BMO

UMR Medicare Secondary Plan Summary Plan Description (SPD)

Employee Benefit Program of Bank of Montreal/Harris

BMO FINANCIAL CORP.
CHICAGO IL

Health Benefit Summary Plan Description
7670-00-040161

Revised 01-01-2022

BENEFITS ADMINISTERED BY

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BMO FINANCIAL CORP.

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the BMO FINANCIAL CORP. Health Benefit Plan (the "Plan"). You are a valued Retiree of BMO FINANCIAL CORP., and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact the Human Resources Center if You have questions or if You have difficulty translating this document.

BMO FINANCIAL CORP. is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims and Express Scripts for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims paying agents for the Plan Administrator.

Funding for Plan benefits are described under Funding of the Plan in the PLAN INFORMATION section. The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Retirees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in Funding of the Plan and in the Schedule of Benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description (“SPD”) and Plan document. It is being furnished to You in accordance with ERISA.

This document becomes effective on January 1, 2014.

PLAN INFORMATION

Plan Name	BMO FINANCIAL CORP. Employee Benefit Program of Bank of Montreal/Harris
Name And Address Of Employer	BMO FINANCIAL CORP. 395 N EXECUTIVE DR 395-HR BROOKFIELD WI 53005
Name, Address And Phone Number Of Plan Administrator	BMO FINANCIAL CORP. BENEFITS ADMINISTRATION COMMITTEE 111 W MONROE ST 7W CHICAGO IL 60603
Human Resources Centre (HRC)	1-888-927-7700
Named Fiduciary	BMO FINANCIAL CORP. 111 W MONROE ST 7W CHICAGO IL 60603
Employer Identification Number Assigned By The IRS	51-0275712
Plan Number Assigned By The Plan	507
Type Of Benefit Plan Provided	Self-funded Health & Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	BMO FINANCIAL CORP. 111 W MONROE ST 7W CHICAGO IL 60603 Services of legal process may also be made upon the Plan Administrator.

Funding of the Plan	The BMO FINANCIAL CORP. Group U.S. Retiree Medical Program is funded through participant and employer contributions (previously contributed to the Employees' Retirement Plan of the Bank of Montreal/Harris under a 401(h) arrangement) which are deposited to the BNY Mellon BMO Retiree Medical Processing Account. If you are a former M&I employee, retiree, long-term disability participant or key retiree* and are eligible for the Plan based upon the legacy M&I Retiree Medical Eligibility provisions, funding is made through participant which are deposited to the M&I Retiree Health Benefits Trust account and employer contributions which were funded into the M&I Retiree Health Benefits Trust at the time of the BMO merger. Benefits for key retirees* are funded through a Rabbi Trust and special key retirees* are funded by employer purchase of insurance or payments from the employers general assets. BNY Mellon acts as trustee for the BMO FINANCIAL Group U.S. Retiree Medical Program for funds deposited into the BNY Mellon Trust. BMO FINANCIAL CORP. acts as trustee of the M&I Retiree Health Benefits Trust and the Rabbi Trust. Independent third parties administer claims submitted under the Plan.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Retirees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31
ERISA And Other Federal Compliance	It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001, 003

Retirees who are age 65 and older and/or Medicare eligible and their Medicare eligible covered Dependents will be enrolled in the Medicare Secondary Plan. This Plan is meant to work with Medicare, which will become the primary payer, which means Medicare pays Your benefits first, as soon as You turn age 65 or qualify for Medicare. The Medicare Secondary Plan becomes the secondary Plan, which means it pays benefits after Medicare pays, except for prescription drugs. The Medicare Secondary Plan is the only option available to Retirees and their covered eligible Dependents over age 65 and/or Medicare eligible.

Different eligibility requirements may apply; refer to the Eligibility section to confirm coverage is available to You when You are over age 65 or qualify for Medicare.

Applying for Medicare
You can apply for Medicare by contacting Your local Social Security Office three months before Your 65th birthday. For the nearest Social Security Office, look in Your telephone directory under U.S. Government Services, or contact Social Security at 1-800-772-1213, or go online to www.ssa.gov and select "Locate a Social Security office." You can also find Medicare information and enroll online at www.medicare.gov.

You must be enrolled in both Medicare Parts A (Hospital Insurance) and B (Medical Insurance) in order to be covered by the Retiree Medical Program. If You fail to enroll, no benefits will be paid under this plan.

If You or Your spouse enrolls in Medicare Part D (prescription drug coverage) Your coverage in the Retiree Medical Program may be affected. Refer to the *Retiree Medical Program Appendix* for more detailed information.

Plan Administration
UMR is the Claims Administrator for the Medicare Secondary Plan. For more information about this plan, contact UMR Member Services at 1-877-561-0366 or go online to www.umr.com.

UMR Member Service representatives can:
- answer questions about Your coverage and claim payments;
- provide information about network providers and services; and
- precertify hospital stays, medical procedures or emergency care.

All health benefits shown on this Schedule of Benefits are subject to the following: individual Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

	MEDICARE SECONDARY PLAN
Annual Deductible Per Calendar Year Benefit • Per Medicare Part A • Per Medicare Part B	 Plan Pays Covered Participant Pays
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	 10% Of The Medicare Approved Amount
Medical Annual Out-Of-Pocket Maximum • Per Person	 $3,850

	MEDICARE SECONDARY PLAN
Prescription Annual Out-Of-Pocket Maximum • Per Person	 $3,000
Ambulance Transportation: • Paid By Plan	 10% Of The Medicare Approved Amount
At-Home Recovery Benefits: • Maximum Benefit Per Calendar Year • Paid By Plan ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.***	 365 Days 100%
Blood: • Benefit Per Calendar Year While Confined In A Hospital Or Skilled Nursing Facility • Paid By Plan	 First 3 Pints 100%
Breast Pumps: • Paid By Plan	 100%
Chiropractic Services: **Office Visit:** • Paid By Plan **Manipulations:** • Paid By Plan **X-rays:** • Paid By Plan ***Note: If Medicare Approves, Plan Will Pay 10% Of The Medicare Approved Amount. If Medicare Does Not Approve, Plan Will Pay At 90%.***	 90% 90% 90%
Contraceptive Methods And Counseling Approved By The FDA: **For Women:** • Paid By Plan	 100%
Durable Medical Equipment: • Paid By Plan	 10% Of The Medicare Approved Amount
Emergency Services / Treatment: • Paid By Plan **Urgent Care:** • Paid By Plan	 100% 10% Of The Medicare Approved Amount
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Maximum Days Per Confinement • Paid By Plan	 Days 21 to 100 100%
Foreign Country Travel Emergency Care: First $250 Is Patient's Responsibility • Paid By Plan After First $250	 80%
Hospice Care Benefits: • Paid By Plan	 10% Of The Medicare Approved Amount

	MEDICARE SECONDARY PLAN
Hospital Services:	
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:	
• Paid By Plan Medicare Part A Deductible	100%
Outpatient Services / Outpatient Physician Charges:	
• Paid By Plan	10% Of The Medicare Approved Amount
Outpatient Imaging Charges:	
• Paid By Plan	10% Of The Medicare Approved Amount
Outpatient Lab And X-ray Charges:	
• Paid By Plan	10% Of The Medicare Approved Amount
Outpatient Surgery / Surgeon Charges:	
• Paid By Plan	10% Of The Medicare Approved Amount
Maternity:	
Routine Prenatal Services:	
• Paid By Plan	100%
Non-Routine Prenatal Services, Delivery And Postnatal Care:	
• Paid By Plan	10% Of The Medicare Approved Amount
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:	
• Paid By Plan	90%
Physician Office Visit:	
• Paid By Plan	10% Of The Medicare Approved Amount
Physician Office Services:	
• Paid By Plan	10% Of The Medicare Approved Amount
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:	
Preventive / Routine Physical Exams At Appropriate Ages:	
• Paid By Plan	100%
Immunizations:	
• Paid By Plan	100%
Preventive / Routine Diagnostic Tests, Lab, And X-rays At Appropriate Ages:	
• Paid By Plan	100%

	MEDICARE SECONDARY PLAN
Preventive / Routine Mammograms And Breast Exams: • Paid By Plan	100%
3D Mammograms For Preventive Screenings: • Paid By Plan	100%
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit: • Paid By Plan	100%
Preventive / Routine PSA Test And Prostate Exams: • Paid By Plan	100%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan	100%
Preventive / Routine Autism Screening: From Age 0 To 2 • Paid By Plan	100%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: • Paid By Plan	100%
Preventive / Routine Hearing Exams: • Paid By Plan	100%
Preventive / Routine Eye Exams And Glaucoma Testing: • Paid By Plan	10% Of The Medicare Approved Amount
Eye Refractions: • Paid By Plan	10% Of The Medicare Approved Amount

	MEDICARE SECONDARY PLAN
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: • Paid By Plan **In Addition, The Following Preventive / Routine Services Are Covered For Women:** ➢ Gestational Diabetes ➢ Papillomavirus DNA Testing ➢ Counseling For Sexually Transmitted Infections (Provided Annually)* ➢ Counseling For Human Immune-Deficiency Virus (Provided Annually)* ➢ Breastfeeding Support, Supplies, And Counseling ➢ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* • Paid By Plan ***These Services May Also Apply To Men.**	100% 100%
Sterilizations: **For Men:** • Paid By Plan **For Women:** • Paid By Plan	10% Of The Medicare Approved Amount 100%
Temporomandibular Joint Disorder Benefits: • Paid By Plan	10% Of The Medicare Approved Amount
Therapy Services: • Paid By Plan	10% Of The Medicare Approved Amount
All Other Covered Expenses: • Paid By Plan	10% Of The Medicare Approved Amount

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) ALL	
Transplant Services: Non-Designated Transplant Facility: **Transplant Services:** • Paid By Plan	 100%

PRESCRIPTION SCHEDULE OF BENEFITS

Benefit Plan(s) 001

PRESCRIPTION DRUGS (Administered By Express Scripts)	**THE COVERED PARTICIPANT**
Retail Pharmacy	
Generic	
• 30-Day Supply	$10 Copayment
• 90-Day Supply	$30 Copayment
Preferred Brand-Name	
• 30-Day Supply	$30 Copayment
• 31-90-Day Supply	$90 Copayment
Non-Preferred Brand-Name	100% Of The Cost, Not Covered
Mail Order Service	
Generic	
• 90-Day Supply	$25 Copayment
Preferred Brand-Name	
• 90-Day Supply	$75 Copayment
Non-Preferred Brand-Name	100% Of The Cost, Not Covered
Injectable Insulin	No Payment, Covered At 100%
Diabetic Supplies	Covered Under Medical

- If You request a Brand-Name medication when a generic equivalent is available, You will pay the generic copayment, plus the difference in cost between the Brand and the Generic. If You are not able to take a generic equivalent due to Medical Necessity, Your doctor may request a review and provide supporting documentation on why the Brand is Medically Necessary. If approved by Express Scripts, You will pay the Brand copayment.

- Manufacturer-funded patient assistance for widely distributed Specialty Medications will not be considered as true Out-of-Pocket expenses and may not apply to Deductible and Out-of-Pocket Maximums.

- Specialty Medications available through Accredo.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the medical Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's in-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the medical out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by BMO FINANCIAL CORP. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated retirees.

ELIGIBILITY

You are eligible for coverage under the Plan as a result of Your employment with BMO FINANCIAL CORP. if You satisfy the eligibility requirements for retiree medical as specified in the BMO FINANCIAL CORP. Group U.S. Retiree Medical Program Eligibility Appendix and:

- You retire from employment with BMO FINANCIAL CORP. at or after age 65 (and Medicare is the primary payer of claims) and You decline COBRA coverage; or

- You retired from employment with BMO FINANCIAL CORP. prior to age 65 and are eligible for Medicare, declined COBRA coverage and were receiving retiree health coverage from BMO FINANCIAL CORP. immediately prior to turning age 65; or are participating in and meet the rules under the U.S. Retiree Medical Program pre-65 waiver program; or

- You are receiving disability benefits under BMO FINANCIAL CORP. Group U.S. Retiree Medical Program LTD Plan (Long Term Disability Income Plan of Bank of Montreal/Harris) plan and are eligible for Medicare. References made to retirees include participants eligible under this paragraph. (Legacy M&I LTD participants only)

EFFECTIVE DATE OF COVERAGE

If eligible, You will be enrolled automatically in the Medicare Secondary Plan and Your coverage begins effective the first day of the month of Your 65th birthday or the first day of the prior month if Your 65th birthday is on the first day of the month if Medicare has determined it is the primary payer of claims.

To receive coverage under the Medicare Secondary Plan, You must sign up for Medicare Parts A and B and pay the required Medicare premiums. The Plan pays the Medicare Part A deductible and You are responsible for the Part B Deductible.

You must also pay the required level of premiums applicable to You (and Your eligible Dependent, if Dependent coverage is desired) as described in Your retirement packet. In addition, the Company will regularly advise You of the required level of premiums applicable to You.

You may enroll Yourself only or You may also enroll Your Dependent by paying any additional required premiums for Dependent coverage as set forth in the retirement packet and communicated to You from time to time by the Company. If You do not enroll yourself by making the required premium payments when first eligible; neither You nor Your Dependent will be able to have coverage through the Retiree Medical Program in the future.

Your premium for any month's coverage is due on the first day of that month. You have a 30-day grace period for the payment of each premium. If Your payment is not received within the grace period, Your coverage is canceled effective as of the date through which the last premium was paid.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

If You have a covered Dependent who is 65 or older (and for whom Medicare has determined it is the primary payer of claims), or Medicare eligible at the same time You become eligible for coverage, the covered Dependent becomes eligible for the Plan at the same time, and coverage begins effective at the same time, so long as You pay the required premiums as discussed below.

If Your covered Dependent is not age 65 or older (if Medicare is the primary payer of claims), or otherwise eligible for Medicare on a primary-payer basis when You first become eligible for the Medicare Secondary Plan coverage, Your covered Dependent will become eligible for coverage effective the first day of the month of Your Dependent's 65th birthday or the first of the previous month if Your birthday is the first of the month (if Medicare is the primary payer of claims), or earlier if Medicare eligible.

If Your covered Dependent is age 65 or Medicare eligible prior to Your eligibility under the Plan, Your covered Dependent's coverage begins effective the first day of the month of their 65th birthday or the first of the previous month if Your birthday is the first of the month or Medicare eligibility. In all cases, You must be covered under the Health Program or be participating in and meet the rules under the Retiree Medical Program pre-65 waiver program.

Coverage will continue, as long as the enrolled adult Dependent Child continues to meet the conditions with the terms of the Plan. You may also need to provide proof of continued disability from time to time to maintain coverage.

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible Dependents regardless if You will be enrolling them in a medical plan at the time of retirement. If You and/or Your dependents are waiving retiree coverage, by declaring your eligible Dependents You are maintaining their future eligibility to enroll at a later date if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of Your retirement will not be allowed to participate in the BMO Retiree Medical Program in the future, with the exception of new biological or adopted Children. (You will need to notify the Human Resources Centre at 1-888-927-7700 within 31 days of the birth or adoption).

The Dependent must meet the definition of an eligible dependent at the time of Your retirement and at the time You request to enroll them in coverage. You are only able to add the following Dependents to Your medical coverage at a later date if they continue to meet the dependent definition, as applicable:

- Your legal spouse or Your qualified Domestic Partner at the time of Your retirement date.
- Your existing eligible Dependent Children at the time of Your Retirement.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Retiree will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify the Human Resources Department Centre at 1-888-927-7700 regarding status changes.

ANNUAL ENROLLMENT PROVISION

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual enrollment period, the following shall apply:

- The employer will give eligible Retirees written notice prior to the start of an annual enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage shall be January 1 following the annual enrollment period

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Retirees.

Retirees are not able to add newly acquired Dependents onto their coverage, unless that Dependent was eligible at the time of their retirement. The retiree would, however, be able to add any new biological child or adopted child.

LOSS OF HEALTH COVERAGE

Current retirees and their eligible Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage and are otherwise eligible under this Plan. Your loss of other health coverage triggers special enrollment rights only if other coverage was in effect at the time You declined coverage. The Plan will not recognize Your special enrollment right due to a loss of coverage if other coverage was not in effect at the time You declined enrollment or you were not otherwise eligible for the plan prior to the loss.

You and/or Your dependents may enroll for health coverage under this Plan due to loss of health coverage if the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was first offered; and

- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

1. Under a federal COBRA continuation provision and that coverage was exhausted; or
2. Under another type of coverage and that coverage terminated as a result of: (a) loss of eligibility for the coverage due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or (b) The current or former employer no longer contributes towards the coverage; and
3. Under either 1 or 2 above, the coverage was not terminated due to the person's failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact; and

- You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

CHANGE IN FAMILY STATUS

If a person becomes your eligible Dependent through marriage, birth, adoption or Placement for Adoption, and you or your Dependent(s) did not have other health coverage as listed above, and are otherwise eligible under this Plan, and did not enroll when first eligible, then the Plan will provide for a special enrollment period.

The Retiree, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must apply for coverage within 31 calendar days of marriage. For the birth, adoption or Placement for Adoption of a new Dependent You must apply for coverage within 90 calendar days of that birth, adoption, or placement for adoption. (Other Dependent(s), such as siblings of a newborn or adopted child are not entitled to special enrollment rights upon the birth or adoption of a child).

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If You properly apply for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of loss of coverage, on the following loss of coverage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state’s Medicaid plan or state child health plan, as of the date of the event.

TERMINATION

ALL PARTICIPANTS

You may drop coverage under the Retiree Medical Program at any time. Coverage then ends on the last day of the month in which the company receives written notification, provided you have paid all premiums on time. If you choose to discontinue your coverage, you permanently give up your right to future coverage under the plan for you and your Dependent(s)/eligible individual(s).

A participant's coverage under the Plan shall end on the earliest of the following dates:

- The date the Plan terminates.
- The date the participant dies; however, in the case of retiree coverage, the Dependents/eligible individual(s) of the Retiree will continue to have coverage based on the Retiree's retiree status subject to all other reasons of Termination.
- The first day of the calendar month for which a participant's required contribution has not been fully paid.
- For a covered Retiree's Dependent/eligible individual(s) who is a participant, the date the covered employee's coverage terminates.

SPOUSE

Coverage under the Plan shall end on the earliest of the dates in subsection "All Participants". Coverage shall also end on the last day of the calendar month in which the spouse is no longer married to the Retiree due to divorce or annulment.

DOMESTIC PARTNER

Coverage under the Plan shall end on the earliest of the dates as described in "All Participants." Coverage shall also end on the last day of the calendar month in which the Domestic Partner no longer qualifies as a Domestic Partner under the definition of a Dependent/Domestic Partner.

RETROACTIVE CANCELLATION OF COVERAGE

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

COBRA CONTINUATION OF COVERAGE

The COBRA Administrator for this Plan is:
PAYFLEX SYSTEMS USA, INC.
PO BOX 953374
ST. LOUIS MO 63195-3374

Additional information about COBRA coverage is available in the general notice. To receive another copy of the general notice, contact the COBRA administrator or visit www.bmousbenefits.com, Forms/Docs, Legal Notices.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage ends, Your covered Dependents may be eligible to continue your coverage for a limited period. To be eligible, a "qualifying event" causing the loss of coverage for You or Your Dependent must take place. Qualifying event include:

- Your divorce or legal separation.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

You may have certain rights related to military leave pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 or similar federal laws ("USERRA"). The Plan will comply with all such legal requirements. If You have questions about your rights under USERRA please contact the Plan Administrator.

LIMITED MEDICAL EXPENSE BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when the Plan receives proof that he/she was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for sickness or Injury. The following benefits are payable during a Benefit Period:

- The Plan pays the Part A Deductible for first 60 days.
- From day 61 through day 90, the Plan will pay the Part A Medicare daily coinsurance charge for Eligible Expenses.
- After day 90, while the Covered Person uses his Medicare Lifetime Reserve Days, the Plan will pay the Part A Medicare daily coinsurance charge for Eligible Expenses.
- When a Covered Person exhausts all Medicare Part A Hospital benefits, including the Medicare Lifetime Reserve Days, the Plan will pay 100% of Medicare eligible Hospital expenses for each day of Confinement for an additional 365 days per person per lifetime.

BLOOD BENEFIT – PART A

The Plan will pay 100% of the Actual Expenses for the first three pints of blood the Covered Person receives in a Calendar Year while confined in a Hospital or Skilled Nursing Facility. Only blood which is not replaced or not already covered by Part B is an eligible expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when the Plan receives proof that, while covered, incurred Part B Medicare Eligible Expenses. The expense must be for a sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

- After a Covered Person's Deductible is satisfied, the Plan will pay for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person as shown on the Benefit Schedule.

If the Covered Person discontinues or lapses his/her Part B Medical Insurance under Medicare, The Plan will not pay any benefits for incurred expenses that would otherwise have been covered under the terms of the Plan.

BLOOD BENEFIT – PART B

The Plan will pay 100% of the Actual Expenses for the first three pints of blood the Covered Person receives in a Calendar Year. Only blood which is not replaced or not already considered under Part A is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Part B Deductible or any additional payment not covered by Medicare.

Additional Medicare eligible blood charges will be subject to the Part B deductible and paid the same as any other Part B Medicare Eligible Expense. The Plan pays nothing after the first 3 pints.

OTHER BENEFIT PROVISIONS

The benefits provided under the Plan will automatically change to coincide with any changes in the Medicare Deductible or any additional payment not covered by Medicare.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Plan or by Medicare.

Benefits are subject to all the terms of the Plan.

COVERED MEDICAL BENEFITS

This Plan covers a portion of the same Medically Necessary benefits that Medicare covers, subject to any limitations that Medicare has.

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits.

2. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically-appropriate Hospital.

3. **Anesthetics and Their Administration.**

4. **Autism Spectrum Disorders (ASD) Treatment**, when Medical Necessity is met.
   (ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).
   ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy.
   Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).
   If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 25 hours per week for 3-6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.
   Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).
   Does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

5. **Breast Pumps** and related supplies. Contact the Claims Administrator regarding limits on frequency, duration, or type of equipment that is covered.

6. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

7. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

8. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who meet medical policy criteria. The cardiac rehab must begin within 90 days of the cardiac event and completed within six months of the event.

   Services covered include:

   - Phase I, while the Covered Person is an Inpatient.
   - Phase II, while the Covered Person is in a Physician-supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

9. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

10. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

11. **Contraceptives and Counseling For Women Only:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

12. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs.

13. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as any other Illness.

14. **Durable Medical Equipment** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds, and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.

15. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

16. **Foreign Country Travel Emergency Care,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits of this SPD.

17. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

18. **Eye Refractions** if related to a covered medical condition.

19. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

20. **Gender Dysphoria:**

    Benefits for the treatment of Gender Dysphoria, limited to the following services:

    - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.
    - Cross-sex hormone therapy:
        - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) as described in the Mental Health Benefits section of this SPD.
        - Cross-sex hormone therapy dispensed from a pharmacy as described in the Prescription Drug Benefits section of this SPD.
    - Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
    - Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
    - Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:
      Male to Female:
        - Clitoroplasty (creation of clitoris)
        - Labiaplasty (creation of labia)
        - Orchiectomy (removal of testicles)
        - Penectomy (removal of penis)
        - Urethroplasty (reconstruction of female urethra)
        - Vaginoplasty (creation of vagina)

      Female to Male:
        - Bilateral mastectomy or breast reduction
        - Hysterectomy (removal of uterus)
        - Metoidioplasty (creation of penis, using clitoris)
        - Penile prosthesis
        - Phalloplasty (creation of penis)
        - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
        - Scrotoplasty (creation of scrotum)
        - Testicular prosthesis
        - Urethroplasty (reconstruction of male urethra)
        - Vaginectomy (removal of vagina)
        - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - The Covered Person must complete at least 12 months of successful, continuous, full-time, real-life experience in the desired gender.
  - The Covered Person must complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan must be based on identifiable external sources, including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Coverage does not include procedures that are cosmetic as stated in the General Exclusions section of this SPD. Cosmetic procedures include, but are not limited to, the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Injection of fillers or neurotoxins.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.

- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's Apple).
- Voice lessons and voice therapy.
- Voice modification surgery.

21. **Hearing Services** include:

    - Exams, tests, services and supplies to diagnose and treat a medical condition.

22. **Home Health Care Services:** (Refer to the At Home Recovery Visits Benefit Provision of this SPD).

23. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

24. **Hospital Services (Includes Inpatient Services, Surgical Centers and Inpatient Birthing Centers).** The following benefits are covered:

    - Semi-private room and board.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services. (private duty nursing and personal care items are not covered)
    - Blood, blood plasma and plasma expanders, when not available without charge.

    Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

25. **Hospital Services (Outpatient).**

    Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

26. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.

27. **Learning Disability:** Special education, remedial reading, school system testing, and other rehabilitation treatment for a Learning Disability except for services that should be legally provided by a school.

28. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary.

29. **Maternity Benefits** for the Retiree or spouse include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Midwives.

30. **Mental Health Treatment** (Refer to the Mental Health Benefits section of this SPD).

31. **Nursery and Newborn Expenses Including Circumcision** are covered for the following Children of the covered Retiree or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

32. **Occupational Therapy.** (See Therapy Services below)

33. **Oxygen and Its Administration.**

34. **Physical Therapy.** (See Therapy Services below)

35. **Physician Services** for covered benefits.

36. **Preventive / Routine Care** as listed under the Schedule of Benefits.
    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Well-Woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

        - Screening for gestational diabetes;
        - Human papillomavirus (HPV) DNA testing;
        - Counseling for sexually transmitted infections;
        - Counseling and screening for human immune-deficiency virus;
        - Screening and counseling for interpersonal and domestic violence; and
        - Breast cancer genetic test counseling (BRCA) for women at high risk.

Please visit the following links for additional information:

https://www.healthcare.gov/preventive-care-benefits/
https://www.healthcare.gov/preventive-care-benefits/children/
https://www.healthcare.gov/preventive-care-benefits/women/

37. **Qualifying Clinical Trials** as defined below, including routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  - *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the Veteran's Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or

- The *Department of Veterans Affairs*, the *Department of Defense,* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
  - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

38. **Radiation Therapy and Chemotherapy.**

39. **Radiology and Interpretation Charges.**

40. **Reconstructive Surgery** includes:

    - Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

41. **Respiratory Therapy.** (See Therapy Services below)

42. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

43. **Skilled Nursing Facility Care**: The Plan will pay for care when a Covered Person is transferred to a Skilled Nursing Facility from a Hospital if:

    - The Covered Person was hospitalized for 3 or more consecutive days, not including the day You leave the Hospital; and
    - You enter the Skilled Nursing Facility within 30 days after leaving the Hospital for the same or related reason that You were in the Hospital, as required by Medicare; and
    - Your doctor has stated that You need daily skilled care and that it must be provided by skilled nursing or rehabilitation staff.

    Benefits are shown in the Schedule of Benefits of this SPD. (See Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility)

44. **Speech Therapy.** (See Therapy Services below)

45. **Sterilizations.**

46. **Substance Use Disorder Services** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

47. **Surgery and Assistant Surgeon Services.**

48. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT), or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT), or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
    - **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

49. **Tobacco Addiction:** Preventive / Routine benefits as required by applicable law.

50. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

51. **X-ray Services** for covered benefits.

AT-HOME RECOVERY VISITS BENEFIT PROVISION

The Covered Person will receive a benefit when the Plan receives proof that the Covered Person required At-Home Recovery Visits due to a sickness or Injury.

The At-Home Recovery services must be primarily services that assist the Covered Person in Activities of Daily Living.

The Covered Person's Physician must certify that the specific type and frequency of At-Home Recovery Visits are Medically Necessary because of a condition for which a home care Plan of Treatment was approved by Medicare.

The At-Home Recovery Visits benefit will be limited to:

- No more than the number and type of At-Home Recovery Visits certified as Medically Necessary by the Covered Person's Physician. The total number of At-Home Recovery Visits will not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care Plan of Treatment;
- Seven (7) visits in any one week;
- Care furnished by a Care Provider, as defined below;
- Care furnished on a visiting basis in the Covered Person's home;
- At-Home Recovery Visits received while the Covered Person is covered under the Plan;
- At-Home Recovery Visits received during the period the Covered Person is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

The Plan will not consider those expenses incurred for:

- At-Home Recovery Visits paid for by Medicare or other governmental programs unless required by law; and
- Care provided by family members, unpaid volunteers or providers who are not Care Providers.

Care Provider means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses' registry.

The maximum Benefit Amount for each visit and the Maximum Benefit Amount per Calendar Year are shown on the Benefit Schedule.

Benefits are payable in accordance with the Benefit Schedule of the Plan.

FOREIGN COUNTRY TRAVEL BENEFIT PROVISION (Medically Necessary Emergency Care)

The Covered Person will receive a benefit when the Plan receives proof that he incurred expenses for Medically Necessary Emergency Hospital, Physician or medical care while in a foreign country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside of the United States.

Only those billed expenses that would have been considered Medicare Eligible Expenses, had the care been provided in the United States, will be considered under this benefit.

The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown on the Benefit Schedule, before expenses are payable under this benefit.

This benefit is subject to the following conditions:

- the Covered Person's primary residence is in the United States; and
- the treatment rendered must be for an Injury or sudden and unexpected onset of a sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, the Plan will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses.

The Plan will pay the Benefit Amount shown in the Benefit Schedule.

Benefits are payable in accordance with the Benefit Schedule of the Plan.

PART A DEDUCTIBLE BENEFIT RIDER

The Covered Person will receive a benefit when the Plan receives proof that the Covered Person incurred Part A Medicare Eligible Expenses.

These expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare-approved expenses will be payable under this benefit.

The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

Benefits are payable in accordance with the Benefit Schedule of the Plan.

PART B ADDITIONAL COVERAGE BENEFIT RIDER

The Covered Person will receive an additional benefit when The Plan receives proof that the Covered Person incurred Part B Medicare Eligible Expenses.

The Plan will pay the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law), and the Medicare Part B Eligible Expense.

However, in no event will the amount paid under this benefit exceed the Maximum Benefit Amount shown on the Benefit Schedule.

Benefits will not be paid if the Covered Person's Physician or medical service provider accepts the Medicare Eligible Expenses as the total amount due.

Benefits are payable in accordance with the Benefit Schedule of the Plan.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders and chemical dependency. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, half-way houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to Prescription benefits, or to benefits provided under an individual Medigap policy**. Prescription drug coverage under Medicare Part D will be coordinated under the Medicare Secondary Payer Rules. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount which will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays or Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as Skilled Nursing Care.
- Medical benefits under group or individual automobile policies. See order of benefit determination rules and General Exclusions: No-Fault State for details (below).
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.
- Medical benefits under homeowner's insurance policies.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- Any plan that has no coordination of benefits provision will pay first.

- The Plan will coordinate benefits in a manner that will comply with the Medicare Secondary Payer (MSP) regulations. The following are examples of how the MSP rules work:

    - If You or Your Dependent are actively employed and covered under an employer's group health plan or policy, the active plan pays first for both the employee and the spouse. Medicare pays second, and any retiree health care coverage would pay third.
    - If You and Your spouse are retired and age 65 or older, Medicare pays first and any retiree plan pays second.
    - For a Covered Person with End Stage Renal Disease (ESRD), an employer's group health plan covering active employees has primary responsibility for payment for 30 months from the date the Covered Person has Medicare eligibility based upon ESRD. At the end of 30 months, Medicare becomes the primary plan, any employer group health plan covering active employees would pay second, and any retiree plan would pay third.

- When medical payments are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- The plan that covers the person as an employee, member or subscriber (that is, other than as a Dependent) is considered primary. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or Retirees.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is secondary, unless both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. In that case the plan that covers a person as a Dependent is primary (see continuation coverage below).

- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:
    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary, unless the Medicare Secondary Payer rules require COBRA to be primary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored.

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or Retiree longer is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
  - Domestic Partners are excluded as provided by Medicare. Refer to Medicare.gov for more information.
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse has retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except to the extent required by federal law or as otherwise specified.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. UMR will normally send payment for Covered Expenses directly to the Covered Person's provider.

ASSIGNMENT OF BENEFITS

UMR will normally send payment for Covered Services directly to Your provider. If You have already paid Your provider for all costs, You will need to submit verification of the paid claim to UMR for reimbursement of Covered Benefits under this Plan.

An assignment of benefits does not mean that Your provider is Your Personal Representative as explained below.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will coordinate payment directly with Medicare on the Covered Person's behalf. If the Covered Person gives UMR his or her Medicare identification number, then Medicare will automatically send information to UMR stating how much Medicare has paid toward Covered Expenses, and how much the Covered Person is responsible for paying. If Medicare states that the Covered Person owes a certain amount toward the bill, then UMR will process the claim according to the provisions in this document to see if this Plan can help cover some of the Covered Person's remaining costs.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the Provider is paid. Covered Persons will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

Because Your Prescription benefits are a component of Your Group Medical Plan, the same circumstances that could cause a loss of denial of Plan benefits under the Group Medical Plan could cause a loss or denial of Prescription Drug benefits.

TIMELY FILING

Complete claims must be submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

NOTIFICATION OF BENEFIT DETERMINATION

Each time a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, please feel free to call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted. EOBs for a prescription drug will only be provided if they are part of a medical claim. Prescription drug benefits are generally determined at the point-of-sale and do not generate an EOB.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment authorization ending or being reduced.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, the Covered Person will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an Explanation of Benefits (EOB) form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. Please note that an appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the Explanation of Benefits (EOB) form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the written EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this document.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal, have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal seven days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this document.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this document for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

CLAIMS REGARDING ELIGIBILITY TO BE COVERED BY THE PLAN

All claims and claims appeals regarding payments for health benefits will be decided by UMR as described above. Claims regarding entitlement to be covered under the Plan (and appeals of those claims) will be decided by BMO FINANCIAL CORP. and should be addressed to:

BMO FINANCIAL CORP.
C/O APPEALS
DEPT 14613
PO BOX 64050
THE WOODLANDS TX 77387-4050

EFFECT OF CLAIMS DECISIONS

UMR with respect to claims for benefits, and BMO FINANCIAL CORP., with respect to eligibility claims, have full and sole discretionary authority to interpret all plan documents and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of the plan. Any final decision by UMR, with respect to claims for benefits, and BMO FINANCIAL CORP., with respect to eligibility claims, shall be final and legally binding on all parties. Any such decision shall not be subject to de novo judicial review unless it is arbitrary or capricious or otherwise an abuse of discretion. Any judicial review of such a decision shall be based only on the evidence presented to or considered by UMR or BMO FINANCIAL CORP., as the case may be, at the time it made the decision that is subject to review.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure (other than a pre-determination of benefits). The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fail to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, A Covered Person has the right to further appeal an Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on his or her appeal.**

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the employer determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

UNCASHED CHECKS

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

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive).

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION (QMCSO)

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Plan Notice of Nondiscrimination

BMO FINANCIAL CORPORATION (BMO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BMO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
BMO:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If You need these services, contact the Privacy Officer, Director of Benefits, by emailing BMOHR.USBenefits@BMO.com.

If You believe that BMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance with: the Privacy Officer, Director of Benefits, by emailing BMOHR.USBenefits@BMO.com. You can file a grievance in person or by mail, fax, or email. If You need help filing a grievance, Dennis Salentine, Director of U.S. Benefits, is available to help You.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You have the right to get help and information in your language at no cost. To request an interpreter, call 1-262-827-2855.

This letter is also available in other formats like large print. To request the document in another format, please call 1-262-827-2855.

Language	**Translated Taglines**
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-827-2855.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-262-827-2855.
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-262-827-2855.
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-262-827-2855.
Tagalog (Tagalog – Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-262-827-2855.
(Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 2855-827-262-1
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-262-827-2855.
ગુજરાતી (Gujarati)	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-262-827-2855.
(Urdu)	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-262-827-2855.
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-262-827-2855.
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-262-827-2855.
हिंदी (Hindi)	ध्यान दें: यिद आप हिंदी बोलते हैं तो आपकेलिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-262-827-2855.
Français (French)	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-262-827-2855.
λληνικά (Greek)	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-262-827-2855.
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-262-827-2855.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by ERISA.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons shall have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) 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 description. The Plan Administrator may make a reasonable charge for the copies.

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

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants. 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.

ENFORCING COVERED PERSONS' RIGHTS

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

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 per day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court after You have exhausted the Plan's claims procedure as described in this Summary Plan description. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If You have any questions about Your Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-866-444-3272.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Company fully intends to maintain this 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.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO EMPLOYMENT GUARANTEE

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

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Actual Expenses means the actual charges made by a Physician, Hospital or other medical service provider for services covered by the Plan, not to exceed the charge limitations established by the federal Medicare program or state law.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the-well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

At-Home Recovery Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the At-Home Recovery Care is in place of Hospital confinement, and specify the type and extent of At-Home Recovery Care required for the treatment of the Covered Person.

Benefit Period begins the day you go to a Hospital or under special circumstances, a Skilled Nursing Facility. The Benefit Period ends when you have not received Hospital or skilled nursing care for 60 days in a row. If you go into the Hospital after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have.

Calendar Year means January 1 through December 31.

Child (Children) means any of the following individuals with respect to an Retiree: a natural biological Child; a step-child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Retiree's or spouse's or Domestic Partner's Legal Guardianship; a Child of a Domestic Partner, or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Retiree, spouse, Domestic Partner, mother, father, grandmother, grandfather, step-parents, step-grandparents, siblings, step-siblings, half-siblings, Children, Domestic Partner's Children, step-children, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Company means BMO FINANCIAL CORP. who sponsors the group health plan.

Confined Or Confinement means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. He/she must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means a Retiree, LTD Participant or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means the amount of Covered Expenses that must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent as determined by the employer under the Employee Benefit Program of Bank of Montreal/Harris – see the Eligibility and Enrollment section of this SPD.

Domestic Partner means an unmarried person of the same sex with whom the covered Retiree shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else. A Domestic Partner certification is required to be completed and filed with the Plan at the time enrollment of the Domestic Partner is requested.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete an affidavit declaring that You and Your partner:

- Are in a relationship of mutual support, care, and commitment and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;

- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

Experimental, Investigational or Unproven means any drug, service, supply, care or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

  The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).

- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; Physician services; physical or occupational therapy; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency and is Qualified to receive payments under the Medicare program, or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the state in which they operate. The term "Hospital" does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section § 530 of the Internal Revenue Code.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Condition means a disease or condition likely to cause death within one year of the request for treatment.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Medicare Eligible Expenses means health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Part A Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

Part B Deductible means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. Medicare sets this amount.

Participating Pharmacy means a licensed entity, acting within the scope of its license in the state in which it dispenses, that has entered into a written agreement with Express Scripts and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: doctor of medicine (MD); doctor of medical dentistry including an oral surgeon (DMD); doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of optometry (OPT). Subject to the limitations below, the term Physician shall also include the following practitioner types: physician assistant (PA); nurse practitioner (NP); certified nurse midwife (CNM); or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Plan means the BMO FINANCIAL CORP. Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means a person who qualifies for coverage under the Retiree Medical Program.

Skilled Nursing Facility Care means an institution that has a transfer agreement with one or more Hospitals. For the most part, it provides inpatients with skilled nursing care and related services. The facility must be licensed by the state in which it operates as a Skilled Nursing Facility. Any service that could be safely done by an average non-medical person (or by one's self) without the supervision of a registered nurse is not considered skilled care.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well-being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That a Retiree is prevented from engaging in any job or occupation for wage or profit for which the Retiree is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

You / Your means the Retiree.

IMPORTANT NOTICE FROM BMO FINANCIAL CORP. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE FOR BENEFIT PLAN 001

Please read this notice carefully and keep it where You can find it. This notice has information about Your current prescription drug coverage with BMO FINANCIAL CORP., ("BMO") and about Your options under Medicare's prescription drug coverage. This information can help You decide whether or not You want to join a Medicare drug plan. If You are considering joining, You should compare Your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in Your area. Information about where You can get help to make decisions about Your prescription drug coverage is at the end of this notice.

There are two important things You need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. BMO has determined that the prescription drug coverage offered under the Employee Benefit Program of Bank of Montreal/Harris (the "Group Medical Plan of BMO") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because Your existing coverage is Creditable Coverage, You can keep this coverage and not pay a higher premium (a penalty) if You later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when You first become eligible for Medicare and each year from October 15th through December 7th.

However, if You lose your current creditable prescription drug coverage, through no fault of your own, You will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If You decide to join a Medicare drug plan, Your current BMO coverage will be affected. As You contemplate Your decisions around the choices that will be offered to You, consider the following options:

OPTION 1: Because You have existing prescription drug coverage through the Group Medical Plan of BMO that, on average, is as good as Standard Medicare Part D coverage, You can choose to keep Your prescription drug coverage through the Group Medical Plan of BMO and join a Medicare prescription drug plan at a later date without penalty because Your Group Medical Plan of BMO prescription drug coverage is considered creditable. See the section titled "*When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan*" below for more information about the late enrollment premiums and when they may apply.

OPTION 2: You may elect one of the new Medicare prescription drug plans and drop Your coverage under the Group Medical Plan of BMO; however, You will also be waiving your health coverage if You make this decision. If You decide to join a Medicare prescription drug plan and drop your BMO prescription drug coverage, be aware that You and Your dependents will not be able to re-enroll in BMO coverage (including medical coverage) at a later date.

LEGACY M&I EMPLOYEES: You may elect one of the new Medicare prescription drug plans and elect to retain Your medical coverage under the Group Medical Plan of BMO. If You make this decision, Your BMO health coverage will continue; however, Your BMO prescription drug coverage will end. If You later decide to cancel your Medicare prescription drug plan, the BMO prescription drug benefit will be reinstated but only if You have retained your BMO health coverage.

Cancellation of Your BMO coverage will mean that all of Your benefits, including the medical portion under the Group Medical Plan of BMO will be terminated.

If You are an active employee who is Medicare eligible or has a Medicare eligible covered dependent and You waive coverage for Yourself and/or Your Dependent, You may be able to re-enroll You and/or Your Dependent in the Group Medical Plan of BMO, but only during future annual enrollment opportunities or as a result of a qualified status event that necessitates a mid-year election change.

If You are a retired employee age 65 or older and drop Your coverage under the Group Medical Plan of BMO, You will not be able to re-enroll in the Group Medical Plan of BMO. In addition, any Dependents that are covered under any Group Medical Plan of BMO as a result of your eligibility would lose coverage and would not be able to re-enroll. If You choose to remain under the Group Medical Plan of BMO and waive coverage for your Medicare eligible dependent, re-enrollment in the Group Medical Plan of BMO may be available to them during future annual enrollment opportunities or as a result of a qualified status event that necessitates a mid-year election change.

For legacy M&I retirees, if You are an under age 65 retired employee with a covered Dependent that is Medicare eligible, and You waive coverage under the Group Medical Plan of BMO for your Medicare eligible covered Dependent, re-enrollment in the Group Medical Plan of BMO may be available during future annual enrollment opportunities or as a result of a qualified status event that necessitates a mid-year election change.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if You drop or lose your current coverage with BMO and don't join a Medicare drug plan within 63 continuous days after Your current coverage ends, You may pay a higher premium (a penalty) to join a Medicare drug plan later.

If You go 63 continuous days or longer without creditable prescription drug coverage, Your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that You did not have that coverage. For example, if You go nineteen months without creditable coverage, Your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as You have Medicare prescription drug coverage. In addition, You may have to wait until the following October to join.

For More Information about this Notice or Your Current Prescription Drug Coverage

Please contact the Human Resources Centre at 1-888-927-7700 for more information. NOTE: You'll get this notice each year. You will also get it before the next period You can join a Medicare drug plan, and if this coverage through BMO changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call Your State Health Insurance Assistance Program (see the inside back cover of Your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If You have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If You decide to join one of the Medicare drug plans, You may be required to provide a copy of this notice when You join to show whether or not You have maintained creditable coverage and, therefore, whether or not You are required to pay a higher premium (a penalty).

Date:	January 1, 2022
Name of Entity/	BMO Financial Corp.
Sender: Contact:	Human Resources Centre
Address:	111 W. Monroe, 7W, Chicago, IL 60603
Phone Number:	1-888-927-7700

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program is administered by Express Scripts. You will receive your Express Scripts prescription ID card shortly after You enroll. You must present your Express Scripts prescription ID card to a network pharmacy when you purchase prescriptions. This card is separate from the Medical Plan ID card You use for medical services. The cost of Your prescription will depend on where You get it filled and if it is a generic, preferred brand name or non-preferred brand name drug. Whether You choose retail or home delivery, Express Scripts offers You convenient, low-cost ways to fill your prescriptions.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. You may be able to postpone enrollment in the Medicare Prescription Drug coverage if Your current drug coverage is at least as good as Medicare Prescription Drug coverage. If You decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, You may have to pay an additional monthly penalty if You change Your mind and sign up later. You should have received a Notice telling You whether Your current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage. If You need a copy of this notice, please contact the Human Resources Centre at 1-888-927-7700.

Prescription Coverage at a Glance

The coverage availability for prescriptions is subject to the terms of the Plan. For specific medication information call the number on the back of your card or visit www.express-scripts.com and log into your account. If you are not yet a member visit the pre-member site at www.express-scripts.com/bmofinancialgroup. The way You and the Plan share in the cost of your prescription drugs varies based on the drug category, as show below.

Prescription medication category	Examples of medications in this category	Plan coverage
Affordable Care Act (ACA) Preventive Drug List	Aspirin products, fluoride products, folic acid products, contraceptive methods, smoking cessation products, vaccines, bowel preps and primary prevention of breast cancer	You pay $0*
Expanded Preventive Drug List	Maintenance medications to treat conditions such as high blood pressure, high cholesterol, diabetes, asthma and more	Deductible does not apply; You pay applicable copayment based on the Plan's cost share structure
Non-Preventive Prescription Drugs	All other covered prescription medications	You pay applicable copayment based on the Plan's cost share structure

** Not all prescriptions for the listed medications are covered at 100% and are subject to change. Specific criteria, exclusions, and other rules or limitations may apply to all categories (i.e. quantity limit, age, gender).*

PRESCRIPTION DRUGS **(Administered by Express Scripts, Specialty medications available through Accredo)**	**THE COVERED PARTICIPANT**
Retail Pharmacy	
Generic • *30-day supply* • *90-day supply*	$10 copayment
Preferred brand name • *30-day supply* • *31-90 day supply* ~~***Non-***~~	$30 copayment $30 copayment $90 copayment
~~***Preferred brand name***~~	100% of the cost, not covered
Home Delivery Service	
Generic • 90-day supply	$25 copayment
Preferred brand name • 90-day supply	$75 copayment
Non-Preferred brand name	100% of the cost, not covered
Injectable Insulin **Diabetic Supplies**	No copayment, covered at 100% Covered under medical

- If You request a brand-name medication when a generic equivalent is available, You will pay the **generic copayment, plus the difference in cost** between the brand and the generic. If You are not able to take a generic equivalent due to medical necessity, Your doctor may request a review and provide supporting documentation on why the brand is medically necessary. If approved by Express Scripts, You will pay the brand copayment.

- Manufacturer-funded patient assistance for widely distributed specialty medications will not be considered as true out-of-pocket expenses and may not apply to deductible and out-of-pocket maximums.

Prescription Drug Formulary

The Plan includes a list of preferred drugs (generic and brand name) that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs are not covered under the prescription drug program. The Plan's Formulary is updated periodically and subject to change, to get the most up-to-date drug information go online to www.express-scripts.com/bmofinancialgroup or call Express Scripts Member Services at 1-877-795-2926.

Formularies can help You save money by alerting you to more affordable and clinically effective medications. Drugs chosen for the formulary have gone through an extensive review process, guided by an independent panel of clinical experts that review quality and efficacy (they're known to work well, with minimal side effects), safety and cost-effectiveness. In addition:

- a drug may be moved to a higher or lower cost-sharing Formulary tier;
- additional drugs may be excluded from the Formulary;
- a restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization);
- a Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is:

- medically necessary and essential to the Covered Person's health and safety and/or
- all Formulary drugs comparable to the excluded drug have been tried by the Covered Person

If approved through that process, the applicable Formulary copayment would apply for the approved drug based on the Plan's cost share structure. Absent such approval, Covered Persons selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Drug Quantity Management, Prior Authorization, and Step Therapy Programs

The Prescription Drug Program utilizes Drug Quantity Management, Prior Authorization and Step Therapy Programs.

- For Drug Management, certain medications have limits to ensure you get the right medicine in the right amount.

  Here's how Drug Quantity Management works

  The Food and Drug Administration (FDA), medical researchers and medicine manufacturers look at individual medicines to determine a recommended maximum quantity considered safe. Drug quantity management provides the medication You need for Your health and the health of Your family, while making sure You receive them in the amount – or quantity – considered safe, according to the drug manufacturers, the FDA, and the most up-to-date clinical information.

- For Prior Authorization, certain medications require Your doctor to ask for and receive approval before they are approved for coverage.

  Here's how Prior Authorization works

  Express Scripts pharmacists regularly review the most current research on newly approved medicines and existing medicines and consult with independent licensed doctors and pharmacists to determine which medicines have been proven to be effective.

  The first time You try to fill a prescription that needs prior authorization Your pharmacist should explain that more information is needed from Your doctor to determine whether the medicine is covered by our plan. The pharmacist should ask Your doctor to call the Express Scripts Prior Authorization department to initiate a coverage review.

- For Step Therapy, certain medications, typically generic or low-cost brands, are used before other more costly medications are covered.

Here's how Step Therapy works

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medicines for the step therapy program. Together, they review the most current research on thousands of prescription medicines tested and approved by the Food and Drug Administration (FDA). Then they determine the most appropriate medicines to include in the program. Medicines are then grouped in categories, or "steps".

First-line medicines – These are the first step and are typically generic and lower-cost brand-name medicines. They are proven to be safe and effective, as well as affordable. In most cases, they provide the same health benefit as more expensive medicines, but at a lower cost.

Second-line medicines – These are the second and third steps and are typically brand-name medicines. They are best suited for the few patients who don't respond to first-line medicines. They're also the most expensive options.

Log in to Your account at express-scripts.com or call Express Scripts at the number on Your member ID card to find out if step therapy applies to the medicine Your doctor prescribed. If it does, You can see a list of first-line alternatives. You can give that list to Your doctor to choose the medicine Your plan covers that best treats Your condition.

The first time You try to fill the prescription, whether it's in person or submitted to the Express Scripts Pharmacy℠ to be delivered, Your pharmacist should explain that step therapy requires You to try a first-line medicine before a second-line medicine is covered. Since only Your doctor can change Your current prescription, either You or Your pharmacist need to speak with Your doctor to request a first-line medicine that's covered by Your plan. If You need Your prescription right away, You may ask Your pharmacist to fill a small supply until You can consult Your doctor. NOTE: You might have to pay full price for this small supply.

For information on formulary medications, Drug Quantity Management, Prior Authorization or Step Therapy programs contact Express Scripts at 1-877-795-2926. To inquire about specific medications, search medications directly by logging into Your account at www.express-scripts.com, or if You are not yet a member, visit the pre-member site at www.express-scripts.com/bmofinancialgroup.

Retail Pharmacy Network

Express Scripts has a large number of participating retail pharmacies across the country where You can purchase smaller quantities of prescriptions to be used for 30 days or less. For example, if Your doctor prescribes short-term antibiotics, or You need to quickly get your initial supply of a maintenance drug, just go to a participating retail network pharmacy and present your Express Scripts prescription ID card and pay the applicable copayment.

For a listing of participating network pharmacies, visit www.express-scripts.com, or call Member Services at 1-877-795-2926. If You use a non-participating pharmacy, You must pay the full cost of the prescription and submit for reimbursement. The reimbursement level will be based upon the cost of the drug if You had used a participating network pharmacy. You will be responsible for the amount above the discounted in network pharmacy rate plus the required copayment.

Home Delivery

Home delivery, also referred to as mail order, is designed for longer-term medication supplies of up to 90 days, such as maintenance drugs for chronic conditions like high blood pressure or diabetes. When You need longer term prescriptions, using home delivery saves You both time and money. Complete the mail order form in Your welcome packet or ask Your doctor to fax your prescription to Express Scripts.

You can request this form by visiting www.express-scripts.com. If You are a first-time visitor, take a moment to register. Please remember to have Your member ID number and a recent prescription number handy. If You do not have a recent prescription number, You may still register; just remember to add a prescription number later so that You can fully manage Your prescription benefit online. Once logged in, on the ***Benefits*** tab, simply click on ***Forms & Cards***.

Specialty Drug Program through Accredo

Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. For these types of prescriptions, You are required to fill Your prescriptions through Express Scripts' dedicated specialty pharmacy, Accredo Health Group, Inc.

You may call Member Services at 1-877-795-2926 for information on how to order Your specialty medications or to find out more information about Accredo.

What's Covered Under Prescription Drugs

Benefits are provided only if the drugs are prescribed by a physician, deemed medically necessary and considered eligible under the plan. Covered drugs may be subject to Express Scripts' clinical programs, including but not limited to prior authorization, step therapy, quantity limits and refill too soon.

Generally, covered drugs include federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription), as well as certain compound prescriptions containing at least one legend ingredient and approved by this plan, including:

- androgens and anabolic steroids;
- contraceptive emergency kit;
- emergency allergic kits;
- glucagon emergency kits;
- growth hormones;
- hemophilia factors;
- impotency treatment drugs;
- insulin;
- infertility medications;
- influenza treatments;
- inhaler assisting devices;
- migraine medication;
- non-insulin syringes with or without needles;
- oral contraceptives;
- prescription drugs used to treat chemical abuse;
- prescription and over-the-counter smoking cessation aids for those 18 years and older;
- prescription anti-obesity medications topical vitamin A derivatives;
- prescription vitamins, including prenatal, hematinics, aspirin (for males age 45 – 79; for women age 55 – 79), folic-acid (for females through age 50), vitamin D preparations, iron (for children up to age one) and pediatric fluoride (for children up to age six);
- standard self-injectable medications on Express Scripts' standard drug list;
- specialty medications on Express Scripts' specialty drug list;
- synagis.

What's Not Covered under Prescription Drugs The

Prescription Drug Program does not cover:

- acts of war: injury or illness caused or contributed to be international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;
- allergy serums;
- any charge for the administration of prescription products;
- all illegal medications or supplies, even if prescribed by a duly licensed medical professional;
- any medication, prescription or non-prescription which is taken or administered at the place where it is dispensed;
- any medication which is meant to be taken by or administered in whole or in part while the covered person is treated at a hospital, physician's office or extended care facility, but is instead self-administered or administered elsewhere, unless expressly designated by the pharmacy benefits administrator;
- charges that are in access of the contracted amount;
- claims received later than 12 months from the date of service;
- compound prescriptions unless approved by this plan;
- compounded prescriptions delivered through home delivery, except for specialty prescriptions through a specialty pharmacy;
- continuous glucose monitors, transmitters and sensors;
- difference in cost between a generic product and brand product when the medical professional has not specified a brand product or has not indicated that the brand product is necessary;
- duplicate services and charges or inappropriate billing;
- glucoWatch products;
- hair growth stimulants and products indicated only for cosmetic use;
- injectable contraceptives;
- insulin pumps and supplies;
- insulin and disposable insulin syringes/needles;
- nutritional supplements;
- over-the-counter contraceptives;
- over-the-counter diabetic supplies, including alcohol swabs, lancets, urine and blood strips and tapes, blood glucose testing monitors, insulin syringes with or without needles and hyperglycemic products;
- over-the-counter products, unless specifically provided under this plan;
- non-specialty implantable medications;
- non-systemic prescription contraceptives (i.e. diaphragm, cervical caps, etc.);
- prescription medications which are administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that requires a physician's prescription;
- prescription products that are not dispensed by a licensed pharmacist or medical professional;
- prescription products dispensed in a foreign country if you traveled solely for the purpose of reimporting prescription drugs into the United States and/or you used other means to ship or bring prescription products from a foreign country into the United States;
- prescription products that may be received without charge under local, state or federal programs, including worker's compensation;
- prescription products that require prior authorization or any other clinical process in which the prescription was denied or was needed and not requested;
- prescriptions and prescription refills which exceed the Plan's quantity limits;
- prescriptions or supplies rendered before coverage begins under this Plan or after coverage ends;
- refilling a prescription in excess of the number specified on the prescription or any refill dispensed after one year from the order of the medical professional;

- replacement prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.

If Your requested medication or supply is not covered, in whole or in part, You still have the right to purchase that product, however the entire cost of the product will be your responsibility.

Claiming Benefits

Limitation of Action

You cannot bring any legal action against BMO Financial Corp. or the claims administrator to recover reimbursement until 90 days after You have properly submitted a request for reimbursement as described in this section and all required reviews of Your claim have been completed. If You want to bring a legal action against BMO Financial Corp. or the claims administrator, You must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or You lose any rights to bring such an action against BMO Financial Corp. or the claims administrator. You cannot bring any legal action against BMO Financial Corp. or the claims administrator for any other reason unless You first complete all the steps in the appeal process described in this section. After completing that process, if You want to bring a legal action against BMO Financial Corp. or the claims administrator You must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against BMO Financial Corp. or the claims administrator.

Mandatory Venue

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

If You do not present your prescription drug ID card at the time of Your purchase at the retail pharmacy, or if You purchase Your prescription from a non-participating pharmacy, You will have to submit the claim Yourself to Express Scripts. You can request this form by visiting www.express-scripts.com. If You are a first-time visitor, take a moment to register. Please remember to have Your member ID number and a recent prescription number handy. If You do not have a recent prescription number, You may still register; just remember to add a prescription number later so that You can fully manage your prescription benefit online.

Once logged in, on the ***Benefits*** tab, simply click on ***Forms & Cards***, and then click on the link to print the retail prescription drug claim form. You can save time and submit Your claim online or request claim forms to be mailed to You.

The amount that You will be reimbursed for using a non-participating pharmacy will be based upon the cost of the drug if You had used a participating network pharmacy. You will be responsible for the amount above the discounted in network pharmacy rate plus the required copayment/coinsurance. The reimbursement claim is generally responded to within 10 business days.

Claim Denials and Appeals

In the event You receive an adverse benefit determination following a request for coverage of a prescription benefit claims, You have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by You or Your authorized representative (such as Your physician). To initiate an appeal for coverage, provide in writing Your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge
Parkway Irving, TX 75063

A decision regarding Your appeal will be sent to You within 15 days of receipt of Your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to Your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to receive, upon request and at no charge, the information used to review Your appeal.

If You are not satisfied with the coverage decision made on appeal, You may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by You or Your authorized representative (such as Your physician). To initiate a second level appeal, provide in writing Your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge
Parkway Irving, TX 75063

You have the right to review Your file and present evidence and testimony as part of Your appeal, and the right to a full and fair impartial review of Your claim. A decision regarding Your request will be sent to You in writing within 15 days of receipt of Your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to Your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review Your second level appeal. If new information is received and considered or relied upon in the review of Your second level appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding.

If Your second level appeal is denied and You are not satisfied with the decision of the second level appeal or Your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA, You also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving urgent care, You will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, You will be notified within 24 hours after receipt of Your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If You don't provide the needed information within the 48-hour period, Your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if You request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or Your physician may call 1-800-864-1135 or send a written request to:

Express Scripts
8111 Royal Ridge
Parkway Irving, TX 75063
Attn: Urgent Appeals

In the case of an urgent appeal for coverage involving urgent care, You will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review Your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if Your appeal is denied or Your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize Your life or health or your ability to regain maximum function You could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided You simultaneously file Your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

For Direct Claims

Your plan provides for reimbursement of prescriptions when You pay 100% of the prescription price at the time of purchase. This claim will be processed based on Your plan benefit. To request reimbursement You will send Your claim to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

If Your claim is denied, You will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30 day period if additional information is needed to process the claim and a one-time extension not longer than 15 days may be requested and Your claim pended until all information is received. Once notified of the extension, You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, You will be notified of the denial within 15 days after the information is received. If You don't provide the needed information within the 45-day period, Your claim will be deemed denied.

If You are not satisfied with the decision regarding Your benefit coverage or Your claim is deemed denied, You have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, You or Your authorized representative (such as Your physician), must provide in writing Your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge
Parkway Irving, TX 75063

A decision regarding Your appeal will be sent to You within 30 days of receipt of Your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to Your appeal, the plan provision on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to receive, upon request and at no charge, the information used to review Your appeal. If You are not satisfied with the coverage decision made on appeal, You may request in writing, within 90 days of receipt notice of the decision, a second level appeal. A second level appeal may be initiated by You or Your authorized representative (such as Your physician). To initiate a second level appeal, provide in writing Your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to our appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge
Parkway Irving, TX 75063

You have the right to review Your file and present evidence and testimony as part of Your appeal, and the right to a full and fair impartial review of your claim. A decision regarding Your request will be sent to You in writing within 30 days of receipt of Your written request for appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to Your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review Your second level appeal. If new information is received and considered or relied upon in the review of Your second level appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding.

If Your second level appeal is denied and You are not satisfied with the decision of the second level appeal or Your adverse benefit determination notice or final adverse benefit determination notice does not contain all the information required under ERISA, You also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

RETIREE MEDICAL PROGRAM APPENDIX

Employee Benefit Program of Bank of Montreal/Harris

About This Summary

This is the Summary for the BMO Financial Group U.S. Retiree Medical Program ("the Retiree Medical Program" or "the Plan"), a participating plan in the Employee Benefit Program of Bank of Montreal/Harris. The Company reserves the right to discontinue, amend or replace the Plan at its discretion at any time for any reason. If you have further questions about the Retiree Medical Program, please contact the Human Resources Centre at 1-888-927-7700. The official plan document contains the full Plan details. If the Summary Plan Description or any oral representation differs from the Plan document, the Plan document prevails.

Retiree Eligibility

You and your eligible dependents may be able to participate in the Retiree Medical Program if you meet the criteria to qualify for the program that was in place at the time that you retire(d).

You are not eligible to participate in the Retiree Medical Program if, while an employee, you perform services for the Company under an agreement or arrangement between the Company and a third party; which
designates you as an independent contractor or consultant; or which excludes you from Plan participation. You are not eligible for retiree medical coverage if your employment with the Company is terminated due to misconduct, including but not limited to, dishonesty, theft, embezzlement, disclosure of trade secrets, commission of a felony or inappropriate behavior; or if you voluntarily terminate your employment after having committed such acts.

The Retiree Medical Program was redesigned effective January 1, 2008 and employees were classified into eligibility groups to determine what benefits and funding would be offered to you and your dependents during retirement. Your age and years of service, as of December 31, 2007, were used to determine your eligibility group. See How BMO Contributes for more information.

Dependents

At the time of your retirement your eligible dependents can enroll in the retiree medical program, regardless of whether they were enrolled in the active medical plan. However, if they were not on your active medical plan, then they need to have a qualified loss of other group coverage life event in order to enroll. The only exception to this is a birth or adoption, in which case, the new child may be added to coverage within 31 days of the event. Children are allowed to stay on coverage until the end of the month in which they turn age 26, at which time they will be offered COBRA (qualified disabled adult children may be able to stay on after age 26).

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless if you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring your eligible dependents you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the BMO Retiree Medical Program in the future, except for new biological or adopted children.

Your dependents do not need to be enrolled in BMO's medical plan when you retire. The dependent must meet the definition of an eligible dependent at the time of your retirement and at the time you request to enroll them in coverage. You are only able to add the following members to your medical coverage later if they continue to meet the dependent definition, as applicable:

- Your legal spouse or your qualified domestic partner at the time of your retirement date
- Your existing eligible dependent children at the time of your retirement

Qualifications for Coverage

You (and your eligible dependents) qualify for the Retiree Medical Program

if:
- you retire at age 55 or older with at least 10 years of service with any BMO entity; and
- you are working as a U.S. employee immediately preceding your retirement; and
- you are enrolled in a Company-sponsored medical plan immediately prior to retirement.

Different eligibility requirements and contribution percentages may apply if you were hired through one of the acquisitions or mergers as stated under Companies Acquired by BMO Financial Group U.S.

Coverage when you become Medicare eligible (because of age or disability) is not available if you were hired or rehired on or after January 1, 2008, or younger than age 35 as of December 31, 2007.

Special Eligibility Rule for Employees of Divested Companies

If your employment with the Company ends in connection with a sale or other divestiture that occurs on or after June 1, 2015 and all of the conditions set forth below are met, you will be eligible to participate in the Retiree Medical Program on the date that you would have first become eligible to participate in the Program had your employment with the Company not ended:

- You are employed by the successor company immediately following the sale or other divestiture;
- You would have been eligible to participate in the Retiree Medical Program within two years of the date of the sale or other divestiture had you remained an employee of the Company; and
- The sale agreement or other document authorizing such sale or divestiture provides for special Retiree Medical Program eligibility as described in this section.

Companies Acquired by BMO Financial Group U.S.

You are eligible for retiree medical coverage if you meet the requirements described above. Generally, your eligibility for the Retiree Medical Program starts on the later of the actual (closing) date your company was acquired or the date your company joined the Bank of Montreal/Harris Retirement Plan, whichever is later.

For certain acquisitions (which are asterisked in the chart below) your period of employment going back to your latest hire date with the acquired company may be recognized for purposes of determining eligibility in the Retiree Medical Program.

Acquired Company	Acquisition Date
Argo State Bank*	July 31, 1982
Chemical Bank	January 3, 1984
National Westminster Bank USA	January 18, 1985
Bank of Montreal*	January 1, 1986
Derivative Markets	March 20, 1986
Wilmette	January 1, 1987
Marine Midland National Bank	September 20, 1985
Naperville	January 1, 1988
Barrington*	January 1, 1989
Roselle*	January 1, 1989
Batavia	January 1, 1989
Glencoe-Northbrook	January 1, 1989
Hinsdale	January 1, 1989
St. Charles	January 1, 1989
Winnetka	January 1, 1989
Libertyville*	May 1, 1990
Frankfort	October 1, 1990
Nesbitt Thompson Securities*	April 1, 1992
Suburban	January 1, 1995
Household	June 29, 1996
Burns Fry*	January 1, 1997
KeyCorp*	January 2, 1997
Burke, Christensen & Lewis (BCL)	January 1, 2000
Village Bank of Naples	July 3, 2000
Freeman Welwood	October 1, 2000
Century Bank	December 15, 2000
First National Bank of Joliet	July 13, 2001
CSFB Direct	February 1, 2002
Northwestern Trust	April 1, 2002
MyCFO	November 1, 2002
Sullivan, Bruyette, Speros and Blayney (SBS)	January 16, 2003
Gerard Klauer Mattison (GKM)	July 3, 2003
Lakeland Community Bank	February 27, 2004
New Lenox State Bank	June 1, 2004
Mercantile National Bank	December 30, 2004
Villa Park Trust and Savings Bank	January 1, 2006
First National Bank & Trust (FNBT)	January 4, 2007
Fidelity Information Services	January 1, 2007 or on employee hire date with Harris N.A., whichever is later
Merchants & Manufacturers Bancorporation, Inc.	March 1, 2008
Ozaukee Bank	March 1, 2008
Griffin, Kubik, Stephens & Thompson	July 1, 2008
Pierce, Givens & Associates, LLC	February 13, 2009
Stoker Ostler Wealth Advisors	September 9, 2009
Citicorp Diners Club Inc.	January 1, 2010
Amcore N.A.	April 24, 2010
Marshall & Ilsley Corporation1 (M&I)	July 6, 2011
CTC Consulting LLC	June 1, 2012
General Electric Transportation Finance	December 1, 2015 (Service date varies depending on hire date.)
Greene, Holcomb, Fisher, LLC	August 1, 2016
FIS	April 8, 2017
KGS Alpha	September 1, 2018

Special Eligibility Provisions for Marshall & Ilsley Corporation Acquisition

If you were an employee of M&I refer to Legacy M&I Retiree Medical Eligibility for important details that are available to you and your eligible dependents.

If you were rehired after M&I's acquisition (closing) date with BMO and were not retiree medical eligible when you terminated the first time, see How BMO Contributes for more information.

Enrolling & changes

Retirees Under Age 65 and not Medicare Eligible

When you retire, you will continue in the same medical plan coverage option that you had while you were actively working.

Retirees Over Age 65 and/or Medicare Eligible

Medical coverage for retirees (and their eligible dependents) who are Medicare Eligible because of age or disability are covered under the Medicare Secondary Plan. The Medicare Secondary Plan is a comprehensive plan that coordinates benefits with Medicare and is administered by UMR. When you enroll in the Medicare Secondary Plan, **you are required to enroll in Medicare Parts A and B**. The Medicare Secondary Plan is the only option available to retirees and their eligible dependents.

Coverage Options

Retirees are eligible to enroll in the following tiers: Retiree Only or Spouse Only, Retiree + Spouse, Retiree + Child(ren) or Spouse + Child(ren), Child(ren) Only, or Family.

You decide which coverage option best meets your and your family's needs. In cases where both the retiree and their eligible dependents are under age 65 (not Medicare Eligible) all must enroll in the Family coverage level in the same coverage option under the retiree. You are not able to choose a separate coverage option for yourself and each of your eligible family members.

In cases where the retiree or eligible dependent(s) is Medicare Eligible because of age or disability but the other individual(s) is under 65 and not Medicare Eligible, coverage will be split. The individual that is Medicare Eligible will enroll in the Medicare Secondary Plan and the individual not Medicare Eligible will enroll in the Consumer Choice Plan option. Any non-Medicare Eligible children will be covered with the individual who is not Medicare Eligible or enrolled in the Child(ren) Only tier.

In cases where both the retiree and their eligible dependent(s) are Medicare Eligible because of age or disability, coverage will be split. Both individuals will be enrolled in the Medicare Secondary Plan, each with individual coverage. If there are remaining eligible children, the children will be enrolled in the Consumer Choice Plan option, if the child is not also Medicare Eligible.

In cases where the retiree no longer qualifies for coverage, any dependent(s) enrolled in coverage will also be impacted and no longer be eligible for coverage.

In the event a Retiree actively elects to cancel their retiree medical coverage any dependent(s) enrolled in coverage will also be cancelled and no longer eligible for coverage.

Medical Coverage When You and Your Spouse/Domestic Partner Both Work at the Bank

In situations where you and your spouse/domestic partner are employees of the Company, there may be different alternatives for continuing medical coverage at retirement. Here are some examples of the options that may be available to dual employed couples.

- If both employees retire from the Company and both are eligible for retiree medical coverage (age 55 or older with 10 or more years of benefit service), each may enroll for single retiree medical coverage with premiums based on his or her own years of service. Or, one retiree may choose to enroll as the dependent of the other, provided at least one retiree qualifies for retiree medical.

- If one employee retires while the spouse continues working at the Company, the working spouse may remain in the active plan and enroll the retiree as a dependent. If the working spouse leaves or retires from the Company, they may be enrolled as the dependent of the retiree within 31 days from the last day of work.

Becoming Medicare Eligible

If you or your dependent(s) become Medicare Eligible as a result of a disability prior to turning age 65, it is your responsibility to inform BMO.

Retirees and dependents that are considered Medicare Eligible, because of age or disability, are covered under the Medicare Secondary Plan, administered by UMR for medical coverage and Express Scripts for prescription drug coverage. The Medicare Secondary Plan is a comprehensive plan that is designed to coordinate benefits with Medicare and therefore you will need to enroll in Medicare Parts A & B.

Your medical coverage will automatically change to UMR and your premium amount will be automatically updated on the first day of the month in which you turn 65 and qualify for Medicare or the first day of the prior month in cases where the date of birth is on the first of a month. If there are individuals under the age of 65 that were covered on your pre-65 coverage, they will remain covered on their current pre-65 plan until becoming Medicare Eligible or no longer meeting the criteria of an eligible dependent.

If you and/or your dependents choose to waive or cancel your post-65 coverage, please complete and return the Retiree Medical Program Election/Waiver form indicating your election. You are encouraged to return your forms as soon as possible to expedite the set-up of your retiree medical coverage or to update your status if you are waiving post-65 coverage.

Eligibility for Medicare Part D (Medicare drug plan)

You (and your covered dependents) are not eligible to participate in the BMO-sponsored Medical Plan if you or your dependents elect coverage under Medicare Part D. In general, the prescription drug benefits provided under this plan are at least as good as or better than the standard Medicare Part D prescription drug benefits. However, you should review the coverages and premiums for both Medicare Part D and the Retiree Medical Program to make the best decision for you and your family.

If you decide to enroll in a Medicare drug plan you will no longer be eligible to participate in the Retiree Medical Program, and you permanently forfeit your rights to enroll in this plan in the future.

If you have any questions about Medicare Part D prescription drug coverage, refer to Important Notice from BMO Financial Corp. About your Prescription Drug Coverage and Medicare or contact Medicare at 1-800-633-4227.

If you Enroll in Coverage

When you complete and return the Retiree Medical Program Election/Waiver form indicating your medical plan election, your retiree coverage will be effective the first of the month following the month you retired.

The form must be returned within 31 days of when active coverage ends, or when the packet is mailed, whichever is later. This will expedite the set-up of your retiree medical coverage and avoid a delay of coverage or receiving new ID cards.

The member verification section on the Retiree Medical Program Election/Waiver form must be completed for all eligible dependents regardless if you will be enrolling them in a medical plan at the time of retirement. If you and/or your dependents are waiving retiree coverage, by declaring your eligible dependents you are maintaining their future eligibility to enroll later if they continue to meet eligibility requirements at that time.

Dependents that are not declared on this form at the time of your retirement will not be allowed to participate in the BMO Retiree Medical Program in the future, except for new biological or adopted children. (You will need to notify the Human Resources Centre at 1-888-927-7700 within 31 days of the birth or adoption).

Coordination of benefits

The medical plans have a coordination of benefits provision that prevents duplication of benefit payments when you or your dependent also has other health coverage through another group plan, including Medicare. Coordination of benefits procedures also determine which plan pays your claim first. Refer to the Coordination of Benefits section in the summary plan description for more information.

If You Decline, Cancel, or Waive Coverage

You have the option to waive your Retiree Medical Coverage through BMO and retain your Retiree Medical eligibility status (under certain circumstances) through the Retiree Medical Waiver Provision by completing the Retiree Medical Program Election/Waiver form.

Your coverage will be cancelled effective the last day of the month in which your completed paperwork is received (or at the end of a future month, if you indicate that on your form).

Permanent Cancellation

You will forfeit your eligibility for the Retiree Medical Program, or your coverage may result in permanent cancellation if you do not follow the provisions of the Retiree Medical Program. Any of the following events would result in permanent cancellation of your retiree medical coverage through BMO:

- You elect COBRA medical insurance at the time of your retirement.
- You do not return the Retiree Medical Program Election/Waiver form within 31 days of your retirement date indicating your intention to elect or waive coverage.
- You do not request re-enrollment in the Retiree Medical Program within 31 days of turning age 65, becoming Medicare Eligible or experiencing another qualifying event. (Exception: You continue to be enrolled in other group coverage.)
- You are Medicare Eligible because of age or disability and have not been enrolled in other group coverage continuously during your waiver period from the time you became Medicare Eligible.
- You enroll in Medicare Part D coverage. (Does not apply to Legacy M&I Retirees)
- You voluntarily choose to permanently cancel your coverage.

Retiree Medical Waiver Provision

You and/or your eligible dependents have the option to waive your retiree medical coverage through BMO under the Retiree Medical Waiver Provision. This option allows you to retain your retiree medical eligibility status and re-enroll when certain qualifying conditions are met. To enroll in the waiver program, indicate your intent to waive on the Retiree Medical Program Election/Waiver form.

This option may be beneficial to you if you are eligible for other employer group medical coverage through a spouse/domestic partner or other employer. If you choose to waive coverage, please carefully read through the provisions to understand your options. If you elect COBRA health insurance coverage at the time of your retirement, you will forfeit your right to participate in the Retiree Medical Program and therefore this waiver provision does not apply.

Eligibility for Waiver Provision

Please refer to the following Retiree Waiver Options Chart for certain rules that apply depending on your age/or Medicare status and how your election impacts your dependents.

If you are under the age of 65 and not Medicare Eligible and decide to waive enrollment, your eligible dependent(s) Consumer Choice Plan is automatically waived. You can only re-enroll when certain conditions are met or at the time of eligible for Medicare because of age or disability.

If you are under age 65 and decide to waive enrollment, your spouse/domestic partner who is eligible for the Medicare Secondary Plan may continue enrollment in the Medicare Secondary Plan. However, if the retiree chooses not to enroll in the post-age 65 coverage when they become eligible, their coverage, if any, would be cancelled at that time.

Retiree Waiver Options Chart			
Retiree Age Status	**Retiree Action**	**Spouse /Domestic Partner Age Status**	**Allowable Spouse/Domestic Partner Action**
Retiree is under 65 or not Medicare Eligible	Enrolls in Consumer Choice Plan - BCBS	Spouse/Domestic Partner is under 65 or not Medicare eligible	Enroll on the Retiree's Medical coverage
			Waive coverage**
		Spouse/Domestic Partner is over 65 or Medicare eligible	Enroll in the Medicare Secondary Plan
			Waive coverage**
	Waives Retiree Medical pre-65 coverage*	Spouse/Domestic Partner is under 65 or not Medicare eligible	Coverage is automatically waived*
		Spouse/Domestic Partner is over 65 or Medicare eligible	Enroll in the Medicare Secondary Plan
			Waive coverage**
Retiree is over 65 or Medicare Eligible	Enrolls in Medicare Secondary Plan	Spouse/Domestic Partner is under 65 or not Medicare eligible	Enroll in Consumer Choice Plan - BCBS
			Waive coverage*
		Spouse/Domestic Partner is over 65 or Medicare eligible	Enroll in the Medicare Secondary Plan
			Waive coverage**
	Waives Retiree Medical coverage due to enrollment in other group coverage**	Spouse/Domestic Partner is under 65 (not Medicare eligible)	Coverage is automatically waived*
		Spouse/Domestic Partner is over 65 or Medicare eligible	Enroll in the BMO Medicare Plan
			Waive coverage**
	Waives Retiree Medical coverage. Does not enroll in other group coverage (Permanent Cancellation)	Spouse/Domestic Partner is under 65 or not Medicare eligible	Permanently Cancelled
		Spouse/Domestic Partner is over 65 or Medicare eligible	

Requesting Re-Enrollment

To request re-enrollment in the BMO Retiree Medical Program you will need to submit a Retiree Medical Program Election/Waiver form to elect coverage.

If you are a Post-65 waiver, it will be necessary to provide supporting documentation of continuous enrollment in other group medical coverage within 31 days of when you lose your other group coverage and Medicare becomes your primary payer.

The following reasons are **NOT considered qualifying events** that would allow re-enrollment in the Retiree Medical Program:

- Annual enrollment;
- You discontinue coverage under an individual medical policy;
- You voluntarily discontinue other group medical coverage;
- You enroll in COBRA medical insurance through BMO;
- You discontinue COBRA medical insurance through another employer before the full COBRA period is exhausted for a reason other than an increase in cost or coverage curtailment as described above;
- You did not request re-enrollment within 31 days of when Medicare became your primary payer of your health coverage or within 31 days of a qualifying event.

*** Pre-65 Waiver**	You have the option to waive your pre-65 coverage at any time with the opportunity to re-enroll once you meet one of the following guidelines. **You have 31 days from the date of the qualifying event to enroll in the Retiree Medical Program.** • You become Medicare Eligible because of age or disability, you have 31 days from the date of becoming eligible for Medicare to enroll in the Medicare Secondary Plan, unless Medicare enrollment can be postponed due to enrollment in other group medical coverage. Refer to the post-65 waiver provision for additional information on eligibility when you become Medicare Eligible. • You lose other group or state-provided medical coverage as a result of one of the qualifying events: - a change in legal marital status or qualified domestic partner relationship; - a change in employment status of the individual that carried the other employer group coverage; - a change in benefit's eligibility status of the individual that carried the other group coverage; - a change in residence. • You experience a significant cost increase or significant coverage curtailment under your other employer group or state provided medical coverage. The cost must exceed the cost of what you would be paying for your BMO retiree medical coverage. • An eligible spouse/domestic partner would be allowed to enroll in the retiree medical coverage in the event of the retiree's death if otherwise eligible under the Plan. The spouse/domestic partner must have a qualifying event consistent with re-enrolling in coverage as outlined above at the time enrollment is requested.

****Post-65 Waiver***	*You may waive or continue to waive your coverage after age 65 with the chance to re-enroll only if you have been continuously enrolled in other group medical coverage from the date the age 65/Medicare eligible waiver was effective until the time you are requesting re-enrollment in the Retiree Medical Program.* • *It will be necessary to provide supporting documentation of continuous enrollment in other group medical coverage within 31 days of when you lose your other group coverage and Medicare becomes your primary payer.*

Death

In the event of the death of a retiree, the retiree's dependents may continue coverage if the Plan is offered, and they meet the definition of an eligible dependent. If the spouse/domestic partner of the deceased retiree remarries or enters into another domestic partner relationship, the new spouse/ domestic partner and any dependents of the new spouse/domestic partner are <u>not</u> eligible for coverage. Call the Human Resources Centre at 1-888-927-7700 to report any changes in status.

Rehired employees

If you are rehired on or after January 1, 2008, you will become part of eligibility group 4 for the Retiree Medical Program. Your prior service time will be counted for Retiree Medical Program eligibility, however the timeframe you were not employed with BMO is considered a "break-in-service" and will not be counted in your service time calculation. Please note, your prior service time will not count towards eligibility for Company funding.

Individuals participating in the Retiree Medical Program immediately prior to the date of rehire are considered an active participant of the Waiver Program and will maintain their current Company contribution, if any, and current Retiree Group classification based on his/her initial retirement date. No additional service time is gained.

Plan cost

You and the Company share in the cost of the Retiree Medical Program. Your share of the premium (and the premium for any eligible dependents you enroll) depends on:

- *your years of benefit service under the Bank of Montreal/Harris Retirement Plan;*
- *your age;*
- *the medical plan coverage option you select.*

Costs for the Retiree Medical Program are based on coverage and administrative fees for the retiree group and are different from the active employee rates.

How BMO Contributes

BMO Financial Group made changes to the retiree medical benefits effective January 1, 2008, and your age and years of service (in months and years) as of December 31, 2007 will be used to determine the group you are classified under. The group will determine your access and Company contribution for retiree medical
benefits.

How to Determine Your Years of Benefit Service

In general, your service begins on your hire date with BMO, however, some employees will need to know their vesting service, while others will need to know their benefit service. Generally, benefit service begins on the actual date your company was acquired or the date your company joined the BMO/Harris Retirement Plan, whichever is later. See Companies Acquired by BMO Financial Group U.S. for more information.

You have the flexibility to view your service dates at any time by accessing your job details in Workday.

How to Determine Your Retiree Group

In addition to meeting the eligibility and qualifications criteria to be eligible for retiree benefits, the following special rules apply:

Group 1 and Group 2	Employees who on 12/31/2007 were age 55 or older with at least 10 years of benefit service* or age 45 or older with at least 60 points (your points are your age plus years of benefit service) will pay a percentage of the medical premium. **BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%. Your spouse/domestic partner and child(ren) will pay an additional 25% of the premium. See the Contribution schedule for more details.** **** Generally, your hire date with the Company can be used to determine your benefit service.***
Example: A retiree with 25 years of benefit service will pay 45% of the monthly premium. The full monthly premium for the Consumer Choice Plan is $1,288.00, the retiree will pay 45% or $579.60 per month. The spouse pays an additional 25% of the full monthly premium, which means the cost for spouse coverage is 70% (45% + 25%) or $901.60. The total cost for retiree + spouse is $1,481.20 per month.	
Group 3	Employees who on 12/31/2007 were age 35 or older, who are not in Groups 1 or 2, for coverage before age 65, will pay a percentage of the medical premium. Beginning at the age of 65 you will receive a subsidy from BMO to offset the cost of the BMO retiree medical plan. This means that instead of paying a percentage of the premium, you will receive a capped annual subsidy of $70, times years of benefit service, up to a maximum of $2,450 per year (An aggregate of $600 less for your spouse/domestic partner/child(ren)). The value of your subsidy will be fixed when you reach age 65 – with no future increase. The subsidy will continue for your lifetime. In the event of your death, your spouse/domestic partner/child(ren) subsidy would also continue for his or her lifetime.
Example: If you retire from BMO with 25 years of benefit service, BMO will pay $70 x 25, or $1,750 per year toward the cost of your retiree medical coverage once you are Medicare eligible because of age or disability. Your spouse's subsidy would be $1,150 per year.	
Group 4	Employees who on 12/31/2007 were under age 35 and who retire before age 65 will have to pay the full cost of coverage. BMO does not offer retiree medical coverage or the subsidy once you reach age 65. You would be responsible for your own coverage, which can be through Medicare and/or an individual insurance plan.

Contribution Schedule					
Years of service	**You Pay**	**Spouse Pays**	**Years of service**	**You Pay**	**Spouse Pays**
10	75%	100%	**23**	49%	74%
11	73%	98%	**24**	47%	72%
12	71%	96%	**25**	45%	70%
13	69%	94%	**26**	43%	68%
14	67%	92%	**27**	41%	66%
15	65%	90%	**28**	39%	64%
16	63%	88%	**29**	37%	62%
17	61%	86%	**30**	35%	60%
18	59%	84%	**31**	33%	58%
19	57%	82%	**32**	31%	56%
20	55%	80%	**33**	29%	54%
21	53%	78%	**34**	27%	52%
22	51%	76%	**35 or more**	25%	50%

BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%.

Your spouse/domestic partner and child(ren) pay an additional 25% of the premium.

Retiree Group	Your Plan Options		How BMO Contributes	
Employees who by 12/31/2007 were:	**Under Age 65**	**Over Age 65**	**Under Age 65**	**Over Age 65**
1 Age 55 or older with at least 10 years of benefit service*	You have access to the same plan options as active employees. (Consumer Choice Plan)	You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary. Your prescription coverage is available through Express Scripts.	BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%. The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	
2 Age 45 or older with at least 60 points (your points are your age plus years of benefit service)*	You have access to the same plan options as active employees. (Consumer Choice Plan)	You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary. Your prescription coverage is available through Express Scripts.	BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%. The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	

3 Age 35 or older (but not in either group above)**	You have access to the same plan options as active employees. (Consumer Choice Plan)	You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary. Your prescription coverage is available through Express Scripts.	BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%. The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	BMO will provide an annual subsidy that can be applied to the BMO plan. The annual subsidy will begin at age 65 and equal $70 times years of benefit service (up to 35 years) earned in the BMO/ Harris Retirement Plan. The spouse domestic partner/child(ren) would receive an aggregate of $600 less.
4 Under age 35**	You have access to the same plan options as active employees. (Consumer Choice Plan)	No coverage available through BMO.	You pay the full cost of coverage.	N/A

** Generally, your hire date with the Company can be used to determine your benefit service.*
*** Employees hired or rehired on or after January 1, 2008 will be part of Group 4.*

How to Determine Your Share of the Monthly Premium

To calculate your share of the premium you will need the full monthly retiree medical premiums and your contribution percentages.

Pre-65/Not Medicare eligible Plan Option	Retiree Only or Spouse Only	Retiree + Spouse	Retiree + Child(ren) or Spouse + Child(ren)	Child(ren) Only	Family
Consumer Choice Plan 2022 rates	$1,288	$2,576	$1,932	$644	$3,220

Pre-65 Plan Option (Not Medicare Eligible)	How to calculate your share of the premium		
Retiree Only	Total premium = ***Retiree Only*** premium x Retiree Pays % ***Example with 20 years of service:*** $1,288 x 55% = $708.40		
Spouse Only	Total premium = ***Spouse Only*** premium x Dependent Pays %		
Retiree+Spouse Determine the share of the premium for the retiree versus the spouse and apply applicable percentages	Step 1 Retiree share of premium = ***Retiree Only*** premium x Retiree Pays %	Step 2 Spouse share of premium = (***Retiree+Spouse*** premium - ***Retiree Only*** premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Spouse share of premium
EXAMPLE **Retiree+Spouse:** 14 years of benefit service	Retiree share of premium = **$1,288** x 67% = $862.96	Spouse share of premium = **($2,576 - $1,288)** x 92% = $1,184.96	Total premium = $862.96 + $1,184.96 = $2,047.92
Retiree+Child(ren) Determine the share of the premium for the retiree versus the child(ren) and apply applicable percentages	Step 1 Retiree share of premium = ***Retiree Only*** premium x Retiree Pays %	Step 2 Children share of premium = ***(Retiree+Child(ren)*** premium - ***Retiree Only*** premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Child(ren) share of premium
Spouse+Child(ren)	Total premium = ***Spouse+Child(ren)*** premium x Dependent Pays %		
Child(ren) Only	Total premium = ***Child(ren) Only*** premium x Dependent Pays %		
Family Determine the share of the premium for the retiree versus the spouse & child(ren) and apply applicable percentages	Step 1 Retiree share of premium = ***Retiree Only*** premium x Retiree Pays %	Step 2 Spouse & Child(ren) share of premium = (***Family*** premium - ***Retiree Only*** premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Spouse & Child(ren) share of premium
EXAMPLE **Family:** 23 years of benefit service	Retiree share of premium = **$1,288** x 49% = $631.12	Family share of premium = **($3,220 - $1,288)** x 74% = $1,429.68	Total premium = $631.12 + $1,429.68= $2,060.80

Premiums for individuals under age 65 are higher than for those that are over age 65 and/or Medicare Eligible. The reason is that Medicare pays a significant share of medical expenses for persons over age 65 and/or Medicare Eligible.

Post-65/Medicare Eligible Plan Option	Available to	Individual
Medicare Secondary Plan 2022 rates	Medicare Eligible Individuals	$444.00

Post-65/Medicare Eligible Plan Option	How to calculate your share of the premium			
Individual Only	Step 1 Retiree share of premium = ***Individual Only*** premium x Retiree Pays %	Step 2 (if applicable) Spouse share of premium = ***Individual Only*** premium x Dependent Pays %	Step 3 (if applicable) Child share of premium = ***Individual Only*** premium x Dependent Pays %	Step 4 Total premium = Retiree share of premium + Spouse+ Child(ren) share of premium
Retiree+Spouse ***example: 30 years of service***	Retiree share of premium = ***$444*** x 35% = $155.40	Spouse share of premium = ***$444*** x 60% = $266.40		Total premium = $421.80

Paying for Retiree Premiums

Retiree medical premium billing is administered by PayFlex Systems USA, Inc. If you would like to pay for your retiree medical premiums via automatic deduction from a checking or savings account, you must complete the PayFlex Automatic Premium Payment Electronic Funds Transfer (EFT) form and return as directed on the form. If you do not enroll in the automatic payment option and wish to pay your premiums by sending a check, you will receive coupons from PayFlex. Payments are due the first of each month and must be made within the 30-day grace period or coverage will be cancelled and cannot be reinstated.

You can view your account online by visiting www.payflex.com and completing the registration. Once you register you can manage your account online, view your payment history, and set up account alerts.

The portion that the Company pays toward the cost of retiree medical coverage, if any, for qualified domestic partners and domestic partner children is considered taxable. Retirees covering a domestic partner under the Retiree Medical Program will receive a Form W-2 each year reflecting this amount. In addition, you will be responsible for applicable payroll taxes.

Legacy M&I Retiree Eligibility

Special Eligibility Provisions for Former Employees of M&I Only

Your Retiree Medical Program eligibility is based off the provisions of the legacy M&I Retiree Medical Program if you were on staff as of July 5, 2011 and have not had a break in service after July 5, 2011. If you experienced a break in service after July 5, 2011 and were rehired, you need to satisfy the eligibility requirements of the BMO Retiree Medical Program provisions from your rehire date, unless you were eligible when you first terminated.

The Retiree Medical Program is available to eligible retirees and their eligible dependents based on the guidelines indicated below.

Eligibility and Qualifications for Pre-65 Coverage

Different eligibility requirements and funding levels may apply if you were hired through one of the acquisitions or mergers as stated under the *Acquisitions/Mergers* section below.

Access to Pre-65 retiree medical coverage is available to employees ages 55 to 64 who at retirement meet the following requirements:

- are at least 55 years old;
- have at least 10 years of vesting service* with M&I and/or BMO; and
- have participated in any M&I and/or BMO medical coverage for at least 10 consecutive years immediately prior to retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).

Retirees who meet the qualifications for the Retiree Medical Program who are eligible for Medicare will have coverage under the Medicare Secondary Plan. In the event you are eligible for Medicare; however, Medicare has determined that they will be the secondary payer to a group health plan; coverage will remain under the pre-age 65 plan until Medicare becomes the primary payer.

** In order to earn one year of vesting service, you must be actively employed and work at least 1,000 hours during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.

Special Eligibility for Retirees who were Employed by Metavante Corporation at the time Metavante Split from M&I Corporation on November 2, 2007: Retirees who met the above eligibility guidelines as of November 2, 2007 are eligible for the Retiree Medical Program as of the date they retire from Metavante Corporation. Funding level is based off of eligibility for the program as of November 2, 2007.

Funding

Employer Group (Employees must also meet the requirements as stated under "Qualifications for Pre-65 Coverage" above)	**Employer Subsidy towards the retiree group rate**
Active employees on staff prior to 9/1/97 (without a break in employment of more than 30 days on or after 9/1/97)	**60%**
Employees hired or acquired on or after 9/1/97	**0%** (Retiree pays 100% of the cost)

Eligibility and Qualifications for Post-65 Coverage

Different eligibility requirements and funding levels may apply if You were hired by M&I through one of the acquisitions or mergers as stated under the *Acquisitions/Mergers* section below.

Access to post-65 retiree medical coverage is available under the portion of the health program known as the Medicare Secondary Plan to employees ages 65 and older, and for who Medicare is the primary payer of claims, who at retirement meet the following requirements:

- are at least 55 years old;
- have at least 10 years of vesting service* with M&I and/or BMO; and

- have participated in any M&I and/or BMO medical coverage** for at least 10 consecutive years immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).

Retirees who meet the qualifications for the Retiree Medical Program who are eligible for Medicare will have coverage under the Medicare Secondary Plan. In the event You are eligible for Medicare; however, Medicare has determined that they will be the secondary payer to a group health plan; coverage will remain under the pre-age 65 plan until Medicare becomes the primary payer.

When you enroll in the Medicare Secondary Plan, you are required to enroll in Medicare Parts A and B.

** In order to earn one year of vesting service, you must be actively employed and work at least 1,000 hours during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on Your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

Special Eligibility for Retirees who were Employed by Metavante Corporation at the time Metavante Split from M&I Corporation on November 2, 2007*: Retirees who met the above eligibility guidelines as of November 2, 2007 are eligible for the Retiree Medical Program as of the date they retire from Metavante Corporation (or its successor). Funding level is based off of eligibility for the program as of November 2, 2007.*

Funding

The following chart applies to active employees on staff prior to September 1, 1997 (without a break in employment of more than 30 days on or after September 1, 1997):

Employee Group (Employees must meet the requirements as stated under "Qualifications for Post-65 Coverage" in addition to the requirements listed below)	Employer subsidy towards the retiree group rate
Employees age 60 or older as of 8/31/02 Who, at the time of retirement: • meet the "Rule of 75" (age + years of vested service = 75)	60%
Employees age 55 to 59 as of 8/31/02 Who, at the time of retirement: • meet the "Rule of 75" (age + years of vested service = 75)	40%
Employees under age 55 as of 8/31/02	0% (Retiree pays 100% of the cost)
Employees over age 54 as of 8/31/02 Who at the time of retirement: • do not meet the "Rule of 75" (age + years of vested service = 75)	0% (Retiree pays 100% of the cost)

Employees hired on or after September 1, 1997 who meet the eligibility requirements as stated under "Qualifications for Post-65 Coverage" are eligible for access to retiree medical coverage (the retiree pays 100% of the retiree group rate).

Waiver Provision Prior to Retirement

After December 31, 2006, if you are age 55 or older, have 10 or more years of vested service, and have participated in a Company-sponsored health plan for 10 or more consecutive years, you may waive your medical coverage as an active employee without losing your eligibility for retiree coverage. As long as you meet these requirements at the time of the waiver, you do not have to meet the 10-year participation requirement immediately prior to retirement. If you waived your M&I medical coverage prior to January 1, 2007 when this provision was implemented, this provision does not apply.

If you choose to waive your medical coverage as an active employee, you may do so during the annual enrollment period or as the result of a qualifying event by making your changes via the online benefits portal. You may re-enroll in coverage during the annual enrollment period (effective the following January 1st); as the result of a qualifying event (effective based on rules under Qualifying Life Event); or at retirement (effective the day following your last working day).

Please note: Enrollment rules vary by health plan and all current options may not be available at the time you request re-enrollment.

Acquisitions/Mergers

The following guidelines apply to both pre- and post-age 65 coverage. Employees who were hired by M&I through an acquisition or merger *prior to September 1, 1997** fall under the guidelines indicated in the above sections. The 10-year participation in an M&I and/or BMO health plan requirement will be waived, provided you meet the following guidelines:

- You enrolled in any M&I or/or BMO health plan at the time of the acquisition/merger and have been continuously enrolled immediately before your retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement).
- You have not had a break in service of more than 30 days since the acquisition/merger date. You meet the other requirements as stated in the above sections: You are at least age 55 at the time of your retirement, and you have at least 10 years of vested service (vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I & BMO and/or the previous employer; any time after 2004 during which you receive severance pay is treated the same as full-time active employment*). Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility*.

Additional qualifications for eligibility and employer funding may apply if you were hired by M&I through a merger or acquisition on or after September 1, 1997* as indicated below.

** Former employees of Valley Bancorporation fall under the guidelines as indicated below.*

Eligibility/Funding

If you were hired by M&I through one of the acquisitions or mergers indicated below, you are eligible for access to retiree medical coverage if at retirement:

- you are at least 55 years old; and
- you meet the requirements as indicated by the categories below.

The guidelines below apply to former employees of Valley Bancorporation – Acquired by M&I 6/1/94:

- Eligible employees who retired prior to *January 1, 1995*, are eligible for employer funding based on years of vested service*:

Years of Service	Employer Funding
0 – 9	0%
10– 14	20%
15 – 19	30%
20 – 24	40%
25+	50%

- Employees who retire *on or after January 1, 1995*, are eligible for the following:
  - Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by the acquired company and/or M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
  - 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by Valley Bancorporation and/or M&I** and/or BMO immediately before retirement: retiree medical coverage is available at 100% of the retiree group rate.
  - 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan** following the acquisition and immediately before retirement: retiree medical coverage is available based on the guidelines as described under the *Qualifications for Pre-65 Coverage and Qualifications for Post-65 Coverage* sections above.

** Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or Valley Bancorporation. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of the following acquired companies: Central Fidelity Bank – Acquired by M&I 9/1/97
Security Bank – Acquired by M&I 10/1/97
Citizens Bank – Acquired by M&I 11/1/97
Advantage Bank – Acquired by M&I 4/1/98
Fifth Third Bank – Acquired by M&I 9/8/01

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO ** immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): retiree medical coverage is available at 100% of the retiree group rate.

** Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I & BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which You are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on Your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of National City Bank (NCB) – Acquired by M&I 8/1/01:

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO ** immediately before retirement (refer to the Waiver Provision Prior to Retirement section for exceptions to this requirement): retiree medical coverage is available at 100% of the retiree group rate.
  Grandfathered Employees: Employees at least age 55 with 10 or more years of vesting service* at the earlier of June 30, 2002 or the date of retirement, and 10 or more consecutive years of participation in a health plan sponsored by NCB or M&I or BMO as of the date of retirement are eligible for pre-age 65 funding based on the declining scale below:

Year	Employer Funding
2004	35%
2005	30%
2006	25%
2007	20%
2008	15%
2009	10%
2010+	0%

** Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which You are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on Your standard hours immediately prior to the severance period begin date.*

*** Effective January 1, 2010, the period in which You are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of the following acquired companies:
First Indiana Bank Trust Company – Acquired by M&I 1/1/06
First Indiana Bank – Acquired by M&I 1/1/08:

- Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by acquired company and/or M&I and/or BMO *** before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.

- 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO *** before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): pre-age 65 and post-age 65 retiree medical coverage is available at 100% of the retiree group rate.

First Indiana Bank Grandfathered Employees: Employees who meet the Rule of 75 (age + years of vested service is equal to or greater than 75*) as of December 31, 2007, are eligible for pre-age 65 employer subsidy based on the following declining schedule in place at the time of retirement provided they meet the eligibility guidelines as described above at the time of retirement:

Year	Employer Subsidy**
2008	75%
2009	50%
2010	25%
2011+	0%

***The subsidy is applied to the portion of the premium which is equal to the difference between the adjusted 2007 First Indiana plan rate and the current retiree group rate. Any remaining portion of the premium is not subsidized. (Employer funding is not provided to former employees of First Indiana Bank Trust Company.)*

Post-age 65 retiree medical coverage is available at 100% of the retiree group rate to former employees of First Indiana Bank and First Indiana Bank Trust Company.

**Vesting service includes your active service time in which you worked at least 1,000 hours during the year with M&I and/or BMO and/or the previous employer. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Any time after 2004 during which you receive severance pay is treated the same as full-time active employment.*

***Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

The guidelines below apply to former employees of the following M&I acquired companies:

Acquired Company	Acquisition Date
CardPro	April 1, 1999
Traveler's Express	April 9, 1999
HUBCO	November 13, 1999
Derivion Corporation	June 1, 2001
CyberBills	June 21, 2001
Brokat	September 8, 2001
401k Services.Com	December 20, 2001
Century Bank	March 1, 2002
Richfield Bank	March 1, 2002
TrustStar Retirement Services – Glendale location	April 8, 2002
– San Mateo location	April 15, 2002
Beneplan	May 1, 2002
Paytrust, Inc.	July 22, 2002
Southwest Bank	October 1, 2002
Printing for Systems, Inc. (PSI)	November 15, 2003
AmerUs Home Lending Inc	January 1, 2004
United Missouri Bank	Various acquisition dates by individual
Kirchman Corporation	May 28, 2004
Advanced Financial Solutions (AFS)	July 1, 2004
NYCE Corporation	July 30, 2004

Response Data Corporation (RDC)	September 8, 2004
NuEdge	October 20, 2004
VECTORsgi Holdings Inc.	November 22, 2004
Prime Associates, Inc.	February 9, 2005
MBI Benefits, Inc.	July 22, 2005
TREEV	August 8, 2005
GHR	August 11, 2005
Brasfield Technology, LLC	October 6, 2005
Link2Gov	November 30, 2005
AdminiSource Communications	January 3, 2006
Gold Banc Corporation, Inc.	April 1, 2006
Trustcorp Financial, Inc. (Missouri State Bank and Trust Company)	April 1, 2006
VICOR, Inc.	September 2, 2006
Valutec Card Solutions, LLC	January 17, 2007
United Heritage Bank	April 1, 2007
North Star Financial Corporation	April 21, 2007
Excel Bank Corporation	July 1, 2007
Citizens Bank (asset purchase)	January 1, 2008
Taplin, Canida & Habacht, Inc. (TCH, LLC)	January 1, 2009
U.S. Bank (asset purchase)	May 3, 2010

- Less than 10 years of vesting service with M&I and/or BMO * following the acquisition, and less than 10 consecutive years of participation in any health plan sponsored by M&I and/or BMO ** immediately before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
- 10 or more years of vesting service with M&I and /or BMO * following the acquisition, and 10 or more consecutive years of participation in any health plan sponsored by M&I** and/or BMO immediately before retirement (refer to the *Waiver Provision Prior to Retirement* section for exceptions to this requirement): retiree medical coverage is available at 100% of the retiree group rate.

** To earn one year of vesting service, you must be actively employed and work at least 1,000 hours with M&I and/or BMO during the year. Exempt-level employees, and employees on Military Leave, may be credited with 95 hours of service per semi-monthly payroll period. Effective January 1, 2005, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 1,000 hours worked during the calendar year for retiree medical eligibility. The hours credited for satisfying the 1,000 hours will be based on your standard hours immediately prior to the severance period begin date.*

***Effective January 1, 2010, the period in which you are receiving benefits under the M&I Severance Plan will be treated the same as active employment for purposes of satisfying the 10-year health plan participation requirement for retiree medical eligibility.*

Eligibility for Medicare Part D and BMO Retiree Coverage

Former Employers of Marshall & Ilsley Corporation

If you are enrolled in the BMO Group Medical Plan and you elect one of the Medicare prescription drug plans, the prescription drug coverage under the Group Medical Plan will be cancelled. Medical coverage will not be cancelled; however, you will continue to pay the full premium amount. If you later decide to cancel your Medicare prescription drug plan, the prescription drug benefit under the BMO medical plan will be reinstated, but only if you have continued to be enrolled in the BMO Retiree Health Program.

If you have any questions about Medicare Part D prescription drug coverage, refer to Important Notice from BMO Financial Corp. About Your Prescription Drug Coverage and Medicare or contact Medicare at 1-800-633-4227.

Plan Cost

You and the Company share in the cost of the Retiree Medical Program. Your share of the premium (and the premium for any eligible dependents you enroll) depends on:

- your years of benefit service under the M&I and/or BMO medical coverage;
- your age; and
- the medical plan coverage option you select.

Note: Costs for the Retiree Medical Program are based on coverage and administration fees for the retiree group and are different from the active employee rates.

How to Determine Your Share of the Monthly Premium

To calculate your share of the premium you will need the retiree medical rate to determine your amount. To calculate your share of the premium:

- **Step 1:** Determine the full premium amount for the option you are choosing.
- **Step 2:** Apply your applicable (pre-65 coverage or post-65 coverage) contribution percentage.

Example: You and your spouse are both under 65: Total premium = **Retiree+Spouse** premium x your contribution % for pre-65 coverage. Eligible dependents will receive the same contribution percentages that the retiree is eligible for. Refer to How to Determine Your Share of the Monthly Premium for the full retiree rates.

Premiums for individuals under age 65 are higher than for those that are over age 65 and/or Medicare eligible. The reason is that Medicare pays a significant share of medical expenses for persons over age 65 and/or Medicare eligible. Your premium amount will be reduced automatically on the first day of the month in which you qualify for Medicare or the first day of the previous month in cases where the date of birth is on the first of a month. On that date, Medicare becomes your primary insurance coverage, and the Company's plan becomes secondary.