BMO

UnitedHealthcare
Summary Plan Description (SPD)

Employee Benefit Program of Bank of Montreal/Harris

Medical Summary Plan Description (SPD)
UnitedHealthcare

Employee Benefit Program of Bank of Montreal/Harris

Effective: January 1, 2021
Group Number: 717480

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-896-0067.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

BMO Financial Corp. is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the BMO Financial Corp. Welfare Benefit Plan. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the *Employee Retirement Income Security Act of 1974 (ERISA)*. It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan

BMO Financial Corp. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many

ways, it does not guarantee any Benefits. BMO Financial Corp. is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Employee Benefit Program of Bank of Montreal/Harris works. If you have questions contact your Human Resources Centre or call the number on your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting your Human Resources Centre.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- BMO Financial Corp. is also referred to as Company.
- This document is the Summary Plan Description (SPD) for the Employee Benefit Program of Bank of Montreal/Harris (the "Plan").
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a full-time Employee or part-time employee who is scheduled to work at least 20 hours per week.

You are considered an "employee" only if you are specifically treated or classified as an employee on 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 or another agency retroactively reclassifies you as an employee.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your legal Spouse, as defined in Section 14, *Glossary*, 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 purposed 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 satisfied certain criteria (see Domestic Partner Eligibility Requirements in this section).
- Your or your Spouse's child who is under age 26, including a biological child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian, foster children living with you, and your domestic partner's child(ren) if they qualify as your dependents for income tax purposes according to Section 152 of the Internal Revenue Code.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you. See Extended Coverage for Disabled Children in this section).

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

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 adult child may continue to be eligible to be covered on your BMO Plan if certain conditions are met:

- 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 Plan will no longer pay benefits for that child.

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 plan 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 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.

Domestic Partner Eligibility Requirements

Medical 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 Internal Revenue Code.

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 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 pretax 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 Internal Revenue Code. In addition, tax dependents must be claimed on your federal tax return. If your domestic partner qualifies under 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.

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.

Two Options for Domestic Partner Status		
	Tax - Dependent Status	**Non Tax – Dependent Status**
Who Qualifies	Domestic partner who satisfies the requirements listed above and is your legal dependent for tax purposes as defined under Internal Revenue 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 Spending Accounts	Your domestic partner's (and/or their qualifying children's) eligible medical, dental and vision expenses may be eligible under your Health Care 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 pretax 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.

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 mattes when you enroll, the Company reserves the right to request proper documentation at its discretion.

Cost of Coverage

You and BMO Financial Corp. share in the cost of the Plan. Your contribution amount depends on the eligible family members you choose to enroll. These premiums are subject to change each year.

Your contributions are deducted from your paychecks on a before-tax basis. Contributions are 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 dollars come out of your pay before federal income and Social Security taxes are withheld and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of BMO Financial Corp.'s cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

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 the 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 pretax rates as biological or adopted children.

You can obtain current contribution rates by calling the Human Resources Centre or navigating to www.bmousbenefits.com.

How to Enroll

Coverage under the Plan is not automatic; you must enroll, go to **Workday**, click on the **My Benefits & Retirement** application As a new employee or an employee who changes to benefit-eligible status, you have 31 calendar days (includes your date of hire*/newly benefit-eligible date) to make your benefit elections.

*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 or special enrollment event. If you have a qualifying life event or special enrollment 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 or special enrollment event.

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

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you initiate the life event and add the coverage you want within 31 calendar days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

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 from the date of the event to change, add or cancel coverage, it is recommended that you initiate the life event immediately in the My Benefits & Retirement enrollment site. You may contact the Human Resources Centre at 1-888-927-7700 for assistance in making a qualifying life event change.

When Coverage Begins

Once you have properly completed enrollment, coverage will begin 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. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

The effective date of coverage is the date of the qualifying life event provided you complete the qualifying life event within 31 calendar days of your event. For example, coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of

your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change.

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.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify UnitedHealthcare of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

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. The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Starting or ending a domestic partnership.
- The birth, legal adoption, placement for adoption or legal guardianship of a child. (You must apply for coverage within 90 calendar days of that birth, adoption or placement for adoption).
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.

- Death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your employment status or that of your spouse or dependent, including starting or ending employment, a strike or lockout, the start of or return from an unpaid leave of absence, or a change in worksite.
- A change in the employment status of you, your spouse or a dependent such that the affected individual becomes eligible or loses eligibility under the Plan or another employer benefit plan.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact your Human Resources Centre within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact your Human Resources Centre within 60 days of the date of determination of subsidy eligibility).
- You or your Dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your Dependent may enroll in other individual market coverage, through or outside of a Marketplace.

Unless otherwise noted above, if you wish to change your elections, you must complete your qualifying life event within 31 calendar days of the change in family status. Otherwise, you will need to wait until the next Annual Enrollment

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

For specific details on the elections changes that you may make based on the type of life event you experience, access the Benefit Changes page on the BMO U.S. Benefits site at www.bmousbenefits.com.

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 enrollment site. 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.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At Annual Enrollment, she elects not to participate in BMO Financial Corp.'s medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under BMO Financial Corp.'s medical plan outside of Annual Enrollment.

How to Change, Add or Cancel Coverage

If you experience a qualified life event or special enrollment event, you have 31 calendar days from the date of the event to change, to add or cancel coverage.

Here's how:

1. Go to **Workday**, click on the **My Benefits & Retirement** application.

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**.

You may contact the Human Resources Centre at 1-888-927-7700 for assistance in making a qualifying life event change.

If you miss the deadline, your next opportunity to enroll, change or cancel coverage is during Annual Enrollment, unless another qualifying life event or special enrollment 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. If after review, the Benefits Administration Committee or Claims Administrator 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.

If you Move Out of Your Plan's Service Area

The plan administrator for the Consumer Choice Plan is UnitedHealthcare for employees that reside in all states, except Illinois.

If you move in or out of the service area, you and any enrolled dependents will automatically be moved to the Consumer Choice Plan available to you based on your new address.

You are eligible to have your annual Deductible and Out-of-Pocket balances for the year that you have already satisfied under the prior administrator transferred over to your new plan administrator. Once you are confident that all claims have been processed by your previous plan administrator, you will need to provide your last Explanation of Benefits (EOB) to the new plan administrator. You will receive information to your work email detailing where to send the information. Call the Human Resources Centre for assistance.

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 12 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 medical 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 own 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 medical, 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 Section 9 – Claims Procedures. This section details the process and timing around filing an eligibility claim or appeal.

An eligibility claim 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:

Claims and Appeals Management
P.O. Box 7122
Rantoul, IL 61866-7122

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.

The *Dependent Verification Services* - 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
P.O. Box 661065
Dallas, TX 75266-1065
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 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
C/O Appeals
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 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.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of BMO Financial Corp. or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered

Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

BMO Financial Corp. has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for anything except your cost sharing obligations. For Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you are responsible to work with the non-Network physician or provider to resolve any amount billed to you that is greater than the amount UnitedHealthcare determines to be an Eligible

Expense as described below. Eligible Expense are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

When Covered Health Services are received from a non-Network provider, Eligible Expenses are an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Advocacy Services

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and UnitedHealthcare, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which require prior authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or

follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed in Section 6, *Additional Coverage Details* have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective

review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible		
■ Individual.	$1,750	$3,500
■ Family (cumulative Annual Deductible).	$3,500	$7,000
The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.		
Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		
Annual Out-of-Pocket Maximum		
■ Individual.	$3,425	$6,850
■ Family (cumulative Out-of-Pocket Maximum).	$6,850	$13,700
The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum.		

Plan Features	Network Amounts	Non-Network Amounts
If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. **Coupons:** The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.		
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential health Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). The state of Utah's definition of what is an "essential health benefit" shall be the controlling definition used by the Plan in determining whether a particular benefit is an essential health benefit for purposes of compliance with the Patient Protection and Affordable Care Act.	Unlimited	

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance. ■ Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	*Ground and/or Air Ambulance* 80% after you meet the Network Annual Deductible 60% after you meet the Annual Deductible
Cellular and Gene Therapy Services must be received at a Designated Provider	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Diabetes Services		
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
Diabetes Self-Management Items		
■ Diabetes equipment.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
■ Diabetes supplies.	For diabetes supplies the Benefit is 80% after you meet the Annual Deductible.	For diabetes supplies the Benefit is 60% after you meet the Annual Deductible.
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient		
■ Emergency	80% after you meet the Annual Deductible and pay a $100 per visit Copay	80% after you meet the Network Annual Deductible and pay a $100 per visit Copay
■ Non-Emergency	80% after you meet the Annual Deductible and pay a $100 per visit Copay	60% after you meet the Annual Deductible and pay a $100 per visit Copay
Emergency Health Services - Foreign		
■ True Emergency	80% after you meet the Annual Deductible	
■ Non-Emergency	60% after you meet the Annual Deductible	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Enteral Nutrition	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.	
Hearing Aids & Exam See Section 6, *Additional Coverage Details*, for limits.		
■ Exam	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Hearing Aid	100% after you meet the Annual Deductible	100% after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Infertility Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Naprapathic Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery See Section 6, *Additional Coverage Details* for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps. ■ Colonoscopy – first of the calendar year, any diagnosis. (Subsequent colonoscopies covered as shown under "Scopic Procedures – Outpatient Diagnostic and Therapeutic").	 100% 100% 100% 100%	 60% 60% 60% 60%
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services For Network Benefits, transplantation services must be received at a Designated Provider. The Claims Administrator does not require that corneal transplants be performed at a Designated Provider in order for you to receive Network Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available.
Vision Examinations See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Wigs See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Related to surgery.

Any combination of Network Benefits and Non-Network Benefits is limited to 20 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation for Non-Network Benefits. If you are requesting non-Emergency air ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air transport) you must obtain prior authorization as soon as possible before transport. If you fail to obtain prior authorization from the Claims Administrator, Benefits will be subject to a $400 reduction.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

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

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

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*

- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

    - ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Benefits also include treatment of a dental injury to sound natural teeth, including but not limited to extraction and initial replacement. Services must begin within 90-days after the date of the dental injury. Benefits will only be paid for the expense incurred for the least expensive service that will produce a professionally adequate result.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services to repair the damage caused by accidental Injury must conform to the following time-frames: Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care), Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.

- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

For non-accident related dental services, if any of the qualifiers below apply to the patient, anesthesia and facility charges related to the dental services are covered:

- Covered Person under age 6.
- Covered Person with a chronic disability and the following three conditions must be met:
  - Attributable to medical or physical impairment.
  - Likely to continue indefinitely.
  - Results in substantial functional limitation (i.e. self-care, learning, (no age restriction applies)).
- Covered Person has medical condition which requires hospitalization or general anesthesia for dental care (no age restriction applies).

The Plan pays for treatment of the following:

- Excision of partially or completely un-erupted impacted teeth, including wisdom teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks lips, tongue, roof and floor of mouth.
- Reduction of the fractures and discolorations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Frenectomy (the cutting of the tissue in the midline of the tongue).
- Gingival mucosal surgery (gingivectomy, osseous, periodontal surgery and grafting) to treat gingivitis or periodontitis.
- Apicoectomy and alveolectomy.
- Removal of retained residual root.
- Gingival and apical curettage.
- Dental implants.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.
- Blood glucose meters, including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type beds.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Shoes, shoe orthotics, shoe inserts and arch supports when medically necessary, prescribed by a physician, and custom molded. This includes Covered Persons wearing leg braces, using blood thinners, with decreased circulation and/or having cardiac health problems.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be subject to a $400 reduction.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment.
- Chronic physical disability.
- Intellectual disability; or
- Loss of life.

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your SPD.

- Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in your SPD.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:

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

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

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

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

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

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed

the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $5,000 per Covered Persons lifetime.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods and Private Duty Nursing, or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while

the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
For Non-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Infertility Services

Therapeutic services for the treatment of Infertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under *Pharmaceutical Products*.

Benefits for Pharmaceutical Products for outpatient use that are filled by a prescription order or refill are described under *Outpatient Prescription Drugs*.

Benefits for oocyte retrieval are limited to four procedures during the entire period of time a Covered person is enrolled under the Plan.

Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Criteria to be eligible for Benefits

To be eligible for the Infertility services Benefit you must have a diagnosis of infertility.

- To meet the definition of Infertility you must meet one of the following:
  - You are not able to become pregnant after the following periods of time of regular unprotected intercourse or Therapeutic Donor Insemination:
    - One year, if you are a female under age 35.
    - Six months, if you are a female age 35 or older.
  - You are female and have failed to achieve or maintain a Pregnancy due to impotence/sexual dysfunction;
  - You are female and have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
  - You are male and have a diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- You are a female:
  - under age 44 and using own oocytes (eggs).
  - under age 55 and using donor oocytes (eggs).
    Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.
- You have Infertility that is not related to voluntary sterilization.
- You are male and have a diagnosis of a male factor causing Infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- Not a Child Dependent.

The waiting period may be waived when you have a known male or female Infertility factor, including but not limited to: congenital malformations, abnormal sperm, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.

- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claim Administrator before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $400 reduction.

Naprapathic Services

The Plan will pay for Covered Health Services for Naprapathic services provided in a Physician's office by an appropriately licensed or healthcare professional.

Any combination of Network Benefits and Non-Network Benefits is limited to 20 visits per calendar year.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $400 reduction.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
- Such services would have been covered if the Covered Person was an inpatient.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under Preventive Care Services in this section.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40.
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

It is expected that appropriate non-surgical treatment should have been attempted prior to surgical treatment of obesity.

Non-surgical treatment of morbid obesity appropriateness criteria must be documented in the records submitted and include the following:

- Medical record documentation of active participation in a clinical-supervised, non-surgical program of weight reduction for at least 6 months, occurring within the twenty-four (24) months prior to the proposed surgery and preferably unaffiliated with the bariatric surgery program.

  Note - The initial BMI at the beginning of a weight reduction program will be the qualifying BMI used to meet the BMI criteria for the definition of morbid obesity used in this policy.

  A program will be considered appropriate if it includes the following components:

  - Nutritional therapy, which may include medical nutrition therapy including but not limited a very low calorie diet such as MediFast or OptiFast, or a recognized commercial diet-based weight loss program such as Weight Watchers, Jenny Craig, etc.
  - Behavior modification or behavioral health interventions.
  - Counseling and instruction on exercise and increased physical activity.
  - Pharmacologic therapy (as appropriate).
  - Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risks factors and improve overall health.
  - Documentation of willingness to comply with preoperative and postoperative treatment plans.
  - Documentation that growth has been completed (18 years of age or documentation of completion of bone growth).

Please note historical medical records corresponding to the time period you were treated for obesity condition signed and dated by health care professionals will be considered appropriate documentation.

Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss surgery limited to:

- One year post bariatric surgery.
- You have maintained a steady weight for a minimum of six months.
- You have significant, recurrent skin infections (i.e., extreme infection every 2-3 months that are treated by a Physician) which are not due to cleanliness issues.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Prior Authorization Requirement
For Non Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions.

It is important that you provide notification regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include Genetic Counseling.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglector for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be subject to a $400 reduction.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedures.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled Reconstructive Procedure you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedures is performed.
- A non-scheduled Reconstructive Procedure you must provide notification within two business days or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits you must provide notification to the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Any combination of Network and Non-Network Benefits are limited to:

- 60 visits per calendar year for physical, occupational and speech therapy combined.
- Unlimited visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- Unlimited visits per calendar year for cognitive & hearing rehabilitation therapy.
- 20 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are

described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission,
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions.)

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds)

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $400 reduction.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within two business days or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

Temporomandibular Joint (TMJ) Services

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for dialysis, IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be subject to a $400 reduction.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for corneal transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Support in the event of serious illness
If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every calendar year. Benefit includes first pair of glasses following cataract surgery.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis when prescribed by a Physician for hair due to injury, disease or treatment of a disease, including diagnosis of alopecia areata.

Any combination of Network Benefits and Non-Network Benefits is limited to one wig per Covered Persons lifetime, limited to $500.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.
- Women's Health/Reproductive.

BMO Financial Corp. believes in giving you tools to help you be an educated health care consumer. To that end, BMO Financial Corp. has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and BMO Financial Corp. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey

You and your covered eligible dependent(s) are invited to learn more about health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

If you need any assistance with the online survey, please call the number on your ID card.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams.

Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Complex Medical Conditions Programs and Services

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

Travel and Lodging Assistance Program

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses

incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient (when not in the Hospital) or the caregiver.
- Per diem, is limited to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Examples of items that are not covered:

  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.

- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to," it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   These exclusion does not apply to services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome unless:

   - Covered Person is 18 months of age or younger for:
     - ♦ Post-operative treatment plan following surgical correction of craniosyntosis.
     - ♦ Positional plagiocephaly that has not adequately responded to a two month trial of repositioning and/or physical therapy.

4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

6. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

7. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

9. Powered and non-powered exoskeleton devices.

Drugs

See "Prescription Drug Program" in Section 6 for what is covered by the Plan through Express Scripts. The medical portion of the Plan does not cover:

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will

not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses.

   This exclusion does not apply to routine/preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details* or:

   - Paraplegic individuals or those requiring them to wear leg braces due to disease.
   - Covered Persons taking blood thinners.
   - Covered Persons with decreased circulation.
   - Covered Persons with severe cardiac health problems.

2. Nail trimming, cutting, or debriding (removal of dead skin or underlying tissue).

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

6. Shoes, shoe orthotics, shoe inserts and arch supports are covered when medically necessary, prescribed by a physician, and custom molded. This is also applicable to a Covered Person when Medically Necessary due to:

   - Wearing leg braces.
   - Use of blood thinners.
   - Decreased circulation.
   - Cardiac health problems.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.

- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies

1. Prescribed or non-prescribed medical supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
     Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - Urinary catheters for which Benefits are provided as described under *Urinary Catheters* in Section 6, *Additional Coverage Details*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section* 6 *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services,*

Neurobiological Disorders - Autism Spectrum Disorder Services and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods.

2. Except as described in Section 6, *Nutritional Counseling*: Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to nutritional counseling services that are billed as *Preventive Care Services* or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

3. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in Section 6, *Additional Coverage Details*.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Safety equipment.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Vehicle modifications such as van lifts.

- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer or

Congenital Anomaly as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Psychosurgery (lobotomy).

7. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

8. Chelation therapy, except to treat heavy metal poisoning.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

10. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*.

11. Medical and surgical treatment of excessive sweating (hyperhidrosis).

12. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

13. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

14. Intracellular micronutrient testing.

15. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. The following treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
   - IVF for a traditional Surrogate.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Costs of donor eggs and donor sperm

4. The reversal of voluntary sterilization.

5. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

6. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.

7. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*.

2. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.

3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

4. While on active military duty.

5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in Section 7, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing received on an inpatient basis.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.

- Room or facility reservations.
- Completion of claim forms.
- Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. For Injury or Sickness for which there is non-group coverage (except individual health insurance plans) providing medical payments or medical expense coverage. If Benefits subject to this provision are paid or provided by the Plan, the Plan reserves all rights to recover the reasonable value of such Benefits as provided in Section 11, *Subrogation and Reimbursement*.

5. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

6. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.

7 In the event a Non-Network provider waives, does not pursue, or fails to collect the Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or deductible are waived.

8. Foreign language and sign language services.

9. Long term (more than 30 days) storage of blood, umbilical cord or other material.

10. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.

- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*.
- Not otherwise excluded in this SPD under this Section 8, *Exclusions and Limitations*.

11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

12. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:

    - Required solely for purposes of sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
    - Related to judicial or administrative proceedings or orders.
    - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your Medical claim is denied, in whole or in part.
- Claiming benefits for the Prescription Drug Program.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Plan will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting your Human Resources Centre. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology (CPT)* codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a non-Network provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to non-Network providers as well as any collection agencies or third parties that have purchased accounts receivable from non-Network providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a non-Network provider.

Any such payment to a non-Network provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a non-Network provider as a convenience to you, the Claims Administrator will treat you, rather than the non-Network provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the

assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the

determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the

external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of

care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against BMO Financial Corp. or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against BMO Financial Corp. or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against BMO Financial Corp. or the Claims Administrator.

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

SECTION 10 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan Sponsor's Self-Funded group medical benefit plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan**. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced

because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense**. For the purposes of COB, an Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its

benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan**. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

C. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the

person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan**. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
      (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         (a) The Plan covering the Custodial Parent.
         (b) The Plan covering the Custodial Parent's spouse.
         (c) The Plan covering the non-Custodial Parent.
         (d) The Plan covering the non-Custodial Parent's spouse.
   c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
   d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. **Longer or Shorter Length of Coverage**. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, if the Secondary Plan would have paid the same amount or less than the Primary Plan paid, This Plan pays no Benefits; If the Secondary Plan would have paid more than the Primary Plan paid, This Plan will pay the difference; and apply that amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim may be less than the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare.
- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if This Plan is secondary to Medicare, This Plan will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, the Claims Administrator may, as the Claims Administrator determines, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts the Claims Administrator needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims

Administrator needs to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information the Claims Administrator needs to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Claims Administrator may process This Plans' payment for that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments This Plan made is more than This Plan should have paid under this COB provision, This Plan may recover the excess from one or more of the persons This Plan have paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future allowable expenses.

If the Plan overpays a health care provider, the Plan reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of you, you, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

If you are disabled, not working and qualify for Medicare coverage, you must enroll in both Parts A and B of Medicare to continue receiving coverage under the Company's Medical Plan. Medicare is considered the primary plan and pays your claims first; your Company medical coverage is considered your secondary plan.

If you are actively working and qualify for Medicare, you are not required to enroll for Medicare coverage. Your Company Medical Plan continues as your primary coverage.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

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

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

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

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a three-year statute of limitations from when the date of the claim is denied.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, BMO Financial Corp. will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends for any reason.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you become ineligible to participate. See "Eligibility" in Section 2.
- The last day of the month UnitedHealthcare receives written notice from BMO Financial Corp. to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends for any reason.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from BMO Financial Corp. to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.
- The last day of the month you do not complete the dependent verification process.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and BMO Financial Corp. find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, BMO Financial Corp. has the right to demand that you pay back all Benefits BMO Financial Corp. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Continuing Coverage

There are certain situations during which you can continue coverage for yourself and your eligible dependents if your employment ends or you otherwise lose coverage under the Medical Plan. The coverage is the same as when you were actively working; however, depending on the reason, your contributions may be different.

If You Die While Employed

Survivors of deceased employees are eligible for retiree medical coverage if the employee had at least 10 years of service at the time of his or her death, and both the employee and the survivors were enrolled in an active Company Medical Plan immediately before the employee's death. The surviving spouse (and eligible dependent children) would pay the active Plan premium until age 65 or until such time in which they do not meet the eligibility rules of the Plan. Once 65, the surviving spouse's Plan access and Company contribution would be based on the group the employee was part of at the time of his or her death.

Note: If the surviving spouse (and eligible dependent children) cancel coverage at any time, the survivors will no longer be eligible to participate in the Retiree Medical Program and permanently forfeit rights to enroll in this plan in the future.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, as defined in Section 14, *Glossary*.

Continuation coverage under *COBRA* is available only to Plans that are subject to the terms of *COBRA*.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

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, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- 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.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
BMO Financial Corp. files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

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. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will 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. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Annual Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

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.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide your COBRA administrator with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

When COBRA Ends

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

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, 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 coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Once you cancel your continued coverage, you cannot re-enroll in the Company's Medical Plan.

Additional information about COBRA coverage is available in the general COBRA notice. To receive another copy of the general notice, contact the COBRA Administrator at:

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

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Employee's absence from work.
- The day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and BMO Financial Corp.
- Relationships with providers.
- Interpretation of Benefits.
- Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits.

Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

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

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and BMO Financial Corp.

In order to make choices about your health care coverage and treatment, BMO Financial Corp. believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

BMO Financial Corp. and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. BMO Financial Corp. and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. BMO Financial Corp. and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and BMO Financial Corp. and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

BMO Financial Corp. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, BMO Financial Corp. and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not BMO Financial Corp.'s employees nor are they employees of UnitedHealthcare. BMO Financial Corp. and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

BMO Financial Corp. is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and BMO Financial Corp. is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

BMO Financial Corp. and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

BMO Financial Corp. and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, BMO Financial Corp. may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that BMO Financial Corp. does so in any particular case shall not in any way be deemed to require BMO Financial Corp. to do so in other similar cases.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology

Information and Records

BMO Financial Corp. and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. BMO Financial Corp. and UnitedHealthcare may request additional information from you to decide your claim for Benefits. BMO Financial Corp. and UnitedHealthcare will keep this information confidential in accordance with applicable law. BMO Financial Corp. and UnitedHealthcare may also use your de-identified data for commercial purposes, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish BMO Financial Corp. and UnitedHealthcare with all information or copies of records relating to the services provided to you. BMO Financial Corp. and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. BMO Financial Corp. and UnitedHealthcare agree that such information and records will be considered confidential.

BMO Financial Corp. and its designee have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as BMO Financial Corp. is required to do by law or regulation. During and after the term of the Plan, BMO Financial Corp. and its designee may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including analytic purposes.

For complete listings of your medical records or billing statements BMO Financial Corp. recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, BMO Financial Corp. and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator, if so allowed under applicable law.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's

health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Plan Highlights*.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but BMO Financial Corp. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

BMO Financial Corp. and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. BMO Financial Corp. and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other 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.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Enrollment - the period of time, determined by BMO Financial Corp., during which eligible Employees may enroll themselves and their Dependents under the Plan. BMO Financial Corp. determines the period of time that is the Annual Enrollment period.

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. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).

- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI - see Body Mass Index (BMI).

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company - BMO Financial Corp.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations*.

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Physician - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Employee has established a Domestic Partnership.

Domestic Partnership - a relationship between an Employee and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee - a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer - BMO Financial Corp.

EOB - see Explanation of Benefits (EOB).

ERISA - see *Employee Retirement Income Security Act of 1974 (*ERISA*).*

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

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

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- *Diagnostic criteria for children:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
    - ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - ♦ A strong preference for playmates of the other gender.
    - ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - ♦ A strong dislike of ones' sexual anatomy.
    - ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical

policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UHCprovider.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by BMO Financial Corp. who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The BMO Financial Corp. Medical Plan.

Plan Administrator - BMO Financial Corp. or its designee.

Plan Sponsor - BMO Financial Corp.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note: If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information, including your rights under *ERISA*.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Plan Administrator

BMO Financial Corp. is the Plan Sponsor and the Benefits Administration Committee (Committee) is the Plan Administrator of the Employee Benefit Program of Bank of Montreal/Harris. The Plan Administrator has the discretionary authority to interpret the Plan. You may contact the Plan Sponsor and Plan Administrator at:

BMO Financial Corp
Benefits Administration Committee
111 West Monroe Street, 7W
Chicago, IL 60603

Human Resources Centre: (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 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 is:

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

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

BMO Financial Corp.
Benefits Administration Committee
111 West Monroe Street, 7W
Chicago, IL 60603
(888) 927-7700

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Employee Benefit Program of Bank of Montreal/Harris
Plan Number:	507
Employer ID:	51-0275712
Plan Type:	Welfare benefits plan and group health plan
Plan Year:	January 1 through December 31
Plan Administration:	Self-Insured

Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Type of Funding

Medical Plan contributions are made by the Company and participating employees. The Medical Plan is self-insured and funded through a trust, with UnitedHealthcare acting as the claims administrator.

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 employers general assets. BNY Mellon acts as trustee for the BMO Financial Group U.S. Retiree Medical Program for funds deposited into the BNY Mellon Trust. BMO Financial Corp. acts as trustee of the M&I Retiree Health Benefits Trust and the Rabbi Trust. Independent third parties administer claims submitted under the Plan.

* *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.*

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.USBeenfits@bmo.com.

Your ERISA Rights

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.

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.

The Plan's Benefits are administered by BMO Financial Corp., the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and BMO Financial Corp. are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider UnitedHealthcare and BMO Financial Corp. are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY 711)
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর

8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	[illegible] ID [illegible] 0 TTY 711
10. Cherokee	Ꮎ ᎠᏎᏯ ᎨᏢ ᏗᏟᏃᎮᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᏨᏙᏢ ᏁᎯ ᎨᎡ ᏗᏧᎪᏁᏗ ᎠᏟᏍᏁᏗ ᏆᎾᏂᏍᏗᎢ, ᏧᏏᏰᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an

	und drücken Sie die 0. TTY 711 ¤
18. Greek ¤	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711 ¤
19. Gujarati ¤	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711 ¤
20. Hawaiian ¤	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono ʻī me ka uku ʻole ʻana. ↵ E kama ʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711. ¤
21. Hindi ¤	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711 ¤
22. Hmong ¤	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711. ¤
23. Ibo ¤	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711. ¤
24. Ilocano ¤	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711 ¤
25. Indonesian ¤	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711 ¤
26. Italian ¤	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711 ¤

27.·Japanese¤	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID· カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は·711です。¤
28.·Karen¤	[illegible] 0 တကုိ.TTY 711
29.·Korean·¤	귀하는·도움과·정보를·귀하의·언어로·비용·부담없이·얻을·수·있는·권리가·있습니다.·통역사를·요청하기·위해서는·귀하의·플랜·ID카드에·기재된·무료·회원·전화번호로·전화하여·0번을·누르십시오.·TTY·711¤
30.·Kru-·Bassa¤	Ni·gwe·kunde·I·bat·mahola·ni·mawin·u·hop·nan·nipehmes·be·to·dolla.·Yu·kwel·ni·Kobol·mahop·seblana,·soho·ni·sebel·numba·I·ni·tehe·mu·I·ticket·I·docta·I·nan,·bep·0.·TTY·711¤
31.·Kurdish-Sorani¤	ماقەی·ئەوەت·هەیە·کە·بڕیەرامبەر،·یارمەتی·و·زانیاری·بڕۆیست·بەزمانی·خۆت·وەرگریت.·بۆ·داواکردنی·وەرگێڕێکی·زارەکی،·یەیوەندی·بکە·بەژمارە·تەلەفۆنی·نووسراو·لەناو·ئای·دی·کارتی·پینسەپی·یانتی·ئەندروستی·خۆت·و·یاشان·0·داگرە.·TTY·711¤
32.·Laotian¤	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ.· ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຜ່ານໝາຍເລກໂທລະສັບຢ່າງບັດສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ· 0.·TTY·711¤
33.·Marathi¤	आपल्याला·आपल्या·भाषेत·विनामूल्य·मदत·आणि·माहिती·मिळण्याचा·अधिकार· आहे.·दूभाषकास·विनंती·करण्यासाठी·आपल्या·आरोग्य·योजना·ओळखपत्रावरील· सूचीबध्द·केलेल्या·सदस्यास·विनामूल्य·फोन·नंबरवर·संपर्क·करण्यासाठी·दाबा·0.·TTY·711¤
34.·Marshallese¤	Eor·aṃ·maroñ·ñan·bok·jipañ·im·meḷeḷe·ilo·kajin·eo·aṃ·ilo·ejjeḷọk·wōṇāān.·Ñan·kajjitōk·ñan·juon·ri-ukok,·kūṛọk·nōṃba·eo·emōj·an·jeje·ilo·kaat·in·ID·in·karōk·in·ājmour·eo·aṃ,·jiped·0.·TTY·711¤
35.·Micronesian-Pohnpeian¤	Komw·ahneki·manaman·unsek·komwi·en·alehdi·sawas·oh·mengihtik·ni·pein·omwi·tungoal·lokaia·ni·soh·isepe.·Pwen·peki·sawas·en·soun·kawehweh,·eker·delepwohn·nempe·ong·towehkan·me·soh·isepe·me·ntingihdi·ni·pein·omwi·doaropwe·me·pid·koasoandi·en·kehl,·padik·0.·TTY·711.¤
36.·Navajo¤	T'áá·jíík'eh·doo·bąąh·'alínígóó·bee·baa·hane'ígíí·t'áá·ni·nizaád·bee·niká'e'eyeego·bee·ná'ahoot'i'.·'Ata'·halne'í·ła·yiníkeedgo,·ninaaltsoos·nit‘iz7·‘ats’77s·bee·baa’ahay1·bee·n44hozin7g77·bik11’·b44sh·bee·hane’7·t’11·j77k’eh·bee·hane’7·bik1’7g77·bich’8’·hodíilnih·dóó·0·bił·

	'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست خود تماس حاصل بهداشتی برنامه شناسایی کارت در شده قید رایگان مترجم شفاهی با شماره تلفن نمودهو 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика

	позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan- Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo- Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic- Fulfulde	Dum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo''u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac- Assyrian	[illegible] [illegible] [illegible] TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సహాయం మరియు సమాచారం పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాసి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చెయ్యి. TTY 711
55. Thai	คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki

Fakatonga	he fika telefoni ta'etotongi ma'ae kau memipa'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. 'TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	اپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên the ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פאר לאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל, דרוקט 0 TTY 711
63. Yoruba	O ní ẹtọ lati ní iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ATTACHMENT V – PRESCRIPTION DRUG PROGRAM – EXPRESS SCRIPTS

The Pharmacy Benefits described below are administered by Express Scripts, independent of UnitedHealthcare.

Prescription Drug Program

When you enroll in the Consumer Choice Plan, you automatically receive prescription drug coverage from Express Scripts, the pharmacy benefits administrator. You will receive your Express Scripts prescription ID card shortly after you enroll. You must present your Express Scripts prescription ID card to a network pharmacy when you purchase prescriptions. This card is separate from the Medical Plan ID card. The cost of your prescription will depend on where you get it filled and if it is a generic, preferred brand name or non-preferred brand name drug. Whether you choose retail or home delivery, Express Scripts offers you convenient, low-cost ways to fill your prescriptions.

Prescription drug benefits are subject to the annual deductible and out-of-pocket maximum. There are also certain categories of prescriptions that are considered preventive and therefore not subject to the deductible and either covered at 100% by the Plan or immediately covered at applicable copayment/coinsurance.

Prescription Coverage at a Glance

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

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

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

Prescription Drug Coverage	**What you pay**	
	Participating Pharmacy	**Non-Participating Pharmacy**
Annual Deductible	Plan deductible applies	Plan deductible applies
Annual Out-of-Pocket Maximum Individual/Family	Eligible expenses count toward the respective medical individual/family In-Network Out-of-Pocket Maximum	Eligible expenses count toward the respective medical individual/family In-Network Out-of-Pocket Maximum
Retail (up to 30-day supply)		
Generic	$10 copay	Copays same as in-network, but retail pricing applies
Formulary (Preferred Brand)	25% (min $20, max $50)	
Nonformulary (Non-Preferred Brand)	35% (min $40, max $70)	
Retail (31-90 day supply)		
Generic	$30 copay	Copays same as in-network, but retail pricing applies
Formulary (Preferred Brand)	25% (min $60, max $150)	
Nonformulary (Non-Preferred Brand)	35% (min $120, max $210)	
Home Delivery (up to 90-day supply)		
Generic	$20 copay	Not covered
Formulary (Preferred Brand)	25% (min $40, max $100)	
Nonformulary (Non-Preferred Brand)	35% (min $80, max $140)	

Prescription Drug Coverage	What you pay	
	Participating Pharmacy	Non-Participating Pharmacy
■ If you request a brand-name medication when a generic equivalent is available, you will pay the **generic copayment, plus the difference in** cost between the brand and the generic. If youare not able to take a generic equivalent due to medical necessity, your doctor may request a review and provide supporting documentation on why the brand is medically necessary. If approved by Express Scripts, you will pay the brand copayment. ■ Manufacturer-funded patient assistance for widely distributed specialty medications will notbe considered as true out-of-pocket expenses and may not apply to deductible and out-of-pocket maximums.		

Prescription Drug Formulary

The Plan includes a list of preferred drugs (both generic and brand name) that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, to get the most up-to-date drug information go online to www.express-scripts.com/bmofinancialgroup or call Express Scripts Member Services at 1-877-795-2926.

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

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

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

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

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

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

Drug Quantity Management, Prior Authorization, and Step Therapy Programs

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

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

Here's how Drug Quantity Management works

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

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

Here's how Prior Authorization works

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

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

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

Here's how Step Therapy works

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medicines for the step therapy program. Together, they review the most current research on thousands of prescription medicines tested and

approved by the Food and Drug Administration (FDA). Then they determine the most appropriate medicines to include in the program. Medicines are then grouped in categories, or "steps".

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

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

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

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

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

Retail Pharmacy Network

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

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

Home Delivery

Home delivery, also referred to as mail order, is designed for longer-term medication supplies of up to 90 days, such as maintenance drugs for chronic conditions like high blood pressure or diabetes. When you need longer-term prescriptions, using home delivery saves you both time and money. Complete the form in your welcome packet or ask your doctor to fax your prescription to Express Scripts. Call 1-888-327-9791 for faxing instructions.

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

Specialty Drug Program through Accredo

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

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

What's Covered Under Prescription Drugs

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

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

- androgens and anabolic steroids;
- contraceptive emergency kit;
- emergency allergic kits;
- glucagon emergency kits;
- growth hormones;
- hemophilia factors;
- impotency treatment drugs;
- insulin;
- insulin and disposable insulin syringes/needles;

- infertility medications;
- influenza treatments;
- inhaler assisting devices;
- migraine medication;
- non-insulin syringes with or without needles;
- oral contraceptives;
- over-the-counter diabetic supplies, including alcohol swabs, lancets, urine and blood strips and tapes, blood glucose testing monitors, insulin syringes with or without needles and hyperglycemic products;
- prescription drugs used to treat chemical abuse;
- prescription and over-the-counter smoking cessation aids for those 18 years and older;
- prescription anti-obesity medications topical vitamin A derivatives;
- prescription vitamins, including prenatal, hematinics, aspirin (for males age 45 – 79; for women age 55 – 79), folic-acid (for females through age 50), vitamin D preparations, iron (for children up to age one) and pediatric fluoride (for children up to age six);
- standard self-injectable medications on Express Scripts' standard drug list;
- specialty medications on Express Scripts' specialty drug list;
- synagis.

What's Not Covered under Prescription Drugs

The Prescription Drug Program does not cover:

- acts of war: injury or illness caused or contributed to be international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;
- allergy serums;
- any charge for the administration of prescription products;
- all illegal medications or supplies, even if prescribed by a duly licensed medical professional;
- any medication, prescription or non-prescription which is taken or administered at the place where it is dispensed;
- any medication which is meant to be taken by or administered in whole or in part while the covered person is treated at a hospital, physician's office or extended care facility, but is instead self-administered or administered elsewhere, unless expressly designated by the pharmacy benefits administrator;
- charges that are in access of the contracted amount;
- claims received later than 12 months from the date of service;

- compound prescriptions unless approved by this plan;
- compounded prescriptions delivered through home delivery, except for specialty prescriptions through a specialty pharmacy;
- continuous glucose monitors, transmitters and sensors;
- difference in cost between a generic product and brand product when the medical professional has not specified a brand product or has not indicated that the brand product is necessary;
- duplicate services and charges or inappropriate billing;
- glucoWatch products;
- hair growth stimulants and products indicated only for cosmetic use;
- injectable contraceptives;
- insulin pumps and supplies;
- nutritional supplements;
- over-the-counter contraceptives;
- over-the-counter products, unless specifically provided under this plan;
- non-specialty implantable medications;
- non-systemic prescription contraceptives (i.e. diaphragm, cervical caps, etc.);
- prescription medications which are administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that requires a physician's prescription;
- prescription products that are not dispensed by a licensed pharmacist or medical professional;
- prescription products dispensed in a foreign country if you traveled solely for the purpose of reimporting prescription drugs into the United States and/or you used other means to ship or bring prescription products from a foreign country into the United States;
- prescription products that may be received without charge under local, state or federal programs, including worker's compensation;
- prescription products that require prior authorization or any other clinical process in which the prescription was denied or was needed and not requested;
- prescriptions and prescription refills which exceed the Plan's quantity limits;
- prescriptions or supplies rendered before coverage begins under this Plan or after coverage ends;
- refilling a prescription in excess of the number specified on the prescription or any refill dispensed after one year from the order of the medical professional;

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

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

Claiming Benefits For Prescription Drugs

Limitation of Action

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

Mandatory Venue

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

If you do not present your prescription drug ID card at the time of your purchase at the retail pharmacy, or if you purchase your prescription from a non-participating pharmacy, you will have to submit the claim yourself to Express Scripts. You can request this form by visiting www.express-scripts.com. If you are a first-time visitor take a moment to register.

Please remember to have your member ID number and a recent prescription number handy. If you do not have a recent prescription number, you may still register; just remember to add a prescription number later so that you can fully manage your prescription benefit online.

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

The amount that you will be reimbursed for using a non-participating or participating retail pharmacy without using your prescription drug ID card, will be the amount the drug would have cost at a participating retail pharmacy minus the retail copayment/coinsurance, up to the days' supply allowed by the plan. The reimbursement claim is generally responded to within 10 business days.

Claim Denials and Appeals

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision.

An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim.

You have the right to receive, upon request and at no charge, the information used to review your appeal.

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

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the

claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

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

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

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

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

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

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal.

The decision made on your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if your appeal is denied or your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

For Direct Claims

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

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

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

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

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provision on which the decision is based, a description of applicable

internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

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

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

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

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

APPENDIX

The information described below is administered independent of UnitedHealthcare.

About this Summary

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

Important Notice

The information in this summary is based on Bank of Montreal/Harris benefit plans in effect as of January 1, 2020. The official plan document contains the full Plan details. If the Summary Plan Description or any oral representation differs from the Plan document, the Plan document prevails.

Retiree Eligibility

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

The Retiree Medical Program was redesigned effective January 1, 2008 and employees were classified into eligibility groups to determine what benefits and funding would be offered to you and your dependents during retirement. Your age and years of full-time service, as of December 31, 2007, were used to determine your eligibility group. See the "How to Determine Your Retiree Group" section for more details about each eligibility group.

Effective March 1, 2017, eligibility to qualify for Retiree Medical Program was changed. Eligibility is based on your age, years of service (inclusive of time worked under any BMO entity), working as a U.S. employee immediately preceding your retirement, and are enrolled in a Company-sponsored medical plan immediately prior to retirement.

Eligibility and Qualifications for Pre-65 Coverage Effective as of March 1, 2017

- You (and your eligible dependents) qualify for the Retiree Medical Program if:
  - you retire at age 55 or older with at least 10 years of service with any BMO entity; and
  - you are working as a U.S. employee immediately preceding your retirement; and

- you are enrolled in a Company-sponsored medical plan immediately prior to retirement.

Eligibility and Qualifications for Coverage Over Age 65 and/or Medicare Eligible Effective as of March 1, 2017*

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

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

Retirees over age 65 or Medicare eligible prior to age 65 are eligible under the portion of the health program known as the Medicare Secondary Plan (administered by UMR). When you enroll in the Medicare Secondary Plan, **you are required to enroll in Medicare Parts A and B**.

If eligible, your coverage in the Medicare Secondary Plan begins effective the first day of the month of your 65th birthday or the first day of the previous month in cases where the date of birth is on the first of a month if Medicare has determined it is the primary payer of claims.

***Coverage after reaching age 65 is not available if you were hired or rehired on or after January 1, 2008, or younger than age 35 as of December 31, 2007.**

You are not eligible to participate in the Retiree Medical Program if, while an employee, you perform services for the Company under an agreement or arrangement between the Company and a third party; which designates you as an independent contractor or consultant; or which excludes you from Plan participation.

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

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

Information about dependents

Effective March 1, 2017, spouses and dependents no longer need to be enrolled in BMO's medical plan when you retire. The dependent must meet the definition of an eligible dependent at the time of your retirement and at the time you request to enroll them in coverage. You are only able to add the following dependents to your medical coverage at a later date if they continue to meet the dependent definition, as applicable:

■ Your legal spouse or your qualified domestic partner at the time of your retirement date.

- Your existing eligible dependent children at the time of your retirement.

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

Rehires

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

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

Special Eligibility Rule for Employees of Divested Companies

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

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

Special Services Leave for Certain Employees

If your employment with the Company ends in connection with an involuntary reduction in force after you have attained age 53 with at least 23 years of service with any BMO entity, you (and your eligible dependents) may remain enrolled in the Plan until you attain age 55. Your cost for this period is equal to the contribution you would have made had your employment with the Company not ended. At the end of this period, you will be eligible to participate in the Retiree Medical Program on the date that you would have first become eligible to participate in the Program had your employment with the Company not ended. The Company retains discretion to lower the age and service requirements of any Special Services Leave.

Companies Acquired by BMO Financial Group U.S.

You are eligible for retiree medical coverage if you meet the requirements described above. Generally your eligibility for the Retiree Medical Program starts on the later of the actual (closing) date your company was acquired or the date your company joined the Bank of Montreal/Harris Retirement Plan, whichever is later. However, for certain acquisitions which are asterisked in the chart below, your period of employment going back to your latest hire date with the acquired company may be recognized for purposes of determining eligibility in the BMO Financial Group U.S. Retiree Medical Program.

Acquired Company	**Acquisition Date**
Argo State Bank*	July 31, 1982
Chemical Bank	January 3, 1984
National Westminster Bank USA	January 18, 1985
Bank of Montreal*	January 1, 1986
Derivative Markets	March 20, 1986
Wilmette	January 1, 1987
Marine Midland National Bank	September 20, 1985
Naperville	January 1, 1988
Barrington*	January 1, 1989
Roselle*	January 1, 1989
Batavia	January 1, 1989
Glencoe-Northbrook	January 1, 1989
Hinsdale	January 1, 1989
St. Charles	January 1, 1989
Winnetka	January 1, 1989
Libertyville*	May 1, 1990
Frankfort	October 1, 1990
Nesbitt Thompson Securities*	April 1, 1992
Suburban	January 1, 1995
Household	June 29, 1996
Burns Fry*	January 1, 1997
KeyCorp*	January 2, 1997

Acquired Company	Acquisition Date
Burke, Christensen & Lewis (BCL)	January 1, 2000
Village Bank of Naples	July 3, 2000
Freeman Welwood	October 1, 2000
Century Bank	December 15, 2000
First National Bank of Joliet	July 13, 2001
CSFB Direct	February 1, 2002
Northwestern Trust	April 1, 2002
MyCFO	November 1, 2002
Sullivan, Bruyette, Speros and Blayney (SBS)	January 16, 2003
Gerard Klauer Mattison (GKM)	July 3, 2003
Lakeland Community Bank	February 27, 2004
New Lenox State Bank	June 1, 2004
Mercantile National Bank	December 30, 2004
Villa Park Trust and Savings Bank	January 1, 2006
First National Bank & Trust (FNBT)	January 4, 2007
Fidelity Information Services	January 1, 2007 or on employee hire date with Harris N.A., whichever is later
Merchants & Manufacturers Bancorporation, Inc.	March 1, 2008
Ozaukee Bank	March 1, 2008
Griffin, Kubik, Stephens & Thompson	July 1, 2008
Pierce, Givens & Associates, LLC	February 13, 2009
Stoker Ostler Wealth Advisors	September 9, 2009
Citicorp Diners Club Inc.	January 1, 2010
Amcore N.A.	April 24, 2010
Marshall & Ilsley Corporation1 (M&I)	July 6, 2011
CTC Consulting LLC	June 1, 2012

Acquired Company	Acquisition Date
General Electric Transportation Finance	December 1, 2015 (Service date varies depending on hire date.)
Greene, Holcomb, Fisher, LLC	August 1, 2016
FIS	April 8, 2017
KGS Alpha	September 1, 2018
Clearpool Group Inc.	April 6, 2020
PeopleScout	July 1, 2020

Special Eligibility Provisions for Certain Acquisitions[1]

For certain acquired companies, special rules will apply in determining eligibility for the BMO Financial Group U.S. Retiree Medical Program, if the employee meets the eligibility requirement described below during the ten-year period immediately following their company's acquisition (closing) date with Bank of Montreal U.S. Group of Companies.

Following the ten-year period, Retiree Eligibility and employer funding rules apply based on the date you became eligible for the Bank of Montreal/Harris Retirement Plan. Refer to the How BMO Contributes section for more information.

Marshall & Ilsley Corporation1 (M&I)

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

Eligibility for Medicare Part D and BMO Retiree Coverage

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

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

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

Enrolling & Changes: Your Retiree Medical Program

Retirees Under Age 65

When you retire, you will continue in the same medical plan coverage option that you had while you were still working. If you experience a change that affects the eligibility of the medical plan option that you are enrolled in your medical coverage will automatically be updated to the plan available to you based on your new address.

Retirees Over Age 65 and/or Medicare Eligible

Medical coverage for retirees (and their eligible dependents) over age 65 and/or Medicare eligible are covered under the Medicare Secondary Plan. The Medicare Secondary Plan is a comprehensive plan that coordinates benefits with Medicare and is administered by UMR. The Medicare Secondary Plan is the only option available to retirees and their covered eligible dependents who are over age 65 and/or Medicare eligible.

If you are age 65 or older when you retire and choose to enroll in a Medicare Part D prescription drug plan, you may not enroll in the Retiree Medical Plan. Once your retiree medical coverage is cancelled, you permanently forfeit your rights to enroll in this coverage in the future (see Eligibility for Medicare Part D and BMO Retiree Coverage).

Coverage Options

Retirees are eligible to enroll in:

- Retiree Only or Spouse Only
- Retiree + Spouse
- Retiree + Child(ren) or Spouse + Child(ren)
- Child(ren) Only
- Family

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

In cases where the retiree or eligible spouse/domestic partner is over age 65 and/or Medicare eligible but the other individual(s) is under 65 and not Medicare eligible, coverage will be split. The individual that is over 65 and/or Medicare eligible will enroll in the Medicare Secondary Plan and the individual under 65 or not Medicare eligible will enroll in a pre-65 plan option. Any non-Medicare eligible children will be covered with the individual that is under 65.

In cases where both the retiree and their eligible spouse/domestic partner are over age 65 and/or Medicare eligible, coverage will be split. Both individuals will be enrolled in the Medicare Secondary Plan, each with individual coverage. If there are remaining eligible

children, the children will be enrolled in a pre-65 plan, if the child is not also Medicare eligible.

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

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

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

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

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

If one employee retires while the spouse continues working at the Company, the working spouse may remain in the active plan and enroll the retiree as a dependent. If the working spouse leaves or retires from the Company, he or she may be enrolled as the dependent of the retiree within 31 days from the last day of work. If both the working spouse and retiree are eligible for retiree medical coverage from the Company, each may enroll for single retiree coverage with premiums based on his or her own years of service. Alternatively, one retiree may enroll as the dependent of the other, provided as least one retiree qualifies for retiree medical.

If You Decline or Cancel Coverage

You have the option to waive your Retiree Medical Coverage through BMO and retain your Retiree Medical eligibility status (under certain circumstances) through the Retiree Medical Waiver Provision by completing the Retiree Medical Program Election/Waiver form. Your coverage will be cancelled effective the last day of the month in which your completed paperwork is received.

Note: If the retiree waives coverage prior to reaching age 65, the spouse's/domestic partner's and/or other member's pre-age 65 coverage is automatically waived. A spouse/domestic partner who is eligible for the Medicare Secondary Plan may continue enrollment in the Medicare Secondary Plan even if the retiree chooses to participate in the pre-65 waiver provision. However, if the retiree chooses not to enroll in the post-age 65 coverage when he/she becomes eligible, the spouse's coverage, if any, would be cancelled at that time.

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

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

Retiree Medical Waiver Provision

You and/or your eligible dependents have the option to "waive" your retiree medical coverage through BMO under the Retiree Medical Waiver Provision. This option allows you to retain your retiree medical eligibility status and re-enroll when certain qualifying conditions are met. To enroll in the waiver program, indicate your intent to waive on the Retiree Medical Program Election/Waiver form. This option may be beneficial to you if you are eligible for other employer group medical coverage through a spouse/domestic partner or other employer. If you choose to waive coverage, please carefully read through the provisions outlined below to understand your options. If you elect COBRA health insurance coverage at the time of your retirement, you will give up your right to participate in the Retiree Medical Program and therefore this waiver provision does not apply.

If you are waiving coverage for yourself any eligible dependent(s) failure to return the *Retiree Medical Program Election/Waiver* form, will forfeit future re-enrollment in the Retiree Medical Program for you and your eligible dependent(s).

Eligibility for Waiver Provision

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

If you are under the age of 65 and decide to waive enrollment, your spouse's/domestic partner's and/or other member's pre-age 65 coverage is automatically waived. You can only re-enroll when certain conditions are met or at the time of reaching age 65 and/or becoming eligible for Medicare.

If you are under age 65 and decide to waive enrollment, your spouse/domestic partner who is eligible for the Medicare Secondary Plan may continue enrollment in the Medicare

Secondary Plan. However, if the retiree chooses not to enroll in the post-age 65 coverage when he/she becomes eligible, the spouse/domestic partner's coverage, if any, would be cancelled at that time.

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

Retiree Waiver Options Chart			
Retiree Age Status	**Retiree Action**	**Spouse /Domestic Partner Age Status**	**Allowable Spouse/Domestic Partner Action**
	other group coverage (Permanent Cancellation)	Spouse/Domestic Partner is over 65 or Medicare eligible	

Requesting Re-Enrollment

*** Pre-65 Waiver**

You have the option to waive your pre-65 coverage at any time with the opportunity to re-enroll once you meet one of the following guidelines:

- You become Medicare eligible by reaching age 65 or as a result of a disability. You have 31 days from the date of becoming eligible for Medicare to enroll in the Medicare Secondary Plan, unless Medicare enrollment is able to be postponed due to enrollment in other group medical coverage. Refer to the post-65 waiver provision for additional information on eligibility when you become Medicare eligible.
- You lose other group or state-provided medical coverage as a result of one of the qualifying events:
  - a change in legal marital status or qualified domestic partner relationship.
  - a change in employment status of the individual that carried the other employer group coverage.
  - a change in benefit's eligibility status of the individual that carried the other group coverage.
  - a change in residence.

You have 31 days from the date of the qualifying event to enroll in the Retiree Medical Program.

- You experience a significant cost increase or significant coverage curtailment under your other employer group or state provided medical coverage. The cost must exceed the cost of what you would be paying for your BMO retiree medical coverage. You have 31 days from the effective date of the cost increase/significant coverage curtailment to enroll in the Retiree Medical Program.
- An eligible spouse/domestic partner would be allowed to enroll in the retiree medical coverage in the event of the retiree's death if otherwise eligible under the Plan. The spouse/domestic partner must have a qualifying event consistent with re-enrolling in coverage as outlined above at the time enrollment is requested.

**** Post-65 Waiver**

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

If you did not complete and return the Retiree Medical Program Election/Waiver form waiving coverage for yourself and any eligible dependents, your re-enrollment in the Retiree Medical Program for yourself and any eligible dependents was forfeited for failing to return the form.

To request re-enrollment in the BMO Retiree Medical Program you will need to submit a *Retiree Medical Program Election/Waiver* form to elect coverage. The following reasons are **NOT** considered qualifying events that would allow re-enrollment in the Retiree Medical Program:

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

Death

In the event of the death of a retiree, the retiree's spouse/domestic partner and members may continue coverage as long as the Plan is offered and they meet the definition of an eligible dependent. If the spouse/domestic partner of the deceased retiree remarries or enters into another domestic partner relationship, the new spouse/domestic partner and any dependents of the new spouse/domestic partner are not eligible for coverage.

To make a change, call the Human Resources Centre at 1-888-927-7700.

How Coordination of Benefits Works

The medical plans all have a "coordination of benefits" provision that prevents duplication of benefit payments when you or your dependent also has other health coverage through another group plan, including Medicare. Coordination of benefits procedures also determine which plan pays your claim first (see Coordination of Benefits in the Summary Plan Description for more information).

If you are eligible to continue coverage and are over age 65 and/or Medicare eligible you must enroll in Medicare Parts A and B to continue in the Company-sponsored medical plan, as explained in the BMO Financial Corp Health Benefit Summary Plan Description, administered by UMR. Medicare always pays first for your medical claims if you are over age 65 and/or Medicare eligible (unless you are working and covered as an active employee).

UMR will normally send payment for covered expenses directly to your provider.

Plan Cost

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

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

Costs for the Retiree Medical Program are based on coverage and administrative fees for the retiree group, and are different from the active employee rates. Contributions for retirees are paid to the Company with after-tax dollars.

How BMO Contributes

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

How to Determine Your Years of Benefit Service

In general, your service begins on your hire date with BMO, however, some employees will need to know their Vesting Service, while others will need to know their Benefit Service.

Most employees — including those who were part of acquisitions in Argo, Bank of Montreal, Barrington, Roselle and Libertyville — will need to know their age and Vesting Service, which is generally measured from your hire date. Employees who were part of all other acquisitions will need to know their age and Benefit Service. Generally, Benefit Service begins on the actual date your company was acquired or the date your company joined the BMO/Harris Retirement Plan, whichever is later. (See Companies Acquired by BMO Financial Group U.S. for more information).

Years Benefit Service

- For individuals who retired prior to March 1, 2017 your years of benefit service are determined based on full-time benefits service under the Bank of Montreal/Harris Retirement Plan.
- For individuals retiring on or after March 1, 2017 your years of benefit service are determined based on all benefits service time under any BMO entity.

You have the flexibility to access your years of service at any time by accessing your job details in Workday. If you have questions on how to calculate your benefit service, please call the Human Resources Centre at 1-888-927-7700.

How to Determine Your Retiree Group

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

- **Groups 1 and 2**: Employees who on 12/31/2007 were age 55 or older with at least 10 years of benefit service* or age 45 or older with at least 60 points (your points are your age plus years of benefit service)* will pay a percentage of the medical premium. BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%. Your spouse/domestic partner and child(ren) will pay an additional 25% of the premium.

  * *Generally, your hire date with the Company can be used to determine your benefit service.*

  Example: A retiree with 25 years of benefit service will pay 45% of the monthly premium. The full monthly premium for the Blue Cross Blue Shield Plan, individual coverage is $1,205.50, the retiree will pay 45% or $542.48 per month. The spouse pays an additional 25% of the full monthly premium, which means the cost for spouse coverage is 70% (25% + 45%) or $843.85. The total cost for retiree + spouse is $1,386.33 per month.

- **Group 3**: Employees who on 12/31/2007 were age 35 or older, who are not in Groups 1 or 2, for coverage before age 65, will pay a percentage of the medical premium. BMO's minimum contribution is 25% of the premium for 10 years of benefit service. For each additional year of benefit service earned (up to 35 years), BMO contributes an additional 2% of the premium, to a maximum of 75%. Your spouse/domestic partner and child(ren) will pay an additional 25% of the premium. Beginning at the age of 65 you will receive a subsidy from BMO to offset the cost of the BMO retiree medical plan.

  This means that instead of paying a percentage of the premium, you will receive a capped annual subsidy of $70, times years of benefit service, up to a maximum of $2,450 per year (An aggregate of $600 less for your spouse/domestic partner/child(ren)). The value of your subsidy will be fixed when you reach age 65 – with no future increase. The subsidy will continue for your lifetime. In the event of your death, your spouse/domestic partner/child(ren) subsidy would also continue for his or her lifetime.

  Example: If you retire from BMO with 25 years of benefit service, BMO will pay $70 x 25, or $1,750 per year toward the cost of your retiree medical coverage once you reach age 65. Your spouse's subsidy would be $1,150 per year.

- **Group 4**: Employees who on 12/31/2007 were under age 35 and who retire before age 65 will have to pay the full cost of coverage. BMO does not offer retiree medical coverage or the subsidy once you reach age 65. You would be responsible for your own coverage, which can be through Medicare and/or an individual insurance plan.

Special eligibility provisions for employees that retired on or before October 31, 1991.

Grandfathered Employees	How You Contribute	
Retired on or before 10/31/1991 (regardless of service)	**Under Age 65**	**Over Age 65**
	Pay active rates	No contributions required

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

Retiree Group	Your Plan Options		How BMO Contributes	
Employees who by 12/31/2007 were:	**Under Age 65**	**Over Age 65**	**Under Age 65**	**Over Age 65**
	Choice Plan	coverage is available through Express Scripts.		
3 Age 35 or older (but not in either group above)**	You have access to the same plan options as active employees. Consumer Choice Plan	You will have access to the Medicare Secondary Plan. Medicare is primary and UMR is secondary. Your prescription coverage is available through Express Scripts.	BMO's minimum contribution is 25% of the premium* for 10 years of benefit service. For each additional year of benefit service earned up to 35 years, BMO contributes an additional 2% of the premium, to a maximum of 75%. The spouse/domestic partner/child(ren) pays an additional 25% of the premium.	BMO will provide an annual subsidy that can be applied to the BMO plan. The annual subsidy will begin at age 65 and equal $70 times years of benefit service (up to 35 years) earned in the BMO/Harris Retirement Plan. The spouse domestic partner/child(ren) would receive an aggregate of $600 less.
4 Under age 35**	You have access to the same plan options as active employees. Consumer Choice Plan	No coverage available through BMO.	You pay the full cost of coverage.	N/A

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

How to Determine Your Share of the Monthly Premium

To calculate your share of the premium you will need the Full Monthly Retiree Medical Premiums sheet to determine the full premium amount for the option(s) you are choosing.

You will also need to know 'Your contribution' percentages, which can be found on your Retiree cover letter or by contacting the Human Resources Centre at 1-888-927-7700. See the chart Premiums for individuals under age 65 are higher than for those that are over age 65 and/or Medicare eligible. The reason is that Medicare pays a significant share of medical expenses for persons over age 65 and/or Medicare eligible. Your premium amount will be reduced automatically on the first day of the month in which you qualify for Medicare or the first day of the prior month in cases where the date of birth is on the first of a month. On that date, Medicare becomes your primary insurance coverage, and the Company's Plan becomes secondary. Please note, your coverage under the Retiree Medical Program will end once you reach age 65 if you were hired or rehired on or after January 1, 2008, or younger than age 35 as of December 31, 2007.

Pre-65 Coverage tier	**How to calculate your share of the premium**		
Retiree Only	Total premium = *Retiree Only* premium x Retiree Pays %		
Spouse Only	Total premium = *Spouse Only* premium x Dependent Pays %		
Retiree+Spouse Determine the share of the premium for the retiree versus the spouse and apply applicable percentages	Step 1 Retiree share of premium = *Retiree Only* premium x Retiree Pays %	Step 2 Spouse share of premium = (*Retiree+Spouse* premium - *Retiree Only* premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Spouse share of premium
Retiree+Child(ren) Determine the share of the premium for the retiree versus the child(ren) and apply applicable percentages	Step 1 Retiree share of premium = *Retiree Only* premium x Retiree Pays %	Step 2 Children share of premium = (*Retiree+Child(ren)* premium - *Retiree Only* premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Child(ren) share of premium
Spouse+Child(ren)	Total premium = *Spouse+Child(ren)* premium x Dependent Pays %		
Child(ren) Only	Total premium = *Child(ren) Only* premium x Dependent Pays %		
Family Determine the share of the premium for the retiree versus the spouse & child(ren) and apply applicable percentages	Step 1 Retiree share of premium = *Retiree Only* premium x Retiree Pays %	Step 2 Spouse & Child(ren) share of premium = (*Family* premium - *Retiree Only* premium) x Dependent Pays %	Step 3 Total premium = Retiree share of premium + Spouse & Child(ren) share of premium

Post-65 Coverage tier	**How to calculate your share of the premium**			
Individual Only	Step 1 Retiree share of premium = *Individual Only* premium x Retiree Pays %	Step 2 *(if applicable)* Spouse share of premium = *Individual Only* premium x Dependent Pays %	Step 3 *(if applicable)* Child share of premium = *Individual Only* premium x Dependent Pays % *(repeat if more than one child)*	Step 4 Total premium = Retiree share of premium + Spouse+ Child(ren) share of premium

Method of Premium Payment

PayFlex Systems, USA, Inc. is responsible for collecting monthly retiree health insurance premiums. Arrangements for premium payment will be made at the time of retirement. Payments are due the first of each month and must be made within the 30-day grace period or coverage will be cancelled and cannot be reinstated. Note: If you are currently having your payments deducted from your pension payments, you may continue this option unless you choose to be billed by PayFlex Systems in the future.

Legacy M&I Retiree Medical Eligibility

Special Eligibility Provisions for former Employees of M&I Only

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

You are not eligible for retiree medical coverage if your employment with the Company is terminated due to misconduct, including but not limited to, dishonesty, theft, embezzlement, disclosure of trade secrets, commission of a felony or inappropriate behavior; or if you voluntarily terminate your employment after having committed such acts.

While the Company intends to continue offering the Retiree Medical Program, the Company reserves the right to change, interpret or end the plan at any time. The Company takes such action through Board of Directors' resolutions or through officers authorized by the Board.

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

Information about dependents

As a Legacy M&I retiree, your dependents are not required to be covered on your medical coverage at the time of your retirement; however, the dependent must meet the definition of an eligible dependent at the time of your retirement and at the time you request to enroll them in coverage. You are only able to add the following dependents to your medical coverage at a later date if they continue to meet the dependent definition, as applicable:

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

Eligibility and Qualifications for Pre-65 Coverage

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

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

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

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

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

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

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

Funding

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

Eligibility and Qualifications for Post-65 Coverage

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

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

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

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

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

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

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

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

Funding

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

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

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

Waiver Provision Prior to Retirement

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

you waived your M&I medical coverage prior to January 1, 2007 when this provision was implemented, this provision does not apply.

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

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

Acquisitions/Mergers

The following guidelines apply to both pre- and post-age 65 coverage.

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

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

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

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

Eligibility/Funding

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

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

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

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

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

Employees who retire *on or after January 1, 1995*, are eligible for the following:

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

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

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

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

Central Fidelity Bank – Acquired by M&I 9/1/97
Security Bank – Acquired by M&I 10/1/97
Citizens Bank – Acquired by M&I 11/1/97
Advantage Bank – Acquired by M&I 4/1/98
Fifth Third Bank – Acquired by M&I 9/8/01

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

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

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

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

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

Grandfathered Employees: Employees at least age 55 with 10 or more years of vesting service* at the earlier of June 30, 2002 or the date of retirement, and 10 or more consecutive years of participation in a health plan sponsored by NCB or M&I or BMO as of the date of retirement are eligible for pre-age 65 funding based on the declining scale below:

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

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

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

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

- **First Indiana Bank Trust Company – Acquired by M&I 1/1/06**
- **First Indiana Bank – Acquired by M&I 1/1/08:**
  - Less than 10 years of vesting service*, and less than 10 consecutive years of participation in any health plan sponsored by acquired company and/or M&I and/or BMO *** before retirement: COBRA coverage may be available at 102% of the active employee group rate. COBRA coverage is typically limited to a period of 18 months.
  - 10 or more years of vesting service*, and 10 or more consecutive years of participation in any health plan sponsored by the acquired company and/or M&I and/or BMO *** before retirement (refer to the Waiver Provision Prior to Retirement section for exceptions to this requirement): pre-age 65 and post-age 65 retiree medical coverage is available at 100% of the retiree group rate.

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

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

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

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

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

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

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

Acquired Company	Acquisition Date
CardPro	April 1, 1999
Traveler's Express	April 9, 1999
HUBCO	November 13, 1999
Derivion Corporation	June 1, 2001
CyberBills	June 21, 2001
Brokat	September 8, 2001

Acquired Company	Acquisition Date
401k Services.Com	December 20, 2001
Century Bank	March 1, 2002
Richfield Bank	March 1, 2002
TrustStar Retirement Services – Glendale location	April 8, 2002
– San Mateo location	April 15, 2002
Beneplan	May 1, 2002
Paytrust, Inc.	July 22, 2002
Southwest Bank	October 1, 2002
Printing for Systems, Inc. (PSI)	November 15, 2003
AmerUs Home Lending Inc	January 1, 2004
United Missouri Bank	Various acquisition dates by individual
Kirchman Corporation	May 28, 2004
Advanced Financial Solutions (AFS)	July 1, 2004
NYCE Corporation	July 30, 2004
Response Data Corporation (RDC)	September 8, 2004
NuEdge	October 20, 2004
VECTORsgi Holdings Inc.	November 22, 2004
Prime Associates, Inc.	February 9, 2005
MBI Benefits, Inc.	July 22, 2005
TREEV	August 8, 2005
GHR	August 11, 2005
Brasfield Technology, LLC	October 6, 2005
Link2Gov	November 30, 2005
AdminiSource Communications	January 3, 2006
Gold Banc Corporation, Inc.	April 1, 2006
Trustcorp Financial, Inc. (Missouri State Bank and Trust Company)	April 1, 2006
VICOR, Inc.	September 2, 2006

Acquired Company	Acquisition Date
Valutec Card Solutions, LLC	January 17, 2007
United Heritage Bank	April 1, 2007
North Star Financial Corporation	April 21, 2007
Excel Bank Corporation	July 1, 2007
Citizens Bank (asset purchase)	January 1, 2008
Taplin, Canida & Habacht, Inc. (TCH, LLC)	January 1, 2009
U.S. Bank (asset purchase)	May 3, 2010

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

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

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

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

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

Eligibility for Medicare Part D and BMO Retiree Coverage
Former Employers of Marshall & Ilsley Corporation

If you are enrolled in the BMO Group Medical Plan and you elect one of the Medicare prescription drug plans, the prescription drug coverage under the Group Medical Plan will be cancelled. Medical coverage will not be cancelled; however, you will continue to pay the

full premium amount. If you later decide to cancel your Medicare prescription drug plan, the prescription drug benefit under the BMO medical plan will be reinstated, but only if you have continued to be enrolled in the BMO Retiree Health Program.

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

Enrolling & Changes

Your Retiree Medical Program Options

Please refer to the *Enrolling & Changes* section of the Retiree Medical Program, no special rules apply to Legacy M&I Retirees.

Coverage Options

Please refer to the Enrolling & Changes section of the Retiree Medical Program, no special rules apply to Legacy M&I Retirees.

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

Please refer to the Enrolling & Changes section of the Retiree Medical Program, no special rules apply to Legacy M&I Retirees.

If You Decline or Cancel Coverage

You have the option to waive your Retiree Medical Coverage through BMO and retain your Retiree Medical eligibility status (under certain circumstances) by completing the *Retiree Medical Program Election/Waiver* form. Your coverage will be cancelled effective the last day of the month in which your completed paperwork is received.

Note: If the retiree waives coverage under the age of 65, the spouse's/domestic partner's and/or other member's pre-age 65 coverage is automatically waived. A spouse/domestic partner who is eligible for the Medicare Secondary Plan may continue enrollment in the Medicare Secondary Plan even if the retiree chooses to participate in the pre-65 waiver provision. However, if the retiree chooses not to enroll in the post-age 65 coverage when he/she becomes eligible, the spouse's coverage, if any, would be cancelled at that time.

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

- You elect COBRA medical insurance at the time of your retirement.
- You do not return the Retiree Medical Program Election/Waiver form within 31 days of your retirement date indicating your intention to elect or waive coverage.
- You do not request re-enrollment in the Retiree Medical Program within 31 days of turning age 65, becoming Medicare eligible or experiencing another qualifying event. (Exception: You continue to be enrolled in other group coverage.)

- You are over 65 and/or are Medicare eligible and have not been enrolled in other group coverage continuously during your waiver period from the time you became Medicare eligible.
- You voluntarily choose to permanently cancel your coverage.

Retiree Medical Waiver Provision

Waiver Provision Prior to Retirement

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

If you choose to waive your medical coverage as an active employee, you may do so during the Annual Enrollment period or as the result of a qualifying event by completing the *Retiree Medical Program Election/Waiver* form. You may re-enroll in coverage during the Annual Enrollment period (effective the following January 1); as the result of a qualifying event (effective based on rules under Qualifying Life Event); or at retirement (effective the day following your last working day). **Please note**: Enrollment rules vary by health plan and all current options may not be available at the time you request re-enrollment.

Waiver Provision Following Retirement

Please refer to the *Enrolling & Changes* section of the Retiree Medical Program, no special rules apply to Legacy M&I Retirees.

Death

Please refer to the Enrolling & Changes section of the Retiree Medical Program, no special rules apply to Legacy M&I Retirees.

How Coordination of Benefits Works

Please refer to the *Enrolling & Changes* section of the Retiree Medical Program, no special rules apply to Legacy M&I Retirees.

Plan Cost

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

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

Note: Costs for the Retiree Medical Program are based on coverage and administration fees for the retiree group, and are different from the active employee rates. Contributions for retirees are paid to the Company with after-tax dollars.

How to Determine Your Share of the Monthly Premium

To calculate your share of the premium you will need the Full Monthly Retiree Medical Premiums sheet to determine the full premium amount for the option(s) you are choosing. You will also need to know 'Your contribution' percentages, which can be found in your Retiree letter or by contacting the Human Resources Centre at 1-888-927-7700. See the chart below to help calculate your share of the premium.

To calculate your share of the premium:

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

Example: You and your spouse are both under 65: Total premium = *Retiree*+*Spouse* premium x your contribution % for pre-65 coverage. Eligible dependents will receive the same contribution percentages that the retiree is eligible for.

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

Method of Premium Payment

PayFlex Systems USA, Inc. is responsible for collecting monthly retiree health insurance premiums. Arrangements for premium payment will be made at the time of retirement. Payments are due the first of each month and must be made within the 30-day grace period or coverage will be cancelled and cannot be reinstated.