Flexible Spending Accounts Summary Plan Description (SPD)

BMO U.S. Health and Welfare Benefit Plan

Contents

About this Summary Plan Description

This document is the Summary Plan Description ("SPD") for the flexible spending accounts portion of the BMO U.S. Health and Welfare Benefit Plan (the "Plan"). The benefits under the Health Care Flexible Spending Account ("HCFSA") and Limited Purpose Flexible Spending Account ("LPFSA") (together the "Health FSAs") are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). The benefits under the Dependent Care Flexible Spending Account ("DCFSA") are not subject to ERISA.

Please read this SPD to help you understand and manage your benefits and keep it for future reference. This SPD only addresses the flexible spending accounts benefits portion of the Plan. Other portions of the Plan discuss other benefits. Those other portions are not covered by this SPD.

The information in this SPD is current as of January 1, 2024. As Plan changes occur, this SPD will need to be revised periodically. Although the Company strives to keep the descriptions up to date, from time-to-time Plan changes may not be incorporated immediately into the SPD. While this SPD summarizes the major provisions of this Plan, it does not provide you with every Plan detail. If there is any discrepancy or any oral representations that differs between this SPD and the legal Plan document, the Plan document controls.

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

Eligibility

Employee

You are eligible to participate in the flexible spending accounts portion of the Plan if you are a:

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

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

You and your eligible dependents (as defined below) do not have to be covered under the Company's Medical, Dental or Vision Plans to participate in the Health FSAs.

Eligible Dependents

For purposes of the Health FSAs, "Dependent" means a dependent under Internal Revenue Code ("Code") section 105(b). If your domestic partner or a child of your domestic partner qualifies as your dependent under Code section 105(b), you may use the Health FSAs to reimburse his or her qualifying medical care expenses.

For purposes of the DCFSA, means:

- your qualifying child (as defined in Code section 152(a)(1)) who is under the age of 13;;
- your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
- your dependent under Code section 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year.

Qualified Medical Child Support Order

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

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

Enrolling & changes

When coverage begins

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 hire date or newly benefit-eligible date) to make your benefit elections. **Please note**: the benefit effective date for employees hired as part of an acquisition and/or merger may be different based upon the terms of the purchase agreement.

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

Participation in the Flexible Spending Accounts is optional. Once made, you generally cannot change your elections during the year. However, you can do so in limited situations. Refer to Mid-year election changes for more information.

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.

Annual enrollment

Annual enrollment occurs once a year (usually in October) and is your chance to re-evaluate what benefits coverage you need in place to best support you and your family. **Annual enrollment requires your active participation.** During annual enrollment you can make changes to your benefit elections. The changes take effect the next January 1. If you have not enrolled in the Plan, you can do so during the annual enrollment period. Elections made during annual enrollment remain in effect throughout the calendar year; unless you experience a qualifying life event (see *Mid-year election changes* for more information). In general, elections must be made each year.

Mid-year election changes

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. Coverage will be effective as of the date of the event, but you only have 31 calendar days (includes the event date) to make changes to your coverage. Benefit changes that you make during a qualifying life event must be consistent with the change in status. You may need supporting documentation, but not when initiating the event.

Change in Status Events

You may change certain elections mid-year if you experience a change in status event listed below. You must notify BMO of the change, as outlined below. **Where applicable, the changes you make to your coverage must be consistent with and "on account of and correspond with" the event.** For example, if your child is no longer an eligible dependent, you may decrease your Health FSA election, but you may not increase it.

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage.
- **Dependent Status:** Any event that causes your eligible dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.

In addition, for the DCFSA only, you may make a mid-year election change if you provide documentation demonstrating that you have experienced and increase or decrease in dependent care provider fees (except for increases by a provider who is related to you), you choose a different dependent care provider who charges a different amount, or you make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

How to change, add or cancel coverage

If you experience a qualified life event during the year, you have 31 calendar days (including the event date) to change, add or cancel coverage. Here's how:

1. Go to **Workday**, click on the **My Benefits & Retirement** app;
2. Select your network status (on or off the BMO network);
3. Click on **Change Your Coverage** from the top menu or click on **Log your life event** tile;
4. Choose the life event that corresponds to your event, enter the date your life event occurred and **follow the rest of the prompts** to make your election changes;
5. After you make the benefit election changes, **verify your benefits summary** to make sure everything is correct and the changes are reflected as you intended. **Keep a copy for your records.**

If you miss the deadline, your next opportunity to change, add, or cancel coverage is during annual enrollment, unless another qualifying life event occurs that would allow a change.

Accessing Workday outside the BMO network

To access Workday outside the BMO network through an internet browser or the Workday app available on the App Store or Google Play you will first need to set up a series of security challenge questions in Workday from a computer or device connected to the BMO network.

1. On the Workday home page, select your Profile icon in the upper-right corner. The icon will be either your photo or a generic cloud image.
2. Select My Account under your name.
3. Select Manage Password Challenge Questions.
4. Select three security challenge questions and provide answers. Then, select OK.

To set up your Workday Password – outside the BMO network – for the first-time launch Workday from your internet browner (https://wd3.myworkday.com/bmo/login.htmld) or the Workday app.

1. On the Login screen, select Outside the BMO network.
2. On the Outside the BMO network screen, select Forgot Password?.
3. Enter your Employee Identification Number (EIN) in the Username field, then select Continue.
4. Answer the three Workday security challenge questions that you set up in Workday previously, then select Submit.

Paid and Unpaid 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 FSA coverage, you must continue paying your premiums while on FMLA leave. If your 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 will continue as well, however when you return from leave, your deductions will be recalculated based on your annual election and the remaining pay cycles.

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. For more information about FMLA leave, access the HR Intranet, Operating Procedures, Leaves of Absence – Family Medical can be found under *About Managing Life's Transitions.*

Maternity and Parental leave

If you are on maternity or parental leave your Plan coverage will continue during both the paid and unpaid portion of your leave. Your benefits coverage will continue during the first 16 weeks of paid leave. Premiums will continue to be deducted from your pay. If you choose to take the additional 8 weeks of unpaid maternity/parental leave, your benefits coverage will continue, however when you return from leave, your deductions will be recalculated based on your annual election and the remaining pay cycles.

Military leave of absence

If you are on military leave, you can elect to continue Health FSA 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). If you continue Health FSA coverage, your contributions will remain the same as when you were actively employed. If you wish to elect Health FSA coverage beyond the end of the Plan Year, you must do so during annual enrollment.

If you become disabled

Your spending account coverage, if applicable, may continue during your disability leave. However, under the DCFSA, you generally must be working to receive reimbursement for dependent care expenses. Premium payments are deducted from any Short-Term Disability payments you may be receiving. Coverage will terminate at the end of the month in which your short-term disability ends, you may claim qualified expenses incurred while you were a participant in the spending account, up to the amount you elected less any prior reimbursements. You may be eligible for COBRA coverage (for the Health FSAs) for the remaining portion of the plan year. COBRA paperwork will be sent directly to your home. Your DCFSA will end on the first day following the last day of your STD leave. If you have a balance in your DCFSA when your coverage ends, you may claim qualified expenses incurred for the remainder of the calendar year. Expenses will be reimbursed up to the total amount of unused funds remaining in your account. COBRA coverage is not available for the DCFSA. 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 benefits or loss of all eligibility for the Plan.

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 twelve (12) months of the final decision on your appeal or you lose any rights to bring such an action against BMO Financial Corp., the Benefits Administration Committee (or any other claims administrator), or the Plan.

Mandatory venue

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

Plan cost

You pay the entire cost of contributions made to the Flexible Spending Accounts.

Tax-saving advantage

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

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to set aside money on a before-tax basis to pay for a variety of eligible health care and dependent care expenses. Today the high cost of health care and the growing need for dependent care are facts of everyday life. Although the Company's medical, dental and vision plans offer you significant protection against the high cost of health care, as you might expect, the plans do not reimburse all your medical, dental and vision expenses. Or you may rely on day care for your children, a disabled spouse, or your elderly parents so that you can work. These expenses can really add up. FSAs can help you save money by reducing your taxable income. As the money you contribute is deducted from your paychecks, your taxable income is reduced – this means you'll pay less in taxes.

In general, there are two types of FSAs:

- **Health Care Flexible Spending Account (HCFSA)**
  The HCFSA helps pay for you and your Dependent's medical, dental, and vision expenses that aren't covered by the Company's or your spouse/domestic partner's benefit plans.

  Limited Purpose Flexible Spending Account (LPFSA)
  The LPFSA is limited to dental and vision expenses and is generally used when you are contributing to a Health Savings Account.

- **Dependent Care Flexible Spending Account (DCFSA)**
  The DCFSA covers expenses for the daily care of your children under age 13 or other qualified individuals who are unable to care for themselves, so that you can work.

The HCFSA, LPFSA, and DCFSA are administered by Smart-Choice.

You can choose to participate in one or both FSAs, depending on your needs. Every year, you decide how much money, if any, you want to contribute to each FSA, up to the maximum amount permitted under the law. The money is then deducted from the first two paychecks of each month and is credited to your nominal FSA on a before-tax basis. Because this money goes into your FSA before federal income or Social Security taxes are withheld, you pay less in taxes. In most cases, the money you set aside is exempt from state and local taxes as well. Since you don't pay Social Security taxes on your FSA contributions, those benefits may be slightly less when you retire or become disabled. Any reduction will depend on the length of time between now and when you retire or become disabled, and whether your taxable income exceeds the Social Security maximum wage level.

Important note about HCFSA participation

If you elect to contribute to a Health Savings Account (HSA), your FSA will be considered a LPFSA subject to special IRS rules.. If you are participating in LPFSA, only the following expenses are considered eligible for reimbursement:

- dental care and orthodontia, such as fillings, X-rays, braces and caps;
- vision care, including eyeglasses, contact lenses, solutions, and LASIK eye surgery.

Contributions

You decide whether to participate in one or both FSAs and how much to contribute. First, you'll need to estimate the amount of out-of-pocket health care and dependent care expenses you are likely to have during

the year. Then, determine how much salary you want to set aside during the year to pay for those expenses. Keep in mind, there are limits on the amounts you can contribute. The annual minimum and maximum contributions are shown below. Account maximum limits are subject to change based on IRS guidelines.

Flexible Spending Account	*Annual minimum*	*Annual maximum (for 2024)*
Health Care	$100	$3,200
Dependent Care	$100	$5,000 if single or married and filing jointly* $2,500 if married and filing separately*

*The maximum amount that you can elect may be less because of other limitations. For example, you cannot elect more than the lower of you or your spouse's earned income for the calendar year.

Note: If you contribute $150 or more to your Health FSA, you can take advantage of the Smart-Choice debit card.

You may elect to contribute up to $5,000 per calendar year to the DCFSA if:

- You are married and file a joint federal income tax return;
- You are married and file a separate federal income tax return, and meet the following conditions:
  - your household constitutes the primary residence for more than one-half of the year of a dependent for whom you are eligible to receive reimbursements under the DCFSA;
  - you furnish over half the cost of maintaining this household during the taxable year; and
  - during the last six months of the taxable year, your spouse was not a member of this household.
- You are single or head of household for federal tax purposes.

If you are married and reside with your spouse but you file separate federal income tax returns, the maximum amount you can contribute to the DCFSA is $2,500 per calendar year. The amount you may elect cannot exceed either your or your spouse's earned income for the calendar year.

The amount you elect will automatically be deducted from your pay on the first two pay periods of each month and deposited into your FSAs. 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). The money remains credited to your DCFSAs until you incur eligible expenses and submit a claim for reimbursement. However, for the Health FSAs, the entire amount that you elected to contribute will be available on the first day of the Plan year (or the effective date of your Health FSA coverage if you elect to participate in the Health FSA mid-year).

Health Care Flexible Spending Account (HCFSA)

You can use your HCFSA to pay for certain expenses for you and your eligible Dependents that your health care plans may not cover. This includes your deductible and coinsurance, and many expenses that are not eligible under the medical, dental and vision plans. Even if you are seldom ill and don't think you'll use the medical, dental or vision plans, you may want to consider using the HCFSA for annual expenses that the medical, dental, or vision plans don't cover.

Eligible health care expenses

Except for medical, dental and vision insurance premiums, most health care expenses that you could deduct from your federal income taxes can be reimbursed through the HCFSA. (Expenses reimbursed from your HCFSA cannot also be deducted from your federal income taxes.)

Listed below are some of the expenses eligible for reimbursement under the HCFSA (provided they are not reimbursed by any other plan):

- acupuncture;
- allergy shots;
- chiropractor's care;
- contact lenses, exams and needed materials, such as saline solution and enzyme cleaner;
- copayments, deductibles and coinsurance not paid by any group carrier (the receipt must clearly indicate it is for a copayment or coinsurance for a qualified expense);
- dentist's charges not covered by a dental plan;
- dietary supplements when medically necessary and prescribed by a physician;
- eyeglasses and vision exams;
- equipment needed for the handicapped, like car controls or special telephones for the deaf;
- hearing exams, and hearing aids and the batteries needed to operate them;
- immunizations;
- insulin;
- LASIK eye surgery;
- medical or dental expenses that exceed reasonable and customary limits;
- nursing home confinement for treatment of illness;
- over the counter (OTC) medicines without a prescription, as well as menstrual care products;
- physical therapy;
- prescription drugs used to treat or alleviate an illness or injury;
- routine medical exams, including school physicals for children;
- smoking cessation and weight loss programs prescribed by a physician;
- syringes, needles and injections;
- transportation expenses, including taxis, buses, plane fares, and parking, when used for travel for necessary medical care;
- vaccinations;
- well-baby care;
- wheelchairs;
- X-rays.

The general list of eligible and ineligible expenses is available in IRS Publication 502 (Medical and Dental Expenses). To obtain a copy, go to www.irs.gov or call 1-800-829-1040 or your local IRS office. Note that IRS Publication 502 is not specific to only HCFSAs and not all expenses may be eligible for reimbursement under the HCFSA. Contact the claims administrator for more information.

Ineligible health care expenses

Items that would not qualify as tax deductible under federal income tax laws are not eligible for reimbursement through the HCFSA.

- The following are examples of ineligible expenses:
- cosmetics;
- cosmetic surgery, except when needed due to an accident or injury;
- custodial care in an institution, such as a nursing home;
- expenses incurred before your effective date of participation;
- expenses paid by any other group health or dental plan;
- external bleaching of teeth or teeth whitening;
- health club dues;
- health care expenses that are reimbursable under any other health plan or insurance;
- health insurance premiums;
- household and domestic help;
- maternity clothes;
- uniforms;
- vitamins taken for general health purposes;
- weight loss and smoking cessation programs not prescribed by a physician.

Dependent Care Flexible Spending Account (DCFSA)

The DCFSA covers eligible dependent care expenses so that you (or you and your spouse if you're married) can work (or look for work) or your spouse can attend school full time.

Eligible dependent care expenses

For dependent care expenses to qualify for reimbursement through the DCFSA, the care must be provided for a Dependent (as defined above) so that you can work (if you're married, your spouse also must work, be looking for work, or attend school full time).

The following expenses are eligible for reimbursement under the DCFSA:

- costs for care at facilities away from home, such as family day care or adult day-care centers, as long as your adult Dependent spends at least eight hours a day in your home;
- recreation programs;
- services of a day-care center, nursery school or preschool (but not kindergarten) if the center complies with all state and local laws;
- summer day camps; and
- wages paid to a baby-sitter or companion in or outside your home.

Ineligible dependent care expenses

The following expenses are not eligible for reimbursement under the DCFSA:

- boarding schools;
- care provided by someone you claim as a dependent;
- educational expenses like swimming, dance lessons or art classes, whether individual or group, even if recommended by a doctor to improve general health;
- expenses incurred before your effective date of participation;
- kindergarten;
- nursing homes;
- overnight camps; and
- providers who watch your eligible dependents while you attend social events.

Dependent Care Flexible Spending Account vs. child and dependent care tax credit

The IRS lets you claim work-related dependent care expenses for this credit on your income tax return. The tax credit amount is determined by applying a percentage to your total work-related dependent care expenses.

You can use the DCFSA and the tax credit, but you cannot claim the same expenses for both. If you decide to use both the DCFSA and the dependent care tax credit, federal regulations require that the amount you have directed into the DCFSA be subtracted from your tax credit. As with any tax matter, you should consult a qualified tax adviser before making your decision since tax laws change often.

Special IRS rules

The special tax advantages of the FSAs are offered based on current Code rules. The same federal tax laws that allow before-tax savings on your reimbursements also place certain restrictions on your accounts as follows:

- Your deductions for one kind of FSA cannot be transferred to the other. For example, you cannot transfer remaining Health FSA funds into your DCFSA to pay for eligible dependent care expenses.
- The money you set aside each calendar year must be used for that calendar year's expenses while you were actively participating. Any money that is not used will be forfeited except for the allowed Health FSA carry-over amount (see Carryover amounts for more information).
- Once you make your Health FSA election, your contributions will continue the first two periods for the rest of the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.
- Your DCFSA elections must also stay in effect for the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.
- The Plan must satisfy applicable IRS nondiscrimination rules. The Plan administrator, in its discretion, may make such adjustments to your contribution elections as may be necessary to satisfy these rules.

Claims for reimbursement

As you incur eligible expenses during the Plan year, you can submit claims to your Smart-Choice flexible spending account for reimbursement. Each expense you submit will be reviewed by Smart-Choice to determine whether it qualifies for reimbursement under IRS rules. The service must be incurred during the Plan year and while you were actively participating to qualify for reimbursement. Pre-paid services that were charged or billed but not provided during the Plan year are not eligible for reimbursement.

Smart-Choice debit card

If you contribute $150 or more to your Health FSAs, you can take advantage of the Smart-Choice card that you can use to pay for eligible health care expenses. As you use your Smart-Choice card, eligible health care expenses will be deducted automatically from your account.

Individuals eligible for a Smart-Choice card will receive a letter with one Smart-Choice card issued in your name, activation instructions, and benefit car cardholder agreement. You may request additional cards for your spouse and/or eligible dependent(s) through the Smart-Choice website.

The Smart-Choice card remains active as long as your account is in good standing, you continue to participate in a Health FSA, and you remain actively employed. Your card will be canceled upon termination of employment—inactive participants may not use the Smart-Choice card. By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible Dependents under the Plan.
- Incurred expenses were for health care services or supplies purchased on or after the date your Health FSAs took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your Dependents are eligible.
- Any expense paid for with the card has not been, or will not be, reimbursed by another source.

The Smart-Choice card has been designed for use at merchants and providers that primarily sell health care products and services (for example, pharmacies, physician's offices, hospitals, and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to use it as either "credit" or "debit." If you choose the credit option, you must provide your signature.

! **The Smart-Choice card has a pre-assigned PIN that cannot be changed.** Once coverage is active, you will be able to obtain your PIN on the Smart-Choice portal. To view this log into the Smart-Choice portal, navigate to the debit cards page, and select the Smart-Choice card for which you need to locate the PIN. Once selected, the card information will expand, and employees will see the four-digit PIN listed on the right side of the information card. Note, the PIN will be displayed once the card is in an active status. You can activate the card directly on the Smart-Choice portal, through the mobile app, or upon the first use with an eligible expense.

Deadline to file Flexible Spending Account claims

You have until April 30 of the following year to submit any health care and dependent care claims incurred in the previous calendar year while you were actively participating.

Important: save your itemized receipts. All Smart-Choice card transactions must be verified as eligible health care expenses, and you may be required to provide Smart-Choice with supporting documentation to validate your expenses. The card provides the convenience of immediate access to your funds. In some situations, your expenses will be automatically validated when you use your Smart-Choice card to purchase eligible items with select merchants that accept health care debit cards. The Smart-Choice card does not eliminate the requirement to keep documentation for your expenses. In many cases, you may need to provide documentation to Smart-Choice for expenses you paid for with your Smart-Choice card. Even if you are not required to submit the itemized receipts, documentation should be retained in the event you are subject to an IRS audit.

Reimbursement for health care expenses

You can file Health FSA claims as often as you like. You will receive reimbursement from your account up to the total amount you elected for the Plan year and any carryover amount if applicable, even if you have not yet contributed the full amount at the time of your request. Refer to the carryover amounts section for additional information on how claims are paid from carryover funds.

Submit your FSA claim form to Smart-Choice along with your receipts for expenses. If you have other group coverage, you will also need to include the Explanation of Benefits (EOB) form provided by the insurance company, if it is an expense that was partially paid by the other group coverage.

All receipts submitted for reimbursement from a Health FSAs must clearly state that the expense is for a qualifying expense as determined by the benefits plan. If a receipt does not clearly identify the expense, you will receive a request for additional information needed to process the claim.

Reimbursement for dependent care expenses

You will need to submit a DCFSA claim form each time you request a reimbursement. You can file DCFSA claims as often as you like. You will receive reimbursement from your account up to the balance in your account at the time you submit your request. If you incur expenses that exceed your available funds, future claims will be reimbursed as additional funds accumulate in your account.

Each time you file a claim, you'll need to include: (1) the name, address and Social Security number or tax ID number of the provider, (2) the name of the person receiving services; and (3) a description of the expense.

Under the DCFSA, you generally must be working to receive reimbursement for dependent care expenses.

How to file a claim for reimbursement

To submit claims for reimbursement online, go to **Workday**, click on the **My Benefits & Retirement** app, select your network status (on or off the BMO network); click on Reimbursement Accounts.

FSA claim forms are available on the **BMO U.S. Benefits site** by navigating to **Forms/Docs**, or call the Human Resources Centre at 1-888- 927-7700. If you are mailing claims for reimbursement, be sure to keep a copy for your records. Send completed claim forms to:

Smart-Choice Accounts
PO Box 64009
The Woodlands, TX 77387-4009

You or your authorized representative may file claims for Plan benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Overpayment process

An overpayment on your account may occur if you have used your Smart-Choice debit card to pay for non-qualified products or services, you have not provided the required documentation to substantiate a qualified expense paid for with your Smart-Choice debit card, or you have been reimbursed for a claim that was subsequently determined to be invalid. Once an overpayment has been identified, you will need to resolve an overpayment on your account to avoid suspension on your Smart-Choice card. If you have received notification of an overpayment, it can be satisfied in the following ways:

1. Resubmit the claim that resulted in an overpayment with additional receipts or other documentation. If the entire claim is approved, the overpayment will be satisfied.
2. Submit new claims for eligible expenses. If your future claims are approved, the overpayment will automatically be paid back by these claims until the full overpayment amount is paid back.
3. Repay the overpayment amount back to be credited to your account by accessing the Smart-Choice website and repaying online, or by mailing a check payable to Smart-Choice Accounts, PO Box 64009, The Woodlands, TX 77387-4009.

Impact of an Overpayment

If your account has an overpayment amount over $100, your Smart-Choice Card will be suspended until the overpayment is repaid. While you're unable to use your card, you may submit claims on the site, via fax, through postal mail, or using the mobile app. **IRS rules state that failure to resolve your overpayment before the end of the plan year can result in tax implications.**

Tips to Avoid an Overpayment

Here are some suggestions to keep in mind when using your Smart-Choice Card:

- Always save your itemized receipts! You may need them if Smart-Choice notifies you to provide documentation for your transaction.
- Send receipts or other documentation for your transaction by the due date on this site.
- Review eligible health care expenses on this site to become familiar with items and services for which you can use your card.

- Don't use your Smart-Choice Card to pay for ineligible health care items.
- Consider shopping at IIAS-certified merchants, where items are automatically identified as eligible or ineligible at checkout.

Notice of a denied claim

If you are denied a full or partial claim for benefits, you will receive written or electronic notice (if valid email on file) of the denial and the notice will:

- explain the reason for the denial;
- refer to the pertinent provision of the Plan on which the denial is based;
- describe any additional material or information necessary for properly completing the claim;
- explain why such material or information is necessary;
- explain the claim review procedures; and
- for HCFSA and LPFSA claims:
  - disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request); or
  - if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

Appealing denied claims

If you are not satisfied with the determination of a claim denial, please contact the Human Resources Centre at 1-888-927-7700 and speak with a Smart-Choice representative. If after investigation, you are still not satisfied with the determination, you may file an appeal within 180 days of receiving a claim denial. To make an official appeal of the denial of your reimbursement, you must complete and return the Claims Review Form by requesting from the Smart-Choice representative. If you do not submit a Claim Review Form during this period, no further action will be taken, and you will not be able to file an appeal for the claim later.

When completing the Claim Review Form, state the reason you think you are entitled to reimbursement, including any documentation or information you feel supports your appeal.

The review will be by a person who was not involved in the initial determination, and will consider all comments, documents, and other information submitted by you, without regard to whether that information was submitted or considered in the initial determination. You are entitled to receive, free of charge upon request, any document relevant to your claim for benefits. Your appeal will be reviewed within 30 days from the date of receipt for health care, or within 60 days from the date of receipt for dependent care and provide you with a written explanation of the benefit determination.

Statements

A statement reflecting the activity in your FSA is distributed at the beginning of the fourth quarter each year. Each statement will show your contributions to date, claims paid and available account balances. This information is also available by navigating to Workday, click on the My Benefits & Retirement app, depending on where you are connecting to Workday from, click on Employees in Canada and US (on BMO Network) or Employees in Canada and US (off BMO Network), click on Reimbursement Accounts.

Please note any amounts that remain in an overpayment status after the Plan year-end deadline (April 30), will appear on your current year W2 as taxable income.

Carryover amounts

The Health FSAs and LPFSA allow for up to $640 (for 2024 carryovers into 2025; this number is indexed each year by the IRS) of unused funds to be carried over into the next Plan year. The carryover funds can then be used for eligible expenses incurred in the current Plan year.

You will not be eligible for any carryover amount if you incur a break in eligibility greater than 31 days at any point within the Plan year, if you are not eligible for the Plan as of December 31, or if you are continuing your coverage through COBRA and have not paid your premiums to extend your coverage through December 31.

How carryover works:

- Carryover only applies to the Health FSAs. Unused DCFSA funds will not carry over and will be forfeited if not used by the deadline.
- Carryover amounts are available as of the first day of the following Plan year.
- Money will carry over from one year to the next only if you are an eligible HCFSA participant on December 31 of any year. For example, you would be eligible for a carryover from 2024 into 2025 if you are an eligible HCFSA participant on December 31, 2024. You are also eligible for the carryover balance if your employment with the company has ended, and you have elected COBRA coverage and pay for your premium through December 31. If you have a balance, your carryover will be available through your full COBRA eligibility period.
- If money from your Health FSA is carried over from one year to the next, you may still contribute up to the maximum Health FSA contribution for the new Plan year.
- Up to $640 (for 2024 carryovers into 2025) may be carried over to the new Plan year, even if you do not elect to contribute to the Health FSA for the new Plan year.
- If you have more than $640 of unused money in your Health FSA as of December 31, of any year, the unused amount exceeding $640 may not be carried over and this unused excess amount will be forfeited. (These numbers are for 2024 carryovers into 2025). However, you can still receive reimbursements for expenses incurred in 2024, if you submit your claim by April 30 deadline.
- If you have unused HCFSA amounts at the end of a Plan year and elect to contribute to an HSA in the following Plan year, any amount (up to the applicable limit) that you carry over into the subsequent Plan year will be carried over to the LPFSA.
- The carryover rule will continue to apply until you are no longer employed by the Company or you become ineligible for benefits with the Company.

Keep in mind that you still may file claims for reimbursement of eligible expenses incurred in the current calendar year until April 30 of the following Plan year, whether unused money is carried over from one year to the next.

Debit cards

The carryover balance will be available on the first day of the new Plan year (January 1). In accordance, the full balance (including any carryover funds) will also be available on the Smart-Choice card – even if you do not re-enroll. The carryover amount does not affect the ability to elect the maximum annual contribution amount available under the Plan. Carryover amounts are not allowed for the DCFSA.

Forfeitures

Before you elect your annual FSA contribution, carefully review and consider your health and dependent day care needs and previous expenses. IRS regulations require that any money left in your DCFSA and any amount over the allowed carryover amount for your HCFSA that is not used for reimbursement of eligible expenses incurred by December 31 and submitted for reimbursement by April 30 be forfeited.

You must submit claims for eligible expenses by April 30 of the **following** calendar year. Your claims must be received by the claim's administrator on or before April 30 to be eligible for reimbursement. Any unclaimed balance remaining in your account above the allowed carryover amount after April 30 will be forfeited.

Example 1: If you have $300 remaining in your DCFSA on December 31, and have not submitted eligible expenses by April 30, you will lose the unused balance of $300.

Example 2: If you have $700 remaining in your HCFSA on December 31 and have not submitted eligible expenses by April 30, you will lose the unused balance in excess of the allowed carryover amount.

Also, remember that you cannot use money in your DCFSA to reimburse health care expenses and vice versa.

Any amounts remaining in your account, including carryover amounts, upon termination of employment will be forfeited unless you are eligible for and elect COBRA continuation coverage (Health FSA only).

When coverage ends

Your contributions to the FSAs end if any of the following events occur:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see Eligibility), or
- you go on Long Term Disability leave.

If you have a balance in your HCFSA when your coverage ends, you may claim qualified expenses incurred while you were a participant in the Plan, up to the amount you elected less any prior reimbursements. Active coverage ends on the last day of the month in which your employment ends.

If you have a balance in your DCFSA when your coverage, ends you may claim qualified expenses incurred for the remainder of the calendar year. Expenses will be reimbursed up to the total amount of unused funds remaining in your account. To be eligible for reimbursement, qualified DCFSA expenses must have been incurred while you are gainfully employed, actively looking for work or a full-time student. Active coverage ends on your last day worked.

To be eligible for reimbursement, your health or dependent care claims must be received by the Claims Administrator no later than April 30th of the following calendar year.

You may be able to continue your HCFSA or LPFSA coverage through COBRA. See Continuing health care coverage under COBRA for more information.

It is your responsibility to notify the Company of any change in your status or the status of any of your Dependents that affects eligibility for coverage under the Plan within 31 days of the status change.

Continuing coverage through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Health FSAs end, you or your covered dependents may be eligible to temporarily continue your coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were eligible to have their eligible expenses reimbursed under the Health FSAs on the day before a qualifying event:

- the Employee.
- the Employee's dependent child.
- the Employee's Spouse.

Special rule for the Health FSAs

If your Health FSA coverage ends because of a COBRA-qualifying event, COBRA continuation coverage for your Health FSA will be available only if the maximum benefit available under the Health FSA for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the Plan year. CORA coverage ends at the end of the Plan year in which the qualifying event occurs. Notwithstanding the foregoing, you can carryover an unused balance of $640 (for 2024 carryovers into 2025) for the duration of your 18 or 36 month continuation period.

Qualifying events for continuation coverage under COBRA

A Qualified Beneficiary may continue coverage under the Health FSAs if coverage ends for one of the following reasons:

- You terminate employment (for reasons other than gross misconduct on your part);
- Your hours are reduced so that you are no longer eligible for the Health FSAs;
- You die;
- You and your spouse divorce (this only applies to your spouse); or
- Your dependent child no longer meets the definition of "dependent" (this only applies to your dependent child).

Getting started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. The benefits provided under COBRA are the same as those provided to

active employees; however, the Company no longer shares the cost with you. You pay the full cost of coverage, plus a 2% administrative fee.

If the qualifying event is divorce or the dependent child no longer meeting the eligibility criteria, you, your spouse, or your dependent child must notify the COBRA Administrator (Inspira Financial) within 60 days. Your spouse or dependent child will not be eligible for COBRA coverage unless you or they notify Inspira Financial within the 60-day deadline.

You must send this notice to:

Inspira Financial Health, Inc..
BENEFITS BILLING DEPARTMENT
P.O. BOX 953374
ST. LOUIS, MO 63195-3374

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

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

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

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

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

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

If you are eligible for the Retiree Medical Program and you elect COBRA health insurance coverage at the time of your retirement, you will forfeit your right to participate in the Retiree Medical Program.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

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

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

When can I make changes to or drop my COBRA coverage?
Generally, you, your covered spouse, and other covered dependents have the same rights and restrictions as other plan participants to change your coverage during the year and at annual enrollment. In addition, you have the freedom to make election decisions independently from one another. Keep in mind that enrollment in a Health Care Flexible Spending Account (HCFSA) is limited to individuals participating in a HCFSA at the time of the qualifying event and continues only until the end of the current plan year.
If you want to make a change to or drop your COBRA coverage outside of the annual enrollment period, you may need to demonstrate proof of a qualified change in status (such as marriage, divorce, or the birth or

adoption of a child). Make sure you notify the COBRA Administrator of your change in status within the required time period that is stated in the plan rules.

Keep Your Plan Informed of Address Changes
To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Administrative information

Plan identification

Plan name
This Summary Plan Description describes the FSA portion of the Plan. The Plan, a group health plan subject to ERISA, provides medical, prescription drug, employee assistance, life, disability, , dental, vision, and Health Care Flexible Spending Account benefits.. The DCFSA is not subject to ERISA.

Separate Summary Plan Descriptions describe the medical, prescription drug, dental, Employee Assistance Program and Life and Disability portions of the Plan.

Plan number
507

Employer Identification Number
51-0275712

Plan year
January 1 – December 31

Plan sponsor
BMO Financial Corp.

Plan Administrator
Benefits Administration Committee

The Plan sponsor and Plan Administrator can be contacted at:

> BMO Financial Corp.
> Benefits Administration Committee
> 320 South Canal Street, Floor 8
> Chicago, IL 60606
> Human Resources Centre (HRC): 1-888-927-7700

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

The Plan Administrator has delegated to 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 is:

BNY Mellon Client Service Center
500 Ross Street, 8th Floor
Pittsburgh, PA 15262-00001

Agent for service of legal process
The Plan Administrator is the agent for legal process against the Plan. Legal process may also be served upon the Plan trustee.

Type of funding
The Plan is funded by the employer's general assets and a trust.

Claims administrators and service providers

Claims administrator	For	Address for filing claims
Smart-Choice **Member Services:** 1-888-927-7700	Flexible Spending Accounts and Health Savings Account administration	Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009

Service provider	For	Address
Alight Solutions –HR Benefits **Member Services:** 1-888-927-7700	Processes eligibility and provides customer service to covered individuals	Alight Solutions –HR Benefits DEPT 14613 PO Box 64050 The Woodlands, TX 77387-4050
Dependent Verification Service (DVS)	Submitting initial Dependent Verification documents	Dependent Verification Service PO Box 1401 Lincolnshire, IL 60069-1401

COBRA administrator	For
Inspira Financial Health, Inc Benefits Billing Department PO Box 953374 St. Louis, MO 63195-3374 **Member Services:** 1-888-678-7835	COBRA continuation coverage www.inspirafinancial.com Employer ID: 139888

Uncashed checks

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

Future of the Plan

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

Privacy information

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

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

Your rights under ERISA

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

Assistance with your questions

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

No employment guarantee

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