Plan Administration

The following section provides you with information about how the components of the Lowe's Welfare plan (referred generally and collectively as the "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 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 – HMO - POS - 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.
<table>
<thead>
<tr>
<th>FIDUCIARY / CLAIM AND APPEAL ADMINISTRATORS TABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are covered by:</strong></td>
</tr>
<tr>
<td><strong>A.C. Newman &amp; Company (Business Travel Accident Insurance Plan)</strong></td>
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<tr>
<td><strong>Aetna (Group Medical Plan Option Copay 500 and Copay 750 Medical Plan Options, according to location assignment)</strong></td>
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<tr>
<td>Insurance Company</td>
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</tr>
<tr>
<td>Blue Care Network - Michigan</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of Alabama (Group Medical Plan Option Copay 500 and Copay 750 Medical Plan Options, according to location assignment)</td>
</tr>
</tbody>
</table>
| CIGNA (Dental Plan Option) | Send all claims and appeals to insurance carrier (the claims administrator):

CIGNA HealthCare
Claims Center
P.O. Box 188037
Chattanooga, TN 37422-8037

1-800-244-6224

www.cigna.com
Group Number: 3151760 |
|--------------------------|---------------------------------------------------------------|
| Cleveland Clinic (Heart Surgery Benefit Plan) (Group Medical Plan Option Copay 500 and Copay 750 Medical Plan Options) | Send all appeals to the claims administrator:

Health Design Plus
Attn: Cleveland Clinic Travel Program
1755 Georgetown Road
Hudson, OH 44236

1-877-543-3875, option 8
Fax 877.885.0650

www.hdplus.com/clients/lowesclevelandclinicprogram.aspx |
<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **CVS Caremark (Prescription Drug Benefits)** | Send all claims and **first and second level** appeals to the 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 |
| **Geisinger Health Plan**       | Send all claims and appeals to insurance carrier (the claims administrator):  
|                                 | Geisinger Health Plan  
|                                 | 100 North Academy Ave.  
|                                 | Danville, PA 17822  
|                                 | 1-800-447-4000  
|                                 | www.thehealthplan.com  
|                                 | Group Number: 102381 |
| **Group Health Plan of Missouri/Coventry** | Send all claims and appeals to insurance carrier (the claims administrator):  
|                                 | Group Health Plan of Missouri / Coventry  
|                                 | 111 Corporate Office Woods Drive, Suite 400  
<p>|                                 | Earth City, MO 63045 |</p>
<table>
<thead>
<tr>
<th>Insurance Carrier</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii Medical Service Association (HMSA)</td>
<td>Send all claims and appeals to insurance carrier (the claims administrator):</td>
</tr>
<tr>
<td></td>
<td>HMSA</td>
</tr>
<tr>
<td></td>
<td>Attn: Appeals Coordinator</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1958</td>
</tr>
<tr>
<td></td>
<td>Honolulu, HI 96805-1958</td>
</tr>
<tr>
<td></td>
<td>808-948-5090 or 1-800-462-2085</td>
</tr>
<tr>
<td></td>
<td>Fax 808-952-7546</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.hmsa.com">www.hmsa.com</a></td>
</tr>
<tr>
<td></td>
<td>Group Numbers:</td>
</tr>
<tr>
<td></td>
<td>95459-1-4 Lowe's Home Improvement Warehouse</td>
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<tr>
<td></td>
<td>95754-1-6 Lowe's Home Improvement Warehouse-COBRA</td>
</tr>
<tr>
<td>Health Plan Nevada Las Vegas</td>
<td>Send all claims and appeals to insurance carrier (the claims administrator):</td>
</tr>
<tr>
<td></td>
<td>Health Plan Nevada Las Vegas</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 15645</td>
</tr>
<tr>
<td></td>
<td>Las Vegas, NV 89114-1564</td>
</tr>
<tr>
<td></td>
<td>1-702-304-6954 or 1-800-777-1840</td>
</tr>
<tr>
<td></td>
<td>Email <a href="mailto:hmbrsrv@sierrahealth.com">hmbrsrv@sierrahealth.com</a></td>
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<tr>
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<td><a href="http://www.healthplanofnevada.com">www.healthplanofnevada.com</a></td>
</tr>
<tr>
<td></td>
<td>Group Number: 50501350 1001</td>
</tr>
<tr>
<td>Kaiser Permanente of California</td>
<td>Send all claims and appeals to insurance carrier (the claims administrator):</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente of California</td>
</tr>
<tr>
<td></td>
<td>393 East Walnut Street</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Address</td>
</tr>
<tr>
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<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kaiser Health Plan of Colorado</td>
<td>Kaiser Health Plan of Colorado&lt;br&gt;P.O. Box 378022&lt;br&gt;Denver, CO 80237-8022&lt;br&gt;1-303-338-3800 or 1-800-632-9700</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of</td>
<td>Kaiser Foundation Health Plan of the Mid-Atlantic States&lt;br&gt;P.O. Box 6233&lt;br&gt;Rockville, MD 20849-6233</td>
</tr>
<tr>
<td>the Mid-Atlantic States</td>
<td></td>
</tr>
<tr>
<td>Kaiser Health Plan of Oregon</td>
<td>Kaiser Health Plan of Oregon&lt;br&gt;500 NE Multnomah St., Ste 100&lt;br&gt;Portland, OR 97232</td>
</tr>
</tbody>
</table>
| **Liberty Life Assurance Company of Boston (Short Term Disability Plan and Long Term Disability Plan Option)** | 1-503-813-2000 or 1-800-813-2000  
www.kp.org  
Group Number: 10117AA  
Send all claims and appeals to insurance carrier (the claims administrator):  
Liberty Life Assurance Company of Boston  
PO Box 7207  
London, KY 40742-7207  
1-704-759-2581 or 1-888-245-2690  
http://www.mylibertyconnection.com  
Group Numbers: GD3-850-275613-01 (Hourly Short Term Disability), GF3-850-275613-01 (Long Term Disability), PD3-850-275613-03 (Salaried Short Term Disability). |
| **Magellan Behavioral Health** | Send all claims and appeals to insurance carrier (the claims administrator):  
Magellan Behavioral Health  
PO Box 2128  
Maryland Heights, MO 63043  
| **MetLife (Life Insurance Options (Basic Term Life, Supplemental Term Life, and Dependent Life), Accidental Death & Dismemberment (AD&D) Plan, Long-Term Care Insurance, Hyatt Prepaid Legal Plan, Auto/Home Insurance)** | Send all life insurance (basic life, supplemental life, dependent life) and Accidental Death & Dismemberment (AD&D) claims and appeals to insurance carrier (the claims administrator):  
MetLife  
Group Life Claims  
P.O. Box 3016  
Utica, NY 13504  
1-866-492-6983  
www.metlife.com/mybenefits |
<table>
<thead>
<tr>
<th><strong>Hyatt Prepaid Legal Group Number:</strong></th>
<th>121189</th>
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</thead>
<tbody>
<tr>
<td>Send all <strong>Hyatt prepaid legal and auto / home insurance</strong> claims and appeals to insurance carrier (the claims administrator):</td>
<td></td>
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<tr>
<td>MetLife</td>
<td></td>
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<tr>
<td>700 Quaker Lane</td>
<td></td>
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<tr>
<td>Warwick, RI 02887</td>
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<tr>
<td>1-800-438-6388</td>
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<tr>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
<td></td>
</tr>
<tr>
<td>Hyatt Prepaid Legal Group Number: 493/0010</td>
<td></td>
</tr>
<tr>
<td>Auto / Home Group Number: 190702</td>
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</tr>
<tr>
<td>Send all <strong>long-term care</strong> claims and appeals to insurance carrier (the claims administrator):</td>
<td></td>
</tr>
<tr>
<td>Metropolitan Life Insurance Company</td>
<td></td>
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<tr>
<td>Long-Term Care Group</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 937</td>
<td></td>
</tr>
<tr>
<td>Westport, CT 06881-0937</td>
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<tr>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<tr>
<td>Group Number: 96802</td>
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<tr>
<th><strong>United Healthcare Vision (Vision Care Plan Option)</strong></th>
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<tbody>
<tr>
<td>Send all claims and appeals to insurance carrier (the claims administrator):</td>
<td></td>
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<tr>
<td>United Healthcare Vision</td>
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<tr>
<td>Claims Department</td>
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<tr>
<td>P.O. Box 30978</td>
<td></td>
</tr>
<tr>
<td>Salt Lake City, UT 84130</td>
<td></td>
</tr>
<tr>
<td>1-800-638-3120</td>
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<tr>
<td>Organization</td>
<td>Contact Information</td>
</tr>
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<tr>
<td>WageWorks (Healthcare Flexible Spending Account (Health FSA) and Dependent Care Flexible Spending Account (DCSA))</td>
<td>Send all claims and <strong>first-level</strong> appeals to the claims administrator: WageWorks Claims Administrator P.O. Box 14053 Lexington, KY 40511 1-877-924-3967 Fax 1-877-353-9236 <a href="http://www.wageworks.com">www.wageworks.com</a> Send all <strong>second-level</strong> appeals to Lowe's: Lowe's Health FSA / DCSA Second-Level Appeals c/o Group Benefits Department 1000 Lowe's Boulevard Mail Code NB2CB Mooresville, NC 28117</td>
</tr>
<tr>
<td>United Healthcare (1750 Medical Plan, Health Savings Account and Limited FSA)</td>
<td>Send all claims and appeals (the claims administrator): Claims: P.O. Box 740800 Atlanta, GA 30374-0800 Appeals: UnitedHealthcare – Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432</td>
</tr>
</tbody>
</table>

In addition, please direct questions regarding COBRA continuation coverage and payment processing for an approved leave of absence to the following administrators*:

COBRA continuation coverage for the Full-time Group Medical Plan, Dental Plan, Full-Time and Part-Time Vision Care Plan Options, and the Health FSA Plan is administered by:
Key Benefit Administrators (KBA)
Attn: Lowe's COBRA Department
P.O. Box 1885
Fort Mill, SC 29716
1-888-309-8232 (phone)
1-803-396-1966 (fax)

COBRA continuation coverage for the Part-time Medical and Part-time Dental Plan Options is administered by:

COBRA Guard, Inc.
P.O. Box 15123
Lemexa, KS 66285-5123
1-866-542-6272 (phone)
1-913-438-8385 (fax)
www.cobraguard.net

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

Key Benefit Administrators (KBA)
Attn: Lowe's LOA Billing Department
P.O. Box 1885
Fort Mill, SC 29716
1-888-309-8232 (phone)
1-803-396-1966 (fax)

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

**NOTE:** For information regarding who administers the Lowe's 401(k) Plan and Lowe's Employee Stock Purchase Plan, please see the [Stock Purchase Plan](#) and [Retirement Benefits](#) sections of this handbook.

**Group Medical (including Prescription Drugs and Cleveland Clinic Heart Surgery Program), Vision Care Options, Dental Plan Options, Part-Time Medical and Dental Plan Options, and Health FSA. The 1750 High Deductible Health Plan’s information is excluded in this document and can be found in the 1750 Medical Plan SPD.**

The Lowe's Welfare Plan has established special claim and review procedures for claims under the Group Medical (including Prescription Drugs), Vision Care Options, Dental Plan Options, Part-time Medical and Dental Plan Options, Cleveland Clinic Heart Surgery Program, and Health FSA (group health benefit claims). The claims review procedures vary depending on the type of claim you have.
Types of Claims

There are three types of group health benefit claims: Pre-service, Concurrent Care, and Post service Claims (these terms are defined immediately following the "Claims and Appeals Procedures Chart"). Also, certain Pre-service or Concurrent Care claims may involve urgent care. See the "Claims and Appeals Procedures Chart" for a detailed description of the types of claims.

Appeals Procedures

The claims administrators for each plan option are listed in the "Fiduciary / Claim and Appeal Administrators Table." In addition, the "Fiduciary / Claim and Appeal Administrators Table" lists the claims administrators for each insurance carrier under the Group Medical Plan Option.

Generally, the following steps describe your appeal procedures (regardless of the type of claim—Pre-service, Concurrent Care, etc.).

Step 1:

You receive notice from the claims administrator of a decision on your claim. If your claim is denied, you will receive written notice from the claims administrator that your claim is denied (in the case of Urgent Care Claims, notice may be oral). The time frame in which you will receive this notice is described in the chart below and will vary depending on the type of claim.

In addition, the claims administrator may, for reasons beyond the claims administrator's control, require an extension of time to review your claim. If the claims administrator requires an extension of time because you need to provide additional information, the claims administrator will give you a certain amount of time to obtain the requested information. The amount of time will vary depending on the type of claim. The claims administrator's deadline to make a decision on your claim will be suspended until the earlier of the date that you provide the information or the end of the time you were given to provide the additional information.

Step 2:

Review your notice carefully. Once you have received your notice from the claims administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;

- A description of any additional information necessary for you to resubmit your claim, why the information is necessary, and your time limit for submitting the information;
• A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;

• A statement indicating whether the claims administrator relied on an internal rule, guideline, or protocol in denying your claim, and upon request, the claims administrator will provide you (free of charge) a copy of the applicable rule, guideline, or protocol;

• If the denial is based on a medical necessity, experimental treatment, or a similar exclusion or limit, the claims administrator will provide you either an explanation of the scientific or clinical judgment for the determination or a statement that the claims administrator will provide you, upon request and free of charge; and

• If the claim was an urgent care claim, a description of the expedited appeal process, the notice may be provided to you orally; however, a written or electronic notification will be sent to you no later than three days after the oral notification.

**Step 3:**

If you disagree with the decision, **file a first-level appeal with the claims administrator.** If you do not agree with the decision of the claims administrator, you may, within 180 days of receipt of the claim denial notice referenced in Step 1 (or oral notice if an Urgent Care Claim), file a written appeal with the claims administrator.

If the claim involves Urgent Care, you may make an oral appeal.

In addition, you must submit with your appeal all additional information identified in the claim denial notice referenced in Step 1 as necessary to resubmit your claim. You should also gather and submit with your appeal any other information you believe will support your claim.

**Step 4:**

You receive notice from the claim administrator of a decision on your first-level appeal. If the claim administrator denies your claim again the claims administrator will notify you of the decision on your appeal within the time period described in the "Claims and Appeals Procedures Chart" below. As explained below, the claims administrator's deadline to notify you of a decision on your appeal depends on the type of claim.

**Step 5:**
Review your notice carefully. You should take the same action that you took in Step 2. The notice of the denial of your first-level appeal will contain the same type of information that the claims administrator provided in the initial claim denial notice.

**Step 6:**

If you still disagree with the claims administrator's decision denying your first-level appeal, file a second-level appeal with the second-level appeal administrator. If you still do not agree with the claims administrator's decision denying your first-level appeal, you may file a written appeal to the second-level appeals administrator within 60 days after receiving the first-level appeal denial notice from the claims administrator.

You must gather and submit any additional information identified in the first-level appeal denial notice as necessary to resubmit your claim, as well as any other information you believe will support your claim. Send your second-level appeal to the second-level appeals administrator address specified in the "Fiduciary / Claims and Appeals Administrators Table" above. If the Table above does not identify a different second-level appeals administrator, send your second-level appeal to the claims administrator.

If the second-level appeals administrator denies your second-level appeal, the second-level appeals administrator will provide written notice of the decision within the time period described in the "Claims and Appeals Procedures Chart" below. As explained below, the claims administrator's deadline to notify you of a decision on your appeal depends on the type of claim. The notice of the denial of your second-level appeal will contain the same type of information listed in Step 2.

**Important Information**

Other important information regarding your appeals:

- Even if the same claims administrator decides claims, first-level appeals and second-level appeals under a Plan, each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinate(s) of the same person(s) involved in a prior level of appeal will not be involved in the second level appeal);

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;

- If a claim involves medical judgment, then the person or persons deciding your appeal will consult during the first- and second-level appeals with a healthcare professional who has expertise in the specific area involving medical judgment; and

- You cannot file suit in federal court until you have exhausted these appeals procedures.
**Short and Long Term Disability**

The same steps described above for group health claims apply to short and long term disability claims; however, the time periods for making decisions on disability claims and appeals are different and there are no Urgent Care or Concurrent Care Claims. Furthermore, there is only one level of appeal. See the "Claims and Appeals Procedures Chart" for more information, including applicable deadlines.

**Life Insurance, Auto and Home Insurance, Hyatt Prepaid Legal, Critical Illness, Business Travel Accident Insurance, Off-The-Job Accident, and Personal Accident Insurance Plans**

The same steps described above for group health claims apply to basic life, supplemental life, dependent term life insurance, auto and home insurance, Hyatt prepaid legal, critical illness, off-the-job accident, business travel accident, and AD&D insurance plans; however, the time periods for making decisions on life insurance, critical illness, business travel accident insurance, and personal accident insurance claims and appeals are different, and there are no Urgent Care or Concurrent Care Claims. See the "Claims and Appeals Procedures Chart" for more information, including applicable deadlines.

**Long Term Care Insurance Plan**

**Filing Claims**

To file a claim for benefits under the Long Term Care Plan Option, follow these steps.

**Step 1:**

All claim forms needed to file for benefits will be given to you by MetLife once you have been authorized to receive benefits through the benefit authorization process. See the "How the Long Term Care Option Works" section for more information regarding authorization of benefits.

**Step 2:**

When you have received covered services, complete the claim form and send it to MetLife (the claims administrator) at the address listed in the "Fiduciary / Claim and Appeal Administrators Table" for the Long-Term Care Option.

**Step 3:**

You will receive payments from MetLife after the waiting period, unless you ask on your claim form that your provider be paid directly.
**Appealing Claims**

If you disagree with MetLife’s claim determination regarding benefits for long term care insurance, you or your duly authorized representative may contact MetLife to have the claim reviewed on appeal. The request for a review on appeal must be made in writing within 60 days of the date of MetLife’s initial denial. It should be submitted to the address listed in the "Fiduciary / Claim and Appeal Administrators Table”.

Your request for an appeal should include any and all information you believe should be considered. MetLife will provide notification of its decision on appeal within 60 days of the date it receives the request for an appeal. If MetLife requires additional time to make a decision on appeal, it will provide written notice setting forth the reasons for the extension. MetLife’s final decision will be made no later than 120 days after it receives the request for appeal. There is only one level appeal in the Long Term Care Plan Option.

**Claims and Appeals Procedures Chart**

This chart shows the time limit for you to submit appeals, and for the claims administrator to respond to your claim or appeals. This chart is intended to be used in conjunction with the other information in this section, including the "Fiduciary / Claim and Appeal Administrators Table."

<table>
<thead>
<tr>
<th>Initial Claims</th>
<th>First-Level Appeals</th>
<th>Second-Level Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Health Benefit Plans (Group Medical (including Prescription Drugs and Cleveland Clinic Heart Surgery Program), Vision Care Options Dental Plans, Limited Benefit Health Plan for Part-Time Employees, and Part-Time Employees Dental Plan Options</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Pre-service Claims** | You'll be notified of determination as soon as possible but no later than 15 days from receipt of claim | If additional information is needed, you must provide within 45 days of date of extension notice | You must file your appeal within 60 days of first level appeal denial  
You'll be notified of determination as soon as |
| One extension | You must file your appeal within 60 days of first level appeal denial  
You'll be notified of determination as soon as |
| **Pre-service involving urgent care** | You'll be notified of determination as soon as possible but no later than 72 hours (24 hours if additional information is needed)  
No extension periods are permitted for pre-service urgent care claims | If additional information is needed, you must provide it within 48 hours (Claims administrator must notify you of determination within 48 hours of your information)  
You must file your first-level appeal within 180 days of claim denial  
You'll be notified of determination as soon as possible but no later than 72 hours of receipt of first-level appeal | No second level appeals for Pre-service Claims involving Urgent Care |
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</thead>
<tbody>
<tr>
<td><strong>Concurrent: To end or reduce treatment(s) prematurely</strong></td>
<td>Notification to end or reduce treatment will allow time to finalize appeal</td>
<td>If your appeal is denied, the denial letter will specify filing limit</td>
<td>If your appeal is denied, the denial letter will specify filing limit for</td>
</tr>
<tr>
<td>Concurrent: To deny your request(s) to extend treatment(s)</td>
<td>before end of treatment</td>
<td>You must file your appeal within 15 days of receipt of appeal</td>
<td>second-level appeal</td>
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<tr>
<td>----------------------------------------------------------</td>
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<tr>
<td>You'll be notified of determination as soon as possible but no later than 15 days from request of the claim. One extension period of 15 days (measured from the end of the original determination due date) is allowed for circumstances beyond administrator's control.</td>
<td>If additional information is needed, you must provide within 45 days of date of extension notice. You must file your first-level appeal within 180 days of claim denial. You'll be notified of determination as soon as possible but no later than 15 days of receipt of first-level appeal.</td>
<td>You must file your second-level appeal within 60 days after first-level appeal denial. You'll be notified of determination as soon as possible but no later than 15 days after receipt of second-level appeal.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Concurrent: involving urgent care | You'll be notified of determination as soon as possible but no later than 24 hours, if your claim is submitted at least 24 hours before the scheduled date of treatment, Otherwise, as | You must file your first-level appeal within 180 days after claim denial. You'll be notified of determination as soon as possible but no later than 72 hours days after receipt of first-level appeal. | No second level appeals for concurrent care involving urgent care. |</p>
<table>
<thead>
<tr>
<th>Other Plans/ Events</th>
<th>Determination Process</th>
<th>Extensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post-service — Group Health Benefit Plans (Group Medical including Prescription Drugs and Cleveland Clinic Heart Surgery Program), Vision Care Options Dental Plans, Limited Benefit Health Plans for Part-Time Employees, Part-Time Employees Dental Plan Options and Health FSA</strong></td>
<td>You’ll be notified of determination as soon as possible but no later than 30 days after receipt of claim. One extension period of 15 days is allowed for circumstances beyond claims administrator’s control. If additional information is needed, you must provide within 45 days after extension notice. You must file your first-level appeal within 180 days of claim denial. You’ll be notified of determination as soon as possible but no later than 30 days after receipt of first-level appeal. You must file your second-level appeal within 60 days after first level appeal denial. You’ll be notified of determination as soon as possible but no later than 30 days after receipt of second-level appeal.</td>
<td>You must file your first-level appeal within 180 days of claim denial. You’ll be notified of determination as soon as possible but no later than 30 days after receipt of first-level appeal.</td>
</tr>
<tr>
<td>Limited Benefits Health Plan for Part-Time Employees, Part-Time Employees Dental Plan, Critical Illness, and Off-the-Job Accident Plan</td>
<td>You’ll be notified of determination as soon as possible but no later than 30 days after receipt of claim. One extension period of 15 days is allowed for. If additional information is needed, you must provide within 45 days after extension notice. You must file your first-level appeal within 180 days of first-level appeal. You’ll be notified of determination as soon as possible but no later than 30 days after receipt of first-level appeal. No second level appeals for limited benefit health, dental, critical illness and off-the-job accident.</td>
<td>No second level appeals for limited benefit health, dental, critical illness and off-the-job accident.</td>
</tr>
</tbody>
</table>

- treated as Pre-service Urgent Care Claims
- No extension periods are permitted for pre-service urgent care claims
<table>
<thead>
<tr>
<th>Dependent Care Spending Account (DCSA)</th>
<th>You'll be notified of determination as soon as possible but no later than 30 days from receipt of claim</th>
<th>If additional information is needed, you must provide within 45 days of extension notice</th>
<th>You must file your appeal within 60 days after first level appeal denial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One extension period of 15 days is allowed for circumstances beyond claims administrator's control</td>
<td>You must file your first-level appeal within 180 days of claim denial</td>
<td>You'll be notified of determination as soon as possible but no later than 30 days from receipt of second-level appeal</td>
</tr>
<tr>
<td></td>
<td>You must file your first-level appeal within 180 days of claim denial</td>
<td>You'll be notified of determination as soon as possible but no later than 30 days of receipt of appeal</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Short and Long Term Disability</th>
<th>You'll be notified of determination as soon as possible but no later than 45 days from receipt of claim</th>
<th>If additional information is needed, you must provide within 45 days of extension notice</th>
<th>No second-level appeals for short and long term disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Two extension periods of 30 days each are allowed for circumstances beyond claims</td>
<td>You must file your appeal within 180 days of claim denial</td>
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<tr>
<td></td>
<td>You'll be notified of determination as soon as possible but no later than 30 days of receipt of appeal</td>
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<tr>
<td>Hyatt Prepaid Legal, Auto and Home, Term Life (Basic, Supplemental and Dependent), and Personal Accident Insurance</td>
<td>You’ll be notified of determination as soon as possible but no later than 45 days from receipt of claim. Two extension periods of 30 days each are allowed for circumstances beyond claims administrator's control. If additional information is needed, you must provide within 45 days of extension notice. You must file your appeal within 180 days of claim denial. You’ll be notified of determination as soon as possible but no later than 45 days of receipt of appeal (with one 45-day extension for reasons beyond the Plan's control); you must submit requested documentation within 45 days.</td>
<td>No second-level appeals for life, business travel accident and personal accident insurance</td>
<td></td>
</tr>
<tr>
<td><strong>Long Term Care</strong></td>
<td>Claims will be processed within 10 working days of receipt of all necessary information</td>
<td>Benefit appeals must be made in writing within 60 days of the date of MetLife’s initial denial</td>
<td>No second-level appeals for long-term care insurance</td>
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<td>-----------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
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<tr>
<td></td>
<td>No extension periods are permitted for pre-service urgent care claims</td>
<td>MetLife will provide notification of its decision on appeal within 60 days of the date it receives the request for an appeal</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Business Travel Accident Insurance</strong></th>
<th>You'll be notified of determination as soon as possible but no later than 90 days from receipt of claim</th>
<th>You must file your appeal within 60 days of claim denial</th>
<th>At your request, additional denial review requests will be granted.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One extension period of 90 days is allowed for circumstances beyond claims administrator’s control</td>
<td>You'll be notified of determination as soon as possible but no later than 60 days of receipt of appeal (with one 60-day extension for reasons beyond the Plan’s control)</td>
<td>You must request additional reviews within 60 days of claim denial.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>You'll be notified of determination as soon as possible but no later than 60 days of receipt of appeal (with one 60-day extension for reasons beyond the Plan’s control)</td>
</tr>
</tbody>
</table>

*The extension period is measured from the end of the original determination due date.*
**Definitions**

**Pre-service Claim:** A claim for healthcare where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you pre-certify (notify for the 1750 Medical Plan) hospital admissions.

**Concurrent Care Claim:** A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.

**Post-service Claim:** A claim for care that has already been received, and any claim for which the Plan does not require preauthorization and Health FSA claims.

**Urgent Care:** Claim: A pre-service or concurrent care claim becomes an urgent care claim when the normal time frame for making a determination would:

- Seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition); or

- Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

**Continuation of Coverage Under COBRA**

In certain circumstances, healthcare coverage for you, your spouse or domestic partner, your dependent children and/or your domestic partner's children can continue beyond the date it would otherwise end. This continuation of coverage is required by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The information included here is a general overview of COBRA provisions. If you become eligible for continued coverage (that is, if you have a qualifying event), you'll be given more information specific to your situation at the time.

**How COBRA Works**

Eligibility for COBRA is triggered by a qualifying event. You and your spouse or domestic partner, dependent children, and/or your domestic partner's children must have been covered under a benefit plan subject to COBRA immediately preceding your qualifying event in order to be eligible for COBRA coverage. The following table describes the types of qualifying events and the maximum length of coverage available for each event. The maximum coverage period is measured from the date of the qualifying event, except as otherwise stated in this SPD.
If you decide to continue coverage, you must pay the full cost of that coverage (tobacco premiums), plus a 2% administrative cost. The applicable premium amount will be provided to you at the time a qualifying event occurs.

Your first COBRA payment is due no later than 45 days after your election date (no grace period). For example, if your first day of COBRA coverage is June 1 and you elect COBRA coverage on June 30, the initial premium is due August 14, which is 45 days from June 30. Subsequent COBRA payments are due on the first of each month. Failure to make subsequent payments within 30 days of the due date (31 days under the Limited Benefit Health Plan for Part-time Employees) will cause your coverage to terminate retroactive to the end of the last month for which full payment was received.

To be eligible for COBRA continuation coverage, you and your spouse or domestic partner, eligible dependents, and/or your domestic partner's children must have been covered by the Group Medical Plan, Dental Plan, Vision Care Options, Limited Benefit Health Plan for Part-time Employees, or the Part-time Dental Plan Options on the day before one of the qualifying events occurred.

COBRA coverage ordinarily will be available for either an 18 or 36 month period, as noted. However, this continued coverage will end sooner for an individual if:

- The premium for continued coverage is not paid when due;
- The person becomes entitled to Medicare after electing COBRA coverage;
- The person becomes covered by another healthcare plan after electing COBRA coverage (except where the person is subject to a preexisting condition, exclusion or limitation); or
- Group health coverage under the Lowe's Welfare Plan terminates for all employees.

The Plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the date you, your spouse or domestic partner, your dependent children, and/or your domestic partner's children become covered under another group health plan if proper notification of such coverage is not provided.

If COBRA continuation coverage is elected and you, your spouse or domestic partner, a covered dependent child, and/or your domestic partner's child are determined by the Social Security Administration to have been disabled at any time within the first 60 days of COBRA coverage, the initial 18 month time period will be extended up to 29 months from the date of the original qualifying event as long as the disability continues throughout this period. You, your spouse or domestic partner, dependent child, and/or domestic partner's child must notify the COBRA administrator of this disability within 60 days of the date of Social Security disability determination and prior to the end of the initial COBRA period in accordance with the notice procedures in this section.
If you or your covered disabled spouse or domestic partner, dependent child, and/or domestic partner’s child are determined by the Social Security Administration to no longer be disabled, your COBRA coverage will terminate before the end of the 29 month extended COBRA continuation period. If you are determined to no longer be disabled, your coverage will end on the earlier of the first day of the month that begins 30 days after the determination that you are no longer disabled, or the end of the applicable coverage period, whichever comes first.

### Qualifying Events

<table>
<thead>
<tr>
<th>Qualifying Events</th>
<th>Continuation of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You</td>
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<tr>
<td>You terminate company employment before retiring</td>
<td>18 months</td>
</tr>
<tr>
<td>Your work hours are reduced*</td>
<td>18 months</td>
</tr>
<tr>
<td>You retire</td>
<td>18 months</td>
</tr>
<tr>
<td>You become divorced or legally separated or your domestic partner relationship ends</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child and/or domestic partner’s child ceases to be a qualified dependent</td>
<td>N/A</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
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</table>

* The extension period is measured from the end of the original determination due date.

### COBRA Notification Deadline

In most cases, you'll be notified when you become entitled to continue healthcare coverage. However, in the case of divorce or legal separation, or a dependent ceasing to be a dependent, you or your dependent should notify the COBRA administrator immediately. It is your duty to notify the COBRA administrator of a qualifying event, and you must notify the COBRA administrator within 60 days of the date of the qualifying event or continued coverage will not be available. The chart below shows when the COBRA administrator will automatically send COBRA enrollment materials and when you or your dependent must notify the COBRA administrator.
### NOTIFICATION DEADLINES

<table>
<thead>
<tr>
<th>EVENTS</th>
<th>RESPONSIBLE FOR NOTIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination</td>
<td>The COBRA administrator will automatically send your COBRA enrollment materials to the employee's home address on file.</td>
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<tr>
<td>Retirement</td>
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<tr>
<td>Layoff</td>
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<td>Death of employee</td>
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<td>Transfer to ineligible position</td>
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<tr>
<td>Reaching 180 days on leave of absence</td>
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<tr>
<td>Loss of dependent status due to age</td>
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</tr>
<tr>
<td>Divorce*</td>
<td>You, your spouse or domestic partner, your dependent child or your domestic partner's child should call the COBRA administrator immediately. If you do not notify the COBRA administrator within the 60 days, you forfeit any right to COBRA coverage.</td>
</tr>
<tr>
<td>Legal Separation*</td>
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<tr>
<td>Loss of dependent status not due to age</td>
<td></td>
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<tr>
<td>Domestic Partner relationship ends</td>
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<tr>
<td>Social Security Administration</td>
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<tr>
<td>Social Security Administration determines you are disabled</td>
<td></td>
</tr>
<tr>
<td>Gain coverage under another group health plan without a preexisting condition limitation</td>
<td></td>
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</tbody>
</table>

* If a legal separation or divorce occurs after an annual enrollment period during which the spouse is dropped from coverage, the spouse may still be eligible for COBRA coverage beginning on the date of the divorce or legal separation (whichever come first) if the termination of coverage was "in anticipation of" the legal separation of divorce.

* The ex-spouse must notify the COBRA administrator within 60 days after the divorce (or legal separation) and submit evidence that the employee cancelled the coverage earlier in anticipation of the divorce (or legal separation). Once notified of the legal separation or divorce after an annual enrollment period during which the spouse is dropped from coverage, the Plan administrator (or its designee) will determine whether the previous termination of coverage was "in anticipation of" the legal separation or divorce in accordance with the Plan's internal policies and procedures. In no event will a termination of coverage be considered "in anticipation of" a legal separation or divorce if the divorce or legal separation occurs more than one year after the termination of coverage.

### COBRA Enrollment
As with active employees, there are two types of enrollment: initial enrollment, when you first become eligible and annual enrollment.

**Initial Enrollment**

When you become eligible for COBRA, you and your covered eligible dependents (who were enrolled in the Group Medical, Dental, Vision Care Options, Part-Time Medical Plan, or the Part-Time Dental Plan Options) may each independently choose to continue medical, dental, and vision coverage for up to the entire coverage period. You may choose to continue your Health FSA deductions on an after-tax basis until the end of that calendar year. You must make your election within 60 days of the date of your enrollment notice or the date coverage is lost, if later.

During initial COBRA enrollment, you may not make changes to your coverage options. You may; however, decrease your coverage level (you only or you plus family).

A change in status at the time of your qualifying event may allow you to change certain coverage during initial COBRA enrollment. See "Change in Status Events" for more information.

**Annual Enrollment**

At each annual enrollment, you can make new choices. An enrollment kit will be sent to you and must be returned by the deadline indicated on the enrollment forms.

**COBRA Administrator**

Lowe’s has contracted with Key Benefit Administrators to administer its COBRA continuation coverage for the Group Medical Plan Option, Dental Option, Vision Care Options, and Health FSA. All notices, payments, telephone calls and communications regarding COBRA for these plan options should be directed to:

Key Benefit Administrators Attn: Lowe's COBRA  
P.O. Box 1885  
Fort Mill, SC 29716  
1-888-309-8232

The COBRA administrator for the Limited Benefit Health Plan for Part-Time Employees (Low and High Options) and Part-Time Dental Plan Options is:

COBRA Guard, Inc.  
P.O. Box 15123  
Lemexa, KS 66285-5123  
1-866-542-6272 (ask for COBRA Administration)
Your Right to Obtain Individual Coverage

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires all health insurance carriers offering coverage in the individual market to accept any eligible individuals who apply for coverage without imposing a preexisting condition exclusion. To take advantage of this HIPAA right, you must complete your 18, 29, or 36 month COBRA coverage period under the Plan and apply for coverage with an individual carrier before you have a 63 day lapse in coverage. Because this coverage is not sponsored by Lowe’s, you will need to contact your state’s department or commission of insurance, or see your independent insurance specialist to secure coverage.

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

This section describes the right of the self-funded medical plan options administered by Blue Cross Blue Shield of Alabama and Aetna (the Copay 500 and Copay 750 Options), the Short-Term Disability Plan and Long-Term Disability Plan Options (referred to individually in this section and as the "Plan") to seek reimbursement of expenses that are paid by the Plan on behalf of you or your covered dependents (referred to in this section as a covered individual) if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit.

The terms of the Plan's reimbursement rights are described below:

If a covered individual incurs expenses covered by the Plan as a result of the act of a third party (person or entity), you may receive benefits pursuant to the terms of the Plan. However, the covered individual shall be required to refund to the Plan all benefits paid if the covered individual recovers from any other party (such as proceeds from a settlement, judgment, lawsuit, or otherwise as a result of the act). 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, 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, by filing claims (assigning benefits or having claims filed on your behalf) related to such act of a third party, the covered individual shall be deemed to agree to the terms of this reimbursement provision;
• 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 subject to reduction for attorney's fees or other expenses of recovery. The reduction is limited to the lesser of the actual attorney fees and other expenses or one-third of the Plan's lien. 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.

The Plan shall have a lien against the proceeds of any recovery by the covered individual and against future benefits due under the Plan in the amount of any claims paid. If the covered individual fails to repay the Plan from the proceeds of any recovery, the Plan administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

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, 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 treat prior claims paid as overpayments recoverable to offset against future Plan benefits or by other action of the Plan administrator.

In addition, 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.

**Specific Information for and Provision Applicable to Participants Covered by the Self-Funded Group Medical Plan Options Administered by Aetna or Blue Cross Blue Shield of Alabama**

**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.

For purposes of this provision, the term "Plan" means the Copay 500, Copay 750 Group Medical Plan Options administered by Aetna and Blue Cross Blue Shield of Alabama. 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).

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, workers compensation coverage, no-fault automobile insurance coverage or any first-party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

**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.

**Reimbursement**

In addition, if a Covered Person receives any payment from any allegedly Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.
Constructive Trust

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 if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to 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 claims administrator for the Plan 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**

If an individual covered by the Lowe's Group Medical Plan Option and/or the Dental Plan Option (referred to here as the "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 coverages. 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).

<table>
<thead>
<tr>
<th>Example 1:</th>
<th>Covered expenses</th>
<th>$2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary plan pays</td>
<td></td>
<td>1,500</td>
</tr>
<tr>
<td>Plan normally pays</td>
<td></td>
<td>1,600</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Example 2:</th>
<th>Covered expenses</th>
<th>$2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary plan pays</td>
<td></td>
<td>1,700</td>
</tr>
<tr>
<td>Plan normally pays</td>
<td></td>
<td>1,600</td>
</tr>
</tbody>
</table>

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.

**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 is at issue.

**Employee Retirement Income Security Act of 1974**

The following information, together with other information contained in this book, comprises the summary plan description under the Employee Retirement Income Security Act of 1974. As a participant in the Lowe's Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits.
Welfare Plans

ERISA entitles all plan participants to:

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

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

ERISA also entitles you to:

- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage; and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon 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 welfare or pension benefit or exercising your rights under ERISA.

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide 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 that 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 domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Other Information-Claim and Appeal Administration-Fiduciary Authority**
The Plan Administrator for the Plan is the Welfare Plan Committee of Lowe's Companies, Inc., which are authorized to delegate its administrative duties to one or more individuals or committees within Lowe's, or to one or more 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 Plan Option (neither Lowe's nor the Welfare Plan Committee of Lowe's Companies, Inc. is the claims or appeals fiduciary for the Group Medical Plan Option, and Lowe's and the Welfare Plan Committee of Lowe's Companies, Inc. are NOT involved in claims determinations and appeals under the Group Medical Plan):
  - Aetna
  - Blue Care Network - Michigan
  - Blue Cross/Blue Shield of Alabama
  - Geisinger Health Plan
  - Group Health Plan of Missouri
  - Hawaii Medical Service Association (HMSA)
  - Health Plan Nevada - Las Vegas
  - Health Design Plus (Cleveland Clinic Heart Surgery Program)
  - Kaiser Permanente of California
  - Kaiser Health Plan of Colorado
  - Kaiser Health Plan of Georgia
  - Kaiser Health Plan of Oregon
  - Kaiser of the Mid-Atlantic
  - United Healthcare HDHP

- Prescription drug coverage under the Group Health Plan Option is administered by CVS Caremark, except for:
  - Kaiser Permanente of California
  - Kaiser Health Plan of Colorado
  - Kaiser Health Plan of Georgia
• Kaiser Health Plan of Oregon

• Kaiser of the Mid-Atlantic

These HMOs currently administer their own prescription drug program. Neither Lowe’s nor the Welfare Plan Committee of Lowe’s Companies, Inc. is the claims or appeals fiduciary with regard to prescription drug claims under the Group Medical Plan Option, and Lowe’s and the Welfare Plan Committee of Lowe’s Companies, Inc. are NOT involved in prescription drug claims determinations and appeals under the Group Medical Plan).

• The Critical Illness Plan Option is administered by:

  o 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 Plan Option (neither Lowe’s nor the Welfare Plan Committee of Lowe’s Companies, Inc. is the claims or appeals fiduciary for the Critical Illness Plan Option, and Lowe’s and the Welfare Plan Committee of Lowe’s Companies, Inc. are NOT involved in claims determinations and appeals under the Critical Illness Plan Option).

• The Off-the-Job Accident Plan Option is administered by:

  o 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 Off-the-Job Accident Plan Option (neither Lowe’s nor the Welfare Plan Committee of Lowe’s Companies, Inc. is the claims or appeals fiduciary for the Off-the-Job Accident Plan Option, and Lowe’s and the Welfare Plan Committee of Lowe’s Companies, Inc. are NOT involved in claims determinations and appeals under the Off-the-Job Accident Plan Option).

• The Limited Benefit Health Plan for Part-Time Employees is administered by:

  o 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 Limited Benefit Health Plan for Part-Time Employees (neither Lowe’s nor the Welfare Plan Committee of Lowe’s Companies, Inc. is the claims or appeals fiduciary for the Limited Benefit Health Plan for Part-Time Employees, and Lowe’s and the Welfare Plan Committee of Lowe’s Companies, Inc. are NOT involved in claims determinations and appeals under the Limited Benefit Health Plan for Part-Time Employees).

• The Dental Plan Option is administered by:

  o Connecticut General Life Insurance Company, which has sole, full and final discretionary authority to decide claims and appeals under the Dental Plan Option (neither Lowe’s nor the Welfare Plan Committee of Lowe’s Companies, Inc. is the claims or appeals fiduciary for the Dental Plan Option, and Lowe’s and the Welfare Plan Committee of Lowe’s Companies, Inc. are NOT involved in claims determinations and appeals under the Dental Plan Option).

• The Vision Care Plan Option (both for full-time and part-time employees) is administered by:
United Healthcare Vision, which has sole, full and final discretionary authority to decide claims and appeals under the Vision Care Plan Option (neither Lowe's nor the Welfare Plan Committee of Lowe's Companies, Inc. is the claims or appeals fiduciary for the Vision Care Plan Option, and Lowe's and the Welfare Plan Committee of Lowe's Companies, Inc. are NOT involved in claims determinations and appeals under the Vision Care Plan Option).

The Part-Time Employee Dental Plan Option is 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 Part-Time Dental Plan Option (neither Lowe's nor the Welfare Plan Committee of Lowe's Companies, Inc. is the claims or appeals fiduciary for the Part-Time Dental Plan Option, and Lowe's and the Welfare Plan Committee of Lowe's Companies, Inc. are NOT involved in claims determinations and appeals under the Part-Time Dental Plan Option).

The Business Travel Accident Option is administered by:

AC Newman & Company, which has sole, full and final discretionary authority to decide claims and appeals under the Business Travel Accident Option (neither Lowe's nor the Welfare Plan Committee of Lowe's Companies, Inc. is the claims or appeals fiduciary for the Business Travel Accident Option, and Lowe's and the Welfare Plan Committee of Lowe's Companies, Inc. are NOT involved in claims determinations and appeals under the Business Travel Accident Option).

The Group Voluntary Term Life Insurance Option for Part-Time Employees is 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 (neither Lowe's nor the Welfare Plan Committee of Lowe's Companies, Inc. is the claims or appeals fiduciary for the Group Voluntary Term Life Insurance Option for Part-Time Employees, and Lowe's and the Welfare Plan Committee of Lowe's Companies, Inc. are NOT involved in claims determinations and appeals under the Group Voluntary Term Life Insurance Option for Part-Time Employees).

The Group Term Life Insurance Plan Options (Basic, Supplemental, and Dependent), Long Term Care Plan Option, Accidental Death and Dismemberment (AD&D), Auto and Home Insurance, and Hyatt Prepaid Legal Plan are administered by:

MetLife, which has sole, full and final discretionary authority to decide claims and appeals under the Group Term Life Insurance Plan Options (Basic, Supplemental, and Dependent), Long-Term Care Plan Option, Accidental Death and Dismemberment (AD&D), Auto and Home Insurance, and Hyatt Prepaid Legal Plan (neither Lowe's nor the Welfare Plan Committee of Lowe's Companies, Inc. is the claims or appeals fiduciary for the Group Term Life Insurance Plan Options (Basic, Supplemental, and Dependent), Long-Term Care Plan Option, Auto and Home Insurance and Hyatt Prepaid Legal Plan, and Lowe's and the Welfare Plan Committee of Lowe's Companies, Inc. are NOT involved in claims determinations and appeals under the Group Term Life Insurance Plan Options (Basic, Supplemental, and Dependent), Long-Term Care Plan Option, Auto and Home Insurance and Hyatt Prepaid Legal Plan).
• The **Short Term Disability Plan and Long Term Disability Plan Option** are administered by:
  
  o **Liberty Life Assurance Company of Boston**, which has sole, full and final discretionary authority to decide claims and appeals under the Group LTD, and fully insured Hourly STD Plan. Liberty Life Assurance Company of Boston also assumes responsibility as plan administrator for the 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 administered by:
  
  o **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 (neither Lowe’s nor the Welfare Plan Committee of Lowe’s Companies, Inc. is the claims or appeals fiduciary for the Group Voluntary Short Term Disability Plan Option for Part-Time Employees, and Lowe’s and the Welfare Plan Committee of Lowe’s Companies, Inc. are NOT involved in claims determinations and appeals under the Group Volunteer Short Term Disability Plan Option for Part-Time Employees).

• The **Health FSA and DCSA** are administered by:
  
  o **WageWorks, Inc.**

• For information regarding who administers the Lowe’s **401(k) Plan Option** and Lowe’s **Employee Stock Purchase Plan Option**, please see **401(k) Plan** and **Stock Purchase Plan**.

• **COBRA Continuation coverage for the Group Health, Dental, Vision Care Plan Options** and the **Health FSA** are administered by:
  
  o **Key Benefit Administrators**.

• **COBRA Continuation coverage** for the Limited Benefit Health Plan for Part-time Employees and Part-Time Dental Plan Options is administered by:
  
  o **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:
  
  o **Key Benefit Administrators**.

**General Information**

• 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): 56-0748358

• Plan Administrator (for ERISA reporting and disclosure purposes): Welfare Plan Committee of 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 DCSA, 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 third-party administrators identified in this summary plan description (e.g., A.C. Newman & Co., Aetna, Blue Cross Blue Shield of Alabama, American Heritage Life Insurance Company (Allstate Benefits), Connecticut General Life Insurance Company, Health Design Plus, Liberty Life Assurance Company of Boston, MetLife, 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 Gaither Keener, Jr.
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: 56-0748358)

• Lowe's HIW Inc (EIN: 91-1465348)
LG Sourcing, Inc. (EIN: 56-2010120).

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

**Plan Amendment or Termination**

Lowe's has established the Plan and each of its component employee welfare benefit plans with the expectation that they will be continued indefinitely. Nevertheless, 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. 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.

**Privacy Notice**

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan - whether received in writing, in an electronic medium, or as an oral communication. This Privacy Notice describes the privacy practices of the group health plan (as defined by HIPAA) components of the Lowe's Welfare Plan: the Group Medical Plan, the Vision Care Options, the Dental Plan, the Long-Term Care Insurance Plan, the Critical Illness Plan, the Off-the-Job Accident Plan, the Health Flexible Spending Account (Health FSA), the Limited Benefit Health Plan for Part-Time Employees, and the Part-Time Employees Dental Plan. The plans covered by this Privacy Notice may share health information with each other to carry out treatment, payment or health care operations. These plans are collectively referred to as the "Plans" in this Privacy Notice, unless specified otherwise. Additionally, the term "Plan" refers to any of the Plans individually. The HIPAA statement can be located by going to My Lowes Life>My Health >Health Resources>HIPAA Privacy Notice.

*The Plan’s Duties with Respect to Health Information About You*

The Plans are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of the Plans' legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important
to note that these rules apply to the Plans, not to Lowe's (or any of its corporate affiliates) as an employer - that's the way the HIPAA rules work. Different policies may apply to other Lowe's programs or to data unrelated to the Plan.

**How the Plans may use or disclose your health information**

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities and health care operations. Here are some examples of what those activities and operations might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plans may share your health information with physicians who are treating you.*

- **Payment** includes activities by the Plans, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as “behind the scenes” plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plans may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

- **Health care operations** include activities by the Plans (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plans may use information about your claims to audit the third parties that approve payment for benefits.*

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plans use or disclose PHI for underwriting purposes, the Plans will not use or disclose PHI that is your genetic information for such purposes. The Plans may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, as permitted by law.

**How the Plan may share your health information with Lowe's**

The Plans, or their insurers, or HMOs may disclose your health information without your written authorization to Lowe's for plan administration purposes. Lowe's may need your health information to administer benefits under the Plans. Lowe's agrees not to use or disclose your health information other
than as permitted or required by the Plan documents and by law. Field, staff and corporate human resources employees and members of the Lowe's Legal Department will have access to your health information, and are the only Lowe's employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Lowe's, as allowed under the HIPAA rules:

- The Plans, or their insurers, or HMOs, may disclose "summary health information" to Lowe's if requested, for purposes of obtaining premium bids to provide coverage under the Plans, or for modifying, amending, or terminating the Plans. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plans, or their insurers or HMOs, may disclose to Lowe's information on whether an individual is participating in one or more of the Plans or has enrolled or disenrolled in an insurance option or HMO offered by one or more of the Plans.

In addition, you should know that Lowe's cannot and will not use health information obtained from any of the Plans for any employment-related actions. However, health information collected by Lowe's from other sources; for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

**Other allowable uses or disclosures of your health information**

In certain cases, your health information can be disclosed without authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care. Information about your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made - for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plans are also allowed by law to use or disclose your health information without your written authorization for the following activities:

<p>| Workers' compensation | Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary to prevent serious threat to health or safety</td>
<td>Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plans reasonably believe may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.</td>
</tr>
<tr>
<td>Public health activities</td>
<td>Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.</td>
</tr>
<tr>
<td>Victims of abuse, neglect, or domestic violence</td>
<td>Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plans believe that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plans' disclosure if informing you won't put you at further risk).</td>
</tr>
<tr>
<td>Judicial and administrative proceedings</td>
<td>Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plans may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).</td>
</tr>
<tr>
<td>Law enforcement purposes</td>
<td>Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plans' premises.</td>
</tr>
<tr>
<td>Decedents</td>
<td>Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.</td>
</tr>
<tr>
<td>Organ, eye, or tissue donation</td>
<td>Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death</td>
</tr>
<tr>
<td>Research purposes</td>
<td>Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project</td>
</tr>
<tr>
<td>Health oversight activities</td>
<td>Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws</td>
</tr>
<tr>
<td>Specialized government functions</td>
<td>Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates</td>
</tr>
<tr>
<td>HHS investigations</td>
<td>Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule</td>
</tr>
</tbody>
</table>

Except as described in this Privacy Notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plans have already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

**Your Individual Rights**

You have the following rights with respect to your health information the Plans maintain. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.
Right to request restrictions on certain uses and disclosures of your health information and the Plans' right to refuse

You have the right to ask one or more of the Plans to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plans to restrict the use and disclosure of your health information to family members, close friends or other persons you identify as being involved in your care or payment for your care. You also have the right to ask one or more of the Plans to restrict use and disclosure of health information to notify those persons of your location, general condition or death - or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to one or more of the Plans must be in writing.

The Plan is not required to agree to a requested restriction. If one or more of the Plans agree, a restriction may later be terminated by your written request, by agreement between you the Plan or Plans (including an oral agreement), or unilaterally by one or more of the Plans for health information created or received after you are notified that the Plans have removed the restrictions. The Plans may also disclose health information about you if you need emergency treatment, even if one more of the Plans have agreed to a restriction.

Effective February 17, 2010, an entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plans for purposes of payment or health care operations if you have paid for the item or service in full out of pocket.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plans will accommodate reasonable requests to receive communications of health information from the Plans by alternative means or at alternative locations.

If you want to exercise this right, your request to one or more of the Plans must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records a Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.
If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request. Effective February 17, 2010, you may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

**Right to amend your health information that is inaccurate or incomplete**

With certain exceptions, you have a right to request that a Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provided a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.
Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information any of the Plans has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or healthcare operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.
Changes to the Information in this Notice

The Plans must abide by the terms of this Privacy Notice currently in effect. This notice takes effect on February 17, 2010. However, the Plans reserve the right to change the terms of their privacy policies, as described in this Privacy Notice, at any time and to make new provisions effective for all health information that the Plans maintain. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plans’ privacy policies described in this notice, you will be provided with a revised Privacy Notice. A revised Privacy Notice will be mailed to the last known address of covered employees. A revised Privacy Notice will also be posted on the Lowe's employee portal, www.myloweslife.com (My Lowe's Life > My Health > Health Benefits> Health Resources>HIPAA Privacy Notice).

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. The Director Welfare Benefits has been designated as the Lowe’s privacy official. Send a written complaint to the Lowe’s privacy official, Kristie Shugart, Director Welfare Benefits, 1000 Lowe's Boulevard, Mail Code NB2CB, Mooresville, NC 28117. Instructions and resources for filing a complaint with the Secretary of Health and Human Services are under the "Health Information Privacy (HIPAA)" link on the HHS web site, www.hhs.gov

Contact

For more information on the Plans’ privacy policies or your rights under HIPAA, contact the Lowe's designated privacy official, Kristie Shugart, Director Welfare Benefits, at 1000 Lowe's Boulevard, Mail Code NB2CB, Mooresville, NC 28117, or call HR Shared Services at 1-888-HRINFO5 (1-888-474-6365).

COBRA Continuation Coverage Rights

The following information constitutes Lowe's general notice of COBRA continuation coverage rights. For further information regarding COBRA continuation coverage, please see "Continuation of Coverage Under COBRA."

Introduction

You are receiving this notice because you are covered under the Lowe's Welfare Plan (the Plan). The Plan includes a Group Health Plan Option, a Dental Plan Option, a Vision Plan, a Part-time Medical Plan
Option, a Part-time Dental Plan Option, and a Health Flexible Spending Arrangement (Health FSA). If you are enrolled in one or more of these plan options, this notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to your covered dependents when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your covered dependents, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the summary plan descriptions for the Plan's group health programs or get a copy of the plan document from the plan administrator.

**Your COBRA Administrator**

Your COBRA administrator depends upon which group health plan option you are enrolled in. The COBRA administrator is:

Group Medical, Dental, and Vision Care Options and Health FSA: Key Benefit Administrators (KBA)

Attn: Lowe’s COBRA Department
P.O. Box 1885
Fort Mill, SC 29716
1-888-309-8232

Limited Benefit Health Plan for Part-Time Employees and Part-Time Dental Plan Options:

COBRAGuard, Inc.
P.O. Box 15123
Lemexa, KS 66285-5123
1-866-542-6272 (ask for COBRA administration)

The COBRA administrator is responsible for administering COBRA continuation coverage. The COBRA administrator for each plan option, or that COBRA administrator's address and telephone number may change from time to time. For the most recent information, check the Plan's most recent summary plan description, or contact the HR Shared Services at 1-888-HRINFO5 (1-888-474-6365).

**COBRA Continuation Coverage Introduction**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this
notice. COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses or domestic partners of employees, and dependent children of an employee and/or domestic partner's children may be qualified beneficiaries. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below). Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary, if you lose your coverage under the Plan because either one of the following qualifying events happens:

• Your hours of employment are reduced; or

• Your employment ends for any reason other than your gross misconduct.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

• Your spouse or domestic partner dies;

• Your spouse's or domestic partner's hours of employment are reduced;

• Your spouse's or domestic partner's employment ends for any reason other than his/her gross misconduct;

• Your spouse or domestic partner becomes enrolled in Medicare (Part A, Part B or both); or

• You become divorced or legally separated from your spouse or your domestic partner relationship with your domestic partner ends.

If the legal separation or divorce occurs within one year after an annual enrollment period during which the spouse is dropped from coverage, the spouse may still be eligible for COBRA coverage beginning on the date of legal separation or divorce (whichever comes first) if the termination of coverage was "in anticipation of" the legal separation or divorce. The ex-spouse must notify the COBRA administrator within 60 days after the divorce (or legal separation) and submit evidence that the employee cancelled the coverage earlier in anticipation of the divorce (or legal separation). Once notified of the legal separation or divorce after an annual enrollment period during which the spouse is dropped from coverage, the Plan administrator (or its designee) will determine whether the previous termination of coverage was "in anticipation of" the legal separation or divorce in accordance with the Plan's internal policies and procedures. In no event will a termination of coverage be considered "in anticipation of" a legal separation or divorce if the divorce or legal separation occurs more than one year after the termination of coverage.
Your dependent children and/or your domestic partner’s children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee or domestic partner-employee dies;
- The parent-employee’s or domestic partner-employee’s hours of employment are reduced;
- The parent-employee’s or domestic partner-employee’s employment ends for any reason other than his/her gross misconduct;
- The parent-employee or domestic partner-employee becomes enrolled in Medicare (Part A, Part B, or both);
- Parents become divorced or legally separated or the domestic partner parents end their relationship; or
- The child stops being eligible for coverage under the plan as a dependent child and/or domestic partner’s child.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse or domestic partner, surviving spouse or domestic partner, dependent children and/or domestic partner’s children also will be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part...
A, Part B, or both), the employer must notify the COBRA administrator of the qualifying event within 44 days of any of these events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or the domestic partner relationship ending or a dependent child and/or domestic partner's child losing eligibility for coverage as a dependent child), you must notify the COBRA administrator. The Plan requires you to notify the COBRA administrator in writing within 60 days after the later of the qualifying event or the loss of coverage. You must send this notice to the COBRA administrator.

How is COBRA Coverage Provided?

Once the COBRA administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If you or your spouse or domestic partner, dependent children and/or domestic partner's children do not elect continuation coverage within this 60-day election period, you will lose your right to elect COBRA continuation coverage.

Payment for Continuation Coverage

In order to continue your coverage, you (or your covered dependent) will need to pay premiums every month in an amount determined by the Plan Administrator. The amount determined by the Plan can be up to 102% of the full regular coverage cost. The cost is calculated as both the part that you presently pay and the part that Lowe’s pays for you. Your first payment will be due no later than 45 days of the date you elect to continue coverage. This initial payment will need to be sufficient to cover time already passed between the date that you would have lost coverage due to the qualifying event and the date of your payment as well as the rest of the month that you are in at the time of payment. Subsequent payments are due on the first day of each month for that month with a grace period of 30 days.

If you don't make the full premium payment by the due date or within the thirty-day grace period, then COBRA coverage will be cancelled retroactively to the first of the month, with no possibility of reinstatement. The Plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the date you or your covered spouse or domestic partner, dependent children, and/or domestic partner's children become covered under another group health plan, if proper notification of such coverage is not provided.

Duration of Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or...
legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability Extension of 18 month Period of Continuation Coverage**

If COBRA continuation is elected due to your termination of employment or reduction in hours and your spouse or domestic partner, a covered dependent child and/or domestic partner's child is determined by the Social Security Administration to have been disabled at anytime within the first 60 days of COBRA coverage, the initial 18 month time period will be extended up to 29 months from the date of the original qualifying event, as long as the disability continues throughout this period. You, your spouse or domestic partner, dependent child and/or domestic partner's child must notify the COBRA administrator of this disability within 60 days of the date of the Social Security disability determination and prior to the end of the initial COBRA period in accordance with the notice procedures in this section.

If you or your covered disabled spouse or domestic partner, dependent or domestic partner's child is determined by the Social Security Administration to be no longer disabled, your COBRA continuation will terminate before the end of the 29 month extended COBRA continuation period. If you are determined to no longer be disabled, your coverage will end on the earlier of the first day of the month that begins 30 days after the determination that you are no longer disabled, or the end of the applicable coverage period, whichever comes first.

**Second Qualifying Event Extension of 18 month Period of Continuation Coverage**

If you lost coverage as a result of a termination of employment or reduction in hours of employment and a second qualifying event occurs during the 18 month continuation period, your dependents covered at the time of the first qualifying event who elected COBRA coverage may be eligible for 36 months of continued coverage measured from the date of the first qualifying event. These second qualifying events are divorce or legal separation, your death, your eligibility for Medicare, or a child ceases to be an eligible dependent. For example, if you terminate employment and have COBRA continued coverage for yourself and your qualified dependents, and during the continuation period, become divorced, the qualified dependents would be entitled to a total of 36 months of coverage from the date your COBRA coverage began.

You or your covered dependents must notify the COBRA administrator at the occurrence of a second qualifying event in accordance with the notice procedures below in order to extend the original 18-month continuation period.
Failure to notify the COBRA administrator of the second qualifying event within 60 days from the date the event occurs will result in forfeiture of your dependent's right to extend coverage under COBRA.

**Trade Act of 2002**

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60 day enrollment period, with coverage beginning on the date of such TAA approval.

**Shorter Maximum Coverage Period for Health FSAs**

The maximum COBRA coverage period for a Health FSA maintained by the employer ends on the last day of the plan year in which the qualifying event occurred.

**Children Born to or Placed for Adoption with the Covered Employee During COBRA Period**

A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, the covered employee is a covered beneficiary, or the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan option, whether through special enrollment or open enrollment. It lasts for as long as COBRA coverage lasts for other covered dependents of the employee. To be enrolled in the plan option, the child must satisfy the otherwise applicable eligibility requirements for that plan option (for example, the age requirements).

**Alternate Recipients Under QMCSOs**

A child of the covered employee who is receiving benefits under a group health plan option pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan administrator during the covered employee's period of employment with Lowe's is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

**If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact the COBRA administrator (Key Benefit Administrators or COBRA Guard, Inc., see contact information above under "Your COBRA Administrator") or you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.
**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.