

Dental Summary Plan Description (SPD)

Employee Benefit Program of Bank of Montreal/Harris

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About this Summary Plan Description

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

The information in this SPD is current as of January 1, 2023. As plan changes occur, this SPD will need to be revised periodically. Although the Company strives to keep the descriptions up to date, from time-to-time plan changes may not be incorporated immediately into the SPD. While this SPD summarizes the major provisions of this Plan, it does not provide you with every Plan detail. If there is any discrepancy or any oral representation that differs between this SPD from the legal Plan documents, the Plan document prevails.

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

Eligibility

Employee

You are eligible to participate in the dental benefits portion of the Plan if you are a:

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

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

Eligible dependents

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

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

Children are defined as:

- your biological children;
- your adopted children or children placed with you for adoption;
- your stepchildren, regardless of where they live (includes stepchildren from your same-sex or opposite-sex legal spouse);
- foster children living with you;
- a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the Plan for dependent coverage;
- any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
- your domestic partner’s children if they qualify as your dependents for income tax purposes according to Section 152 of the IRS Code.
-

Non-duplication of coverage

Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

If you and your spouse or domestic partner are both BMO employees and eligible to enroll in the Plan, you may each enroll for individual coverage or one of you may enroll and cover the other. If you each enroll for individual coverage, only one of you may enroll your children as dependents.

Qualified Medical Child Support Order

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

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

Extended coverage for disabled children

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

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

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

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

Verifying dependents

As a contingency for coverage under the Plan, you must submit documentation to demonstrate that all your covered dependents meet the Plan's eligibility criteria. You will need to submit the required documentation to Dependent Verification Services for all dependents you are covering on your Medical, Dental and/or Vision Plans. You must also provide documentation to demonstrate any other matters required by the Plan (not just for verifying dependents). Shortly after you choose to enroll your dependent(s) on your Medical, Dental and/or Vision Plans for the first time, you will be contacted by Dependent Verification Services to complete the verification process. If you do not complete the verification process within the allotted timeframe, any unverified dependents will be removed from your coverage effective the 1st of the month following the date

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your final determination letter is sent from Dependent Verification Services. Failure of the dependent verification process is not a qualifying event, and COBRA will not be offered. Periodically the Plan will conduct follow-up verifications of all covered dependents to ensure ongoing eligibility for the Plan.

The documentation that is required to verify your dependents includes:

| <i>Dependent type</i> | <i>Required documentation category 1</i> | <i>Required documentation category 2</i> |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Spouse (1 document from each category required) | <ul style="list-style-type: none"> • Government-issued Marriage Certificate; or • Notarized Affidavit of common law marriage | <ul style="list-style-type: none"> • Joint federal tax return filed within prior 2 years; or • Proof of joint ownership within last 6 months |
| Domestic partner (1 document from each category required) | <ul style="list-style-type: none"> • Certificate of Domestic Partner registration; or • Notarized Affidavit of Domestic Partnership; or • Government-issued certificate of Civil Union Partnership | <ul style="list-style-type: none"> • Joint tax return filed within prior 2 years; or • Proof of joint ownership within last 6 months |
| Biological child (document from category 1 required) | <ul style="list-style-type: none"> • Government-issued Birth certificate including parent's names | |
| Adopted child (1 document from category 1 required) | <ul style="list-style-type: none"> • Government-issued Birth certificate; or • Adoption Certificate; or • Placement Agreement | |
| Step-child (documents from both categories required) | <ul style="list-style-type: none"> • Government-issued Birth certificate including parent's names | <ul style="list-style-type: none"> • Verification of parent's spouse relationship status to the employee (must satisfy documentation requirements for spouse) |
| Domestic partner's child (documents from both categories required) | <ul style="list-style-type: none"> • Government-issued Birth certificate including parent's names | <ul style="list-style-type: none"> • Verification of parent's partner relationship status to the employee (must satisfy documentation requirements for Domestic Partner) |
| Legal ward (documents from both categories required) | <ul style="list-style-type: none"> • Government-issued Birth certificate including parent's names | <ul style="list-style-type: none"> • Court ordered document of legal guardianship |
| Grandchild (all documents from both categories required) | <ul style="list-style-type: none"> • Grandchild's Government-issued Birth certificate including parent's names; and • Biological parent's Government-issued Birth certificate including parent's names | <ul style="list-style-type: none"> • Federal tax return filed within prior 2 years claiming grandchild as tax dependent |

| <i>Dependent type</i> | <i>Required documentation category 1</i> | <i>Required documentation category 2</i> |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| Foster child (documents from both categories required) | <ul style="list-style-type: none"> • Government-issued Birth certificate | <ul style="list-style-type: none"> • Foster care letter of placement |
| Disabled adult child (all documents from both categories required) | <ul style="list-style-type: none"> • Documentation listed above to prove child relationship status; and • Proof of disability document | <ul style="list-style-type: none"> • Federal tax return filed within prior 2 years claiming disabled adult child as tax dependent |

Domestic partner eligibility requirements

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

Domestic partners

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

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

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

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

Domestic partner's children

If your domestic partner meets the requirements, then his or her children may also be considered eligible

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dependents under the Plan. Children of domestic partners are subject to the same eligibility requirements that biological and adopted children must meet.

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

Qualifying for tax-dependent status

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



Certification

When you enroll your domestic partner, you'll be asked to certify that your domestic partner meets the [eligibility requirements](#). You'll also be asked to certify whether your domestic partner qualifies as a tax dependent. The Company assumes all employees will be truthful in making representations about both eligibility and tax status. While you won't be asked to provide proof of these matters when you enroll, the Company reserves the right to request proper documentation at its discretion.

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

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

Imputed income

The additional premium for enrolling a domestic partner is equal to that for a spouse. Similarly, children of domestic partners are subject to the same premium rates as biological or adopted children.

For *tax-dependent* domestic partners and their eligible children, the additional premium is deducted from your pay on a before-tax basis. For *non-tax dependent* domestic partners, the additional premium is deducted from your pay after taxes, and the BMO paid portion of the premium appears on your pay stub as additional taxable income ("imputed" income). If you reside in a state that recognizes civil unions, you may be able to take a tax deduction for post-tax premiums paid when filing your state taxes. Consult with a tax advisor for more information.

Enrolling & changes

When coverage begins

Coverage under the Plan is not automatic; you must enroll. As a new employee or an employee who changes to benefit-eligible status, you have 31 calendar days (includes your hire date* or newly benefit-eligible date) to make your benefit elections. **Coverage begins on the first day of the month following 30 days from your date of hire or change in benefit eligible status date if you enroll within this 31-day period.**

*The benefit effective date for employees hired as part of an acquisition and/or merger may be different based upon the terms of the purchase agreement.

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

Retroactive changes to benefits and deductions may be necessary in a few situations, such as late entry of a benefit change or missed payroll cutoff, therefore any missed benefit deductions from the benefit effective date will be caught up on future payrolls.

Rehired employees

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

Annual enrollment

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

Qualifying life event

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

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



Do not wait to initiate your life event

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

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

How to change, add or cancel coverage

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

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

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

Family and Medical Leave of Absence

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

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

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

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

Maternity and Parental leave

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

- Your benefits coverage will continue during the first 16 weeks of paid maternity/parental leave. Premiums will continue to be deducted from your pay.
- If you choose to take unpaid maternity/parental leave, your benefits coverage will continue, and you will owe premiums. Your premiums will accumulate in arrears. When you return from leave, your regular deductions will resume, and any arrears will be collected at a rate of one additional deduction per pay until your balance is zero.

Military leave of absence

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

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

If you take a leave of absence

You can continue your dental coverage while you are on an approved leave of absence. If you are on a paid leave, your premium is deducted from your pay as usual. If any portion of your leave is unpaid, your benefits coverage will continue, and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume, and any accumulated arrears will be collected at a rate of one additional deduction per pay until your arrears balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums. Your contribution amount is the same as when you were actively working and is subject to change each January 1.

If you become disabled

Your dental coverage, if applicable, may continue during your disability leave. Premium payments are deducted from any Short-Term Disability payments you may be receiving. If you are on Long Term Disability, you will be required to send in payment on an after-tax basis to continue your coverage. Please refer to the Disability SPD for detailed information regarding your benefits during your disability.

Retroactive cancellation of coverage

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

Eligibility claims and appeals

There are two types of claims under this benefit program: eligibility claims and benefit claims. The claims and appeals process differ depending on which type of claim is involved (and, as described below, there is a different process for eligibility claims involving dependent verification). Benefit claims and appeals are handled by a Claims Administrator as described under [Claiming benefits](#). This section details the process and timing around filing an eligibility claim or appeal.

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

As described below, the claim process differs depending on whether the claim involves cancellation of coverage or denial of enrollment due to failure to provide dependent verification or not.

Procedure for filing an eligibility claim involving dependent verification

If your dependent was not enrolled in the Plan or your dependent's coverage under the Plan was terminated due to your failure to provide any requested dependent verification information or documentation (e.g., failure to provide a marriage certificate for a spouse or failure to provide a birth certificate or proof of adoption for a child), you may file a claim with the Dependent Verification Services team. In order for a communication from you to constitute a valid claim, it must be in writing on a Dependent Verification Claim Initiation Form, include your name and employee ID, and be delivered, along with any supporting comments, documents, records, and other information to:

Dependent Verification Center – Claims and Appeals

PO Box 1434

Lincolnshire, IL 60069-1434

Your claim must be received by claims and appeals management within 60 days from the later of the coverage termination date or eligibility enrollment date.

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The dependent verification center claims and appeals management team will respond to your claim in writing within 30 days of the date the claim is received. If claims and appeals management needs additional information in order to determine whether to grant your claim, they will notify you of the additional information needed. If you do not provide that information within 30 days, your claim will be considered invalid.

Please note that submitting an appeal does not guarantee that your dependent(s) will be reinstated on your coverage. As part of the appeal process, you will need to demonstrate that there was an extenuating circumstance that prevented you from being able to complete the verification process within the required timeframe or that an error occurred.

Procedure for filing an eligibility claim not involving dependent verification

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

BMO Financial Corp.
C/O Appeals
DEPT 14613
PO Box 64050
The Woodlands, TX 77387-4050
Fax: 1-866-894-6684

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

Appeal of a denied eligibility claim

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

BMO Financial Corp.
Benefits Administration Committee
395 N. Executive Drive
Brookfield, WI 53005

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

Dental Plan – Summary Plan Description

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

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

Limitation of action

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

Mandatory venue

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

Plan cost

The Company pays a significant portion of the cost for coverage under the Dental Plan. The amount of your premiums depends on which coverage level option you choose (based on which eligible dependents you enroll in your coverage). These premiums are subject to change each year.

Tax-saving advantage

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

If you enroll a tax dependent domestic partner, the additional premium is equal to that for a spouse. However, if you enroll a non-tax dependent partner, you pay the premium on an after-tax basis and it creates imputed income. For more information, see Domestic partner eligibility requirements, including the [Two options for domestic partner status chart](#). Your domestic partner's children qualify for coverage only if they are your tax dependents, so children of a domestic partner are subject to the same before-tax rates as biological or adopted children.

Additional savings opportunities

Not all of your expenses are covered by the Dental Plan. Some of these extra expenses can be reimbursed tax-free if you make contributions to the Health Care Flexible Spending Account and/or a Health Savings Account. To learn more about the HCFSAs, review the SPD.

To learn more about the HSA (available only if you enroll in the BMO Consumer Choice Plan), see the Health Savings Account Plan Details. If you enroll in the Consumer Choice Plan and sign up for a Health Savings Account, you have the option to also enroll in a Limited Purpose Flexible Spending Account, which allows you to take advantage of additional before-tax savings for eligible dental and vision expenses only.

To access your account(s): Go to Workday, click on the **My Benefits & Retirement** app, depending on where you are connecting to Workday from, click on **Employees in Canada and US (on BMO Network)** or **Employees in Canada and US (off BMO Network)**, click on **Reimbursement Accounts**.

Dental Plan

The Company's Dental Plan provides dental care for you and your eligible dependents, including preventive care (e.g., cleanings), basic and major services (e.g., fillings, crowns, etc.), oral surgery and orthodontia.

The Company offers you the Delta Dental Plan. The Plan is designed to encourage preventive care while also helping you and your dependents handle the cost of major dental expenses.

Keep in mind, you always have a choice of what dental care services you receive and who provides them, regardless of what the Dental Plan covers or pays.

Dental Plan at a glance

Below is a high-level look at the features and benefits of the Dental Plan.

| Features | Delta Dental |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Choice of dentists | You may go to any dentist you choose |
| Deductible | <ul style="list-style-type: none">• \$50 per person• \$150 family maximum (three individual deductibles per family)• Applies to basic and major services |
| Coinsurance | |
| Preventive services | 100% |
| Basic services | 80% |
| Major services | 50% |
| Annual maximum benefit | \$2,000 |
| Orthodontia benefit (dependent children age 19 or younger) | 50% |
| Lifetime orthodontia maximum | 50% of reduced fee subject to separate \$2,000 lifetime maximum |
| Temporomandibular Joint (TMJ) | Separate \$1,000 lifetime maximum |

Meeting the annual deductible

Under the Delta Dental Plan, an annual deductible per person applies for all covered services except preventive and orthodontia. The deductible will not exceed the equivalent of three individual family members' deductible.

How the Dental Plan works

The Dental Plan provides in-network and out-of-network benefits for eligible employees and dependents, including preventive care (e.g., cleanings), restorative care (e.g., fillings), oral surgery and orthodontia. You may choose to receive care from any dentist, even if he or she is not part of the network. However, your out-of-pocket costs may be higher when you receive care from an out-of-network provider since he or she may bill you for fees exceeding the maximum Plan allowance.

In some situations, a rebate, refund or other similar payment may be paid by an insurance company which provides coverage under the Plan or a third-party administrator that provides administrative services under the Plan. In addition, in some situations, an insurance company or third-party administrator may withhold payment to a health care provider or provide an incentive or other additional payments to a provider based on satisfaction of certain standards. Any such payment or withholding of payment will not affect the amount of deductible, copayment, coinsurance or out-of-pocket amounts that you pay for any service under the Plan.

Finding a dental provider

The Dental Plan provides in-network benefits and out-of-network benefits. You may obtain dental services from the dentist of your choice. However, you generally receive the highest level of benefits when you use an in-network provider. In-network providers offer covered services at discounted prices and handle all claim filings. If you use an out-of-network provider, your benefits are subject to certain limits, and you may be responsible for paying for services when they are provided and filing a claim for reimbursement. You always have the choice of what dental services you receive and who provides them, regardless of what the Dental Plan covers or pays.

Network providers

You have the freedom to choose any dentist and still receive dental benefits, but you can save money and avoid claim forms by choosing dentists in either of Delta Dental's two participating provider networks:

- **Delta Dental PPO network.** The Delta Dental PPO network is smaller than the Delta Dental Premier network, but Delta Dental PPO dentists accept the deepest discounts on covered services, saving you the most on your out-of-pocket costs and stretching your annual maximum benefit dollars.
- **Delta Dental Premier network.** The Delta Dental Premier network is a larger dentist network when you can't find a Delta Dental PPO dentist. A Delta Dental Premier dentist will usually save you more money than if you visit a non-Delta Dental dentist. While Premier dentists' contracted fees are often slightly higher than Delta Dental PPO dentists' fees, Premier dentists cannot bill you above Delta Dental's approved amount.

To locate a network dentist near you, visit www.deltadentalil.com, or call 1-800-323-1743.

Out-of-network provider

Out-of-network dentists usually charge more than Delta Dental's contracted fees, so you'll reach your annual maximum benefit sooner. Plus, you will be responsible for all charges in excess of the maximum Plan allowance as determined by Delta Dental for specific services in a geographic area. Out-of-network dentists could charge you up to their full fees. You may be required to pay the dentist the full amount at the time of service and then submit a claim form to Delta Dental for reimbursement.

Pretreatment estimate

If you and/or your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed \$200, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services, including your dental needs and a description of procedures and services the dentist plans to perform, (including the actual fees to be charged for each procedure).

Pretreatment estimate requests are not required but may be submitted for more complicated and expensive procedures, such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pretreatment estimate to you and the attending dentist with non-binding verification of the level of payment under this Plan. The pretreatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate. This may be due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

What's covered under the Delta Dental Plan

The Dental Plan covers charges for diagnostic and preventive services at 100%, up to the annual maximum. You pay nothing (the annual deductible is waived), except for charges above the maximum Plan allowance for out-of-network care.

Diagnostic and preventive care is important to maintain your dental well-being. If you maintain your dental health by regularly receiving dental care, you may avoid more costly dental expenses. Following are covered services under the Delta Dental Plan.

Diagnostic Services

- Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused): two per calendar year.
- Comprehensive oral evaluations – new or established patient: *once per dentist*.
- Detailed and extensive oral evaluation – problem focused, by report: *once per dentist*.
- Comprehensive periodontal evaluation: new or established patient: *once per dentist*.
- Periodic oral evaluations: *twice per calendar year*.
- Intra-oral periapical radiographs.
- Bitewing x-rays (not including vertical bitewings): *one per calendar year*.
- Complete full mouth x-rays: *once per 36-month interval*. A full mouth x-ray includes bitewing x-rays. Panoramic x-ray in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full-mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.
- Diagnostic casts: when rendered more than 30 days prior to definitive treatment.
- Pulp vitality tests: *once per visit*.
- Screening or assessment of a patient: *once in a 12-month interval*.

Detailed or comprehensive oral evaluations count toward the calendar year maximum of two oral evaluations.

Preventive Services

- Dental prophylaxis (cleaning): *twice per calendar year.* *
- Topical fluoride applications: twice per calendar year for covered dependents under age 19.
- Space maintainers: covered when they replace prematurely lost teeth for covered dependents under age 19.
- Recementation of space maintainers: once per lifetime for covered persons under age 19.
- Sealants: applied once per tooth to the occlusal surface of molars that are free of decay and restorations; for covered dependents under age 19.

With an indicator of surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit ear for periodontal maintenance or adult prophylaxis.

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*

**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated.*

**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated.*

**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

Basic restorative services

You pay 20% coinsurance after your annual deductible for basic restorative services, plus charges above the maximum Plan allowance for out-of-network care.

Following are basic restorative services covered under the Delta Dental Plan:

Restorative Services

- Fillings, including amalgam and resin-based composite fillings: *once per surface in a 12-month interval.*
- Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns.
- Crown repair.
- Additional procedures to construct a new crown under an existing partial denture framework.
- When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.

Endodontic Services

- Pulpal and root canal therapy.

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When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.

When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.

Pulpal therapy (resorbable filling) is a covered dental benefit once per tooth per lifetime.

Surgical Periodontic Services

- Gingivectomy or gingivoplasty, gingival flap procedure.
- Clinical crown lengthening – hard tissue.
- Osseous surgery (including flap entry and closure).
- Guided tissue regeneration, per site: only when performed in association with natural teeth.
- Bone replacement and soft tissue grafts.

Surgical periodontics is allowed once every 3 years.

Non-Surgical Periodontic Services

- Periodontal scaling and root planning.
- Full mouth debridement to enable comprehensive evaluation and diagnosis: *once per lifetime.*
- Periodontal maintenance: *twice per calendar year.*

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

With an indicator or surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*

**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated.*

**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated.*

**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

Removeable Prosthodontic Services

- Adjustments and repairs to complete and partial dentures, *twice every 12-months.*
- Repairs to complete and partial dentures, *once every 24-months.*

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- Replace missing or broken teeth.
- Add tooth or clasp to existing partial denture, *once per lifetime*.
- Replace all teeth and acrylic on cast metal framework, *once per lifetime*.
- Denture rebase or reline: *once in a 3-year period*.
- Tissue conditioning: *once in a 12-month interval*.

Fixed Prosthodontic Services (Bridges)

- Recement fixed partial denture, *once per lifetime*
- Fixed partial denture (bridge) repair, *once per lifetime*

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 96 months following placement of the initial appliance is not a covered benefit.

When the edentulous between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

Adjunctive General Services

- Palliative (emergency) treatment of dental pain minor procedure.
- Deep sedation/general anesthesia: when provided by a dentist in conjunction with oral surgery other than simple extractions.
- Intravenous conscious sedation/analgesia: when medically necessary and provided in conjunction with oral surgery other than simple extractions.
- Consultations (100% paid).

Other

- Treatment of fractures of facial bones.

Major restorative services

You pay 50% coinsurance after your annual deductible for major services, plus charges above the maximum Plan allowance for out-of-network care.

Following are major restorative services covered under the Delta Dental Plan:

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Restorative Services

- Onlays: permanent teeth only.
- Crowns and ceramic restorations (permanent teeth only): *once every eight years*.
- Prefabricated stainless steel crowns.
- Sedative filling: once per tooth per lifetime.
- Pin retention.
- Cast or prefabricated post and core; core build-up.

When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.

Removeable Prosthodontic Services

- Complete and partial dentures.
- Stayplate, once in a 5-year interval.

Fixed Prosthodontic Services (Bridges)

- Pontics.
- Fixed partial denture retainers – inlays/onlays/crowns (placed as abutments, i.e., to retain or support fixed partial dentures).
- Cast or prefabricated post and core; core build up.

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 96 months following placement of the initial appliance is not a covered benefit.

When the edentulous between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

Other

- Implants once every 8-years for covered persons age 16 and older.
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction (includes occlusal guards).

Oral surgery

You pay 20% coinsurance after your annual deductible for oral surgery services, plus charges above the

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maximum Plan allowance for out-of-network care.

Following are oral surgery services covered under the Delta Dental Plan:

- Simple extractions.
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
- Removal of impacted tooth – soft tissue, partially bony, completely bony.
- Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus.
- Surgical access of an unerupted tooth.
- Biopsy of oral tissue; brush biopsy.
- Alveoloplasty – per quadrant.
- Surgical excision of soft tissue lesions.
- Surgical excision of intra-osseous lesions.
- Other surgical/repair procedures: removal of exostosis, torus palatinus or totus mandibularis, incision and drainage of abscess – intraoral soft tissue, frenulectomy or frenuloplasty, excision of hyperplastic tissue or pericoronal gingiva, surgical reduction of osseous or fibrous tuberosity, dilation of salivary duct.

Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a dentist's office.

Orthodontic Services

Orthodontic services are treatments performed by a licensed dentist for the proper alignment of teeth. Dependent children are eligible for orthodontic services until age 19. You pay 50% coinsurance, plus charges above the maximum Plan allowance for out-of-network care and lifetime maximum orthodontic benefit limit of \$2,000 per covered person.

If specialized techniques (for example, clear or “Invisalign” braces) are elected, a Delta Dental PPO dentist is not obligated to accept the scheduled fee as full payment and may charge the patient any difference in cost between the optional method and a conventional appliance in addition to scheduled copayment amounts.

Enhanced Benefits Program

Delta Dental of Illinois' Smile Smart Enhanced Benefits Program allows additional frequency for some treatments. This program enhances coverage for individuals who have specific health conditions. Those eligible for the Enhanced Benefits Program include the following:

- People with periodontal (gum disease)
- People with diabetes
- Pregnant women
- People with high-risk cardiac conditions
- People with kidney failure or who are undergoing dialysis
- People undergoing cancer-related chemotherapy and/or radiation
- People with suppressed immune systems due to HIV positive status, organ transplant, and/or stem cell (bone marrow) transplant
- People with special healthcare needs

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These enhancements are based on scientific evidence that shows treating and preventing oral disease in these situations can improve overall health. To enroll, visit the subscriber section of www.deltadentalil.com, or call 1-800-323-1743.

What's not covered by the Delta Dental Plan

Dental benefits are not provided for any of the following charges:

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.
- Replacement of a stainless-steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.
- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.
- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.
- The repair of any component of a cast restoration is not a covered benefit.
- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.
- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.
- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

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- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.
- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.
- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 96 months following initial placement of existing appliance is not a covered benefit.
- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.
- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.
- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.
- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

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- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants*.
- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement and a Subscriber elects Family Unit coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.
- Charges for services completed prior to the date the person became covered under this program.
- Services for anesthetists or anesthesiologists.
- Temporary procedures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.
- Drugs or the administration of drugs, except for general anesthesia and intravenous sedation.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Surgical services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

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- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plaque control programs.
- Services or supplies to correct harmful habits.

Claiming benefits under the Delta Dental Plan

If you're covered under the Delta Dental Plan and another dental plan, see Coordination of Benefits.

For care received from in-network providers, you do not have to submit a claim. In-network providers will submit claims directly to the Claims Administrator.

For care received from out-of-network providers, you may be required to file a claim for reimbursement with the Claims Administrator. Simply pay the out-of-network provider in full at the time you receive service and obtain an itemized receipt. Mail the itemized receipt to the Claims Administrator, along with the claim form, within 90 days of service. All claims must include:

- A proper claim form; and
- An itemized bill for the services or supplies provided.

For a claim form, visit www.deltadentalil.com. Properly completed claim forms should be submitted to the Claims Administrator at the following address:

Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

Disputed claims procedure under the Delta Dental Plan

Prior approval of benefits

This group Dental Plan does not require prior approval of dental services. Nonetheless, a covered individual and his/her treating dentist may request a predetermination of benefits to obtain advance information on the Plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this Plan and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this Plan's payment policies.

Notice of adverse benefit determination

If a claim is denied in whole or in part, Delta Dental of Illinois (DDIL) shall notify the enrollee of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not

exceeding 15 days, for processing. DDIL will notify the treating dentist as well by issuing an Explanation of Payment. If an extension is necessary, DDIL shall notify the enrollee and the treating dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the enrollee or the treating dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits form

This form includes the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific Plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary.
- A description of DDIL's appeal process and the time limits applicable to the process, including a statement of the enrollee's right to bring a civil action under the Employee Retirement Income Security Act (ERISA) following an adverse benefit determination.
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination.
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Request for appeal of adverse benefit determination

If the enrollee disagrees with DDIL's adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of DDIL within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that DDIL's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, DDIL will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Reevaluation committee's review

The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of review decision

The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific Plan provisions upon which the determination is based.
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request.
- A statement of the claimant's right, to bring a civil action under the Employee Retirement Income Security Act (ERISA).
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination.
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Employer's review of claims for eligibility reasons

Notwithstanding the above procedures, employer has the right to review and override all claim determinations related to eligibility or loss of eligibility, whether said claims are approved or denied.

If you have a question about a dental claim, call the Claims Administrator at 1-800-323-1743.

Coordination of benefits

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If you are thinking about carrying dual coverage for yourself and your family, it's important to understand the way the dental plan coordinates coverage with other group plans.

The dental plan has a coordination of benefits provision that prevents duplication of benefit payments when you or your dependent also has other coverage through another group plan. Coordination of benefits procedures also determine which plan pays your claim first.

How coordination of benefits works

Here's how the coordination of benefits provision works: When you have a claim, determine which plan will be your primary plan (see [Determining your primary plan](#)). Then, send your claim to the primary plan, which pays benefits up to its plan limits, without regard to any other plans. After the primary plan processes your claim, send copies of the same medical bills and the primary plan's explanation of benefits (EOB) to the secondary plan.

Under the Dental Plan, when another plan is primary Delta Dental is the secondary plan. Depending on the benefit you have already received and what your other plan covers, you may receive up to 100% of your benefit between the two plans, but not more than that.

As the secondary plan, Delta Dental calculates your benefit as if there were no other plan. Then they subtract what the other plan paid, taking deductibles and copayment levels for the benefit into consideration. The difference between what Delta pays as the secondary plan and what Delta would have paid as the primary plan is available to pay for allowable expenses incurred but not paid in a calendar year for the person making the claim.

Determining your primary plan

If a covered individual is entitled to coverage under two or more policies or prepaid health care plans, then the covered dental benefits are paid as follows:

1. The benefits of the plan which covers the person directly as the employee and not as a dependent will be determined before those of the plan which covers the person as a dependent.
2. Except as set forth in paragraph 3, when two or more plans cover the same child as a dependent of different parents:
 - The benefits of the plan of the parent whose birthday, excluding year of birth, falls earlier in a year will be determined before those of the plan of the parent whose birthday, excluding year of birth, falls later in that year; but
 - If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time will be determined before those of the plan which covered the parent for a shorter period of time.

However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state plan which has a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. If two or more plans cover a dependent child of divorced or separated parents, benefits of the child are determined in this order:
 - **First**, the plan of the parent with custody of the child;
 - **Second**, the plan of the spouse of the parent with custody of the child; and
 - **Third**, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before that entity has that actual knowledge.

But if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules as set forth in paragraph 2.

4. The benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, will be determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other plan is not subject to this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.
5. If none of the rules in paragraphs 1, 2, 3 or 4 determine the order of benefits, the benefits of the plan which covered an employee for a longer period of time will be determined before those of the plan which covered that person for the shorter period of time.

Dental Plan – Summary Plan Description

If this Dental Plan provides only secondary coverage, it shall not be obligated to make payment until Delta Dental of IL receives a copy of the primary carrier's proof of payment and calculation of benefits.

Where an individual has dual coverage, this Dental Plan shall not be charged with a greater amount than the amount for which it would be liable if such dual coverage did not exist. In any event, the benefits under both plans shall not total more than the dentist's billed fees.

If you are uncertain whether your plan is primary, call your plan's Member Services.

Right of recovery

This Plan reserves the right to recover benefit payments made for an allowable expense under this Plan in the amount which exceeds the maximum amount this Plan is required to pay under these provisions. This right of recovery applies to this Plan against:

1. any persons to, for or with respect to whom, such payments were made; or
2. any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

This Plan alone will determine against whom this right of recovery will be exercised.

When coverage ends

Your coverage ends on the last day of the month in which any of these events occur:

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

Your dependent's coverage ends on the last day of the month in which any of these events occur:

- your employment with the Company ends for any reason,
- you or your covered dependents become ineligible to participate (see [Eligibility](#)),
- you divorce or become legally separated from your spouse,
- you no longer share a sole, committed relationship with your domestic partner,
- you fail to pay premiums when due,
- the Plan ends coverage for employees, dependents and/or domestic partners, or
- failure of the dependent verification process.

You may be able to continue your coverage through COBRA. It is your responsibility to notify the Company of any change in your status or the status of any of your covered dependents that affects eligibility for coverage under the Plan within 31 days of the status change.

Continuing coverage through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Dental Plan ends, you or your covered dependents may be eligible to temporary continue your coverage at

Dental Plan – Summary Plan Description

your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

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

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

Qualifying events for continuation coverage under COBRA

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

| <i>Who can continue coverage</i> | <i>In what situations</i> | <i>For how long</i> |
|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| You, your spouse, your eligible children | <ul style="list-style-type: none">• A reduction in your work hours (scheduled to work less than 20 hours a week)• Your termination of employment (except in cases of gross misconduct) | 18 months* |
| Your spouse | <ul style="list-style-type: none">• Your death• Divorce or legal separation• Employee’s entitlement to Medicare (Part A, B, or both)** | 36 months |
| Your eligible children | <ul style="list-style-type: none">• Your death• Divorce or legal separation• Employee’s entitlement to Medicare (Part A, B, or both)**• Children no longer meet the eligibility rule | 36 months |

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

***The covered employee’s Medicare entitlement is a listed triggering event, but it will not be a qualifying event unless it causes a loss of plan coverage.*

Getting started

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

Under federal law, you have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. **If this election period is missed, you and your eligible dependent(s) will lose the opportunity to continue coverage under COBRA.**

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You must make your first payment for continuation coverage within 45 days after the date of your election, and coverage is retroactive to the date your Plan coverage ended. If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

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

Notification requirements

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage. If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation, or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the affected Qualified Beneficiary **will lose the opportunity to continue coverage under COBRA**. If you are continuing coverage under federal law, you must notify the COBRA Administrator within 60 days of the birth or adoption of a child.

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

PayFlex Systems USA, Inc.
BENEFITS BILLING DEPARTMENT
P.O. BOX 953374
ST. LOUIS, MO 63195-3374

Disability

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

Dental Plan – Summary Plan Description

Security-disabled. **You are required to notify the Plan Administrator of any change in your disabled status.** You must notify PayFlex of that fact within 30 days of SSA's determination at the following address:

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

Second qualifying event

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

When COBRA coverage ends

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

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



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

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

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer), the Health Insurance Marketplace or Medicaid within 30 days after your group health coverage ends because of a qualifying event. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you are eligible for the Retiree Medical Program and you elect COBRA health insurance coverage at the

time of your retirement, you will forfeit your right to participate in the Retiree Medical Program.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

When does COBRA coverage become effective?

Once you enroll in COBRA coverage and make your first payment, coverage is effective retroactive to the date your active group health coverage ended.

When can I enroll?

You, your covered spouse, and/or your covered dependent(s) (covered qualified beneficiaries), have the right to choose COBRA coverage independently. If you or they decide to enroll, COBRA elections must be made within **60** days of the date that coverage is lost or within **60** days of the statement date on the COBRA Group Health Benefits Right of Continuation Coverage Election Notice you receive, whichever is later. If this election period is missed, you and your eligible dependent(s) will lose the opportunity to continue coverage under COBRA.

Why is COBRA coverage so expensive?

The monthly premiums for COBRA can come as a surprise if you're accustomed to your employer paying a portion of the cost of health insurance. When you choose COBRA coverage, you must pay the full monthly premium amount (the total of what you and your employer were paying for your coverage), plus a 2% administration fee, as allowed by law. In addition, your first monthly premium payment (due within 45 days of your COBRA enrollment) is likely to be higher than subsequent payments because it may include more than one month of coverage and is retroactive to the date that you lost your employer provided coverage.

When can I make changes to or drop my COBRA coverage?

Generally, you, your covered spouse, and other covered dependents have the same rights and restrictions as other plan participants to change your coverage during the year and at annual enrollment. In addition, you have the freedom to make election decisions independently from one another. Keep in mind that enrollment in a Health Care Flexible Spending Account (HCFSAs) is limited to individuals participating in a HCFSAs at the time of the qualifying event and continues only until the end of the current plan year.

If you want to make a change to or drop your COBRA coverage outside of the annual enrollment period, you may need to demonstrate proof of a qualified change in status (such as marriage, divorce, or the birth or adoption of a child). Make sure you notify the COBRA Administrator of your change in status within the required time period that is stated in the plan rules.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Administrative information

Plan identification

Plan name

This Summary Plan Description describes the Dental Plan portion of the Employee Benefit Program of Bank of Montreal/Harris. The Plan, a group health plan subject to the Health Insurance Portability and Accountability Act (HIPAA), provides medical, prescription drug, mental health and chemical abuse, dental, vision, Flexible Spending Accounts and before-tax premium benefits.

Separate Summary Plan Descriptions describe the Medical, Vision, Flexible Spending Accounts, Employee Assistance Program and Life and Disability portions of the Employee Benefit Program of Bank of Montreal/Harris Plan.

Plan number

507

Employer Identification Number

51-0275712

Plan year

January 1 – December 31

Plan sponsor

BMO Financial Corp.

Employee Benefit Program of Bank of Montreal/Harris

Plan administrator

Benefits Administration Committee

The Plan sponsor and Plan administrator can be contacted at:

BMO Financial Corp.
Benefits Administration Committee
111 West Monroe Street, 7W
Chicago, IL 60603
Human Resources Centre (HRC): 1-888-927-7700

The Plan administrator has complete discretionary authority to make all determinations under the Plan, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Plan. It is the principal duty of the Committee to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. To the extent not delegated to another named fiduciary or to a Claims Administrator, the Committee shall have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. The Committee shall have discretionary and final authority to interpret the terms of the Medical Plan regarding matters for which it is responsible as set forth above and its decisions shall be final and binding on all parties.

The Plan administrator has delegated to the Claims Administrator the discretionary authority to make decisions regarding the interpretation and application of Plan provisions, to make determinations (including

Dental Plan – Summary Plan Description

factual determinations) as to the rights and benefits of employees and participants under the Plan and to make claims and final appeals determinations under the Plan. Benefits under the Plan will only be paid if the Plan administrator or the Claims Administrator, as applicable, determines in its discretion that the claimant is entitled to them.

Plan trustee

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

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

Agent for service of legal process

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

Type of funding

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

- Blue Cross and Blue Shield
- Express Scripts (Prescription Drug)
- UMR (Medicare Secondary Plan)
- Delta Dental

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

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

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

Dental Plan – Summary Plan Description

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.

Claims administrators and service providers

| <i>Claims Administrator</i> | <i>For</i> | <i>Address for filing claims</i> |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Blue Cross and Blue Shield of Illinois www.bcbsil.com Member Services: 1-888-979-4516 | Medical benefits and pre-certification under the Blue Cross and Blue Shield Consumer Choice Plan | Blue Cross and Blue Shield PO Box 805107 Chicago, IL 60680-4112 |
| Express Scripts www.express-scripts.com Member Services: 1-877-795-2926 | Retail and home delivery medications | Express Scripts PO Box 14711 Lexington, KY 40512 |
| Delta Dental of Illinois www.deltadentalil.com Member Services: 1-800-323-1743 | Dental benefits | Delta Dental of Illinois PO Box 5402 Lisle, IL 60532 |
| Smart-Choice Human Resources Centre (HRC): 1-888-927-7700 | Flexible Spending Accounts and Health Savings Account (HSA) administration | Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009 |
| WealthCare Saver Human Resources Centre (HRC): 1-888-927-7700 | Health Savings Account Custodian | Within Workday , click on the My Benefits & Retirement app, under Reimbursement Accounts select Health Savings Account. This will direct you to the Smart-Choice platform to access your Health Savings Account. |
| UMR www.umar.com Member Services: 1-877-561-0366 | Retirees who are Medicare eligible because of age or disability | UMR Claims Appeal PO Box 30541 Salt Lake City, UT 84130-0541 |
| VSP Vision Care Member Services: 1-800-877-7195 | Vision benefits | Send completed VSP Member Reimbursement Form and a legible copy of your itemized receipt(s) to: VSP Vision Care PO Box 385018 Birmingham, AL 35238-5018 |

| <i>Service provider</i> | <i>For</i> | <i>Address</i> |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Alight Solutions –HR Benefits Human Resources Centre (HRC): 1-888-927-7700 | Processes eligibility and provides customer service to covered individuals | Alight Solutions –HR Benefits DEPT 14613 PO Box 64050 The Woodlands, TX 77387-4050 |

| <i>Service provider</i> | <i>For</i> | <i>Address</i> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Dependent Verification Center | Submitting initial Dependent Verification documents | Dependent Verification Center PO Box 1401 Lincolnshire, IL 60069-1434 |
| <i>COBRA administrator</i> | <i>For</i> | |
| PayFlex Systems USA, Inc Benefits Billing Department PO Box 953374 St. Louis, MO 63195-3374 Member Services: 1-888-678-7835 | COBRA continuation coverage www.payflex.com Employer ID: 139888 | |

Uncashed checks

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

Future of the Plan

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

Privacy information

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

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

Your rights under ERISA

As a participant in the Employee Benefit Program of Bank of Montreal/Harris, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive information about our Plan and benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The administrator may make a reasonable charge for the copies.

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

Continue group health plan coverage

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

Prudent actions by plan fiduciaries

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

Enforce your rights

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

Dental Plan – Summary Plan Description

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide all of the materials and pay up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedure as described in this SPD. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with your questions

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

No employment guarantee

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

Glossary of terms

If you have any questions about the Glossary of Terms, please contact Member Services for Delta Dental.

Approved Fee

The lesser of the Dentist's fee or the Maximum Plan Allowance.

Annual Benefit Maximum

The maximum amount that the Plan will pay for benefits during the calendar year.

Annual Deductible (or Deductible)

The amount you must pay for covered health services in a calendar year before the Plan will begin paying benefits in that calendar year.

Appeal

A review of an adverse benefit determination by the Plan.

Benefit Year

The reference period specified in the Dental Plan Specifications for purposes of determining the application of Deductibles, waiting periods and coverage limits for each Covered Individual.

Covered Individual

Any employee or any Dependent of that employee who enrolls in this Group Dental Plan and who is entitled to receive Dental Benefits, unless and until coverage terminates as provided herein.

Covered Individual's Effective Date of Coverage

The date an individual meets the required conditions of eligibility and becomes enrolled in this Group Dental Plan.

Claim(s) Administrator

Means Delta Dental of Illinois

Complaint

An expression of dissatisfaction by you either orally or in writing.

Copayment (or Copay)

A copay is the flat dollar amount that you pay for a specific covered service before the Plan pays any benefits.

Delta Dental PPO Dentist

A Dentist who, by written agreement with DDIL, will provide dental services to Covered Individuals in accordance with DDIL's negotiated fee schedules and has agreed to abide by the bylaws, rules and regulations established by DDIL.

Dependent

An individual who meets the eligibility requirements specified in the Plan.

Dentist

A licensed dentist or physician legally entitled to practice dentistry at the time and in the place services are provided.

Maximum Plan Allowance

The amount that a Delta Dental Premier dentist agrees contractually to accept as full payment for covered procedures. The maximum Plan allowance is calculated as a percentile of billed fees.

Non-Delta Dental PPO Dentist

A dentist who has not agreed to be a Delta Dental PPO dentist. There are two categories of non-Delta Dental PPO dentists:

- Delta Dental Premier dentists are bound to accept DDIL's approved fee as full reimbursement for their services after application of any deductibles and DDIL's benefit payment.
- Non-Dental Dental Premier dentists have not agreed to accept DDIL's approved fee as full payment of their services. Non-Delta Dental Premier dentists may bill the patient the difference between his/her fee and DDIL's benefit payment.