments, or your loan will default. While on LTD, if you fall behind on making your loan payments, you have a period of one-year to bring your payments current before your loan defaults.

For information on how to access your Empower account and make loan payments while on LTD, please refer to the BMO 401(k) Savings Plan Summary Plan Description located on BMOUSBenefits.com.

Employee Assistance Program (EAP)

You may continue to receive EAP services through TELUS Health while you are receiving LTD benefits.

When coverage and benefits end

Your coverage and benefits under the Sick Pay Operating Procedure, STD Operating Procedure and LTD Plan will end if any of the following events occur:

- you terminate employment for any reason, unless your termination is due to an involuntary separation from service or lay-off and the Company has agreed to extend coverage, while you meet the applicable Procedure's or Plan's definition of disability, in connection with such involuntary separation from service or lay-off in accordance with policies adopted by the Company for such purpose,
- you retire,
- you are on Special Service Leave,
- you no longer meet the eligibility rules (for example, your standard hours are reduced to less than 20 hours a week, making you eligible for Sick Pay but not eligible for STD pay or LTD benefits),
- you stop making contributions if you elected supplemental LTD coverage,
- you are no longer disabled,
- you refuse to provide proof, or provide insufficient proof, of your disability,
- you refuse a medical exam if requested by the claims administrator,
- you fail to sign the SSDI Repayment Agreement,
- you fail to pay back the SSDI overpayment amount,
- you die, or
- the program is terminated.

Claims

Claims and appeals for disability benefits will be adjudicated in a way to ensure the independence and impartiality of the persons involved in making the decision. This means decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Filing a claim

Short Term and Long Term Disability benefits are not automatic. If you expect your absence to last for more than 10 consecutive business days, you must call the claims administrator, Matrix Absence Management, at 1-888-295-7862. They can also be reached by through the Human Resources Centre (HRC) at 1-888-927-7700. The sooner you call, the earlier you will receive the materials needed to apply for benefits. The claims administrator can answer any questions you have about the plans and how to file a claim for benefits.

You may file claims for plan benefits yourself or through an authorized representative. An authorized representative is a person you authorize in writing to act on your behalf. The claim materials must be completed by you, the claims administrator, and your health care provider. Once completed, the claim materials must be forwarded to the claim administrator and be evaluated to determine if benefits are payable.

You will have 30 days from the day you initiated your claim to submit all materials needed to apply for benefits, and the claim administrator will notify you if additional materials are needed. If no materials are received by the claims administrator by day 30, your claim for benefits will be denied. Your claim will not be re-opened for review even if materials are received after day 30.

Most claims are processed within one month, but special circumstances may require more processing time. The final decision about your claim is made after you submit all needed information.

During your disability, the claims administrator may require periodic, independent medical exams as evidence of your continuing disability. The plan may pay the expense for any required exams. If you fail to provide proof of disability, benefits may end.

Status of your claim

The claims administrator will provide you with notice of the status of your claim within a reasonable period of time after a complete claim has been filed, but no later than 45 days after receiving your claim for benefits. The claims administrator may request an additional 30-day extension if special circumstances warrant by notifying you of the extension before the end of the initial 45-day period. If a decision still cannot be made within this 30-day extension period due to circumstances outside the plan's control, the time period may be extended for an additional 30 days, in which case you will be notified in writing identifying the circumstances and the date the claims administrator expects to render its decision before the end of the original 30-day extension.

If you have not submitted sufficient information to the claims administrator to process your claim, you will be notified of the incomplete claim and given 45 days to submit additional information. This extends the time in which the claims administrator has to respond to your claim from the date the notice of insufficient information is sent to you until the date you respond to the request. If you do not submit the requested missing information to the claims administrator within 45 days of the date of the request, your claim will be denied.

If the claims administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Appeal process for a denied claim

You are entitled to a written explanation of why your benefit was denied or terminated, and you may request to have your claim reviewed and reconsidered. If your claim for benefits is denied or terminated in whole or in part, the claims administrator will provide you with a written notice that:

- specifies the reason for the denial,
- refers to the pertinent plan or operating procedure provisions on which the denial is based,
- describes any additional material or information necessary for properly completing the claim,
- explains why such material or information is necessary,
- describes the claims review and appeal procedures and time limits that apply to the procedures,
- states you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal
- discusses the decision, including an explanation of the basis for disagreeing with or not following:
    - the views presented by you to the claims administrator of health care professionals treating you and vocational professionals who evaluated you,
    - the views of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
    - a disability determination regarding you presented by you to the claims administrator made by the Social Security Administration,
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request,
- specifies the internal rules, guidelines, protocols, standards, or other similar criteria of the claims administrator relied upon in making the adverse determination or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the claims administrator do not exist,

- 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 your claim for benefits, and
- prominently displays in any applicable non-English language clearly indicating how to access the language services provided by the claims administrator.

Standard STD appeal

You or your authorized representative may appeal a denial of a claim for benefits by filing a written request with the claims administrator within 30 days of your receipt of the initial STD pay denial notice. In connection with your appeal, you may request that the claims administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim. You may also submit written comments, records, documents, and other information relevant to your appeal, whether or not you submitted such documents in connection with the initial claim. The claims administrator may consult with medical or vocational experts in connection with deciding your claim for benefits.

The claims administrator will conduct a full and fair review of the documents and evidence submitted and will ordinarily render a decision no later than 45 days after receipt of your request for review on appeal. If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receiving your request for review on appeal. If such an extension of time is needed, you will be notified in writing identifying the circumstances and the date the claims administrator expects to render its decision before the end of the first 45-day period.

STD does not have any additional appeal rights as it is an operating procedure and not an ERISA governed plan. While you are not able to purse any additional appeals, if you would like to share your concerns about the decision of the claims administrator you may contact:

BMO Financial Corp.
Head of US Benefits
395 N Executive Drive
Brookfield, WI 53005

Standard LTD appeal

You or your authorized representative may appeal a denial of a claim for benefits by filing a written request with the claims administrator within 180 days of your receipt of the initial LTD denial notice. In connection with your appeal, you may request that the claims administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim. You may also submit written comments, records, documents, and other information relevant to your appeal, whether or not you submitted such documents in connection with the initial claim. The claims administrator may consult with medical or vocational experts in connection with deciding your claim for benefits.

The claims administrator will conduct a full and fair review of the documents, comments, records, and other evidence submitted without regard to whether such information was submitted or considered in the initial determination. Before the claims administrator can issue an adverse benefit determination on review, the claims administrator shall provide you, free of charge, any new or additional evidence considered, relied upon, or generated by or at the direction of the claims administrator in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of

adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the claims administrator can issue an adverse benefit determination on review based on a new or additional rationale, the claims administrator shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The claims administrator will ordinarily render a decision no later than 45 days after receipt of your request for review on appeal. If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receiving your request for review on appeal. If such an extension of time is needed, you will be notified in writing identifying the circumstances and the date the claims administrator expects to render its decision before the end of the first 45-day period.

If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the claims administrator receives your response to the request. The claims administrator may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the claims administrator provides you with new or additional evidence or a new or additional rationale, and end when the claims administrator receives the response or on the date by which the claims administrator has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the claims administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual.

If the claims administrator grants your appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination will be a written notice that:

- specifies the reason or reasons for the decision,
- specifies references to the Plan provisions on which the decision is based,
- states you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim,
- states you have the right to bring a civil action under section 502(a) of ERISA and describes any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim,

- discusses the decision with an explanation for disagreeing with or not following:
  - the views presented by you to the claims administrator of health care professionals treating you and vocational professionals who evaluated you,
  - the views of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - a disability determination regarding you presented by you to the claims administrator made by the Social Security Administration,

- the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request,

- specifies internal rules, guidelines, protocols, standards, or other similar criteria of the claims administrator 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,

- prominently displays in any applicable non-English language clearly indicating how to access the language services provided by the claims administrator, and

- gives any other notice(s), statement(s) or information required by applicable law.

Voluntary LTD appeal

You may file a voluntary appeal with the claims administrator of any final standard appeal determination. Subject to verification procedures that the Disability Plan may establish, your authorized representative may act on your behalf in filing and pursuing this appeal. All of the levels of standard appeal described in Appeal process for a denied claim must be completed before you can file a voluntary appeal. The appeal must be filed for review within 60 days after you receive the final denial notice under the standard appeal processes.

In connection with your appeal, you may request that the claims administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim. You may also submit written comments, records, documents, and other information relevant to your appeal, whether or not you submitted such documents in connection with the initial claim. The claims administrator may consult with medical or vocational experts in connection with deciding your claim for benefits.

The claims administrator will conduct a full and fair review of the documents, comments, records, and other evidence submitted without regard to whether such information was submitted or considered in the initial determination. Before the claims administrator can issue an adverse benefit determination on review, the claims administrator shall provide you, free of charge, any new or additional evidence considered, relied upon, or generated by or at the direction of the claims administrator in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the claims administrator can issue an adverse benefit determination on review based on a new or additional rationale, the claims administrator shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The claims administrator will ordinarily render a decision no later than 45 days after receipt of your request for review on appeal. If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receiving your request for review on appeal. If such an extension of time is needed, you will be notified in writing identifying the circumstances and the date the claims administrator expects to render its decision before the end of the first 45-day period.

If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the claims administrator receives your response to the request. The claims administrator may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the claims administrator provides you with new or additional evidence or a new or additional rationale, and end when the claims administrator receives the response or on the date by which the claims administrator has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the claims administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual.

If the claims administrator grants your appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination will be a written notice that:

- specifies the reason or reasons for the decision,
- specifies references to the Plan provisions on which the decision is based,
- states you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim,
- states you have the right to bring a civil action under section 502(a) of ERISA and describes any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim,
- discusses the decision with an explanation for disagreeing with or not following:
    - the views presented by you to the claims administrator of health care professionals treating you and vocational professionals who evaluated you,

  - the views of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - a disability determination regarding you presented by you to the claims administrator made by the Social Security Administration,

- the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request,
- specifies internal rules, guidelines, protocols, standards, or other similar criteria of the claims administrator 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,
- prominently displays in any applicable non-English language clearly indicating how to access the language services provided by the claims administrator, and
- gives any other notice(s), statement(s) or information required by applicable law.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of an appeal will have no effect on your rights to any other benefits under the plan. You are not required to file the voluntary appeal before taking legal action. If you choose not to file for voluntary review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Mail your written appeal directly to:
Matrix Absence Management Quality Assurance Review
c/o RSLI
PO Box 13498
Philadelphia, PA 19101

During the appeal process your LTD benefit and elected benefits will be terminated. The LTD benefit will be stopped on the denial date and the elected benefits will be stopped at the end of the month in which you receive the denial. If your claim is denied, you will be issued COBRA. If you do not elect COBRA and your claim is reversed, you will be unable to pick up your elected benefits until Annual Enrollment or as the result of a life event.

All decisions by the claims administrator with respect to your claim are final and binding. If any judicial proceeding is undertaken to appeal the denial of a claim or bring any other action under Section 502 of ERISA other than a breach of fiduciary duty claim, the evidence presented will be strictly limited to the evidence timely presented to the claims administrator. In addition, any such judicial proceeding must be filed within six (6) months after the final decision of the plan administrator or claims administrator, as applicable.

If the claims administrator fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under

section 502(a) of ERISA on the basis that the claims administrator has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on nominal violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the claims administrator demonstrates that the violation was for good cause or due to matters beyond the control of the claims administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between the claims administrator and you. This exception is not available if the violation is part of a pattern or practice of violations by the claims administrator. Before filing a civil action, you may request a written explanation of the violation from the claims administrator, and the claims administrator must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the claims administrator met the standards for the exception, your claim shall be considered as re-filed on appeal upon the claim administrator's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the claims administrator shall provide you with notice of the resubmission.

Administrative information

Plan identification

Plan name
This Summary Plan Description describes the BMO U.S. Long Term Disability Income Plan portion of the BMO U.S. Health and Welfare Benefit Plan. The Short Term Disability and Sick Pay benefits described in this SPD are provided under Company Operating Procedures and not a formal plan.

Separate Summary Plan Descriptions describe the Medical, Dental, Vision, Flexible Spending Accounts, Employee Assistance Program, and Life portions of the BMO U.S. Health and Welfare Benefit Plan.

Plan number
507

Employer Identification Number
51-0275712

Plan year
January 1 – December 31

Plan sponsor
BMO Financial Corp.
BMO U.S. Health and Welfare Benefit Plan

Plan administrator
The Benefits Administration Committee (the "Committee") is the plan administrator.

The Plan sponsor and Plan administrator can be contacted at:

> BMO Financial Corp.
> Benefits Administration Committee
> 320 South Canal Street 7W-HR
> Chicago, IL 60606
> Human Resources Centre (HRC): 1-888-927-7700

The Plan administrator has complete discretionary authority to make all determinations under the Plan, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Plan. It is the principal duty of the Committee to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. To the extent not delegated to another named fiduciary or to a Claims Administrator, the Committee shall have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. The Committee shall have discretionary and final authority to interpret the terms of the LTD Plan regarding matters for which it is responsible as set forth above and its decisions shall be final and binding on all parties.

The Plan administrator has delegated to the Claims Administrator the discretionary authority to make decisions regarding the interpretation or application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan. Benefits under the Plan will only be paid if the Plan administrator or Claims Administrator, as applicable, determines in its discretion that the claimant is entitled to them.

Plan trustee
The Plan trustee for the BMO U.S. Health and Welfare Benefit Plan is:

BNY Mellon Client Service Center
500 Ross Street, 8th
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 and source of funding
Sick pay and STD pay are self-insured and paid from the general assets of the Company. LTD benefits are self-insured and funded through a trust with contributions made by the Company and participating employees.

Claims Administrator

Matrix Absence Management, Inc.
2421 W. Peoria Avenue, Suite 200
Phoenix, AZ 85029
(800) 866-2301

Future of the Plan

The Company reserves the right to amend modify, replace, or terminate the Plan, or part of the Plan, or Operating Procedures at any time for any reason. Any amounts payable under the terms of the Plan as of the date of such amendment or termination will be paid in accordance with those terms.

Your rights Under ERISA

As a participant in the BMO U.S. Health and Welfare Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive information about our Plan and benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial

report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent actions by Plan fiduciaries

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

Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide all of the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedure as described in this SPD. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-866-444-3272.

No employment guarantee

This document does not create a contract of employment between BMO Financial Corp. (the Company) and any employee. Being a participant in the Plan does not grant any current or future employment rights. And Plan participation is not a condition of employment.