BMO

Short-Term Disability

Plan Details

reliancematrix

Quick Facts

Claims Administrator	Reliance Matrix Absence Management, Inc.
Claims Support	Reliance Matrix Member Services: 1-888-295-7862
Payroll Administrator	Strada
Payroll Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Short-Term Disability plan is designed to comply with the federal regulations such as the Americans with Disabilities Act (ADA), Family and Medical Leave Act (FMLA), as well as applicable state leave regulations.

Overview

BMO's Short-Term Disability (STD) Plan is designed to provide you with income replacement if you are unable to work due to a non-work-related illness, injury, or medical condition. The plan helps ensure financial stability during a temporary period of disability by replacing all or a portion of your regular earnings during the time that you are unable to work.

The most common conditions covered by the STD plan include:

- Injuries and accidents (not work related)
- Surgery and recovery
- Complications during pregnancy or following childbirth
- Mental health conditions with medical diagnosis and documented treatment plan
- Serious Illnesses such as cancer, heart attack or stroke, pneumonia or complications from autoimmune diseases
- Treatment for substance abuse

Eligibility for Short-Term Disability Benefits

If you experience an illness or injury that renders you unable to work for more than 10 consecutive business days, you will be required to apply for STD benefits. You should begin this process by the 5th consecutive day of your absence to avoid delays in benefit eligibility determination, claims processing and payroll.

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

- Be considered a Benefits-eligible employee, as defined in BMO's Health and Welfare Plan Summary Plan Description
- 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
- Submit a claim to the Claims Administrator and provide 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 as needed throughout the duration of your claim
- Receive approval from the Claims Administrator for STD benefits

While receiving STD income replacement benefits, you are not permitted to work (whether paid or unpaid) for any other employer, individual, family-owned business, or as a volunteer.

Benefit Duration

Recovery time varies widely depending on the condition; therefore, the actual duration of STD benefits is primarily based on how long you are medically unable to perform your job duties. The Claims Administrator determines the duration of your approved leave and STD benefits 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.

Unpaid Waiting Period

The first 10 consecutive business days of your leave constitute an unpaid waiting period (also referred to as the elimination period).

In Workday, your status will be changed to “On Leave” effective the first day of your absence with an Absence Type of “Disability Waiting Period – Unpaid”. This will stop your regular pay.

During the unpaid waiting period, you may use your available sick time or vacation time to maintain 100% of your regular pay. This substitution is not automatic - you must enter the sick or vacation time you intend to use in Workday to receive the sick pay or vacation pay on your paycheck. If you are unable to enter this time yourself, you should ask your manager to do so on your behalf or contact the HRC for assistance.

If your STD claim is approved, you will transition to being paid STD beginning on the 11th day of your absence. If your STD claim is denied, you will stay on unpaid leave. Your Workday status will reflect either *FML – Unpaid* or *Other – Unpaid*, based on the type of leave you are on.

STD Benefit Period

Short-Term Disability (STD) income replacement benefits begin on the 11th consecutive

business day of your approved leave and may continue for up to 100 business days thereafter.

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

**STD benefits continue for as long as you remain disabled, as determined by the Claims Administrator, or until you reach the 100th business day of your STD period, whichever comes first. Holidays are included in the 100 days of STD.*

Maximum Benefit Period

Short-Term Disability (STD) income replacement benefits are provided for a maximum of 100 business days.

Once you reach 110 consecutive business days of absence (which includes the 10-day unpaid waiting period and the 100-day STD benefit period), your paid STD income replacement benefits will end.

At that point, you must take one of the following actions:

- Return to work, if medically cleared.
- Apply for Long-Term Disability (LTD) benefits, if your condition continues to prevent you from working.
- Request an unpaid leave of absence as an accommodation, if additional time off is needed but LTD is not appropriate.
- Voluntarily terminate your employment, if you choose not to pursue continued leave or return to work.

If no action is taken once STD benefits end, Employee Relations may be engaged to review your employment status and your continued need for leave will be assessed through an interactive process.

Returning to Work

You will be expected to return to work at the end of your approved STD benefit period, unless you are transitioning to Long-Term Disability (LTD).

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. A Partial Return to Work status allows you to work reduced hours while continuing to receive STD benefits, supporting a gradual and medically appropriate return to full duties.

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

While on a Partial Return to Work:

- You will continue to receive STD income replacement benefits for the hours you are medically unable to work.
- You will also be paid for the actual hours worked, up to your standard weekly schedule.
- Any day in which STD benefits are used (regardless of the number of hours) is counted as one full day toward your available 100 days of STD.

Timekeeping Requirements:

- All employees (Exempt and Non-Exempt) must enter their actual hours worked, in addition to any Holiday, Sick, and Vacation time, 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.

Any days in which partial STD benefits are used will count towards your long term-disability (LTD) elimination period.

Recurring or Multiple Disabilities

If you experience a second disability or a series of disabilities, your STD 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 do not need to satisfy the unpaid 10-day waiting period again.
    - The second disability will count toward your original 100 covered business days of STD.
- 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.
    - You may use available sick or vacation time during this waiting period.
    - Your 100 covered business days of STD will restart.

- 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 STD benefits for one condition and experience a second disability (whether related or unrelated) the second disability is considered a continuation of the first. Your STD coverage will continue under the original claim and count toward the same 100-day limit.

When STD Coverage or Benefits End

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

- Exhaustion or End of STD Benefit Period: You exhaust your STD benefits or reach the end of your approved STD benefit 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 STD plan.
- End of Disability: You are no longer considered disabled.
- 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.
- Death: You pass away.
- Program Termination: The applicable program is terminated by BMO.

STD Benefit Calculation and Schedule

Your STD benefit is calculated by the Claims Administrator using your base pay (or Base Benefit Rate (BBR) for certain commissioned employees) in place as of the last business day before your disability began, divided by 26 (which represents the number of pay periods in a calendar year).

Note that your STD pay amount may appear slightly higher than your usual bi-weekly pay, as BMO calculates bi-weekly pay by dividing annual salary by 26.0714286.

Once the STD pay amount is determined, the applicable 100% or 70% benefit rate is applied. Your *Years of Service* for STD benefit purposes is calculated based on the difference between the date your absence began and your Continuous Service Date, which can be found in Workday. This calculation determines your eligibility for 100% or 70% STD pay as outlined in the following table:

Years of Service	Number of Days at 100%	Number of Days at 70%
Less than 1	0	100
1	10	90
2	20	80
3	30	70
4	40	60
5	50	50
6	60	40
7	70	30
8	80	20
9	90	10
10 or more	100	0

Coordination with State Paid Leave Benefits

If you reside in a state that provides paid leave benefits, you are required to apply for those benefits when you initiate a Short-Term Disability (STD) claim. BMO coordinates your STD benefits with any payments you receive from your state program.

If your state benefit is less than the STD benefit amount, STD will pay the difference so that your total benefit equals either 100% or 70% of your base pay, depending on your eligibility.

The Claims Administrator will automatically apply the maximum state benefit as an offset to your STD payments unless you provide documentation showing a different amount. To ensure your STD benefits are calculated accurately, you must submit your state award letter to the Claims Administrator as soon as it becomes available.

Coordination with BMO's Paid Maternity Leave

For birth mothers, STD benefits do not apply separately when receiving BMO's Paid Maternity Leave benefit. Instead, the maternity leave benefit runs concurrently with the STD

payment schedule, meaning you will receive maternity leave pay in lieu of STD pay. You will not receive both STD and maternity pay at the same time.

Pregnancy Complications Before Birth

If you experience complications that require leave before the birth, you must apply for STD benefits:

- The 10 day unpaid waiting period prior to STD applies.
- You must submit medical documentation from your treating physician to the Claims Administrator.
- If approved, you will receive STD pay starting on the 11th consecutive day of disability.
- Upon delivery, you will transition to the maternity leave benefit for up to 16 weeks of income replacement.

Complications After Maternity Leave Ends

If complications arise after your paid maternity leave period and you are unable to return to work:

- You must apply for STD benefits to continue receiving pay.
- The 16 weeks of maternity leave count toward satisfying the STD unpaid waiting period, so no additional waiting period is required.
- You must submit medical documentation to the Claims Administrator as soon as possible to avoid delays in pay.
- Once approved, STD benefits will begin after the maternity leave ends.
- The 16 weeks of maternity leave count toward your 100-day STD limit. Any additional STD pay will follow the standard STD payment schedule, based on your years of service and length of leave.

STD Benefits Payments and Payroll Coordination

STD benefits are paid on the same bi-weekly schedule as your regular paycheck. The Claims Administrator will notify the Payroll Administrator of the amount of STD pay to issue each pay period. This may include:

- Your regular bi-weekly STD payment
- Any retroactive payments due based on the timing of your claim approval or extension
- Offsets for state-paid leave benefits, if applicable

All STD payments are subject to standard payroll deductions and tax withholdings.

You can verify your expected STD benefit payments by reviewing your Award Letter or contacting the Claims Administrator. You can also view your paychecks, including STD payments, directly in Workday under the Pay section.

Benefits Deductions During STD

While receiving approved STD benefits your benefits coverage (medical, dental, vision, life, and voluntary benefits) continues uninterrupted and you remain responsible for your benefit premiums and contributions. These deductions will automatically be taken from your STD pay.

If you miss a paycheck due to claim approval timing or receive insufficient earnings to cover your deductions, your missed deductions will accumulate in arrears. They will be recovered once you have sufficient pay, typically through one extra deduction per pay period until the balance is paid in full. Your HSA and FSA contributions will automatically recalculate and adjust based on the number of remaining pay periods in the calendar year.

If you are enrolled in Commuter Benefits, you are responsible for discontinuing your deduction while on STD and reinstating it, if desired, when you return to work. While you are on STD you must terminate your commuter election by the 10th of the month (or the 4th for Long Island and Metro North Railroad users in New York) in order to cancel for the following month's order.

Recovery of Overpayments

BMO reserves the right to offset any future STD 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.

Short-Term Disability Claims

Decisions about STD 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 expertise, independence and impartiality.

Filing a Claim

STD benefits are not automatic, meaning you will need to take action to file a claim. If you expect your absence to last more than 10 consecutive business days, **you must contact the Claims Administrator, Reliance Matrix Absence Management, at 1-888-295-7862 to initiate your claim.** You can also file your claim online at www.matrixabsence.com. The process to apply for STD 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 STD.

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 STD 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 and will not be reopened, even if documentation is submitted later.

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.
- STD 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 leave of absence, 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 STD 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 STD benefits may be terminated.

Exclusions

The STD 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
- 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

Appealing a Short-term Disability Claim Decision

You or your authorized representative may appeal a denial of a claim for STD benefits by filing a written request with the Claims Administrator within 30 days of receiving the initial STD pay denial notice.

In connection with your 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

Submitting your STD Appeal

Your STD Appeal should be sent to:

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

The Claims Administrator will conduct a full and fair review of all submitted documents and evidence and will ordinarily render a final and binding decision within 45 days of receiving your appeal request. If special circumstances apply, the decision will be made as soon as possible, but no later than 90 days from the date of receipt. If an extension is needed, you will be notified in writing before the end of the initial 45-day period, including the reason for the delay and the expected decision date.

The STD plan is not an ERISA-governed plan therefore there are no additional appeal rights available once the Claims Administrator makes their final determination. While no further appeals are available, if you wish to share concerns about the Claims Administrator's decision, you may contact:

BMO Financial Corp.
ATTN: Head of US Benefits
395 N Executive Drive, 3rd Floor HR
Brookfield, WI 53005
usleaves@bmo.com

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 (financially or otherwise) 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.