BMO

Long-Term Disability

Plan Details

reliancematrix

Quick Facts

LTD Claims and Pay Administrator	Reliance Matrix Absence Management, Inc.
LTD Claims and Pay Support	Reliance Matrix Member Services: 1-888-295-7862
Billing Administrator (for benefit premium payments)	Inspira Financial: 1-888-678-7835
Governance	The Long-Term Disability Plan is governed by the Employment Retirement Income Security Act of 1974 (ERISA).

Overview

BMO's Long-Term Disability (LTD) Plan is designed to provide income replacement if you are unable to work for an extended period due to serious, long-lasting medical or mental health conditions. The plan helps ensure financial stability by replacing a portion of your compensation after your Short-Term Disability (STD) period ends.

Common conditions covered by the LTD plan include debilitating injuries, musculoskeletal disorders, cancer, heart disease, organ transplants, neurological conditions, and severe mental health disorders - each of which can significantly impair your ability to perform your job over time.

Eligibility for Long-Term Disability Benefits

If you experience a serious medical condition that prevents you from working for an extended period, you may be eligible to transition to LTD benefits after exhausting your STD benefits.

To qualify for LTD income replacement benefits, you must meet all of the following criteria:

- Be a benefits-eligible employee, as defined in BMO's Health and Welfare Plan Summary Plan Description
- Have exhausted 100 days of STD leave and benefits. (Any days in which partial STD benefits are applied will count towards your LTD elimination period.)
- Be under the ongoing care of a qualified physician for the illness or injury that prevents you from working
- Be receiving and adhering to appropriate medical treatment for your condition
- Be unable to perform the essential duties of your job or a similar role due to the illness or injury for the first 24 months. To continue receiving LTD benefits beyond 24 months, you must be unable to perform the duties of any occupation for which you are, or may reasonably become, qualified based on your education, training, and experience
- Submit a claim to the Claims Administrator with all required documentation in a timely manner
- Ensure your physician provides any requested medical records, forms, or notes

related to your condition, both at the time of claim initiation and throughout the duration of your claim
- Receive approval from the Claims Administrator for LTD benefits

While receiving LTD income replacement benefits, you are not permitted to work (paid or unpaid) for any other employer, individual, family-owned business, or as a volunteer. However, you may engage in approved rehabilitation employment.

Benefit Duration

Recovery time varies widely depending on the condition; therefore, the actual duration of LTD leave is primarily based on how long you are medically unable to perform your job duties. The Claims Administrator determines the duration of LTD leave based on documentation from your treating physician, evidence of functional limitations, your ongoing treatment plan, periodic medical updates, and standard recovery timelines for your specific condition.

LTD Benefit Period

Long-Term Disability (LTD) income replacement benefits begin on the 111th consecutive business day following your approval of LTD benefits and leave and may continue up to your maximum benefit period.

Unpaid Waiting Period	STD Benefit Period (up to 100 days)	LTD Benefit Period*
Days 1 - 10	Days 11 – 110	Days 111+

**LTD benefits continue for as long as you remain disabled, as determined by the Claims Administrator, or until you reach your maximum benefit period, whichever comes first.*

Maximum Benefit Period

The maximum duration of your LTD income replacement benefits are based on the age when your disability began (age on the first date of your absence).

Age when disability began	LTD 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

Once you reach Maximum Benefit period, your paid LTD income replacement benefits will end. If your employment status has not already been terminated at that point, your continued need for leave will be assessed through an interactive process coordinated by BMO's Employee Relations team.

Limits for specific conditions

Alcohol, Drug, or Substance Abuse

You may receive up to 24 months of LTD benefits in your lifetime for disabilities caused by alcohol, drug, or substance abuse or addiction. You must participate in a recovery program recommended by a physician to qualify.

Your LTD income replacement benefits will end at the earliest of:

- When you reach the 24-month limit
- When your LTD coverage ends
- When you stop or refuse to participate in the recovery program
- When you complete the recovery program

Mental or Nervous Disorders

(For disabilities beginning before January 1, 2024)

LTD benefits are limited to 24 months total, even if the disability periods are non-continuous or unrelated. This limit does not apply while you are confined to a hospital or institution.

Conditions subject to this limit include those defined in the Diagnostic and Statistical Manual of Mental Disorders, except:

- Schizophrenia
- Dementia
- Organic brain disease

Note that these limits do not apply to disabilities due to Mental or Nervous Disorders that begin after January 1, 2024.

Subjective Disorders and Related Conditions

LTD benefits are limited to 24 months total, even if the disability periods are non-continuous or unrelated. This limit does not apply while you are confined to a hospital.

Conditions subject to this limit include:

- Neuro-musculoskeletal and soft tissue disorders (e.g., sprains, strains)

- Chronic Fatigue Syndrome
- Fibromyalgia
- Fibrositis
- Chronic Pain
- Environmental Sensitivity Disorder

Exceptions (benefits may continue beyond 24 months if supported by objective evidence):

- Seropositive Arthritis
- Spinal Tumors, malignancy, or vascular malformations
- Radiculopathies
- Traumatic Spinal Cord Necrosis
- Musculopathies (confirmed by biopsy or EMG)

Returning to Work

If you recover from your disability and are medically cleared to work, you will be expected to return to work at the end of your approved LTD benefit period.

Before you can return to work, your treating physician must confirm that you are medically fit to resume your duties. This includes specifying your return-to-work date and identifying any restrictions or accommodations that may be necessary.

If you are medically cleared to return to work, you must return to work on the date indicated by your treating physician. Failure to return to work as scheduled may result in placement on Unapproved, Unpaid Leave and could impact your employment status.

Partial Return to Work

During your recovery, it may be determined that you are able to resume work on a partial or limited basis as you transition back to your full schedule, this is known as Rehabilitation Employment. A Partial Return to Work status allows you to work reduced hours while continuing to receive LTD benefits, supporting a gradual and medically appropriate return to full duties. You may continue to receive partial LTD benefits for up to 24 months while you transition back to your standard hours.

While on Partial Return to Work status, your Workday status will still reflect (On Leave) status. This status will be present until you can resume working your full scheduled weekly hours.

While on a Partial Return to Work:

- You will continue to receive LTD income replacement benefits for the hours you are medically unable to work on a monthly basis.
- You will also be paid for the actual hours worked, up to your standard weekly schedule.

Timekeeping Requirements:

- All employees (Exempt and Non-Exempt) must enter their actual hours worked in Workday during a Partial Return to Work period in order to receive payment.
- Managers are responsible for reviewing and approving time entries at the end of each week to ensure timely payroll processing. You may need to prompt your manager to do this to ensure there are no payment delays for time worked.

Please note that regular hours worked entered into Workday are paid two weeks in arrears.

Recurring or Multiple Disabilities

If you experience a second disability or a series of disabilities, your LTD benefits may either continue or restart, depending on the timing and nature of the condition:

If You Return to Work and Become Disabled Again

- Same or Related Condition Within Six Months - If you become disabled from the same or a related illness or injury within six months of returning to work:
  - The second disability is considered a continuation of the first.
  - You will resume your LTD benefits at the same amount that was in place at the time of your original disability.
- Same or Related Condition After Six Months - If the second disability occurs more than six months after you return to work:
  - It is considered a new disability.
  - You must satisfy a new 10-day unpaid waiting period and you will apply for Short-term Disability again.
  - You may transition to LTD again if your disability lasts longer than your maximum STD period.
- Unrelated Condition (Any Timeframe) - If the second disability is caused by an unrelated illness or injury, it is considered a new disability, regardless of how long you've been back at work:
  - A new 10-day unpaid waiting period applies.
  - You may use available sick or vacation time during this waiting period.
  - STD coverage will continue for up to 100 business days.

If You Experience a Second Disability While Already on Leave

If you are already receiving LTD benefits for one condition and experience a second disability (whether related or unrelated) the second disability is considered a continuation of the first. Your LTD coverage will continue under the original claim and count toward the same maximum benefit duration limits.

When LTD Coverage or Benefits End

Your coverage and benefits under LTD will end if any of the following events occur:

- Exhaustion or End of LTD Leave: You exhaust your LTD benefits Maximum Duration or reach the end of your approved LTD leave period, whichever comes first.
- Termination of Employment: You terminate employment for any reason (unless your termination is due to an involuntary separation from service or layoff, and BMO has agreed to extend coverage, in accordance with BMO policies).
- Retirement: You retire from BMO.
- Special Service Leave: You are on a Special Service Leave.

- Loss of Eligibility: You no longer meet the eligibility rules for benefits or specific to the LTD plan.
- End of Disability: You are no longer considered disabled and are cleared to return to work.
- Failure to Provide Proof: You refuse or fail to provide sufficient proof of your disability.
- Refusal of Medical Exam: You refuse to undergo a medical examination requested by the Claims Administrator.
- SSDI Repayment Agreement: You fail to sign the Social Security Disability Insurance (SSDI) Repayment Agreement.
- SSDI Overpayment: You fail to repay any SSDI overpayment amount.
- Death: You pass away.
- Program Termination: The applicable program is terminated by BMO.

LTD Monthly Benefit Calculation

BMO automatically provides Basic Long-Term Disability (LTD) coverage that replaces 60% of your Total Compensation. You can choose to enroll in the Supplemental LTD Plan to increase your coverage to 75% (60% Basic LTD + 15% Supplemental LTD).

Plan	Coverage	Automatic or Elected	Paid by
Basic LTD	60% of your Total Compensation*	Automatic	BMO
Supplemental LTD	15% of your Total Compensation*	Must be elected during initial enrollment, annual enrollment or a qualifying life event	You

Your LTD benefit is calculated as a monthly lump sum by the Claims Administrator, rounded to the nearest dollar, and based on your Total Compensation Base Benefits Rate (TCBBR) as of the last business day before your leave started. If your disability period is shorter than a full month, your payment will be pro-rated based on the number of days you are considered disabled.

*The maximum monthly LTD benefit (including both basic and supplemental coverage) is capped at $20,000.

Supplemental LTD Plan disclaimer:

- If your TCBBR is *$400,000 or more*, you will not receive any additional benefit from electing Supplemental LTD coverage.
- If your TCBBR is between *$320,000 and $399,999*, you may elect Supplemental coverage, but you will not receive the full 15% due to the monthly cap.

Note for Leaves Beginning Before January 1, 2024: If your disability leave (first date of absence) began before this date, your LTD benefit is based on your base pay (or Base Benefit Rate (BBR) for certain commissioned employees) as of the last business day before your leave started.

For more details on what is included in your TCBBR and how it is calculated, see the "Earnings Used for Benefits" section of the U.S. Health and Welfare Plans Summary Plan Description.

Coordination with other plans

Your LTD benefit may be reduced (offset) by payments you receive from the following sources:

- Social Security (on your own behalf)
- State or federal disability programs
- Workers' compensation
- Retirement or group disability plans paid by another employer

If these payments are less than your calculated LTD benefit, the LTD Plan will pay the difference so your total benefit equals 60% of your TCBBR, or 75% if you elected Supplemental LTD coverage.

Social Security and Medicare requirements during LTD

To remain eligible for LTD benefits and continued medical coverage through BMO, you are required to apply for Social Security Disability Insurance (SSDI) and enroll in Medicare Parts A and B when eligible. These steps are not optional and must be completed within the specified timeframes. BMO provides support through Allsup, Inc. to assist you with these processes at no cost to you.

Social Security Disability (SSDI)

- If your disability is expected to last 12 months or more and you haven't reached full retirement age, you must apply for SSDI.
- The approval process may take several months and could involve denials and appeals.
- You are required to file all levels of appeal.
- Allsup, Inc. will assist you with the SSDI application and appeals process at no cost to you.
- While Allsup is actively supporting your case, BMO will continue to pay your full LTD benefit.
- Once SSDI is approved:
    - Your LTD benefit will be reduced by the SSDI amount.
    - Any retroactive SSDI payments will also be offset, and you may need to repay a portion.
    - You must sign a Repayment Agreement when applying for LTD.

- If you do not apply for SSDI or file appeals, your LTD benefit will automatically be reduced by an estimated SSDI amount starting six months after your LTD start date.

Medicare Enrollment

- After 24 months on SSDI, you are automatically enrolled in Medicare Part A (Hospital Insurance).
- You must enroll in Medicare Part B (Medical Insurance), which has a monthly premium.
- You'll receive a Medicare packet and card from the Social Security Administration.
- Under the LTD Plan, you must be enrolled in Medicare Parts A & B to continue coverage under BMO's medical plan.
    - Medicare becomes the primary payer.
    - BMO's plan becomes the secondary payer.
- Allsup, Inc. will help you understand when and how to submit claims to Medicare.
- You must notify the Human Resources Centre with proof of Medicare enrollment to receive a credit toward your Part B premium, applied to your LTD benefit check (as long as you remain eligible and the benefit is offered).

Rehabilitation Employment

If you're receiving LTD benefits, you are encouraged, and may even be required, to participate in rehabilitation employment when medically appropriate. This program supports your return to work and must be recommended by your physician and approved by the Claims Administrator.

- You may continue to receive partial LTD benefits for up to 24 months while participating in an approved rehabilitation program.
- Your LTD benefit will be reduced by 70% of your outside earnings during this time.
- The combined amount of your reduced LTD benefit and rehabilitation earnings cannot exceed 100% of your pre-disability base pay.

LTD Benefits Payments

LTD benefits are paid on a monthly basis directly from the Claims Administrator. All LTD payments are subject to applicable tax withholdings. LTD Payments will be issued by the 20th day of each month.

You can verify your expected LTD benefit payments by reviewing your Award Letter or contacting the Claims Administrator.

Benefit Continuation and Premiums During LTD

When you transition to LTD you will have the option to maintain certain benefits for a specified length of time and some coverage will terminate.

Medical, Dental and Vision Plans

During LTD, you may continue your Medical, Dental and Vision coverage at Active Employee rates for a designated period of time depending on when your LTD Leave began.

LTD Start Date	Active Medical, Dental & Vision benefits continue until
Before January 1, 2025	The earlier of your LTD leave ending or December 31, 2027
January 1, 2025 – December 31, 2025	The earlier of your LTD leave ending or 36 months from the start of your LTD leave
January 1, 2026 and forward	The earlier of your LTD leave ending or your active employment ending with BMO

If you have Medical, Dental or Vision coverage during LTD, you will be billed by BMO's Direct Billing Administrator, Inspira Financial. You will be required to remit payment for your benefits to Inspira Financial in a timely basis to maintain your coverage. Failure to make payments will result in the cancellation of your coverage.

After your active coverage ends, you and your dependents may be able to continue coverage through COBRA and/or retiree medical, if eligible.

Life Insurance Plans

When you transition to LTD, you'll be automatically enrolled in Waiver of Premium (WOP) for Basic and Supplemental Life Insurance if:

- Approved for LTD before age 60
- Meet the plan's disability definition

Coverage continues at no cost until:

- You turn 65, or
- You're no longer disabled per the plan

Your Family Life Insurance ends upon WOP enrollment or 12 months from your total disability date (LTD effective date) if you are not eligible for WOP. You may be able to convert or port your coverage for your dependents. BMO will mail your conversion paperwork with your options by mail.

Voluntary Benefit Plans

Coverage for any Voluntary benefit plans you are enrolled in will terminate at the end of the month in which your STD ends for:

- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Legal Plan

Once your benefits have terminated, you may contact the Voluntary Benefits Claims Administrators and request conversion coverage.

Supplemental LTD

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

Health Savings Accounts (HSA)

When you transition to LTD you are no longer eligible to contribute to your HSA directly through BMO but you may contribute on an after-tax basis. Your HSA is yours to keep and will be converted to a Consumer Account.

You can continue to use your HSA funds for eligible expenses during LTD.

Flexible Spending Accounts (FSAs)

When you transition to LTD you are no longer eligible to contribute to the FSA plans.

Your Health Care and Limited Purpose FSAs will terminate at the end of the month your STD ends.

- You can claim expenses incurred while enrolled in the FSA.
- COBRA may be available for the rest of the plan year to allow you to continue to submit eligible expenses for reimbursement.

Your Dependent Care FSA will terminate the day after your STD leave ends.

- If you have a balance remaining, you can continue to claim expenses for the rest of the calendar year.
- COBRA is not available for Dependent Care FSA.

Commuter Benefits

You are not eligible to continue participation in the commuter program while on LTD.

Retirement and Savings Plans

When you transition to LTD you are no longer eligible to contribute to Retirement & Savings Plans.

401(k) Savings Plan:

- You become 100% vested upon LTD approval.
- All contributions (BMO's and your own) will stop during LTD.
- You can resume participation if you return to work.
- Loan payments are not deducted from LTD pay. You must make payments directly to the 401(k) Administrator to avoid 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.

Employee Stock Purchase Plan (ESPP):

- Your contributions to the ESPP will stop.
- Unused contributions will be used to purchase shares on the next quarterly purchase date.
- If you return to work, deductions resume at your previous rate.

BMO U.S. Pension Plan: If you are eligible for the Pension plan, your earned benefits are preserved and payable after LTD ends, you retire or leave BMO.

Employee Assistance Program (EAP)

You can continue using EAP services while on LTD.

Vacation and Sick Time

When you transition to LTD, you will no longer accrue Vacation or Sick time. Any unused, earned Vacation time will be paid out to you within 30 business days of being approved for LTD leave. Unused Sick time is not eligible for payout and cannot be used during LTD.

Recovery of Overpayments

BMO reserves the right to offset any future LTD benefits or regular paycheck earnings to recover any overpayments caused by a change in disability status, a retroactive leave request, substitution or removal of sick or vacation time, a full or part-time return to work, or an administrative error.

If future payments or earnings are not available to recover the overpayment, you may receive a letter requesting repayment of the overpaid amount. Failure or refusal to repay an overpayment may result in disciplinary action, termination of employment, or legal action.

Long-Term Disability Claims

Decisions about LTD Claims are not made by BMO personnel. BMO has hired a Claims Administrator that specializes in evaluating and determining eligibility for disability benefits based on medical and vocational evidence to ensure claims are adjudicated with independence and impartiality.

Filing a Claim

LTD benefits are not automatic, meaning you will need to take action to file a claim when you experience a medical condition that prevents you from working on a long-term basis. If you expect your absence to last more than your maximum STD benefit period, **you must contact the Claims Administrator, Reliance Matrix Absence Management, at 1-888-295-7862 to initiate your LTD claim.** The process to apply for LTD and gather the required documentation can take time, therefore the earlier you contact Reliance Matrix, the sooner you will receive the materials needed to apply for LTD.

Note that prior approvals for STD benefits does not guarantee approval of your LTD claim.

You may file a claim yourself or through an authorized representative (someone you designate in writing to act on your behalf).

Claim materials must be completed by:

- You (the employee)
- The Claims Administrator
- Your health care provider

All completed materials must be submitted to the Claims Administrator for evaluation. You have 30 days from the date you initiate your claim to submit all required documentation. However, you are strongly encouraged to submit your forms and documentation as quickly as possible to avoid pay disruption, since LTD pay will not begin until your claim is approved and payroll payments have been set up with the Payroll Administrator.

If no materials are received by day 30, your claim will be denied.

Claim Processing Timeline

- Most claims are processed within one month, though special circumstances may require additional time.
- The Claims Administrator will notify you of your claim status within 45 days of receiving a complete claim.
- If needed, a 30-day extension may be requested, with written notice provided before the end of the initial 45-day period.

- If circumstances beyond the plan's control prevent a decision within the first extension, a second 30-day extension may be granted, with written notice explaining the delay and expected decision date.
- LTD pay will not begin until the Claims Administrator has approved your claim.

If your claim lacks sufficient information:

- You will be notified and given 45 days to submit the missing documentation.
- The claim response timeline is paused until you respond.
- If you do not submit the requested information within 45 days, your claim will be denied.

Medical Exams and Proof of Disability

During your LTD leave, the Claims Administrator may require periodic, independent medical exams performed by a physician or medical professional who is not your personal doctor and is selected by the Claims Administrator. These exams are intended to verify your continuing eligibility for LTD benefits. The plan may cover the cost of these exams. If you fail to provide proof of disability or refuse the required medical exams, your benefits may be terminated.

Pre-existing Conditions

If you have a medical condition that existed before your eligibility for LTD coverage began, special rules apply. Pre-existing conditions includes any accidental bodily injury, sickness, mental illness, pregnancy, episode of substance abuse that existed prior to when you became eligible for LTD coverage; and/or symptoms, findings, aggravations related to these conditions.

New Employees: If you become disabled within your first six months of employment due to a condition you received medical care for during the three months before your coverage started, LTD benefits will not be paid for that condition.

Supplemental LTD Coverage: If you didn't enroll in supplemental LTD coverage when first eligible and later enrolled during Annual Enrollment or after a Qualifying Life Event, the same rule applies. If you become disabled within the first six months of supplemental coverage due to a condition you were treated for in the three months before your supplemental coverage began, benefits will not be paid for that condition.

Exclusions

The LTD plan does not cover 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
- any disability that begins while on you are on a Special Service Leave
- any conditions resulting from a workplace illness or injury (which may be covered by BMO's Worker's Compensation program)

Claim Status and Decision

Approved Claims: Once your claim is approved, the Claims Administrator will issue a written decision that includes sufficient information to reasonably inform you of the outcome and the duration of your approval.

Denied or Terminated Claims: 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
- States that you have the right to bring a civil action under **Section 502(a) of ERISA** after you appeal the decision and 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, regardless of whether the advice was relied upon
    - 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, experimental treatment, or similar exclusion or limit, provides either:
    1. An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or
    2. A statement that such explanation will be provided free of charge upon request
- Specifies the internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination, or states that such criteria do not exist
- Informs you that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim

- Prominently displays in any applicable non-English language how to access the language services provided by the Claims Administrator

Impact on your benefits

- LTD income replacement benefits stop on the denial date.
- Elected Medical, Dental and Vision benefits will terminate at the end of the month in which you receive the denial. COBRA Continuation coverage will be offered. If you don't elect COBRA and your claim is later approved, you must wait until Annual Enrollment or a qualifying life event to re-enroll.
- Your Life Insurance coverage will end and you will have conversion and portability options through the Plan Administrator.

Appealing a Long-term Disability Claim Decision

The Employee Retirement Income Security Act of 1974 (ERISA) gives you the right to appeal a denied LTD claim. If your claim is denied, you may request a full and fair secondary review of the decision by the Claims Administrator. This process ensures that you have an opportunity to present additional information and have your claim reconsidered before pursuing any further legal remedies. It is important to follow the appeal procedures outlined in this section to preserve your rights under ERISA.

Standard Appeal

You or your authorized representative may appeal a denial of a claim for LTD benefits by filing a written request with the Claims Administrator within 180 days of receiving the initial LTD denial notice. Your Standard Appeal is considered the first-level appeal.

In connection with your Standard Appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to the claim
- You may submit written comments, records, documents, and other information relevant to your appeal, whether or not they were submitted with the initial claim
- The Claims Administrator may consult with medical or vocational experts in connection with deciding your appeal

Access to Evidence

Before issuing a final denial, the claims administrator will provide you free copies of:

- Any new or additional evidence considered or generated during the review
- Any new rationale for the decision

This information will be shared in advance of the final decision so you have a reasonable opportunity to respond.

Decision Timeline

A decision is typically made within 45 days of receiving your appeal.

- If special circumstances apply, the review may take up to 90 days (you will be notified in writing).
- If additional information is needed from you, the timeline will be paused until you respond.
- The timeline may also pause to allow you time to review and respond to new evidence or rationale.

Reviewer Independence

The person reviewing your appeal will:

- Give **no deference** to the initial decision
- Be different from the original decision-maker and not their subordinate
- If medical judgment is involved, an independent medical professional with appropriate expertise will be consulted.

Final Decision Notice

If your appeal is concluded and the denial is upheld, the written notice will include:

- Specific reasons for the decision and references to plan provisions
- Your right to request all relevant documents free of charge
- Your right to bring a civil action under **ERISA Section 502(a)** and the deadline for doing so
- Explanation of why the decision disagrees with:
    - Your healthcare providers' opinions
    - Vocational experts' opinions
    - Social Security disability determinations
- Scientific or clinical rationale if based on medical necessity or experimental treatment
- Any internal rules or guidelines relied upon (or a statement that none exist)
- Language assistance information and any other notices required by law

Submitting your Standard Appeal

Your Standard Appeal should be sent to:

Matrix Absence Management Quality Assurance Review
C/O: RSLI
P.O. Box 13498
Philadelphia, PA 19101

Voluntary Appeal

If your Standard Appeal is denied, you have the right to request a second-level review by filing a Voluntary Appeal within 60 days of the final denial of your Standard Appeal. This step is entirely optional and does not affect your right to pursue legal action. You are not required to file a Voluntary Appeal before initiating a lawsuit. However, you must complete all levels of the Standard Appeal process before submitting a Voluntary Appeal.

In connection with your Voluntary Appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to the claim
- You may submit written comments, records, documents, and other information relevant to your appeal, whether or not they were submitted with the initial claim or Standard Appeal
- The Claims Administrator may consult with medical or vocational experts in connection with deciding your appeal
- The review will be independent and follow the same standards as the standard appeal.
- Filing a voluntary appeal tolls the statute of limitations on legal action while it is pending.

Access to Evidence

Before issuing a final denial on your Voluntary Appeal, the Claims Administrator will provide you free copies of:

- Any new or additional evidence considered or generated during the review
- Any new rationale for the decision

This information will be shared in advance of the final decision so you have a reasonable opportunity to respond.

Decision Timeline

A decision is typically made within 45 days of receiving your appeal.

- If special circumstances apply, the review may take up to 90 days (you will be notified in writing).
- If additional information is needed from you, the timeline will be paused until you respond.
- The timeline may also pause to allow you time to review and respond to new evidence or rationale.

Tolling

Tolling refers to pausing the time period within which the Claims Administrator must make a decision on your appeal. This pause occurs under specific circumstances to ensure you have a fair opportunity to provide necessary information or respond to new developments without exhausting your statute of limitations timeframe for legal action or running down the decision clock on your appeal.

When Tolling Applies:

1. Failure to Submit Required Information:
   If your appeal cannot be decided because you have not provided requested information, the decision timeframe will be tolled.
   - Tolling starts on the date the claims administrator sends you a notification of the extension.
   - Tolling ends when the administrator receives your response.
2. New Evidence or Rationale:
   If the claims administrator introduces new or additional evidence or a new rationale during your appeal, tolling may occur to give you time to respond.
   - Tolling begins on the date the administrator provides the new evidence or rationale.
   - Tolling ends when your response is received **or** on the date by which the administrator requested your response, whichever comes first.

Reviewer Independence

The person reviewing your appeal will:

- Give **no deference** to the initial decision
- Be different from the original decision-maker and not their subordinate
- If medical judgment is involved, an independent medical professional with appropriate expertise will be consulted.

Final Decision Notice

If your appeal is concluded and the denial upheld, the written notice will include:

- Specific reasons for the decision and references to plan provisions
- Your right to request all relevant documents free of charge
- Your right to bring a civil action under **ERISA Section 502(a)** and the deadline for doing so
- Explanation of why the decision disagrees with:
  - Your healthcare providers' opinions
  - Vocational experts' opinions
  - Social Security disability determinations
- Scientific or clinical rationale if based on medical necessity or experimental treatment

- Any internal rules or guidelines relied upon (or a statement that none exist)
- Language assistance information and any other notices required by law

Submitting your Voluntary Appeal

Your Voluntary Appeal should be sent to:

Matrix Absence Management Quality Assurance Review
C/O: RSLI
P.O. Box 13498
Philadelphia, PA 19101

Legal Rights and Civil Action

You may bring a civil action under ERISA Section 502(a) once you have completed the full Standard Appeal process. Any lawsuit must be filed within 6 months of the final decision. Only evidence submitted during the appeal process will be considered. If the Claims Administrator fails to follow ERISA procedures, you may be deemed to have exhausted administrative remedies and can proceed with legal action - unless the violation was minor and did not cause harm.

Finality of Decisions
All decisions made by the Claims Administrator regarding your claim are final and binding. If you initiate a judicial proceeding to appeal a claim denial or pursue any other action under Section 502 of ERISA (other than a breach of fiduciary duty claim), the evidence considered will be strictly limited to what was timely submitted to the Claims Administrator.

Time Limit for Filing
Any such judicial proceeding must be filed within six (6) months after the final decision of the Plan Administrator or Claims Administrator, as applicable.

Exhaustion of Administrative Remedies
If the Claims Administrator fails to strictly comply with ERISA requirements for your claim, you will be deemed to have exhausted the administrative remedies under the Plan, subject to certain exceptions. In this case, you may bring a civil action under Section 502(a) of ERISA on the basis that the claims administrator did not provide a reasonable claims procedure. Your claim or appeal will then be considered denied on review without discretionary judgment by a fiduciary.

Exceptions to Exhaustion
Administrative remedies will not be deemed exhausted for nominal violations that do not cause, and are not likely to cause, prejudice or harm, provided the Claims Administrator shows:

- The violation was for good cause or beyond its control; and
- The violation occurred during an ongoing, good-faith exchange of information.

This exception does not apply if the violation is part of a pattern or practice of noncompliance.

Request for Explanation
Before filing a civil action, you may request a written explanation of the violation. The Claims Administrator must respond within 10 days, including a specific description of its basis for asserting that the violation should not result in exhaustion of remedies.

Court Determination
If a court denies your request for immediate review because the Claims Administrator met the exception standards, your claim will be considered re-filed on appeal upon the Claims Administrator's receipt of the court's decision. The Claims Administrator will notify you of the resubmission within a reasonable time.

Decision-Making Disclaimer

To ensure there is no conflict of interest when making decisions on claims, our Claims Administrator, and its decision makers (including claims adjudicators, medical consultants, and vocational experts), are not rewarded or penalized based on the number or nature of claims they approve or deny. There is no connection between the decisions they make and their employment status, performance ratings, compensation, or opportunities for promotion. This ensures that all benefit determinations are made impartially and in accordance with applicable plan provisions and governing regulations.