Plan Administration

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The following section provides you with information about how the components of the Lowe's Welfare Plan (Plan) are administered. This section covers topics such as filing claims and appeals, the continuation of benefits coverage under COBRA, and your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

Information about Filing Claims

Refer to the section for each Plan benefit option to determine how to file claims. If you have any questions about filing claims, please call the appropriate claims administrator, carrier, or HR Shared Services at 1-888-HRINFO5 (1-888-474-6365**)**.

If Your Claim is Denied

If your claim for benefits under the Plan is denied, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is.

Denial of Claims Where Insurer or Other Entity Is Claims Fiduciary

Certain benefits offered under the Plan are provided through an insurance contract issued to Lowe's by an insurance carrier or under an arrangement where a third party administrator is responsible for handling claim appeals. In this case, the insurance carrier or third party administrator is the applicable claims fiduciary (collectively, such insurers and responsible third party administrators shall be referred to herein as claims fiduciaries) with respect to claims for benefits provided under the Plan. This means that Lowe's has no discretionary authority with respect to such benefit claims and appeals. Any claim appeals must be filed with the claims fiduciary.

If you are enrolled in any of the HMO/POS options offered by Lowe's, you should refer to the applicable policy, HMO/POS book, certificate of coverage provided by the carrier, or contact the insurance carrier or HMO/POS for more information on the applicable claims procedures. The fiduciary chart below identifies which claims and appeals should be submitted to the insurance carrier or third party administrator as claims or appeals fiduciary.

Claims and Appeal Process

Filing a Claim

To ensure proper filing of claims, follow the claims filing procedures that are set forth in the SPD section for each benefit option provided by the applicable insurance companies and/or service providers. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. Once the Claims Administrator receives your claim, the Claims Administrator will be responsible for reviewing it and determining how to pay it on behalf of the Plan. In general, a claim must be filed within 12 months of the date the claim was incurred. A different period may apply for claims for insured benefits.

Claims Administrators

Lowe's provides the following benefits under the Plan through contracts with the insurance companies or third-party administrators listed below. The insurance companies or third-party administrators listed below administer claims for the benefits listed below.

- Those benefit options administered by a third-party administrator are self-insured and are paid out of the general assets of Lowe's, rather than under a contract or policy of insurance.
- Those benefit options administered by the insurance carrier are fully-insured benefits. The benefit options are guaranteed under contracts of insurance with the insurance companies. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

A.C. Newman & Company (Business Travel Accident Insurance)	Send all claims and appeals to the insurance carrier (the claims administrator): A.C. Newman & Company 7060 N. Marks Avenue, Suite 108 Fresno, CA 93711-0269 1-559-252-2525 Fax 1-559-252-1515 Email: claims@acnewman.com www.acnewman.com Group/Policy Number: BTA-10369
American Heritage Life Insurance Co. (Allstate Benefits) (Critical Illness, Fixed Indemnity, Group Voluntary Term Life Insurance for Part-Time Employees, Group Voluntary Short-Term Disability for Part-Time Employees, and Accident)	Send all claims and appeals to the insurance carrier (the claims administrator): American Heritage Life Insurance Company 1776 American Heritage Life Drive Jacksonville, FL 32224 1-800-780-3724 www.allstateatwork.com Group Numbers: 90635 (Critical Illness and Accident); 90635 (Fixed Indemnity); 82221 Group Voluntary Term Life Insurance for Part-Time Employees, and Group Voluntary Short-Term Disability for Part-Time Employees.)
Blue Cross Blue Shield of Alabama (Group Medical Option 1 and Option 2, according to location assignment, HDHP, Out-of-Area, and Retiree Medical)	Send all claims and appeals to the third-party administrator (the claims administrator): Blue Cross Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244-2858 1-888-258-1710 www.bcbsal.com Group Numbers: 84672, 84674, 84677, 84688, 84690, 84691, 84678, 84681, 84684, 84692, 84694, 84696 (Please reference your I.D. card)

CIGNA (Accidental Death & Dismemberment, Full-time Dental, Basic Life Insurance, Dependent Life Insurance, Long-Term Disability, Short-Term Disability, and Supplemental Life Insurance)	**For Accidental Death & Dismemberment, Basic Life Insurance, Dependent Life Insurance and Supplemental Life Insurance** Send all claims and appeals to the insurance carrier (the claims administrator): Life Insurance Company of North America (CIGNA) P. O. Box 16491 Pittsburgh, PA 15242 1-800-238-2125 www.cigna.com **For Full-Time Dental Option** Send all claims and appeals to the third-party administrator (the claims administrator): CIGNA Dental Appeals P.O. Box 188044 Chattanooga, TN 37422-8044 1-800-244-6224 www.cigna.com Group Number: 3151760 **For Long-Term Disability** Send all claims and appeals to the insurance carrier (the claims administrator): CIGNA Group Insurance P.O. Box 16491 Pittsburgh, PA 15242 1-800-238-2125 ext. 4030 **For Short-Term Disability** Send all claims and appeals to the third-party administrator (the claims administrator): Disability Management Solutions P.O. Box 16491 Pittsburgh, PA 15242 1-800-362-4462
Cleveland Clinic (Heart Surgery Benefit) (Group Medical Option 1, Option 2, and HDHP)	Send all appeals in writing to the third-party administrator (claims administrator): Health Design Plus Attn: Appeals Coordinator 1755 Georgetown Road Hudson, Ohio 44236
ConnectYourCare (Health Savings Account)	Send all claims and appeals to: Claims Department P.O. Box 622317 Orlando, FL 32862-2317 1-844-598-3634 Fax: (443) 681-4602

CVS Caremark (Prescription Drug Benefits)	Send all claims and first and second level appeals to the third-party administrator (claims administrator): CVS Caremark Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866-443-1172 Physicians may submit urgent appeal requests by calling the physician only toll-free number: 866-443-1183
Health Design Plus (Joint Replacement and Spine Care Program for Group Medical Option 1, Option 2, and HDHP)	Send all appeals in writing to the third-party administrator (claims administrator): Health Design Plus Attn: Appeals Coordinator 1755 Georgetown Road Hudson, Ohio 44236
Kaiser Permanente of Hawaii	Send all claims and appeals to the insurance carrier (the claims administrator): Hawaii (HMO) Kaiser Foundation Health Plan, Inc. Attn: Appeals Coordinator P.O. Box 378021 Denver, CO 80237 877-875-3805 www.kp.org Group Number: 8902 Hawaii (POS) KPIC (Kaiser Permanente Insurance Company) P.O. Box 261205 Plano, TX 75026-1205 1-800-238-5742 www.kp.org Group Number: 8902

Kaiser Permanente of California	Send all claims and appeals to the insurance carrier (the claims administrator): For Southern California Members: Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 For Northern California Members: Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 1-800-390-3510 www.kp.org Group Number: Southern California 226530, Northern California 48084
Kaiser Health Plan of Colorado	Send all claims and appeals to the insurance carrier (the claims administrator): Kaiser Health Plan of Colorado P.O. Box 373150 Denver, CO 80237-3150 Claims Department: 303-338-3600 Member Services: 303-338-3800 or 1-800-632-9700 www.kp.org Group Number: 22289
Kaiser Health Plan of Georgia	Send all claims and appeals to the insurance carrier (the claims administrator): Kaiser Health Plan of Georgia Claims address: Kaiser Permanente Claims Administration P.O. Box 190849 Atlanta, GA 31119-0849 Appeals address: Kaiser Permanente Appeals Department 3495 Piedmont Road, N.E. Atlanta, GA 30305-1736 www.kp.org Group Number: 05522

Kaiser Foundation Health Plan of the Mid-Atlantic States	Send all claims and appeals to the insurance carrier (the claims administrator): Kaiser Foundation Health Plan of the Mid-Atlantic States P.O. Box 6233 Rockville, MD 20849-6233 1-301-468-6000 www.kp.org Group Number: 16061-0
Kaiser Health Plan of Oregon	Send all claims and appeals to the insurance carrier (the claims administrator): Kaiser Health Plan of Oregon 500 NE Multnomah St., Suite 100 Portland, OR 97232 1-503-813-2000 or 1-800-813-2000 www.kp.org Group Number: 10117AA
Magellan Healthcare	Send all claims and appeals to the insurance carrier (the claims administrator): Send appeals to the Family Assistance Program (FAP): Magellan Healthcare PO Box 2128 Maryland Heights, MO 63043
MetLife (Long-Term Care Insurance, and Part-Time Dental)	Send all Long Term Care claims and appeals to the insurance carrier (the claims administrator): MetLife Long-Term Care Claims P.O. Box 14407 Lexington, KY 40512-4407 Group Number: 96802 For all Part-Time Dental claims and appeals, request a MetLife claim form for part-time Dental, at 1-800-942-0854. Group Number: 109702-1-G
WageWorks (Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account)	Send all claims and first-level appeals to the third-party administrator (claims administrator): WageWorks Claims Administrator P.O. Box 14053 Lexington, KY 40511 1-877-924-3967 Fax 1-877-353-9236 www.wageworks.com

United Healthcare (Part-Time Preventive, Part-Time Preventive Plus, HDHP, Health Savings Account, Group Medical Option 1, Option 2, Out of Area Option 1, and Out of Area Option 2 depending on location assignment.)	Send all claims and appeals to the third-party administrator (the claims administrator): Claims submittal address: P.O. Box 740800 Atlanta, GA 30374-0800 Appeals: United Healthcare – Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 Group Number: 742883 (for all)
VSP (Vision Options)	Send all claims and appeals to the insurance carrier (the claims administrator): Claims: VSP Out-of-Network Claims P.O. Box 997105 Sacramento, CA 95899 Appeals: VSP P.O. Box 997100 Sacramento, CA 95899

Claim-Related Definitions

Claim

"Claim" is any request for Plan benefits made in accordance with each option's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those

treatments. A concurrent care claim may be treated as an “urgent care claim,” “pre-service claim,” or “post-service claim,” depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an “adverse benefit determination” — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the ERISA. The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan’s review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

For Medical claims, the notice will include information sufficient to identify the claim involved. This includes the:

- Date of service;
- Health care provider;
- Claim amount (if applicable); and

- Denial code.

For Medical claims, the notice will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health Care FSA claims are considered non-urgent "post-service" claims.

	Medical, Dental, Vision & Health Care FSA plans				Short-Term & Long-Term Disability	Life, AD&D and Business Travel
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, Dental, Vision & Health Care FSA plans				Short-Term & Long-Term Disability	Life, AD&D and Business Travel
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	N/A

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

Critical Illness, Accident and Fixed Indemnity:

Notice of Claim: Covered persons to notify of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given within 60 days after the occurrence or commencement of any benefit covered by the policy, or as soon as reasonably possible. Notice given by, or on behalf of, a covered person or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with your name and certificate number, is notice.

Filing a Claim: A claim form can be requested. If it is not received within 15 days of the request, notice of the claim may be sent without waiting for the form. The claimant must complete his or her own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to Allstate.

Proof of Claim: Written proof must be given within 180 days of each covered critical illness. If it is not possible to give written proof in the time required, Allstate will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 15 months from the time specified unless the covered person is legally incapacitated.

Appealing a Claim

The following section generally describes the Plan's internal claim appeals process. The claim procedures for a specific benefit are set forth in the SPD section for each benefit option. Please consult the applicable SPD section for the specific benefit involved. Where not otherwise covered by the applicable SPD section, the following procedures will apply.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For Medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical benefit option (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimus, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in the "Time Frames for Appeals Process" below. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims) and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For Medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
- The health care provider;
- The claim amount (if applicable); and
- The denial code.

For Medical claims, the notice will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 12 months of the date on which your claim is incurred under the Plan.

Time Frames for Appeals Process

The claim appeals procedures for a specific benefit are set forth in the SPD section for each benefit option. Please consult the applicable SPD section for the specific benefit involved. Where not otherwise covered by the applicable SPD section, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical, Dental, Vision, EAP & Health Care FSA Plans			Short-Term & Long-Term Disability	Life, AD&D and Business Travel
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

Designation of a Primary Care Provider

Many of the Lowe's medical benefit options do not require that you designate a primary care provider (PCP). However, if you are enrolled in a non-grandfathered medical benefit option that requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, one may be designated for you. For children, you may designate a pediatrician as the primary care provider.

Access to OB/GYN

You do not need prior authorization from the Plan 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-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.

Right of Recovery (Also Known as Subrogation or Acts of Third Parties)

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan, any payment of the eligible expenses will be conditioned upon your reimbursing the Plan with any amounts recovered from or otherwise received from a third party for the illness or injury. To receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

The terms of the Plan's reimbursement and subrogation rights are described below. However, if the provisions in this Right of Recovery section conflict with recovery/subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern.

The covered individual may be required to:

- Execute an agreement provided by Lowe's, the network manager or the claims fiduciary or administrator acknowledging the Plan's right of recovery, agreeing to repay any claims paid by the Plan for any injury or illness caused by a third party, pledging amounts recovered by the covered individual from the third party as security for repayment of any claims paid by the Plan and, to the extent provided below, assigning the covered individual's cause of action or other right of recovery to the Plan. If the covered individual fails to execute such an agreement, the covered individual shall be deemed to agree to the terms of any such agreement upon filing a claim, assigning benefits or otherwise exercising the individual's Plan rights for such injury or illness;
- Place any funds that you (or your attorney or other representative) receive from any source – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, into a separate, identifiable account and agree that the Plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.
- Provide such information as Lowe's, the network manager, or a claims fiduciary or administrator may request;
- Notify Lowe's and/or the network manager or claims fiduciary or administrator in writing with a copy of the complaint or other pleading of the commencement of any action by the covered individual to recover damages from a third party; and
- Agree to notify Lowe's and/or the network manager or claims fiduciary or administrator of any recovery.

The Plan's right to recover the benefits it has paid is not subject to reduction for attorney's fees or other expenses of recovery. The Plan's right of recovery shall apply to the entire proceeds of any recovery by the covered individual. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (i.e., the Plan has a right of reimbursement out of any recovery, even if the covered individual is not fully compensated), or the

characterization of the nature or purpose of the amounts recovered, or by the identity of the party from which recovery is obtained.

If the covered individual fails to take action against a responsible third party to recover damages within one year, or within 30 days after the Plan requests (this does not apply to UnitedHealthcare Plans), the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the covered individual's claim equal to the amounts the Plan has paid on the covered individual's behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to waive its rights to commence action against a third party if it fails to act after the expiration of one year, nor shall the Plan's failure to act be deemed a waiver or discharge of the lien described above.

The covered individual shall cooperate fully with the Plan in asserting claims against a responsible third party, and such cooperation shall include, where requested, the filing of suit by the covered individual against a responsible third party and the giving of testimony in any action filed by the Plan. If a covered individual fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan's claim administrator may deny payment of claims and seek repayment of prior claims paid by offset against future Plan benefits. The Plan may also terminate your Plan participation in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the plan.

DEFINITIONS

As used throughout this provision, the term "Responsible Party" means any party actually, possibly or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

The term "Covered Person" means any participant or beneficiary seeking, receiving or accepting benefits from the Plan (regardless of whether the payment of such benefits is made to the participant or beneficiary or made on behalf of the participant or beneficiary to a healthcare provider), and includes minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, worker’s compensation coverage, no-fault automobile insurance coverage or any first-party insurance coverage.

Subrogation

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any allegedly Responsible Party with respect to any payment made by the allegedly Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan, including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first-priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation reimbursement and right of recovery provision shall apply and the Plan is entitled to full recovery, regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall cooperate fully with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The Plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator (or its delegate) shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Maintenance of Benefits (How the Plan Works with Other Group Plans)

Unless otherwise specified in the applicable SPD section for a particular benefit option, if an individual covered by a Lowe's Plan is also covered by another group plan, specific rules known as maintenance of benefits will determine the benefits payable by the Plan.

For purposes of the maintenance of benefits provisions, these terms are defined as follows:

Plan includes:

- Group, blanket, or franchise insurance plan, if not individually underwritten;
- Health maintenance organization or hospital or medical service prepayment plan available through an employer, union, or association;
- Trusteed plan, union welfare plan, multiple employer plan, or employee benefit plan;
- No-fault automobile coverage or any other automobile insurance; and
- Governmental program or a plan required by a statute except Medicaid.

Primary plan is defined as the plan which pays its benefits first, without regard to any other coverage. If a plan does not have a maintenance of benefits or coordination of benefits provision, that plan is primary. If the other plan includes a maintenance of benefits or coordination of benefits provision, the plan covering the person the longest is primary, except that:

- The plan that covers the individual, other than as a dependent, will pay its benefits before the plan that covers the person as a dependent.
- The plan that covers a person other than as a laid-off or retired person or as a dependent of such person will pay its benefits before the plan that covers the person as a laid-off or retired person or as a dependent of such person. This item shall not apply if the other plan does not have a maintenance or coordination of benefit provisions regarding laid-off or retired persons.
- When a child is covered by the plan of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the year, regardless of the year of birth, will pay first. However, if the other plan's maintenance or coordination of benefit provisions does not use the parent's birthdays to determine which of the parent's plans pays first, the other plan's provisions will make the determination.
- If a child's parents are divorced or legally separated, payment will be made under the plan of the parent with custody before the plan of the stepparent or of the parent without custody; or under the plan of a stepparent before the plan of the parent without custody. However, if, by court decree, one parent is held responsible for the child's healthcare expenses, payment will be made first under the plan of that parent.
- When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

How Maintenance of Benefits Works

With respect to the above definitions, the maintenance of benefit provisions applies when the Plan is considered the secondary plan for benefits. If the benefits paid by the primary plan are less than the benefits normally payable under the Plan, then the Plan will only pay the difference between the two plans (see example 1 below).

If the benefits paid by the primary plan equal or exceed the benefits normally paid by the Plan, then the Plan pays nothing (see example 2 below).

Example 1:	***Covered expenses***	***$2,000***
	Primary plan pays	1,500
	Plan normally pays	1,600

In this case the Plan, as the secondary plan, would pay $100 ($1,600 - $1,500).

Example 2:	***Covered expenses***	***$2,000***
	Primary plan pays	1,700
	Plan normally pays	1,600

In this case, the Plan, as the secondary plan, would pay nothing, since the primary plan payment exceeds the benefit normally payable under the Plan.

Overpayments

The Plan has a right to recover benefits that were paid in error (e.g., benefits paid to an ineligible person), or benefits that were obtained in a fraudulent manner, as determined by the Plan's claim administrator. Benefits may be recovered either by direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action), or by an offset of future benefits equal to the amount of the overpayment.

Misrepresentation

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Plan, by submitting an application or files a claim containing a false, incomplete or misleading statement, is guilty of fraud. The claims administrator, network manager and Lowe's reserve the right to take appropriate action in any instance where fraud or intentional misrepresentation is at issue, including irrevocable termination of coverage (including retroactively to the extent permitted by law) and/or employee discipline up to and including termination.

Forfeitures

If a claimant has not cashed a benefit payment check within 12 months from the date the check was issued for a self-insured benefit, the payment shall be forfeited and the Plan shall have no further liability for such payment.

Any amounts forfeited shall not be segregated or invested in an interest bearing account, but shall remain the property of the Employer to be used to pay administrative expenses, to cover other Plan expenses, or used in any other manner as the Employer in its discretion, exercised in a uniform and nondiscriminatory manner, directs.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the ERISA. ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

- Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the 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 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 (if any) 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 the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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 publications hotline of the Employee Benefits Security Administration.

Other Information-Claim and Appeal Administration-Fiduciary Authority

The Plan Administrator for the Plan is Lowe's Companies, Inc., which is authorized to delegate its administrative duties to one or more individuals or committees within Lowe's, or to one or more insurers or outside administrative services providers. Presently, certain administrative services with regard to the processing of claims and the payment of benefits are provided under contract as follows:

- **The Group Medical Plan Option** is administered by the following entities, which have sole, full and final discretionary authority to decide claims and appeals under the Group Medical Option (Lowe's is not the claims or appeals fiduciary for the Group Medical Option, and Lowe's is NOT involved in claims determinations and appeals under the Group Medical):
    - Blue Cross/Blue Shield of Alabama
    - Health Design Plus (Cleveland Clinic Heart Surgery Program)
    - Health Design Plus/ECEN Network
    - Kaiser Permanente of California
    - Kaiser Health Plan of Colorado
    - Kaiser Health Plan of Georgia
    - Kaiser Health Plan of Hawaii
    - Kaiser Health Plan of Oregon
    - Kaiser of the Mid-Atlantic
    - United HealthCare Services, Inc. (United Healthcare)

- **Prescription drug coverage Medical Benefit Options** is self-insured and administered by CVS Caremark, except that you are not eligible for CVS/Caremark prescription drug coverage if you enroll in the following Medical Benefit Options:
    - Kaiser Permanente of California
    - Kaiser Health Plan of Colorado
    - Kaiser Health Plan of Georgia
    - Kaiser Health Plan of Hawaii
    - Kaiser Health Plan of Oregon
    - Kaiser of the Mid-Atlantic

    These HMOs currently administer their own fully-insured prescription drug program.

Lowe's is neither the claims nor appeals fiduciary with regard to prescription drug claims under the any Medical Benefit Option, and Lowe's is NOT involved in prescription drug claims determinations and appeals.

- The **Fixed Indemnity Options** (for both full-time and part-time employees) are insured and administered by:

    American Heritage Life Insurance Company, also known as Allstate Benefits, which has sole, full and final discretionary authority to decide claims and appeals under the Fixed Indemnity Option (Lowe's is not the claims or appeals fiduciary for the Full-Time and Part-Time Fixed Indemnity Option, and Lowe's is NOT involved in claims determinations and appeals under the Fixed Indemnity Options).

- The **Critical Illness Option** is insured and administered by:

    American Heritage Life Insurance Company, also known as Allstate Benefits, which has sole, full and final discretionary authority to decide claims and appeals under the Critical Illness Option (Lowe's is not the claims

or appeals fiduciary for the Critical Illness Option, and Lowe's is NOT involved in claims determinations and appeals under the Critical Illness Option).

- The **Accident Option** is insured and administered by:

  American Heritage Life Insurance Company, also known as Allstate Benefits, which has sole, full and final discretionary authority to decide claims and appeals under the Accident Option (Lowe's is not the claims or appeals fiduciary for the Accident Option, and Lowe's is NOT involved in claims determinations and appeals under the Accident Option).

- The **Part-Time Employee Medical Options** are self-insured and administered by:

  UnitedHealthcare, which has sole, full and final discretionary authority to decide claims and appeals under the Part-Time Employees Medical Plans (Lowe's is not the claims or appeals fiduciary for the Part-Time Employees Medical Plans, and Lowe's is NOT involved in claims determinations and appeals under the Part-Time Employees Medical Plans).

- The Full-Time **Dental Options** are self-insured and administered by:

  Connecticut General Life Insurance Company, which has sole, full and final discretionary authority to decide claims and appeals under the Dental Options (Lowe's is not the claims or appeals fiduciary for the Dental Options, and Lowe's is NOT involved in claims determinations and appeals under the Dental Options).

- The **Vision Options (both for full-time and part-time employees)** are insured and administered by:

  VSP, which has sole, full and final discretionary authority to decide claims and appeals under the Vision Care Options (Lowe's is not the claims or appeals fiduciary for the Vision Options, and Lowe's is NOT involved in claims determinations and appeals under the Vision Options).

- The **Part-Time Employee Dental Option** is insured and administered by:

  MetLife, which has sole, full and final discretionary authority to decide claims and appeals under the Part-Time Dental Option (Lowe's is not the claims or appeals fiduciary for the Part-Time Dental Option, and Lowe's is NOT involved in claims determinations and appeals under the Part-Time Dental Option)

- The **Business Travel Accident Insurance** is insured by Gerber and administered by:

  AC Newman & Company, which has sole, full and final discretionary authority to decide claims and appeals under the Business Travel Accident Option (Lowe's is not the claims or appeals fiduciary for the Business Travel Accident Option, and Lowe's is NOT involved in claims determinations and appeals under the Business Travel Accident Option).

- The **Group Voluntary Term Life Insurance for Part-Time Employees** is insured and administered by:

  American Heritage Life Insurance Company, also known as Allstate Benefits, which has sole, full and final discretionary authority to decide claims and appeals under the Group Voluntary Term Life Insurance Option for Part-Time Employees (Lowe's is not the claims or appeals fiduciary for the Group Voluntary Term Life Insurance Option for Part-Time Employees, and Lowe's is NOT involved in claims determinations and appeals under the Group Voluntary Term Life Insurance Option for Part-Time Employees).

- The **Long Term Care** is insured and administered by:

MetLife, which has sole, full and final discretionary authority to decide claims and appeals under the Long-Term Care option (Lowe's is not the claims or appeals fiduciary for the Long Term Care Plan option, and Lowe's is NOT involved in claims determinations and appeals under the Long Term Care Plan option).

- The **Group Term Life Insurance Plan for Full-Time Employees, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability Option** are administered by:

  Connecticut General Life Insurance Company, which has sole, full and final discretionary authority to decide claims and appeals under the insured Group Term Life Insurance Plan, Accidental Death and Dismemberment Plan, Group LTD, and fully insured Hourly STD Plan. Connecticut General Life Insurance Company also assumes responsibility as claims administrator for the self-insured Salaried Self Insured STD Plan for Lowe's, which includes making initial claim determinations and providing recommendations regarding appealed claims.

- The **Group Voluntary Short Term Disability Plan Option for Part-Time Employees** is insured and administered by:

  American Heritage Life Insurance Company, which has sole, full and final discretionary authority to decide claims and appeals under the Group Voluntary Short Term Disability Plan Option for Part-Time Employees (Lowe's is not the claims or appeals fiduciary for the Group Voluntary Short Term Disability Plan Option for Part-Time Employees, and Lowe's is NOT involved in claims determinations and appeals under the Group Volunteer Short Term Disability Plan Option for Part-Time Employees).

- The **Health Savings Account** is self-insured and administered by:

  ConnectYourCare which has sole, full and final discretionary authority to decide claims and appeals under the Health Savings Account Option (Lowe's is not the claims or appeals fiduciary for the Health Savings Account Option, and Lowe's is NOT involved in claims determinations and appeals under the Health Savings Account Option).

- The **Health FSA and DDCSA** are self-insured and are administered by:

  WageWorks, Inc.

- **COBRA Continuation coverage for the Full-Time, Medical, Dental, and Vision Care Options** and the **Health FSA** are administered by:

  WageWorks, Inc.

- **COBRA Continuation coverage** for Part-Time Employees Vision is administered by:

  VSP

- **COBRA Continuation coverage** for the Part-Time Employees Medical Plan Options are administered by:

  UnitedHealthcare

- **COBRA Continuation coverage** for the Part-Time Employees Dental Options are administered by:

  COBRA Guard, Inc.

- **Payment Processing for an approved Leave of Absence (e.g., FMLA Leave)** for Full-Time and Part-Time Employees is administered by:

  WageWorks, Inc.

General Information About the Plan

- Name of Plan: Lowe's Welfare Plan
- Plan Number: 511
- Plan Year: January 1 through December 31
- Employer and Plan Sponsor:

  Lowe's Companies, Inc.
  1000 Lowe's Boulevard
  Mooresville, NC 28117
  1-704-758-4000

- Employer Identification Number (EIN): 56-0578072
- Plan Administrator (for ERISA reporting and disclosure purposes): Lowe's Companies, Inc.

  1000 Lowe's Boulevard
  c/o Group Benefits Department
  Mail Code NB2CB
  Mooresville, NC 28117
  1-888-HRINFO5 (1-888-474-6365) (HR Shared Services)

With the exception of the Health FSA and DDCSA, final and exclusive fiduciary authority for the determination of benefit claims and appeals under the component employee welfare benefit plans has been delegated to the insurers or third-party administrators identified in this summary plan description (e.g., A.C. Newman & Co., Blue Cross Blue Shield of Alabama, American Heritage Life Insurance Company (Allstate Benefits), Connecticut General Life Insurance Company, Health Design Plus, MetLife, VSP, WageWorks, Inc., United HealthCare) (listed above under "Other Information — Claim and Appeal Administration / Fiduciary Authority").

- Agent for Service of Legal Process:

  Lowe's Companies, Inc.
  c/o Bill McCanless
  General Counsel and Secretary
  1000 Lowe's Boulevard
  Mooresville, NC 28117

- The following Lowe's Affiliates participate in this Plan:
  - Lowe's Home Centers, Inc. (EIN: 56-0578072)
  - Lowe's HIW Inc. (EIN: 91-1465348)
  - LG Sourcing, Inc. (EIN: 56-2010120).
  - ATG (EIN: 91-1977410)

- Type of Plan:

  Welfare benefit plan providing the following types of benefits:

  - Medical
  - Dental
  - Vision
  - Short-Term Disability (STD)
  - Long-Term Disability (LTD)
  - Basic Life Insurance
  - Supplemental Life Insurance
  - Voluntary Term Life Insurance
  - Dependent Life Insurance
  - Accidental Death and Dismemberment (AD&D)
  - Business Travel Accident
  - Long-Term Care Insurance
  - Health Care Flexible Spending Account (FSA)
  - Health Savings Account (HSA)
  - Accident Insurance
  - Critical Illness Insurance
  - Fixed Indemnity Insurance

  Although the Dependent Day Care FSA is described in this SPD, it is not an ERISA plan.

- Source of Contributions:

  Depending on the benefits selected by the employee, the cost of contributions for certain benefits offered within the Plan will either be covered by contributions from Lowe’s, contributions by the employee, or will be shared by Lowe’s and the employee.

  - The cost of Medical and Dental coverage for full-time employees is shared by Lowe’s and its employees enrolled in those coverages.

- Lowe’s pays 100% of the cost of the Business Travel Accident, Short-Term Disability for full-time employees, Long-Term Disability for full-time salaried employees, and Basic Life Insurance for full-time salaried employees.
- Employees pay 100% of the Retiree Medical, Part-time Medical, Part-time Dental, Vision, Basic Term Life for hourly employees, Supplemental Life, Dependent Life, Short-Term Disability for Part-time Employees, Long-Term Disability for Full-Time hourly employees, AD&D, Accident Insurance, Critical Illness Insurance, Fixed Indemnity Insurance, Long-Term Care Insurance and coverages and contributions to the Health Care Flexible Spending Accounts, Dependent Day Care Flexible Spending Accounts, and Health Savings Accounts.

Where Lowe’s and employees share the cost of coverage, Lowe’s shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan.

The Plan Administrator will notify employees annually as to what the employee contribution rates will be. Lowe’s Companies, Inc., in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse Lowe’s for its contributions, unless otherwise provided in that group insurance contract or required by applicable law

For general information regarding the Lowe's 401(k) Plan and Lowe's Employee Stock Purchase Plan, please see the 401(k) Plan SPD and the Employee Stock Purchase Plan SPD.

Plan Amendment or Termination

Lowe's reserves the right to amend or terminate the Plan or any component employee welfare benefit plan at any time and for any reason. The right to amend or terminate the Plan or any plan option applies to all coverage hereunder, including coverage for active, retired and disabled employees. Lowe’s reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Lowe’s will be done in accordance with Lowe’s normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination of this Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment or termination.

Continuing Coverage Under COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

Federal law does not recognize your domestic partner as your spouse and a domestic partner is not recognized as a COBRA qualified beneficiary. However, Lowe’s will extend COBRA-like coverage to your domestic partner and his or her covered children. However, COBRA rights and protections do not apply to this extension of domestic partner coverage.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical (including the prescription drug benefit provided with a particular Medical benefit option—there is no separate COBRA election for prescription drug benefits), Dental, Vision and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan or by Lowe’s (such as Life, LTD, or AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

See “COBRA Administrators” at the end of this section for contact information.

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a “qualifying event”. After a qualifying event occurs and any required notice of that event is properly provided to Lowe’s, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a “qualified beneficiary”. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan’s group health coverage elected by the qualified beneficiaries, including Annual Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun “you” in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of Lowe's, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events:

- A reduction in your hours of employment with Lowe's or
- The termination of your employment with Lowe's (for reasons other than gross misconduct on your part).

Retiree

If you are retiree, spouse or dependent of Lowe's, you will have the right to elect COBRA if you lose your group health coverage under the Plan because the employer declares bankruptcy under Chapter 11.

Spouse

If you are the spouse of an employee of Lowe's, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment with Lowe's (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with Lowe's; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with Lowe's (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- You were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- You lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- When you definitively inform Lowe's that you are not returning at the end of the leave; or
- The end of the leave, assuming you do not return to work.

Newly Eligible Child

If you, the former employee of Lowe's, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing Lowe's (see Contact Information) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 60 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify Lowe's within the 60 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO

A child of the covered employee who is receiving benefits under the Plan pursuant to a QMCSO received by Lowe's during the covered employee's period of employment with Lowe's is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify Lowe's of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify Lowe's (see contact information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if Lowe's requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to Lowe's at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to Lowe's within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to the COBRA administrator.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). When you complete the election form, you must notify Lowe's if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Health Care FSA COBRA Coverage

COBRA coverage under the Health Care Flexible Spending Account will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care Flexible Spending Account by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care Flexible Spending Account COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage for the Health Care Flexible Spending Account, if elected, will consist of the Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply, except for the $500 carryover rule which allows you to carry up to $500 over to the next year. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. (See "Duration of COBRA," below for a description of the duration of COBRA coverage for the Health Care FSA. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care Flexible Spending Account annual coverage limit and a separate COBRA premium.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check, money order, debit or on-line credit card payment, as permitted by the COBRA Administrator. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred. Notwithstanding the previous sentence, a Qualified Beneficiary will carryover up to $500, or, if less, the unused balance in his/her Health Care FSA at the end of the Plan Year, to a subsequent Plan Year. The carryover shall only be available for the duration of the period of COBRA continuation coverage. No premium will be charged for the subsequent Plan Year.

If you lose Plan coverage because of the bankruptcy of the employer, the law requires that you be given the opportunity to maintain COBRA coverage until the death of the retiree, or in the case of surviving spouse or children, for up to 36 months after the death of the retiree.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the COBRA administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 has extended the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

Your eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects your eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, you must choose one or the other, and if you receive both during a tax year, the IRS will reconcile your eligibility for each subsidy through your individual tax return. You may wish to consult your individual tax advisor concerning the benefits of using one subsidy or the other. Although it is unlikely that a Lowe's employee would qualify, you may contact Lowe's for additional information or if you have any questions about these new provisions, or you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is also available at www.doleta.gov/tradeact.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Lowe's no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee);
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or

- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, Lowe's reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. Lowe's, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Other options - 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.

Keep Your Plan Informed of Address Changes

In order to protect your rights, you should keep the COBRA administrator informed of any changes in the addresses of you or your covered dependents. You should also keep a copy for your records as well as any notices you send to the COBRA administrator.

COBRA Administrators

Lowe's has contracted with WageWorks to administer its COBRA continuation coverage for the full-time Group Medical Plan Options, full-time Dental Option, full-time Vision Option, and Health FSA. All notices, payments, telephone calls and communications regarding COBRA for these plan options should be directed to:

WageWorks, Inc.
P.O. Box 14055
Lexington, KY 40512-4055
Phone: 877-502-6272
Fax: 877-220-3249
Website: www.wageworks.com

The COBRA administrator for Part-Time Employees Vision is:

VSP Vision Care
Attn: Client Admin Services
P.O. Box 997100
Sacramento, CA 95899
1-800-400-4569

The COBRA administrator for Part-Time Employees Medical Plans (Preventive and Preventive Plus) is:

UnitedHealthcare Benefit Services
P.O. Box 221709
Louisville, KY 40252
1-866-747-0048

The COBRA administrator for Part-Time Employees Dental is:

CobraGuard
P.O. Box 39
Mission, KS 66201
1-800-442-6272

Premium payment processing during an approved Leave of Absence for Full-Time and Part-Time Employees is administered by:

WageWorks, Inc.
P.O. Box 14055
Lexington, KY 40512-4055
Phone: 877-502-6272
Fax: 877-220-3249

Website: www.wageworks.com

*Claim inquiry questions need to be directed to the appropriate claims administrator.