Vision

Lowe's offers Vision Insurance through VSP (Vision Service Plan), to all regular, full-time and part-time employees and their eligible dependents. See Plan Overview, Employee Eligibility section for further information. This plan is designed to provide for regular eye examinations and benefits toward vision care expenses including glasses or contact lenses. Lowe's offers two levels of plans, the "High Plan" and the "Low Plan" with differing benefits and premiums.

If you need to locate a VSP participating provider, visit the VSP website, accessible via the Lowe's enrollment site at www.myloweslife.com (My Lowe's Life>My Benefits>Contacts>Other Providers>Vision) or call the VSP customer care department at 1-800-877-7195.

BENEFIT COSTS

The employee pays 100% of the cost of the Vision Care Plan Option.

OUTLINE OF BENEFITS

LOW PLAN

<table>
<tr><th>SERVICE OR MATERIAL</th><th>VSP NETWORK DOCTOR BENEFIT</th><th>NON-VSP PROVIDER BENEFIT</th><th>FREQUENCY</th></tr>
<tr><td>Eye Examination</td><td>Covered in full after $15.00 Copayment</td><td>Up to $45.00</td><td>Available once every calendar year</td></tr>
<tr><td colspan="4">Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.</td></tr>
<tr><td colspan="3">Lenses</td><td rowspan="4">Available once each calendar year</td></tr>
<tr><td>Single Vision</td><td>Covered in full after $15.00 Copayment</td><td>Up to $40.00</td></tr>
<tr><td>Bifocal</td><td>Covered in full after $15.00 Copayment</td><td>Up to $60.00</td></tr>
<tr><td>Trifocal</td><td>Covered in full after $15.00 Copayment</td><td>Up to $80.00</td></tr>
</table>

Lenticular	Covered in full after $15.00 Copayment	Up to $80.00	
Plan Benefits for lenses are per complete set, not per lens.			
LENS OPTIONS			Available once each calendar year
Scratch coating	Covered in full	Not covered	
Progressive lenses	Covered in full after a $40.00 copayment	Up to $80.00	
FRAMES	Covered up to the Plan Allowance of $150.00*. 20% discount above allowance.	Up to $45.00	Available once every 2 calendar years
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary.			
ELECTIVE CONTACT LENSES			Available once every calendar year
Professional Fees and Materials* **	Up to $150.00	Up to $150.00	
*Less any applicable Copayment ***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.			
Elective Contact Lenses are provided in lieu of all other lens and frame benefits available herein.			

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for calendar year.			
SERVICE OR MATERIAL	**VSP NETWORK DOCTOR BENEFIT**	**NON-VSP PROVIDER BENEFIT**	**FREQUENCY**
NECESSARY CONTACT LENSES			Available once every 12 months
Professional Fees and Materials	Covered in full *	Up to $210.00*	
*Less any applicable Copayment Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.			
Necessary Contact Lenses are provided in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for calendar year.			
SERVICE OR MATERIAL	**VSP NETWORK DOCTOR BENEFIT**	**NON-VSP PROVIDER BENEFIT**	**FREQUENCY**
Low Vision Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full	Up to $125.00*	
Includes evaluation, diagnosis and prescription of vision aids where indicated.			
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	
*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.			

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials. THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

HIGH PLAN

SERVICE OR MATERIAL	**VSP NETWORK DOCTOR BENEFIT**	**NON-VSP PROVIDER BENEFIT**	**FREQUENCY**
Eye Examination	Covered in full after $10.00 Copayment	Up to $45.00*	Available once every calendar year
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			
Lenses			Available once each calendar year
Single Vision	Covered in full after $10.00 Copayment	Up to $40.00*	
Bifocal	Covered in full after $10.00 Copayment	Up to $60.00*	
Trifocal	Covered in full after $10.00 Copayment	Up to $80.00*	
Lenticular	Covered in full after $10.00 Copayment	Up to $80.00*	
LENS OPTIONS			Available once each

			calendar year
Scratch coating	Covered in full after a $10.00 Copayment	Not covered	
Anti-Reflective Coating	Covered in full after a $10.00 Copayment	Not covered	
Progressive lenses	Covered in full after a $10.00 copayment	Up to $80.00	
FRAMES	Covered up to the Plan Allowance of $220.00*. 20% discount above allowance.	Up to $45.00*	Available once every calendar year

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.

ELECTIVE CONTACT LENSES			Available once every calendar year
Professional Fees and Materials* **	Up to $220.00	Up to $150.00	

*Less any applicable Copayment

***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Elective Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for calendar year.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
NECESSARY CONTACT LENSES			Available once every 12 months
Professional Fees and Materials	Covered in full*	Up to $210.00*	

*Less any applicable Copayment

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Necessary Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for calendar year.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Low Vision Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full	Up to $125.00*	*
Includes evaluation, diagnosis and prescription of vision aids where indicated.			
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE

PROVIDER'S FULL FEE.

EXCEPTIONS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating. (For Low Plan)
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2. (For Low Plan)
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing, or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

FILING CLAIMS

If obtaining services from a VSP participating provider simply identify yourself as a VSP member and provide your Lowe's ID. Your doctor will handle the rest, and file your claim directly with VSP. You will be responsible for any co-payments or overages at the time of service.

If obtaining services from an out-of-network provider, pay your bill up front and send the following to VSP for reimbursement:

- A legible copy of your itemized receipt
- A completed out-of-network reimbursement form, which can be found online by logging into your VSP account
- A reimbursement form is not required, and is intended to ensure we receive all the information needed to process your claim. If you do not include a completed reimbursement form please provide the following details along with your itemized receipt;
    - The first and last name of the Lowe's Employee
    - The ID number of the Lowe's employee
    - Patient's name and relationship to the employee
    - Patient's date of birth
    - Your return mailing address
- Mail your claim to the following address:
    - VSP, Attention Out-of-Network claims, P.O. Box 997105, Sacramento, CA 95899
- For any questions regarding claims, please contact VSP's Customer Care department at 800-877-7195.

CLAIMS PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make an oral or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP

Member Appeals

3333 Quality Drive

Rancho Cordova, CA 95670

(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.