Flexible Spending Accounts Summary Plan Description (SPD)

Employee Benefit Program of Bank of Montreal/Harris

Contents

About this Summary Plan Description

This document is the Summary Plan Description ("SPD") for the flexible spending accounts portion of the Employee Benefit Program of Bank of Montreal/Harris (the "Plan"). Please read this SPD to help you understand and manage your benefits and keep it for future reference. This SPD only addresses the flexible spending accounts benefits portion of the Plan. Other portions of the Plan discuss other benefits. Those other portions are not covered by this SPD.

The information in this SPD is current as of January 1, 2021. As plan changes occur, this SPD will need to be revised periodically. Although the Company strives to keep the descriptions up to date, from time to time plan changes may not be incorporated immediately into the SPD. While this SPD summarizes the major provisions of this Plan, it does not provide you with every Plan detail. If there are any discrepancies or any oral representations differs between this SPD from the legal Plan documents, the Plan document prevails.

If you have questions about the Plan or would like a complete copy of the Plan document, contact the Human Resources Centre (HRC) at 1-888-927-7700.

Eligibility

Employee

You are eligible to participate in the flexible spending accounts portion of the Plan if you are a:

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

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

You and your eligible dependents (including tax-dependent domestic partners or your partner's qualifying children that you claim as a dependent on your federal income tax return) do not have to be covered under the Company's Medical, Dental or Vision Plans to participate in the Health Care Flexible Spending Account (HCFSA).

Eligible dependents

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

- your legal spouse, unless you are legally separated or divorced. A legal spouse includes a same-sex or opposite-sex individual who is recognized as your spouse for purposes of federal tax laws (a common-law spouse is eligible if you legally establish the marriage in a state that recognizes common-law marriages and is recognized as your spouse for purposes of federal tax laws);
- your qualifying same-sex or opposite-sex domestic partner if your relationship satisfies certain criteria (see Domestic partner eligibility requirements in this section); and
- your children under age 26.

Children are defined as:

- your biological children;
- your adopted children or children placed with you for adoption;
- your stepchildren, regardless of where they live (includes stepchildren from your same-sex or opposite-sex legal spouse);
- foster children living with you;
- a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the Plan for dependent coverage;

- any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
- your domestic partner's children if they qualify as your dependents for income tax purposes according to Section 152 of the IRS Code.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO recognizes the rights of a child to coverage for health care benefits. Under a medical child support order, the court or an administrative agency can require you to provide coverage to a child under the Medical, Dental or Vision Plans.

BMO will comply with the requirements for coverage outlined in a QMSCO. If BMO is notified that any of your children are covered by a QMSCO, you will be required to remain enrolled in BMO's Medical, Dental or Vision Plans, covering the applicable children, until the QMSCO is no longer valid. You may call the Human Resources Centre at 1-888-927-7700 for information regarding the procedures governing QMCSOs.

Extended coverage for disabled children

If you have an adult dependent child age 26 or over that is physically or mentally incapable of self-support, the child may continue to be eligible to be covered on the Plan if certain conditions are met.

The Plan will cover the adult dependent child, as long as:

- the child is unmarried;
- the child is unable to be self-supporting due to a disabling condition;
- the child depends mainly on you for support;
- the child is considered your tax dependent;
- the child's disability existed prior to the child reaching age 26;
- you provide to proof of the child's disability and dependency within 31 days of the date coverage would have otherwise ended because the child reached age 26; and
- you provide proof, upon request by the Plan, that the child continues to meet these conditions.

The proof may include medical records, determination of disability, and copies of your federal tax returns. If you do not supply the required documentation within 31 days of the child's 26th birthday or when requested, the child will not be eligible for benefits under the Plan.

Coverage will continue, as long as the enrolled adult dependent child continues to meet the conditions above, unless coverage is otherwise terminated in accordance with the terms of the Plan. You may also need to provide proof of continued disability from time to time to maintain coverage.

Domestic partner eligibility requirements

Plan eligibility is available to employees' domestic partners, whether same-sex or opposite-sex. Your domestic partner's children may also qualify as dependents under the Plan if they meet the same requirements that apply to all dependent children and they qualify as your dependents for income tax purposes according to Section 152 of the IRS Code.

Domestic partners
For your domestic partner to be eligible under the Plan, the two of you must meet all of the following requirements:

- you share a sole, committed relationship with each other that has existed for at least one year and is expected to last indefinitely;
- you are jointly responsible for each other's welfare and financial obligations;
- you share your principal place of residence;
- you are both at least 18 years old and mentally competent to consent to a contract;
- neither of you is married to, legally separated from or in another domestic partner relationship with anyone else; and
- you are not related to each other in a way that would prohibit a legal marriage from being recognized in the state in which you live.

The following documentation that demonstrates you meet the eligibility requirements is required. Two of the items listed must be provided, however, additional documentation may be requested if necessary to determine eligibility:

- federal and state tax returns
- domestic partnership agreement
- joint mortgage, lease or ownership of real estate property
- primary beneficiary designation for will, life insurance and/or retirement benefits
- assignment of durable power of attorney
- joint ownership of motor vehicle or investments
- joint checking or credit account
- joint responsibility for debts
- other document stating common residency

Domestic partner's children
If your domestic partner meets the requirements, then his or her children may also be considered eligible dependents under the Plan. Children of domestic partners are subject to the same eligibility requirements that biological and adopted children must meet.

You can enroll your domestic partner's children only if they qualify as your legal tax dependents. As a result, premiums for coverage of all dependent children are made on a before-tax basis with no imputed income.

Qualifying for tax-dependent status

To qualify as a tax dependent, your domestic partner or domestic partner's children must meet the rules under Section 152 of the IRS Code. In addition, tax dependents must be claimed on your federal tax return. If your domestic partner qualifies under IRS Code Section 152, he or she may enroll as a *tax-dependent*. Otherwise, your domestic partner may enroll as a *non-tax dependent*. You can enroll your domestic partner's children only if they qualify as your legal tax dependents.

If your domestic partner meets the domestic partner eligibility requirements, he or she can enroll as either a *tax dependent* or a *non-tax dependent*. The following chart summarizes the differences between *tax dependent* and *non-tax dependent* status.

Two options for domestic partner status		
Dependent type	***Tax-dependent status***	***Non-tax dependent status***
Who qualifies	Domestic partner who satisfies the requirements listed above and is your legal dependent for tax purposes as defined under IRS Code Section 152. Domestic partner's children if they meet eligibility requirements and qualify as your tax dependents.	Domestic partner who satisfies the requirements listed above but is not your legal dependent for tax purposes. Domestic partner's children are not eligible for coverage if they are non-tax dependents.
How premiums are deducted	Domestic partner's portion of the premium is deducted from your pay before taxes, just like your own premium.	Domestic partner's portion of the premium is deducted from your pay after taxes.
Tax impact	You are not taxed on the Company's contribution toward your domestic partner's premium.	The Company's contribution toward your domestic partner's premium is considered additional imputed income, which is taxable to you on your paycheck when deductions are taken.
Impact on Flexible Spending Accounts	Your domestic partner's (and/or their qualifying children's) eligible medical, dental and vision expenses may be eligible under your Health Care Flexible Spending Account or Health Savings Account.	None of your domestic partner's expenses are eligible

Enrolling & changes

When coverage begins

Coverage under the Plan is not automatic; you must enroll. 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. 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.

*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.

Once made, you generally cannot change your elections during the year. If you miss the 31-day deadline and want to enroll in the Plan during the year, you can do so only in limited situations; for example, if you experience a qualifying life event (see *Qualifying life event* for more information). If you have a qualifying life event you have 31 calendar days from the date of the event to enter any applicable coverage changes. Otherwise you must wait until the next annual enrollment to make coverage changes, which take effect the next January 1, or until you experience another qualifying life event.

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.

Rehired employees

If you are an eligible employee rehired within 30 days of your termination date, your benefit elections in effect on the date of your termination are automatically reinstated back to the benefit end date. If you are an eligible employee rehired more than 30 days after your termination date, but within 13 weeks of your termination date, your benefit elections are effective on the first day of the month following your date of rehire and you must enroll within 31 calendar days of your rehire date. If you are an eligible employee with a rehire date greater than 13 weeks following your termination date, your effective date will be the same as a new employee and you must enroll within 31 calendar days of your rehire date. If you are an eligible employee rehired after the annual enrollment for the next calendar year, you must enroll or re-enroll to have coverage in the next calendar year.

Annual enrollment

During annual enrollment, held each fall, you can make changes to your benefit elections. The changes take effect the next January 1. If you have not enrolled in the Plan, you can do so during the annual enrollment period. Elections made during annual enrollment remain in effect throughout the calendar year; unless you experience a qualifying life event (see *Qualifying life event* for more information). In general, your elections remain in effect for future years unless you make a change or you are notified by the Company of coverage changes. However, Flexible Spending Account (FSA) and Health Savings Account (HSA) elections must be made each year.

Qualifying life event

There may be times that you experience an event in your life that would allow you to make mid-year changes to your benefit elections. The change you make in your elections must be consistent with your qualifying life event. For example, if you adopt a child, you can add your child as a covered dependent; however, you cannot drop your spouse/domestic partner from coverage under the Plan under the adoption event. Note that some qualifying life events are not applicable to particular benefits. When you make a change, or request a change, you must follow applicable Internal Revenue Service rules on what changes are allowed.

Life Event	Medical, Dental and/or Vision Plans	Spending Accounts	Supplemental LTD	Life Insurance	Other Voluntary Benefits
Birth/Adoption *Having a baby or finalizing an adoption with the court*	Enroll/Change tier	Enroll/Change election	Enroll – No waive	Enroll/Change tier – No waive	Enroll/Change tier
Acquired Guardianship	Change tier – No Waive	Enroll/Change election	Enroll – No waive	Enroll/Change Tier – No waive	Change tier – No waive
Death of Dependent/Child	Enroll/Change tier	Decrease only/No waive	Enroll – No waive	Enroll/Change tier	Change Tier – No waive
Death of Spouse/Domestic Partner	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change Tier – No waive
Divorce/Legal Separation	Enroll/Change Tier – No waive	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change Tier – No waive
Marriage	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
Gain of Dependent/Child Eligibility *Your child becomes newly eligible for benefits through another employer or state*	Change tier – No waive	Change election	--	Enroll/Change tier	Change tier – No waive
Loss of Dependent/Child Eligibility *Your child involuntarily loses other benefits coverage through another employer or state*	Change tier – No waive	Change election	--	Enroll/Change tier	Change Tier – No waive
Gain of Spouse Benefits/Eligibility *Your spouse becomes newly eligible for benefits through another employer or state*	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
Loss of Spouse Benefits/Eligibility *Your spouse involuntarily loses other benefits coverage through another employer or state*	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
Start of Domestic Partnership	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
End of Domestic Partnership	Enroll/Change Tier – No waive	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier – No waive
Other Life Events *(Turning 26, loss or gain of state coverage, etc.)*	Call the Human Resources Centre (HRC) at 1-888-927-7700				

Do not wait to initiate your life event

You may be required to provide documentation for your life event. It is important to note that you do not need to submit the documentation at the time you initiate the life event. Since you only have 31 calendar days (includes the event date) to change, add or cancel coverage, it is recommended that you initiate the life event immediately in the My Benefits & Retirement enrollment site. You may contact the Human Resources Centre at 1-888-927-7700 for assistance in making a qualifying life event change.

The effective date of coverage is the date of the qualifying life event, except in the case where you become a newly benefit eligible employee for coverage under the Employee Benefit Program of Bank of Montreal/Harris. The effective date for an employee newly eligible for benefits is the 1st of the month following 30 days from the date your increase in standard hours to over 20 hours/week occurred ("newly benefit eligible date"). You must make your benefit elections within 31 calendar days from your newly benefit eligible date.

How to change, add or cancel coverage

If you experience a qualified life event during the year, you have 31 calendar days from the date of the event to change, add or cancel coverage. Here's how:

1. Go to Workday, click on the My Benefits & Retirement application
2. Depending on where you are connecting to Workday from, click on Employees in Canada an US (on BMO Network) or Employees in Canada and US (off BMO Network)
3. Click on the Log your Life event tile
4. Choose the Life Event that corresponds to your event, enter the date your life event occurred and follow the rest of the prompts to make your election changes
5. After you make the benefit election changes, verify your benefits summary to make sure everything is correct and the changes are reflected as you intended. Keep a copy for your records.

If you miss the deadline, your next opportunity to enroll, change or cancel coverage is during annual enrollment, unless another qualifying life event occurs that would allow a change. You may file an appeal to request a change, but your right to add or drop coverage is not guaranteed.

Family and Medical Leave of Absence

You may be able to continue Plan coverage for up to 12 weeks during a leave of absence if that leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) and you are eligible under the terms of FMLA.

To continue your coverage, you must continue paying your premiums while on FMLA leave. If your FMLA leave is paid, your premium contributions are deducted from your pay as usual and your benefits coverage will continue without interruption during your leave. If any portion of your leave is unpaid, your benefits coverage will continue and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume and any accumulated arrears will be collected at a rate of one additional deduction per pay until your arrears

balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums.

If, during your FMLA leave, you give notice that you are terminating employment, your coverage ends on the last day of the month in which your employment ends. If you do not return to work on your expected return date and do not notify the Company of your intent either to terminate or extend your leave, your coverage ends on the last day of the month in which your employment ends. Also, you cannot change your Plan coverage tier (e.g., employee only) while on FMLA leave, except at annual enrollment or if you have a qualifying life event or special enrollment event. For more information about FMLA leave, access the HR Intranet, Operating Procedures, Leaves of Absence – Family Medical can be found under *About Managing Life's Transitions*.

Maternity and Parental leave

If you are on maternity or parental leave your Plan coverage will continue during both the paid and unpaid portion of your leave.

- Your benefits coverage will continue during the first 12 weeks of paid maternity/parental leave. Premiums will continue to be deducted from your pay.
- If you choose to take unpaid maternity/parental leave, your benefits coverage will continue and you will owe premiums. Your premiums will accumulate in arrears. When you return from leave, your regular deductions will resume and any arrears will be collected at a rate of one additional deduction per pay until your balance is zero.

Military leave of absence

If you are on military leave, you can elect to continue Plan coverage for yourself and enrolled dependents for up to 24 months during your absence or, if earlier, until the day after the date you are required to apply for or return to active employment with the Company under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your contributions are the same as for active employees and you will be required to pay the active premiums.

Whether or not you decide to continue coverage during military leave, that coverage will be reinstated when you return to employment under USERRA. Your reinstatement will be without any waiting period.

If you take a leave of absence

You can continue your spending account coverage while you are on an approved leave of absence. If you are on a paid leave, your premium is deducted from your pay as usual. If any portion of your leave is unpaid, when you return from leave, your deductions will be recalculated based on your annual election and the remaining pay cycles.

If you become disabled

Your spending account coverage, if applicable, may continue during your disability leave. Premium payments are deducted from any Short-Term Disability payments you may be receiving. Coverage will terminate at the end of the month in which your short-term disability 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. Please refer to the Disability SPD for detailed information regarding your benefits during your disability.

Retroactive cancellation of coverage

The Plan expects that you will provide complete and accurate information. If you or your dependents commit fraud against the Plan or make a misrepresentation, the Plan may take appropriate actions in response to such fraud or misrepresentation. The actions can include a loss of particular benefits or loss of all eligibility for the Plan.

Eligibility claims and appeals

Benefit claims and appeals are handled by a claims administrator as described under Claims for reimbursement. This section details the process and timing around filing an eligibility claim or appeal.

An eligibility appeal is a claim to participate in a Plan option or to change an election to participate during the year. It may be a claim to start, add or stop participation in the Plan -- that is, it could be a claim related to enrollment in a Plan or eligibility for coverage in a Plan -- or a claim relating to the premium you are being charged for coverage under this benefit program. For instance, you may feel an error was made during annual enrollment that resulted in your being assigned incorrect coverage. In these situations, you should contact the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concerns.

Procedure for filing an eligibility claim

If the HRC does not resolve the issue to your satisfaction, you may file a claim. In order for a communication from you to constitute a valid claim, it must be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records, and other information to:

BMO Financial Corp.
C/O Appeals
PO Box 661065
Dallas, TX 75266-1065
Fax: 1-866-894-6684

The eligibility administrator will review the appeal and the determination to your claim will be provided to you in writing within 30 days of the date the claim is received. If the eligibility administrator needs additional information in order to determine whether to grant your claim, you will be notified of the additional information needed. If you do not provide the requested information within 30 days, your claim will be considered invalid. If after review, the request is approved, you must pay any premium, or will be refunded premiums, retroactive to the date of the event and be consistent with the eligibility claim.

Appeal of a denied eligibility claim

If your eligibility claim is denied, you or your authorized representative may appeal that decision by submitting an appeal request in writing within 60 days of receiving the eligibility claim denial. In order for a communication from you to constitute a valid appeal, it must be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records or other information that you have not previously provided to:

BMO Financial Corp.
Benefits Administration Committee
C/O Appeals
395 N. Executive Drive
Brookfield, WI 53005

For a second level appeal you must be able to prove that your claim falls outside the usual Plan rules. In connection with your request for appeal, you may review pertinent Plan documents and submit issues and comments in writing. You may also submit additional information about your claim to the Committee to

consider upon reviewing your appeal. Upon request, you will be provided with copies of all documents and information relevant to your claim free of charge.

The Benefit Administration Committee will respond to your appeal in writing of its final decision regarding your claim for benefits under the Plan within 60 days (or, 120 days if an extension is required) of the date the claim is received. If the Benefits Administration Committee needs additional information in order to determine whether to grant your claim, they will notify you. If you do not provide the requested information within 30 days, your appeal will be considered invalid. If after review, the Benefits Administration Committee approves the request, you must pay any premiums, or will be refunded premiums, retroactive to the date of the event and be consistent with the eligibility claim.

Limitation of action

You cannot bring any legal action against BMO Financial Corp., the Benefits Administration Committee (or any other claims administrator), or the Plan, unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against BMO Financial Corp., the Benefits Administration Committee (or any other claims administrator), or the Plan, you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against BMO Financial Corp., the Benefits Administration Committee (or any other claims administrator), or the Plan.

Mandatory venue

Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to the Plan must be brought in federal court in Cook County, Illinois. The federal courts governing Cook County, Illinois, along with the United States Supreme Court, have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

Plan cost

You pay the entire cost of contributions made to the Flexible Spending Accounts.

Tax-saving advantage

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

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to set aside money on a before-tax basis to pay for a variety of eligible health care and dependent care expenses. Today the high cost of health care and the growing need for dependent care are facts of everyday life. Although the Company's medical, dental and vision plans offer you significant protection against the high cost of health care, as you might expect, the plans do not reimburse all of your medical, dental and vision expenses. Or, you may rely on day care for your children, a disabled spouse or your elderly parents so that you can work. These expenses can really add up. Flexible Spending Accounts can help you save money by reducing your taxable income. As the money you contribute is deducted from your paychecks, your taxable income is reduced – this means you'll pay less in taxes.

In general, there are two types of Flexible Spending Accounts:

- Health Care Flexible Spending Account (HCFSA)
  The Health Care Spending Account helps pay for you and your dependent's medical, dental and vision expenses that aren't covered by the Company's or your spouse/domestic partner's benefit plans. The Limited Purpose Flexible Spending Account (LPFSA) is limited to dental and vision expenses and is generally used when you are contributing to a Health Savings Account.
- Dependent Care Flexible Spending Account (DCFSA)
  The Dependent Care Flexible Spending Account covers expenses for the daily care of your children under age 13 or other qualified individuals who are unable to care for themselves, so that you can work.

The Health Care and Dependent Care Flexible Spending Accounts and the Limited Purpose Flexible Spending Account are administered by Your Spending Account (YSA).

You can choose to participate in one or both of the accounts, depending on your needs. Every year, you decide how much money, if any, you want to contribute to each account. The money is then deducted from the first two paychecks of each month and is credited to your account on a before-tax basis. Because this money goes into your Health Care and Dependent Care Flexible Spending Accounts before federal income or Social Security taxes are withheld, you pay less in taxes. In most cases, the money you set aside is exempt from state and local taxes as well. Since you don't pay Social Security taxes on your Flexible Spending Account contributions, those benefits may be slightly less when you retire or become disabled. Any reduction will depend on the length of time between now and when you retire or become disabled, and whether or not your taxable income exceeds the Social Security maximum wage level.

Important note about HCFSA participation

If you participate in both the Health Care Flexible Spending Account and the UMB Health Savings Account (HSA), your Health Care Flexible Spending Account will be considered a Limited Purpose Flexible Spending Account (LPFSA) subject to special IRS rules. You may also elect to participate in the LPFSA if you are contributing to a Health Savings Account other than through UMB. If you are participating in LPFSA, only the following expenses are considered eligible for reimbursement:

- dental care and orthodontia, such as fillings, X-rays, braces and caps;
- vision care, including eyeglasses, contact lenses, solutions and LASIK eye surgery.

Contributions

You decide whether to participate in one or both accounts and how much to contribute. First, you'll need to estimate the amount of out-of-pocket health care and dependent care expenses you are likely to have during the year. Then, determine how much salary you want to set aside during the year to pay for those expenses. Keep in mind, there are limits on the amounts you can contribute. The annual minimum and maximum contributions are shown below. Account maximum limits are subject to change based on IRS guidelines.

Flexible Spending Account	Annual minimum	Annual maximum
Health Care	$100	$2,750
Dependent Care	$100	$5,000 if married and filing jointly $2,500 if filing separately

Note: If you contribute $150 or more to your Health Care Flexible Spending Account, you can take advantage of the YSA card.

You may elect to contribute up to $5,000 per calendar year to the Dependent Care Flexible Spending Account if:

- You are married and file a joint federal income tax return;
- You are married and file a separate federal income tax return, and meet the following conditions:
    1. your household constitutes the primary residence of a dependent for whom you are eligible to receive reimbursements under the Dependent Care Flexible Spending Account;
    2. you furnish over half the cost of maintaining this household during the taxable year; and
    3. during the last six months of the taxable year, your spouse was not a member of this household; or If you are married and reside with your spouse but you file separate federal income tax returns, the maximum amount you can contribute to the Dependent Care Flexible Spending Account is $2,500 per calendar year. The amount you may elect cannot exceed either your or your spouse's earned income for the calendar year.
- You are single or head of household for federal tax purposes.

The amount you elect will automatically be deducted from your pay on the first two pay periods of each month and deposited into your Spending Accounts. If there is a third pay period in the month, deductions will not be taken (exceptions may apply in certain circumstances such as missed deductions). The money remains in your accounts until you incur eligible expenses and submit a claim for reimbursement.

Health Care Flexible Spending Account (HCFSA)

You can use your Health Care Flexible Spending Account to pay for certain expenses for you and your eligible dependents (including your tax-dependent domestic partner or his or her qualifying children) that your health care plans may not cover. This includes your deductible and coinsurance, and many expenses that are not eligible under the medical, dental and vision Plans. Even if you are seldom ill and don't think you'll use the medical, dental or vision Plans, you may want to consider using the Health Care Flexible Spending Account for annual expenses that the Plans don't cover.

Eligible health care expenses

Except for medical, dental and vision insurance premiums, most health care expenses that you could deduct from your federal income taxes can be reimbursed through the Health Care Flexible Spending Account. (Expenses reimbursed from your Health Care Flexible Spending Account cannot also be deducted from your federal income taxes.)

Listed below are some of the expenses eligible for reimbursement under the Health Care Flexible Spending Account (provided they are not reimbursed by any other plan):

- acupuncture;
- allergy shots;
- chiropractor's care;
- contact lenses, exams and needed materials, such as saline solution and enzyme cleaner;
- copayments, deductibles and coinsurance not paid by any group carrier (the receipt must clearly indicate it is for a copayment or coinsurance for a qualified expense);
- dentist's charges not covered by a dental plan;
- dietary supplements when medically necessary and prescribed by a physician;
- eyeglasses and vision exams;
- equipment needed for the handicapped, like car controls or special telephones for the deaf;
- hearing exams, and hearing aids and the batteries needed to operate them;
- immunizations;
- insulin;
- LASIK eye surgery;
- medical or dental expenses that exceed reasonable and customary limits;
- nursing home confinement for treatment of illness;
- over-the-counter (OTC) medicines without a prescription, as well as menstrual care products
- physical therapy;
- prescription drugs used to treat or alleviate an illness or injury;
- routine medical exams, including school physicals for children;
- smoking cessation and weight loss programs prescribed by a physician;
- syringes, needles and injections;
- transportation expenses, including taxis, buses, plane fares, and parking, when used for travel for necessary medical care;
- vaccinations;
- well-baby care;

- wheelchairs;
- X-rays.

The list of eligible and ineligible expenses are available in IRS Publication 502 (Medical and Dental Expenses). To obtain a copy, go to www.irs.gov or call 1-800-829-1040 or your local IRS office. Note that IRS Publication 502 is not specific to only Health Care Flexible Spending Accounts and not all expenses may be eligible for reimbursement under the Health Care Flexible Spending Account. Contact the claims administrator for more information.

Ineligible health care expenses

Items that would not qualify as tax deductible under federal income tax laws are not eligible for reimbursement through the Health Care Flexible Spending Account.

The following are examples of ineligible expenses:

- cosmetics;
- cosmetic surgery, except when needed due to an accident or injury;
- custodial care in an institution, such as a nursing home;
- expenses incurred before your effective date of participation;
- expenses paid by any other group health or dental plan;
- external bleaching of teeth or "teeth whitening;"
- health club dues;
- health care expenses that are reimbursable under any other health plan or insurance;
- health insurance premiums;
- household and domestic help;
- maternity clothes;

- uniforms;
- vitamins taken for general health purposes;
- weight loss and smoking cessation programs not prescribed by a physician.

The complete lists of eligible and ineligible expenses are available in IRS Publication 502 (Medical and Dental Expenses). To obtain a copy, go to www.irs.gov or call 1-800-829-1040 or your local IRS office. Note that IRS Publication 502 is not specific to only Health Care Flexible Spending Accounts and not all expenses may be eligible for reimbursement under the Health Care Flexible Spending Account. Contact the claims administrator for more information.

Dependent Care Flexible Spending Account (DCFSA)

The Dependent Care Flexible Spending Account covers eligible dependent care expenses so that you (or you and your spouse, if you're married) can work (or look for work) or your spouse can attend school full time.

Eligible dependent care expenses

For dependent care expenses to qualify for reimbursement through the Dependent Care Flexible Spending Account, the care must be provided:

- so that you can work (if you're married, your spouse also must work, be looking for work or attend school full time);
- for your eligible dependents under age 13; to qualify as a dependent, the person must be claimed as an exemption on your tax return and;
- for any other adult living with you for more than half of the year, including your spouse or parents, must be incapable of self-care and must spend at least eight hours a day in your home.

The following expenses are eligible for reimbursement under the Dependent Care Flexible Spending Account:

- costs for care at facilities away from home, such as family day care or adult day-care centers, as long as your adult dependent spends at least eight hours a day in your home;
- recreation programs;
- services of a day-care center, nursery school or preschool (but not kindergarten) if the center complies with all state and local laws;
- summer day camps; and
- wages paid to a baby-sitter or companion in or outside your home.

Ineligible dependent care expenses

The following expenses are not eligible for reimbursement under the Dependent Care Flexible Spending Account:

- boarding schools;
- care provided by someone you claim as a dependent;
- educational expenses like swimming, dance lessons or art classes, whether individual or group, even if recommended by a doctor to improve general health;
- expenses incurred before your effective date of participation;
- kindergarten;
- nursing homes;
- overnight camps; and
- providers who watch your eligible dependents while you attend social events.

Dependent Care Flexible Spending Account vs. child and dependent care tax credit

The IRS lets you claim work-related dependent care expenses for this credit on your income tax return. The tax credit amount is determined by applying a percentage to your total work-related dependent care expenses.

You can use the Dependent Care Flexible Spending Account and the tax credit, but you cannot claim the same expenses for both. If you decide to use both the Dependent Care Flexible Spending Account and the dependent care tax credit, federal regulations require that the amount you have directed into the Flexible Spending Account be subtracted from your tax credit. As with any tax matter, you should consult a qualified tax adviser before making your decision since tax laws change often.

As an alternative to using the Dependent Care Flexible Spending Account, when filing your income tax return you may wish to apply some or all of your eligible dependent care expenses to the after-tax child tax credit. By law, you cannot apply the same expense to both tax-savings methods, but you can apply a certain amount to the credit and reimburse yourself for the remaining amount through your Flexible Spending Account.

The maximum amount you can apply to the tax credit is currently $3,000 ($6,000 for two or more dependents). If you use both tax-savings methods, the maximum amount you can use under the tax credit is reduced by any amount your Flexible Spending Account reimburses.

Remember, if you have questions, discuss them with a qualified tax adviser.

Special IRS rules

The special tax advantages of Health Care and Dependent Care Flexible Spending Accounts are offered on the basis of current IRS Code rules. The same federal tax laws that allow before-tax savings on your reimbursements also place certain restrictions on your accounts as follows:

- Funds placed in one kind of Flexible Spending Account cannot be transferred to the other. For example, you cannot transfer remaining Health Care Flexible Spending Account funds into your Dependent Care Flexible Spending Account to pay for eligible dependent care expenses.
- The money you set aside each calendar year must be used for that calendar year's expenses while you were actively participating. Any money that is not used will be forfeited except for the allowed Health Care carry-over amount (see Carryover amounts for more information).
- Once you make your Health Care Flexible Spending Account election, your contributions will continue each pay period for the rest of the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.
- Your Dependent Care Flexible Spending Account elections must also stay in effect for the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.
- The Plan must satisfy applicable IRS nondiscrimination rules. The Plan administrator, in its discretion, may make such adjustments to your contribution elections as may be necessary to satisfy these rules.

Claims for reimbursement

As you incur eligible expenses during the Plan year, you can submit claims to Your flexible spending account for reimbursement. Each expense you submit will be reviewed by YSA to determine whether it qualifies for reimbursement under IRS rules. The service must be incurred during the Plan year and while you were actively participating to qualify for reimbursement. Pre-paid services that were charged or billed but not provided during the Plan year are not eligible for reimbursement.

YSA debit card

If you contribute $150 or more to your Health Care Flexible Spending Account, you can take advantage of the YSA card that you can use to pay for eligible health care expenses. As you use your prepaid YSA card, eligible health care expenses will be deducted automatically from your account.

Individuals eligible for a YSA card will receive a package containing one YSA card issued in your name, activation instructions, a cardholder agreement, additional disclosures, and information explaining approved use of the card. You may request additional cards for your spouse and/or eligible dependent(s) through the Your Spending Account website.

The YSA card remains active as long as your account is in good standing, you continue to participate in a Health Care Flexible Spending Account, and you remain actively employed. Your card will be canceled upon termination of employment—inactive participants may not use the YSA card. By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible dependents under the Plan.
- Incurred expenses were for health care services or supplies purchased on or after the date your Health Care Flexible Spending Account took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible.
- Any expense paid for with the card has not been, or will not be, reimbursed by another source.

The YSA card has been designed for use at merchants and providers that primarily sell health care products and services (for example, pharmacies, physician's offices, hospitals, and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to use it as either "credit" or "debit." If you choose the credit option, you must provide your signature. If you choose debit, you must use your personal four-digit Personal Identification Number (PIN) that you set up when your YSA card was issued. If you forgot or need to change the PIN associated with your card, you can call 1-888-999-0194 to make an update.

Deadline to file Flexible Spending Account claims

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

Important: save your itemized receipts

All YSA card transactions must be verified as eligible health care expenses, you may be required to provide YSA with supporting documentation to validate your expenses. The card provides the convenience of immediate access to your funds. In some situations, your expenses will be automatically validated when you use your YSA card to purchase eligible items with select merchants that accept health care debit cards. The YSA card does not eliminate the requirement to keep documentation for your expenses. In many cases you may need to provide documentation to YSA for expenses you paid for with your YSA card. Even if you are not required to submit the itemized receipts, documentation should be retained in the event you are subject to an IRS audit.

Reimbursement for health care expenses

You can file Health Care Flexible Spending Account claims as often as you like. You will receive reimbursement from your account up to the total amount you elected for the Plan year and any carryover amount if applicable, even if you have not yet contributed the full amount at the time of your request. Refer to the carryover amounts section for additional information on how claims are paid from carryover funds.

Submit your flexible spending account claim form to YSA along with your receipts for expenses. If you have other group coverage, you will also need to include the Explanation of Benefits (EOB) form provided by the insurance company.

All receipts submitted for reimbursement from a Health Care Flexible Spending Account must clearly state that the expense is for a copayment or coinsurance as determined by the benefits plan. If a receipt does not clearly identify the expense, you will receive a request for additional information needed to process the claim.

Reimbursement for dependent care expenses

You will need to submit a Dependent Care Flexible Spending Account claim form each time you request a reimbursement. You can file Dependent Care Flexible Spending Account claims as often as you like. You will receive reimbursement from your account up to the balance in your account at the time you submit your request. If you incur expenses that exceed your available funds, future claims will be reimbursed as additional funds accumulate in your account.

Each time you file a claim, you'll need to include:

- the name, address and Social Security number or tax ID number of the provider;
- the name of the person receiving services; and
- a description of the expense.

How to file a claim for reimbursement

To submit claims for reimbursement online, go to Workday, click on the My Benefits & Retirement application, depending on where you are connecting to Workday from, click on Employees in Canada and US (on BMO Network) or Employees in Canada and US (off BMO Network), click on the Your Spending Account (YSA) tile.

Flexible Spending Account claim forms are available on the BMO U.S. Benefits site. Select Forms/Docs. Or call the Human Resources Centre at 1-888- 927-7700. If you are mailing claims for reimbursement, be sure to keep a copy for your records. Send completed claim forms to:

Your Spending Account
PO Box 661147
Dallas, TX 75266-1147
Fax: 1-888-211-9900

You or your authorized representative may file claims for Plan benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Overpayment process

An overpayment on your account may occur if you have used your YSA debit card to pay for non-qualified products or services, you have not provided the required documentation to substantiate a qualified expense paid for with your YSA debit card, or you have been reimbursed for a claim that was subsequently determined to be invalid. Once an overpayment has been identified, you will need to resolve an overpayment on your account to avoid suspension on your YSA card. If you have received notification of an overpayment, it can be satisfied in the following ways:

- Resubmit the claim that resulted in an overpayment with additional receipts or other documentation. If the entire claim is approved, the overpayment will be satisfied.
- Submit new claims for eligible expenses. If your future claims are approved, the overpayment will automatically be paid back by these claims until the full overpayment amount is paid back.
- Repay the overpayment amount back to be credited to your account by accessing the YSA website and repaying online, or by mailing a check payable to Your Spending Account, PO Box 661147, Dallas, TX 75266-1147.

Impact of an Overpayment

If your account has an overpayment amount over $100, your YSA Card will be suspended until the overpayment is repaid. While you're unable to use your card, you may submit claims on the site, via fax, through postal mail, or using the mobile app.

IRS rules state that failure to resolve your overpayment before the end of the plan year can result in tax implications.

Tips to Avoid an Overpayment

Here are some suggestions to keep in mind when using your YSA Card:

- Always save your itemized receipts! You may need them if YSA notifies you to provide documentation for your transaction.
- Send receipts or other documentation for your transaction by the due date on this site.
- Review eligible health care expenses on this site to become familiar with items and services for which you can use your card.
- Don't use your YSA Card to pay for ineligible health care items.
- Consider shopping at IIAS-certified merchants, where items are automatically identified as eligible or ineligible at checkout.

Notice of a denied claim

If you are denied a full or partial claim for benefits, you will receive written notice of the denial and the notice will:

- explain the reason for the denial;
- refer to the pertinent provision of the Plan on which the denial is based;
- describe any additional material or information necessary for properly completing the claim;
- explain why such material or information is necessary; and
- explain the claim review procedures.

Appealing denied claims

If you are not satisfied with the determination of a claim, you may call the Human Resources Centre at 1-888-927-7700 and speak with a Your Spending Account representative. If after investigation, you are still not satisfied with the determination, you may appeal the denial at no cost to you by completing and submitting a Claim Review Form within 180 days. To help determine if your claim is eligible for reimbursement, you should submit information that would help substantiate a timely valid claim under Plan provisions (e.g., third party receipts). If you do not submit a Claim Review Form during this period, no further action will be taken, and you will not be able to file an appeal for the claim at a later date. The Claim Review form is available to employees by calling the Human Resources Centre at 1-888-927-7700 and speak with a Your Spending Account representative.

When completing the Claim Review Form, state the reason you believe the claim for benefits was improperly denied. You may submit any comments, questions, documents, or information that you deem appropriate. The review will be by a person who was not involved in the initial determination nor a subordinate of that person and will not defer to the initial determination. It will take into account all comments, documents, and other information submitted by you, without regard to whether that information was submitted or considered

in the initial determination. You will be provided at no charge upon request all documents relevant to your claim.

Your appeal will be reviewed within 30 days from the date of receipt for health care, or within 60 days from the date of receipt for dependent care and provide you with a written explanation of the benefit determination.

If, after review, you are still dissatisfied with the determination, you may make a final appeal to the Benefits Administration Committee. A written appeal must be filed with the Committee within 60 days from the last benefit determination. The Committee will make a final decision according to Plan provisions. You will be notified of the decision within 60 days of the date your appeal is received by the Committee. In order for a communication from you to constitute a valid appeal, it must be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records or other information that you have not previously provided to:

BMO Financial Corp.
C/O Appeals
395 N. Executive Drive
Brookfield, WI 53005

If after that final review your benefit is still denied, you may file suit in a federal court. If, after you exhaust the grievance procedures, you wish to file a claim against the Plan, any legal action must be filed within 90 days after the Plan administrator's final decision. You have a right to bring civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA). Dependent care plans are not subject to ERISA.

The Plan administrator has full discretionary authority to determine eligibility for benefits, to interpret the Plan and to make factual determinations under the Plan. The Plan administrator shall have the discretionary authority to decide and review claims under the Plan. Subject to applicable law, any interpretation of the provision of the Plan, and any decision on any matter within the discretion of the Plan administrator made in good faith, shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan administrator or claims administrator, as applicable, shall make such adjustment on account thereof as it considers equitable and practicable. Neither the Plan administrator nor the claims administrator shall be liable in any manner for any determination of fact made in good faith. Benefits shall be paid under the Plan only if the Plan administrator decides in its discretion that the claimant is entitled to them.

Statements

A statement reflecting the activity in your Flexible Spending Account is distributed at the beginning of the fourth quarter each year. Each statement will show your contributions to date, claims paid and available account balances. This information is also available by navigating to Workday, click on the My Benefits & Retirement application, depending on where you are connecting to Workday from, click on Employees in Canada and US (on BMO Network) or Employees in Canada and US (off BMO Network), click on the Your Spending Account (YSA) tile.

Please note!

Any amounts that remain in an overpayment status after the Plan year-end deadline (April 30), will appear on your current year W2 as taxable income.

Carryover amounts

New federal regulations provide relief for deadlines and carryover limits, refer to bmousbenefits.com for just-in-time response to COVID-19 benefits information.

The Health Care Flexible Spending Account and Limited Purpose Flexible Spending Account allow for up to $550 of unused funds to be carried over into the next Plan year. The carryover funds can then be used for eligible expenses incurred in the current Plan year.

You will not be eligible for any carryover amount if you incur a break in eligibility greater than 31 days at any point within the Plan year, if you are not eligible for the Plan as of December 31, or if you are continuing your coverage through COBRA and have not paid your premiums to extend your coverage through December 31.

If you terminate employment and you have a carryover balance only from a prior plan year, no Health Care Flexible Spending Account election in the current plan year, you will continue to have access to your carryover balance for 18 months from the date of your termination. You are not required to enroll in COBRA; YSA will automatically extend coverage on your behalf. If you want to forfeit your carryover balance, you may do so by contacting YSA.

How carryover works:

- Carryover only applies to Health Care Flexible Spending Account. Unused Dependent Care Flexible Spending Account funds will not carry over and will be forfeited if not used by the deadline.
- Carryover amounts are available as of the first day of the Plan year.
- Money will carry over from one year to the next only if you are an eligible HCFSA participant on December 31 of any year. For example, you would be eligible for a carryover for 2021 if you are an eligible HCFSA participant on December 31, 2020. You are also eligible for the carryover balance if your employment with the company has ended and you have elected COBRA coverage and pay for your premium through December 31. If you have a balance your carryover will be available through your full COBRA eligibility period.
- If money from your Health Care Flexible Spending Account is carried over from one year to the next, you may still contribute up to the maximum Health Care Flexible Spending Account contribution for the new Plan year.
- Up to $550 may be carried over to the new Plan year, even if you do not elect to contribute to the Health Care Flexible Spending Account for the new Plan year.
- If you have more than $550 of unused money in your Health Care Flexible Spending Account as of December 31, of any year, the unused amount exceeding $550 may not be carried over and this unused excess amount will be forfeited.

  The carryover rule will continue to apply until you are no longer employed by the company or you become ineligible for benefits with the company.

Keep in mind that you still may file claims for reimbursement of eligible expenses incurred in the current calendar year until April 30 of the following calendar year, whether or not unused money is carried over from one year to the next.

Example: You have an available balance of $800 in 2020 and elect $1,000 for 2021. As of January 1, you have $800 available in 2020 and $1,500 available in 2021. The carryover, while inflating the current year balance, is still available for prior year claim submission. Approved claims will always process in a hierarchy, drawing funds first from the current year election and subsequently from the carryover balance.

Debit cards

The carryover balance will be available on the first day of the new Plan year (January 1). In accordance, the full balance (including any carryover funds) will also be available on the YSA card – even if you do not re-enroll.

In the event that a participant is contributing to a Health Savings Account and/or enrolled in the High Deductible Health Plan in the current Plan year, any carryover funds will be designated in a Limited Purpose Flexible Spending Account. Only dental and vision expenses would be eligible for reimbursement. If the rollover funds were not previously in a Limited Purpose Flexible Spending Account, eligible claims from the prior year would not be limited to only dental and vision.

The carryover amount does not affect the ability to elect the maximum annual contribution amount available under the Plan.

Carryover amounts are not allowed for the Dependent Care Flexible Spending Account.

Forfeitures

Before you elect your annual flexible spending account contribution, carefully review and consider your health and dependent day care needs and previous expenses. IRS regulations require that any money left in your DCFSA and any amount over the allowed carryover amount for your HCFSA that is not used for reimbursement of eligible expenses incurred by December 31 will be forfeited. New federal regulations provide relief for deadlines and carryover limits, refer to bmousbenefits.com for just-in-time response to COVID-19 benefits information.

You must submit claims for eligible expenses by April 30 of the following calendar year. Your claims must be received by the claims administrator on or before April 30 to be eligible for reimbursement. Any unclaimed balance remaining in your account above the allowed carryover amount after April 30 will be forfeited.

Example 1: If you have $300 remaining in your Dependent Care Flexible Spending Account on December 31, and have not submitted eligible expenses by April 30, you will lose the unused balance of $300.

Example 2: If you have $700 remaining in your Health Care Flexible Spending Account on December 31 and have not submitted eligible expenses by April 30, you will lose the unused balance in excess of the allowed carryover amount.

Also, remember that you cannot use money in your Dependent Care Flexible Spending Account to reimburse health care expenses and vice versa.

Any amounts remaining in your account, including carryover amounts, upon termination of employment will be forfeited unless you are eligible for and elect COBRA continuation coverage.

When coverage ends

Your contributions to the flexible spending accounts end if any of the following events occur:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see Eligibility), or
- you go on Long Term Disability leave.

If you have a balance in your Health Care Flexible Spending Account when your coverage ends, you may claim qualified expenses incurred while you were a participant in the Plan, up to the amount you elected less any prior reimbursements. Active coverage ends on the last day of the month in which your employment ends.

If you have a balance in your Dependent Care Flexible 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. To be eligible for reimbursement, qualified Dependent Care Flexible Spending Account expenses must have been incurred while you are gainfully employed, actively looking for work or a full-time student. Active coverage ends on your last day worked.

To be eligible for reimbursement, your health or dependent care claims must be received by the Claims Administrator no later than April 30th of the following calendar year.

You may be able to continue your Health Care Flexible Spending Account coverage through COBRA. See Continuing health care coverage under COBRA for more information.

It is your responsibility to notify the Company of any change in your status or the status of any of your covered dependents that affects eligibility for coverage under the Plan within 31 days of the status change.

Continuing coverage through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the healthcare spending account ends, you or your covered dependents may be eligible to continue your coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- An Employee.
- An Employee's enrolled Dependent.
- An Employee's former Spouse.

Special rule for Health Care Flexible Spending Account

If your Health Care Flexible Spending Account eligibility ends because of a COBRA-qualifying event, COBRA continuation coverage for your Health Care Flexible Spending Account will be available only through the end of the Plan year in which the qualifying event occurred. You are also eligible for the carryover balance if your employment with the company has ended and you have elected COBRA coverage and pay for your premium through December 31. If you have a balance your carryover will be available through your full COBRA eligibility period (see Carryover amounts for more information).

Qualifying events for continuation coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events

Who can continue coverage	*In what situations*	*For how long*
You, your spouse, your eligible children	• A reduction in your work hours • Your termination of employment (except in cases of gross misconduct)	18 months*
Your spouse	• Your death • Divorce or legal separation • Your eligibility for Medicare	36 months
Your eligible children	• Your death • Divorce or legal separation • Your eligibility for Medicare • Children no longer meet the eligibility rule	36 months

* *Coverage can continue for an additional 11 months if you or a covered dependent is determined to be disabled by the Social Security Administration within the first 60 days of COBRA coverage.*

Getting started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. The benefits provided under COBRA are the same as those provided to active employees; however, the Company no longer shares the cost with you. You pay the full health care premium, both employee and employer costs, plus a 2% administrative fee.

Under federal law, 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 eligible dependent(s) 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.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect

to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

Notification requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation 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.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents 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 federal law, you must notify the COBRA Administrator within 60 days of the birth or adoption of a child.

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify PayFlex of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

If you or a covered dependent is determined to be disabled by the Social Security Administration (SSA) during the first 60 days of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify PayFlex of that fact within 30 days of SSA's determination at the following address:

PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

When the disabled person is no longer considered disabled by Social Security, you must notify the COBRA Administrator within 30 days following the end of the disability. The notice must be sent in writing to the COBRA Administrator at the above address. Coverage exceeding the first 18-month continuation ends when

the individual is no longer Social Security-disabled.

Second qualifying event

If more than one qualifying event occurs, a maximum of 36 months of COBRA continuation is available. The second qualifying event must occur during the first 18 months of COBRA. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify PayFlex within 60 days after a second qualifying event occurs. If you fail to alert the Plan administrator of your qualifying event within this 60-day period, you forfeit the right to continued coverage for yourself and your dependents.

When COBRA coverage ends

COBRA continuation coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing COBRA, you or your dependent(s) becomes covered under another group health plan.
- The date, after electing COBRA, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date the Social Security Administration determines you are no longer disabled, if you have qualified for the 11-month disability extension.

Additional information about COBRA coverage is available in the COBRA Continuation of Rights, located under Legal Notices at www.bmousbenefits.com.

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

In considering whether to elect continuation coverage, you should take into account 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.

Administrative information

Plan identification

Plan name
This Summary Plan Description describes the Spending Account portion of the Employee Benefit Program of Bank of Montreal/Harris. The Group Medical Plan of Bank of Montreal/Harris is also called the Medical Plan or Plan in this Summary Plan Description. The Plan, a group health plan subject to the Health Insurance Portability and Accountability Act (HIPAA), provides medical, prescription drug, mental health and chemical abuse, dental, vision, spending accounts and before-tax premium benefits.

Separate Summary Plan Descriptions describe the Employee Assistance Program and Life and Disability portions of the Employee Benefit Program of Bank of Montreal/Harris Plan.

Plan number
507

Employer Identification Number
51-0275712

Plan year
January 1 – December 31

Plan sponsor
BMO Financial Corp.
Employee Benefit Program of Bank of Montreal/Harris

Plan administrator
Benefits Administration Committee

The Plan sponsor and Plan administrator can be contacted at:

> BMO Financial Corp.
> Benefits Administration Committee
> 111 West Monroe Street, 7W
> Chicago, IL 60603
> 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 Medical Plan regarding matters for which it is responsible as set forth above and its decisions shall be final and binding on all parties.

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

Plan trustee
The Plan trustee for The Employee Benefit Program of Bank of Montreal/Harris (except for the accident insurance plans and cafeteria plan) is:

BNY Mellon
One Mellon Center, Suite 1315
Pittsburgh, PA 15258-0001

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
Medical, Dental and Vision Plan contributions are made by the Company and participating employees. The following portions of the Medical and Dental Plans are self-insured and funded through a trust, with various companies acting as claims administrators:

Blue Cross and Blue Shield

UnitedHealthcare

Express Scripts (Prescription Drug)

UMR (Medicare Secondary Plan)

Delta Dental

The Plan trust name is the Employee Benefit Trust of Bank of Montreal/Harris.

The Vision Plan is considered fully insured. Employee contributions are used to pay the premiums to the provider and the provider pays all benefit claims. The Vision Plan premiums are also funded through the trust.

The BMO Financial Group U.S. Retiree Medical Program is funded through participant and employer contributions (previously contributed to the Employees' Retirement Plan of the Bank of Montreal/Harris under a 401(h) arrangement) which are deposited to the BNY Mellon BMO Retiree Medical Processing Account. If you are a former M&I employee, retiree, long-term disability participant or key retiree* and are eligible for the Plan based upon the legacy M&I Retiree Medical Eligibility provisions, funding is made through participant contributions which are deposited to the M&I Retiree Health Benefits Trust account and employer contributions which were funded into the M&I Retiree Health Benefits Trust at the time of the BMO merger. Benefits for key retirees* are funded through a Rabbi Trust and special key retirees* are funded by employer

purchase of insurance or payments from the employer's general assets. BNY Mellon acts as trustee for the BMO Financial Group U.S. Retiree Medical Program for funds deposited into the BNY Mellon Trust. BMO Financial Corp. acts as trustee of the M&I Retiree Health Benefits Trust and the Rabbi Trust. Independent third parties administer claims submitted under the Plan.

* *Key retirees are defined as individuals who receive funding based on a specific individual merger related agreement. Special key retirees are defined as individuals who receive funding based on their individual agreement.*

Claims administrators and service providers

Claims administrator	For	Address for filing claims
Blue Cross and Blue Shield of Illinois www.bcbsil.com Member Services: 1-888-979-4516	Medical benefits and pre-certification under the Blue Cross and Blue Shield Consumer Choice Plan	Blue Cross and Blue Shield PO Box 805107 Chicago, IL 60680-4112
UnitedHealthcare www.myuhc.com Member Services: 1-800-896-0067	Medical benefits and pre-certification under the UnitedHealthcare Choice Plus Consumer Choice Plan	UnitedHealthcare – Claims PO Box 30555 Salt Lake City, UT 84130-0555
Express Scripts www.express-scripts.com Member Services: 1-877-795-2926	Retail and home delivery drug programs	Express Scripts PO Box 14711 Lexington, KY 40512
Delta Dental of Illinois www.deltadentalil.com Member Services: 1-800-323-1743	Dental benefits through the PPO Plan option	Delta Dental of Illinois PO Box 5402 Lisle, IL 60532
Your Spending Account (YSA) Member Services: 1-888-927-7700	Flexible Spending Accounts administration and Health Savings Account (HSA)	Your Spending Account PO Box 661147 Dallas, TX 75266-1147 Fax: 1-888-211-9900
UMB Bank N.A. UMB Healthcare Services Member Services: 1-866-520-4472	Health Savings Account Trustee/Custodian	UMB Bank N.A. UMB Healthcare Services PO Box 419226 Kansas City, MO 64141
UMR www.umr.com Member Services: 1-877-561-0366	Retirees over age 65 and/or Medicare eligible	UMR Claims Appeal PO Box 30541 Salt Lake City, UT 84130-0541

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

Service provider	For	Address
Alight Solutions –HR Benefits Member Services: 1-888-927-7700	Processes eligibility and provides customer service to covered individuals	Alight Solutions –HR Benefits PO Box 661065 Dallas, TX 75266-1065
Dependent Verification Service (DVS)	Submitting initial Dependent Verification documents	Dependent Verification Service (DVS) PO Box 7114 Rantoul, IL 61866-7114

COBRA administrator	For
PayFlex Systems USA, Inc Benefits Billing Department PO Box 953374 St. Louis, MO 63195-3374 Member Services: 1-888-678-7835	COBRA continuation coverage www.payflex.com Employer ID: 139888

Uncashed checks

Benefit payment or reimbursement checks under the Plan that relate to benefits that are paid from the bank's or the company's general assets and that remain uncashed after 180 days (or, if later, the expiration date set forth on the reimbursement check) shall be returned to the bank or the company, as applicable. Benefit payment or reimbursement checks under the Plan that relate to benefits that are paid from the trust fund and that remain uncashed after 180 days (or, if later, the expiration date set forth on the reimbursement check) shall be returned to the trust fund. The treatment of uncashed checks relating to benefits under the Plan that are paid by an insurer shall be determined by the insurer.

Future of the Plan

The Company intends to continue the Plan indefinitely. However, the Company reserves the right to amend, modify, replace or terminate the Plan or part of the Plan at any time for any reason. The Company takes such action through Board of Directors' resolutions or through an administrative committee or other persons authorized by the board of directors. In such case, you would be properly notified of any changes, and all changes would be subject to the Plan's provisions and applicable laws. Keep in mind, health care benefits do not vest like retirement plan benefits. If the Plan is terminated, you will not receive any further benefit under

the Plan other than payments of benefits for losses or covered expenses incurred before the Plan was terminated.

Privacy information

During the administration of the Plan, certain Company employees and claims administrators may come into contact with what is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA).

As part of our compliance efforts, we have previously provided a privacy notice to employees that describe the Plan's use and disclosure of your protected health information, as well as your rights and protections under the HIPAA privacy law. If you would like to receive another copy of the privacy notice, or just need more information, please contact the Privacy Officer, Director of US Benefits, by emailing BMOHR.USBenefits@BMO.com.

If you are enrolled in the Vision Plan, contact the Vision Plan to receive another copy of the applicable privacy notice.

Your rights under ERISA

As a participant in the Employee Benefit Program of Bank of Montreal/Harris, 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.

Continue group health plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent actions by plan fiduciaries

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

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce your rights

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

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