Life & Business Travel Accident Plans Summary Plan Description (SPD)

BMO U.S. Health and Welfare Benefit Plan

Contents

About this Summary Plan Description

This document is the Summary Plan Description (SPD) for the life insurance portion of the BMO U.S. Health and Welfare Benefit Plan (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 life insurance 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, 2024. 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 is any discrepancy or any oral representation that 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 for Basic Life and Supplemental Life Insurance 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 these plans, even if a court, the Internal Revenue Service ("IRS") or another agency retroactively classifies you as an employee.

Eligible dependents

Dependents eligible for coverage:

- your legal spouse unless you are legally separated or divorced. A legal spouse includes a same-sex or different-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; and
- your children under age 26, defined as:
  - your biological children;
  - your adopted children or children place with you for adoption;
  - your stepchildren, regardless of where they live;
  - 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 who 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 105(b) of the Internal Revenue Code ("Code").

Domestic partner eligibility requirements

Family Life eligibility is available to employees' domestic partners, whether same-sex or different-sex. Your domestic partner's children may also qualify as ***D***ependents 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 ***105(b)*** of the IRS Code.

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

- you share your principal place of residence;
- you are both at least eighteen (18) years of age and mentally competent to consent to a contract;
- 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;
- neither of you is currently married to or legally separated from another person, nor has any other domestic partner, civil union partner, spouse or equivalent of the same or opposite gender;
- 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.

The following documentation that demonstrates your domestic partner meets the eligibility requirements is required. Two of the items listed must be provided. Additional documentation may be requested if necessary to determine eligibility:

- federal and state tax returns
- domestic partnership agreement
- joint, unexpired mortgage, lease agreement or ownership of real estate property (issued within last 6 months)
- 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 bank checking or credit card account
- joint responsibility for debts
- other document stating common residency

How and when to enroll

When coverage begins

Coverage for Basic Life Insurance; participation in the Supplemental Life and Family Life Insurance is voluntary; you must elect this coverage to participate. Go to **Workday**, click on the **My Benefits & Retirement** application. As a new employee or an employee who changes to benefit-eligible status, you have 31 calendar days (includes your hire date or newly benefit-eligible date) to make your benefit elections. **Please note**: the benefit effective date for employees hired as part of an acquisition and/or merger may be different based upon the terms of the purchase agreement.

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

Once made, you generally cannot change your elections during the year, however, you can do so only in limited situations, refer to Mid-year election changes for more information.

You must provide satisfactory evidence of good health to the insurance company to elect Supplemental Life and Family Life Insurance. The effective date of coverage is the date ReliaStar Life approves your proof of good health.

Enroll by navigating to **Workday**, click on the My **Benefits & Retirement** application, click on the **Log your Life event** tile, and then 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. If you are not actively at work on the date your life insurance would otherwise become effective, your coverage takes effect on the date you return to work. You are eligible for Business Travel Accident Insurance on your date of hire.

Non-duplication of coverage. Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan. If you and your spouse or domestic partner are both BMO employees and eligible to enroll in the Plan, you may each enroll for individual coverage or one of you may enroll and cover the other. If you each enroll for individual coverage, only one of you may enroll your children as Dependents.

Annual enrollment

During annual enrollment, you can make changes to your benefits elections. The changes take effect the next January 1 or when ReliaStar Life approves your proof of good health. If you did not enroll in Supplemental Life or Family Life Insurance when you were initially eligible, you may do so during the annual enrollment period and any life coverage election is subject to Evidence of Insurability due to your late entrant status. You will be provided with an Evidence of Insurability form to complete and submit to the insurance company for review and approval. In some circumstances the insurance company may require that you or your dependent(s) undergo a medical evaluation, paid for by the insurance company.

The new or increased coverage takes effect only if the insurance company approves your application. Elections you make during annual enrollment remain in effect throughout the year unless you experience a qualifying life event.

Beneficiaries

A beneficiary is the person who receives your survivor benefits under Basic Life, Supplemental Life, and Family Life Insurance if you die while covered by the plans. You may name anyone you wish, and you may change your beneficiary at any time by completing a new beneficiary designation via **Workday**, in the **My Benefits & Retirement** application. If you name two or more beneficiaries, you need to designate what portion of the entire benefit should be paid to each. If you elect family coverage, benefits are paid to you.

If you die without naming a beneficiary, or if the beneficiary you name dies before you, your life insurance benefits are paid to your estate.

Plan cost

The Company pays the full cost of your Basic Life and Business Travel Accident Insurance coverage. If you choose to enroll in Supplemental Life Insurance and/or Family Life Insurance, you pay the full cost of coverage with post-tax dollars deducted from your paycheck. There is a combined coverage limit of $3 million for basic and supplemental coverage. Rates are based on your age, who you choose to cover, and the amount of coverage you purchase. You can review the premiums on the **BMO U.S. Benefits** site.

Salary and premium adjustments

Your Basic and, if elected, Supplemental Life Insurance amounts and your cost for Supplemental Life Insurance coverage are effective on the January 1 following the adjustment.

In addition, the cost of Supplemental Life Insurance coverage is based on your age. If you are not actively at work on the date your life insurance or increased amount would become effective, the change becomes effective on the date you return to work. Any cost increase related to age occurs on the January 1 following your birthday.

For certain commissioned groups, life insurance is determined using a Benefits Base Rate (BBR). Refer to the *Earnings Used for Benefits* located on the HR Intranet via **Workday** or **BMO Central** for more information.

Life insurance and business travel accident plan

Life Insurance provides financial protection for you and your family. BMO automatically provides Basic Life and Business Travel Accident insurance to eligible employees. You can purchase additional Supplemental Life and Family Life Insurance for your eligible dependents.

Insurance options at a glance

For more information about each type of coverage, go to the appropriate section in this SPD.

Type of insurance	Who the plan covers	Benefit amount	Who pays for coverage
Basic Life	**You**	**Two times your total compensation up to $500,000***	**Company**
Supplemental Life	**You**	**One to eight times your total compensation, up to a combined maximum (including basic life insurance) of $3 million**	**You**
Family Life	**Your spouse/ domestic partner**	**Four coverage options:**** • $25,000 • $50,000 • $100,000 • $150,000	**You**
	Your eligible child(ren)	**Four coverage options:***** • $10,000 • $15,000 • $20,000 • $25,000	**You**
Business Travel Accident	**You**	**Three times annual base pay to a maximum of $600,000 (minimum $100,000)**	**Company**

* You can cap your benefit amount at $50,000 to avoid imputed income

** The amount of insurance for your spouse/domestic partner cannot exceed your total combined amount of Basic and Supplemental Life Insurance.

** The amount of insurance for your child(ren) cannot exceed your total combined amount of Basic and Supplemental Life Insurance.

Note: You must provide satisfactory evidence of good health for Supplemental Life amounts if you enroll later than 31 days from your start date or at annual enrollment.

Total Compensation Defined

Your eligible total compensation is your base salary, overtime, shift differential and any variable pay that is related to work performance that you receive between October 1 and September 30 of the prior year. For example, for 2024, your total compensation is based on eligible pay paid from October 1, 2022, to September 30, 2023. You can view your total compensation in Workday. In your worker profile, select "Actions"- "Benefits" – "View Benefits Annual Rate".

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

Basic Life Insurance

The amount of your Company-paid Basic Life Insurance equals one times your total compensation, up to $500,000. If your annual base pay is less than $10,000, your life insurance benefit equals $10,000.

For life insurance purposes, your total compensation is rounded to the nearest $1,000. For example, if your total compensation is $31,200, your Basic Life Insurance amount is $31,000. If, however, your annual base pay is $31,500, your Basic Life Insurance amount is $32,000.

For certain commissioned groups, life insurance is determined using a Benefits Base Rate (BBR). Refer to the *Earnings Used for Benefits* located on the HR Intranet via **Workday** or **BMO Central** for more information.

Supplemental Life Insurance

If you would like more coverage than your Basic Life coverage provides, you can purchase Supplemental Life Insurance when you are first eligible, during annual enrollment, or if you experience a qualifying life event. If you do not enroll when you are first eligible, Evidence of Insurability (EOI) may be required when electing or increasing coverage during annual enrollment or at the time of a life event. You may choose a benefit amount from one to eight times your total compensation, up to a combined maximum of $3 million (including basic life insurance). If you elect coverage later than 31 days from your date of hire or at annual enrollment, you must provide satisfactory evidence of good health.

Your Supplemental Life Insurance benefit is based on your total compensation. In determining your Supplemental Life Insurance benefit, your total compensation amount is multiplied by your option level, and then rounded to the nearest $1,000. For example, if your annual base pay is $33,400 and you elect a supplemental benefit of two times this amount, your Supplemental Life Insurance equals $67,000 ($33,400 x 2 = $66,800, rounded to $67,000).

Your premiums for Supplemental Life are based on your age bracket and the benefit amount you select. Non-tobacco users pay lower group rates than tobacco users.

For certain commissioned groups, life insurance is determined using a Benefits Base Rate (BBR). Refer to the *Earnings Used for Benefits* located on the HR Intranet via **Workday** or **BMO Central** for more information.

Accelerated death benefit

ReliaStar Life pays accelerated death benefits if it has been determined that you have a terminal condition. If the insurance carrier approves your request, you can receive a one-time lump sum amount of 50% of your combined Basic and Supplemental Life Insurance amount in effect at the time of your request.

To receive the accelerated death benefit, **all** the following conditions must be met. You must:

- request this benefit in writing while you are living. If you are unable to request this benefit yourself, your legal representative may request it for you.

- be insured as an employee for Life Insurance benefits.
- have Life Insurance benefits of at least $10,000 as shown on the Schedule of Benefits in your group certificate.
- provide to ReliaStar Life a doctor's statement which gives the diagnosis of your medical condition; and states that because of the nature and severity of such condition, your life expectancy is no more than 24 months. ReliaStar Life may require that you be examined by a doctor of its choosing. If ReliaStar Life requires this, ReliaStar Life pays for the exam.
- provide to ReliaStar Life written consent from any irrevocable beneficiary, assignee, and, in community property states, from your spouse.

You are not eligible for this benefit if your terminal condition is directly caused by attempted suicide or intentionally self-inflicted injury.

Benefits reduced after age 70

Beginning on and after your 70th birthday the amount of your Supplemental Life Insurance, and if elected, Spouse/Domestic Partner Life Insurance decreases based on your age. You pay the premium for the amount of coverage for which you are eligible.

Age	*Percentage of regular Supplemental Life benefit amount provided*
Through age 69	100%
Age 70 through 74	60%
Age 75 through 79	40%
Age 80 through 84	25%
Age 85 and over	17%

The example below shows how benefits are limited after age 70. Let's assume:

- your annual salary is $25,000;
- you elect optional coverage of two times your annual salary; and
- you die at age 76.

Your benefit will be figured as follows:

$25,000 *times* 2 = $50,000 *times* 40% (from the chart above) = $20,000

If you die at age 76, your beneficiary will receive $20,000. This amount is in addition to the Company-provided Basic Life Insurance amount your beneficiary will receive.

Family Life Insurance

You can also purchase life insurance coverage for your family through the Company. Participation in Family Life Insurance is not automatic; you must enroll for coverage. If you are a new hire, you have 31 days from

your start date to enroll. If you miss this deadline, you cannot enroll until the next annual enrollment unless you experience a qualifying life event.

After the initial new hire enrollment period, you and your dependents must provide satisfactory evidence of good health if you elect or increase Family Life Insurance at any time, whether at annual enrollment or due to a qualifying life event.

Spouse/domestic partner coverage options

You have four life insurance coverage options for your spouse/domestic partner:

- $25,000
- $50,000
- $100,000*
- $150,000*

*Evidence of Insurability (EOI) is required for initial eligibility.

The amount of insurance for your spouse/domestic partner cannot exceed your total combined amount of Basic and Supplemental Life Insurance.

Age	*Percentage of regular Supplemental Life benefit amount provided*
Through age 69	100%
Age 70 through 74	60%
Age 75 through 79	40%
Age 80 through 84	25%
Age 85 and over	17%

Child life coverage options

You have four life insurance coverage options for your dependent child(ren):

- $10,000 each child
- $15,000 each child
- $20,000 each child
- $25,000 each child

The amount of insurance for your child(ren) cannot exceed your total combined amount of Basic and Supplemental Life Insurance. These amounts do not change based on the number of covered children.

If you and your spouse or domestic partner are both employees under the Company life insurance policy, either you or your spouse or domestic partner, but not both, can apply for Dependent's life insurance. If the spouse or domestic partner carrying the Dependent's life insurance stops being insured as an employee, the other spouse or domestic partner may become insured for Dependent's life insurance by applying within 31 days.

Business Travel Accident insurance

Business Travel Accident Insurance provides accident coverage for you while you are on business anywhere in the world. This coverage is automatically applied from your first day of your employment, and no enrollment is required. Business travel coverage is *in addition to* any personal accident coverage you may have purchased through the employee, spouse, or child accident insurance plans.

Coverage begins when you leave your home, office, or other location to start a business trip and ends when you return from that trip or make a personal side trip (an activity not related to the purpose of the business trip). The plan does not cover your normal commute to and from work.

Plan benefits

The basic benefit provided by your Business Travel Accident coverage depends on your employment status and who is being covered.

Eligible employees are:

- Under the age of seventy (70) and are
- Employed by the policyholder or an affiliate thereof.

Employee status	Business Travel Accident benefit	Type of Coverage
U.S. Executive	300% of annual earnings*, rounded up to the next $1,000, up to a maximum of USD $1,000,000.	Twenty-four (24) Hour Coverage**
All Other U.S. Permanent Employees	300% of annual earnings*, rounded up to the next $1,000, up to a maximum of USD $600,000.	Business travel while on a trip
U.S. Temporary Employees	USD $100,000	Business travel while on a trip
Spouse while on business travel	50% of employee's basic benefit, minimum $50,000 up to maximum $300,000.	While on business travel with an insured employee
Dependent Children while on business travel	USD $25,000	While on business travel with an insured employee

This table explains the "basic benefit" paid when 100% of the benefit is paid out. The actual amount that will be paid depends on the type and extent of your injury.

**"Annual Earnings" means the Insured Employee's annual salary from employment with the Policyholder or the Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.*

***"Twenty-Four (24) Hour Coverage" if applicable, to a Class of Eligible Employee, means coverage hereunder for Injury occurring at any time, regardless of whether: (1) the Insured Employee is engaged in Business Travel While on a Trip, or (2) the accident occurs to the Insured Employee While on the*

Business of the Policyholder.

Schedule of loss

The chart below shows examples of qualifying serious injuries and the benefit that will be paid as a percentage of your basic benefit depending on the extent of the injury. This applies to business travel accidents.

Loss	When due to an accident
- Quadriplegia - Paraplegia - Hemiplegia	200%* of basic benefit
- Loss of life - Loss of both hands or both feet - Loss of entire sight of both eyes - Loss of one hand and one foot - Loss of one hand and the entire sight of one eye - Loss of one foot and the entire sight of one eye - Brain death - Loss of speech and hearing - Loss of use of both arms or both hands	100% of basic benefit
- Loss of one arm or one leg - Loss of use of one arm or one leg	80% of basic benefit
- Loss of one hand or one foot - Loss of the entire sight of one eye - Loss of speech or hearing - Loss of use of one hand or one foot	75% of basic benefit
- Loss of hearing in one ear	66.67% of basic benefit
- Loss of thumb and index finger of the same hand - Loss of four fingers of one hand	33.33% of basic benefit
- Loss of all toes of one foot	25% of basic benefit
* To a maximum benefit amount of $1,000,000	

If your loss causes permanent and total disability

If the benefit you receive is less than 100% of basic benefit, and after 12 months your disability continues to be permanent and prevents you from participating in any occupation for which you have at least the minimum qualifications, additional benefits will be paid to bring your total benefit up to 100%.

For example, if you were to lose hearing in one ear during a business travel accident, you would receive 50% of the basic benefit. If 12 months later, your doctor determines the loss has caused total and permanent disability, the additional amounts would be paid to bring you up to 100% of basic benefit.

When multiple losses occur

The total benefit paid cannot exceed the benefit that would be paid for any one loss. For example, the loss of use of an arm would result in 100% of the benefit paid. Similarly, the loss of sight would result in 100% of the benefit being paid. However, if both losses occur in the same accident, the total benefit paid would be 100%, not 200%.

Supplemental benefits

Your Business Travel Accident Insurance also provides a variety of supplemental benefits up to specified maximums. Benefits include:

- Childcare expense
- Education expense
- Excess medical expense
- Family transportation benefit
- Funeral expenses
- Home/vehicle adaptation
- Increased benefit if your accident causes a permanent and total disability.
- Medical evacuation and repatriation
- Rehabilitation/retraining
- Serious injury, death, and dismemberment benefit

Note: There are maximums for the above benefits/expenses.

What the plans do not cover

Supplemental Life and Family Life Insurance benefits are not paid if the insured's death occurs from attempted suicide or intentionally self-inflicted injuries, while sane or insane, within two years of the date the Supplemental or Family Life Insurance coverage begins. In this instance, the premium amount the insured already paid will be refunded and the claim will not be paid.

Additionally, for Basic and Supplemental Life Insurance, you, and your dependent's insurance have a contestable period starting with the effective date of your insurance and continuing for two years. During those two years, the insurance company can contest the validity of your or your dependent's life insurance because of inaccurate or false information received related to any evidence of good health you or your dependents provide.

If you or your dependent(s) fails to provide information, misrepresents any facts, or provides fraudulent information about an accident or member's age, that insurance is voidable. Statements may be contested for up to two years from the date a statement about this insurance is made.

When coverage ends

Basic Life and Supplemental Life
Your insurance stops on the earliest of the following dates:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see Eligibility),
- you fail to pay premiums when due, or
- the Plan ends coverage for employees.

Family Life
Your dependent's insurance stops on the earliest of the following dates:

- the date your Life Insurance premiums are waived due to total disability,
- your employment with the Company ends for any reason,
- you or your covered dependents become ineligible to participate (see Eligibility)
- you divorce or become legally separated from your spouse,
- you no longer share a sole, committed relationship with your domestic partner,
- you fail to pay premiums when due, or
- the Plan ends coverage for employees, dependents and/or domestic partners.

Business Travel Accident Insurance
Coverage for you and your dependent(s) ends on your last day of work.

Continuation of life insurance

If you are no longer eligible for Life Insurance because you stop active work, BMO may continue your insurance and premiums must be paid. The length of time your insurance continues depends on the reason you stop active work. Continuation of insurance stops on the earliest of the following dates:

- the end of the period for which your premiums were paid, if the next premium contribution is not paid on time;
- the end of the 12th policy month after the policy month during which you stop active work, if you stop active work due to a military leave of absence;
- for coverage not continued under the portability option, if you are age 65 or older and you take a leave of absence due to sickness or accidental injury, including total disability, coverage may be continued for up to 110 days. If you are under age 65 when you take your leave of absence and turn age 65 during your leave, coverage may be continued for up to 110 days minus the number of days you were already on leave prior to turning age 65;
- for coverage not continued under the portability option, the date your Life Insurance has been continued for 12 months if you stop active work due to sickness or accidental injury, including total disability;
- for coverage not continued under the portability option, the date your Life Insurance premiums are waived under the Waiver of Life Insurance Premium Disability Benefit.

If you take a leave of absence

Your Basic Life Insurance coverage continues while you are on a leave of absence. If you are on a paid leave and you have elected Supplemental Life or Family Life Insurance, your premium is deducted from your pay as usual. If you are on an unpaid leave, such as a Family and Medical Leave Act of 1993 (FMLA) Leave, you must pay the required contribution by the due date. Your continuation amount is the same as when you were actively working and is subject to change each January 1.

Porting and converting coverage

You can apply to continue your terminated Supplemental Life Insurance by Portability benefit until age 80 if certain conditions are met. You may elect to decrease your ported coverage; however, you will not be eligible to increase your ported coverage. Family Life Insurance may only be continued through Portability if your Life Insurance is ported. Employer provided Basic Life coverage may be continued by Conversion only.

You must apply for portability or conversion within 31 days of the date your insurance terminates. Please call ReliaStar Life Insurance at 1-800-955-7736 to request forms. Please reference the BMO Financial Corp. Life Insurance Schedule of Benefits (ReliaStar) certificate, located on www.bmousbenefits.com if you would like more details on the continuation options available.

Waiver of life insurance premium disability benefit

If you become totally disabled you will be automatically enrolled for Waiver of Premium (WOP), which allows you to continue your elected Supplemental Life and/or Basic Life Insurance provided by the Company. When you are enrolled in WOP, you will not have to pay the premium for your elected Supplemental Life Insurance. Your Basic Life Insurance provided by the Company and your Supplemental Life Insurance, if enrolled at the time of total disability, will continue at no cost to you. WOP does not apply to Family Life Insurance, and all dependent life insurance will be cancelled upon WOP enrollment. You may be required to submit ongoing proof of disability directly to the insurance carrier to continue WOP benefits.

For premiums to be waived written notice of claim and proof of total disability are required and all of the following conditions must also be met:

- total disability must begin before your 60th birthday;
- you are insured for the Waiver of Life Insurance Premium Disability Benefit on the date you become totally disabled;
- you must be continuously totally disabled for at least 110 days;
- you continue to be totally disabled;
- your insurance is in force when you suffer the sickness or accidental injury causing the total disability;
- all premiums are paid up to the date total disability begins.

The written notice of claim before any premium can be waived must be received:

- while you are living and enrolled in the plan;
- while you are totally disabled,
- within one year from the date total disability begins.

Proof of your total disability is required before any premiums can be waived. ReliaStar Life may require you to have a physical exam by a doctor it chooses, and ReliaStar Life pays for that exam.

The waiver of premium may continue if your disability is permanent and completely prevents you from engaging in any job for which you are qualified or may become qualified by reason of training, education, and experience. The waiver of premium ends immediately if you are no longer totally disabled, you do not provide proof that you are still disabled when asked, or the date you attain age 65.

For more information, please refer to the BMO Life Insurance Schedule of Benefits (ReliaStar) certificate, located on the **BMO U.S. Benefits** site.

Claims

Life insurance claims

To apply for benefits under the Company-provided Basic Life and the Supplemental Life Insurance programs, you or your beneficiary should call the Human Resources Centre at 1-888-927-7700 as soon as possible. The insurance company will determine if a death benefit is payable.

Appeal process for a denied life insurance claim

You are entitled to a written explanation of why your benefit was denied within 90 days after receipt of the claim. An extension of 90 days will be allowed if special circumstances are involved. You will be notified if any such extension is necessary. The notice will state the special circumstances involved and the date a decision in expected. If your claim for benefits is denied in whole or in part, the insurance company will provide you with a written notice that:

- specifies the reason for the denial;
- refers to the specific provision of the plan 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; and
- explains the claim review procedures including time limits applicable to such procedures and notice of your rights to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.

If your claim is denied under the procedures described above, you may request a review of your denied claim by written request to the life insurance company within 60 days after receiving notice of the denial. In connection with such request, you may review pertinent documents and may submit issues and comments in writing. The life insurance company will provide a full and fair review that considers all comments, documents, records, and other information submitted. Review of claim denials and final decisions on appeal are the responsibility of the life insurance company.

You are entitled to a written decision of the final determination of your benefit within 60 days. An extension of 60 days will be allowed if special circumstances are involved. You will be notified if any such extension is necessary. Your written notice will:

- be written in an understandable way;
- specify the reason for the decision; and
- refer to the specific provision of the plan on which the decision is based

The life insurance company has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of the policy, and to make claim determinations.

Appeal process for a denied waiver of life insurance premium disability benefit

You are entitled to a written explanation of why your benefit was denied, and you may request to have your claim reviewed and reconsidered. Written notice will be furnished to you within 45 days after receipt of your claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed. You will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected. If your claim for benefits is denied in whole or in part, the claims administrator, insurance company or plan administrator will provide you with a written notice that:

- specifies the reason for the denial;
- refers to the specific provision of the plan 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;
- explains the claim review procedures, including the time limits applicable to such procedures; and
- notice of your right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse appeal decision

If your claim is denied under the procedures described above you may request a review of your denied claim by written request to the life insurance company within 180 days after receiving notice of the denial. In connection with such request, you may review pertinent documents and may submit issues and comments in writing. The life insurance company will provide a full and fair review that takes into account all comments, documents, records, and other information submitted. Review of claim denials and final decisions on appeal are the responsibility of the life insurance company.

Prior to notifying you of an adverse decision, the life insurance company will provide you notice of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. The life insurance company will also notify if it has new or additional rationale for an adverse decision. The life insurance company will then provide you with an opportunity to review and respond to the new information before they make a decision. The time period the life insurance company has to make its determination will be tolled while it is waiting for your response.

If you receive and adverse determination, the insurance company will provide you with a written notice that is written in an understandable manner and includes:

- specifies the reason for the denial;
- refers to the specific provision of the plan on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies to all documents and records relevant to the claim;
- a statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date which such limitations expire;
- if an internal rule or similar criterion was relied upon in making the adverse determination, then a copy of any such rule or other criterion will be provide free of charge; and

- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. Once way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless and extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from you. You will be given notice fi this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from you, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If you receive an adverse decision, you then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

The life insurance company has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of the policy, and to make claim determinations.

Administrative information

Plan identification

Plan name
This summary plan description describes the Group Life Insurance Plan and Business Travel Accident Plan (collectively, the "plans" of BMO). The Plans are participating plans in the BMO U.S. Health and Welfare Benefit Plan.

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

Plan number
507

Employer Identification Number
51-0275712

Plan year
January 1 – December 31

Plan sponsor
BMO Financial Corp.

Plan administrator
The Benefits Administration Committee (the "Committee") is the plan administrator for the Group Life Insurance Plan. BMO Financial Corp. is the plan administrator for the Group Business Travel Accident Insurance Plan.

The Plan sponsor and Plan administrator can be contacted at:

BMO Financial Corp.
Benefits Administration Committee
320 South Canal Street Floor 8
Chicago, IL 60606

Human Resources Centre (HRC): 1-888-927-7700

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 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 one or more Claims Administrators 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 BMO U.S. benefits is:

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

Agent for service of legal process

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

Type of funding

Group Life Insurance Plan contributions are made by the Company and participating employees. Business Travel Accident Plan contributions are made by the Company. The following portions of the plan are insured through contracts with the insurance companies, with the various companies acting as claims administrators:

- Group Life Insurance Plan of BMO Financial Corp.: ReliaStar Life Insurance Company
- Group Business Travel Accident Insurance Plan of BMO Financial Group: Crawford Adjusters Canada (for Chubb Insurance Company of Canada)

Claims administrators

The Company has different claims administrators for the plans as shown below:

Claims administrator	For	Address for filing claims/appeals
ReliaStar Life Insurance Company	Life Insurance Plan of BMO Financial Corp: • Group • Family	ReliaStar Life Insurance Company P.O. Box 1548 Minneapolis, MN 55440

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 encounter 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, Head of US Benefits, by emailing usbenefits@bmo.com.

Your rights Under ERISA

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

Receive information about our Plan and benefits

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

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

Prudent actions by Plan fiduciaries

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

Enforce your rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide all the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied

or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedure as described in this SPD. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with your questions

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

No employment guarantee

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