Limited Benefit Health Plan for Part-Time Employees

This information describes the Limited Benefit Health Plan for Part-Time Employees also known as AHL minimedical® (the "Part-Time Medical Plan Option"), that is available to part-time employees, and the Group Voluntary Term Life Insurance and Group Voluntary Short Term Disability Options when an employee chooses to enroll in these additional options. Participation is subject to timely enrollment and the payment of premiums specified by Lowe’s. These options are not available to part-time employees working at locations in Massachusetts, Minnesota and New Hampshire and employees living in Massachusetts.

The following sections summarize the Part-Time Medical Plan, Group Voluntary Term Life and Group Voluntary Short Term Disability Options. Please review these provisions and retain this booklet for future reference. Key terms used in this text are specifically defined in each section.

About This Coverage

Allstate Benefits (AB) is the marketing name for American Heritage Life Insurance Company (AHL), which insures the Part-Time Medical Plan, Group Voluntary Term Life and Group Voluntary Short Term Disability Options. AHL certifies that, subject to the terms and conditions of the group policy issued to Lowe’s by AHL, coverage is provided for each employee who has satisfied the eligibility and enrollment provisions of the Part-Time Medical Plan, Term Life, and Short Term Disability Options described in the following sections.

Employees enrolled in the Part-Time Medical Plan Option can choose between two coverage options:

- The Low Plan
- The High Plan

See the section titled "Outline of Part-Time Medical Plan Option Benefits" for a description of the coverage options.

Dependents enrolled in the Part-Time Medical Plan Option must be enrolled in the same coverage option as the employee.

Employees enrolled in the Part-Time Medical Plan Options and/or the Group Voluntary Term Life Option can choose between two coverage options:

- Employee Only
- Family

Employee coverage is the only option for the Group Voluntary Short Term Disability option.
Outline of Part-Time Medical Plan Option Benefits

• Maximum Benefit (per Coverage Year)

Your maximum benefit per Coverage Year depends upon whether you are enrolled in the Low Plan or the High Plan Option. The maximum annual benefit for each covered individual for all covered medical expenses is $2,500 for the Low Plan and $5,000 for the High Plan Option. Within this maximum, the following limits apply per insured for each coverage option:

• Maximum Coverage Year Limit for Hospital Services

<table>
<thead>
<tr>
<th>Hospital Inpatient services (other than Room and Board)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low &amp; High Plan</td>
<td>$500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low &amp; High Plan</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

• Daily Maximum Limit for Hospital Room and Board Charges

<table>
<thead>
<tr>
<th>Intensive care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Plans</td>
<td>$300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All other accommodations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Plans</td>
<td>$150</td>
</tr>
</tbody>
</table>

• Hospital Indemnity Benefit

<table>
<thead>
<tr>
<th>Inpatient Daily Benefit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low &amp; High Plan</td>
<td>None</td>
</tr>
</tbody>
</table>

• Insured Percentage for Medical Expenses

  • Physician office visits – 100% of Reasonable and Customary expenses; and

  • All other covered medical expenses utilizing PPO providers, or insureds residing outside the Servicing Area – 80% of Reasonable and Customary expenses; or
• All other covered medical utilizing Non-PPO providers – 70% of Reasonable and Customary expenses.

You and your covered dependents must pay the following deductible and co-payment amounts before any amount will be paid from the Part-Time Medical Plan Option.

• Deductible Per Coverage Year (does not apply to doctor's office visits)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per insured person</td>
<td>$300</td>
</tr>
<tr>
<td>Per family</td>
<td>$600</td>
</tr>
</tbody>
</table>

• Co-payment Per Doctor's Office Visit (not subject to deductible)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office co-payment (PPO/Outside Service Area)</td>
<td>$20</td>
</tr>
<tr>
<td>Office co-payment (Non-PPO)</td>
<td>$30</td>
</tr>
</tbody>
</table>

• Maternity Care

When the mother’s pregnancy is covered under the Group Policy, charges for inpatient care of the mother and newborn child will be covered subject to deductible hospital and medical plan limits for a minimum of 48 hours after vaginal delivery and for a minimum of 96 hours after delivery by caesarean section. If discharged earlier, charges for outpatient post-delivery care will also be covered. This post-delivery care must be received within 72 hours of such early delivery. The dependent child is covered from date of birth, provided you notify AB and pay the additional premium, if any, within 31 days of the date of birth.

Covered Medical Expenses

Covered Medical Expenses are only the charges and fees incurred by you or your covered dependents for those services and supplies listed below. They are subject to the exclusions and other limits that may apply to this section. Such charges and fees are limited to what is Reasonable and Customary within the area in which the services and supplies are furnished. Such services and supplies must be performed by, prescribed in writing by, or under the supervision of an attending Physician. They must be Medically Necessary for the care and treatment of you or your covered dependents due to a Sickness or an Injury.

• **Ambulance Services:** This is for local transportation by professional ambulance service to/from a hospital. Local means to/from the nearest hospital with appropriate staff and equipment prepared to care for or treat the patient's condition. In no case more than 100 miles away.
• **Birthing Center Services:** These are services received in such a center for prenatal care, delivery of a child or children, and postpartum care during the first 24 hours after giving birth.

• **Diagnostic Services:** These are for X-ray exams and laboratory tests to find the cause of sickness or the extent of an injury.

• **Home Health Services:** These are for services and supplies provided in the home of a covered individual. They must be in lieu of Inpatient care that otherwise would be required. Such services must be therapeutic in nature and must be supervised by the Physician who prescribes them. The maximum benefit payable for such services is $1,000 in a Coverage Year.

• **Hospice Services:** These include treatment provided in accordance with a Hospice Care Program and Room and Board and other services of a Hospice Facility during Inpatient confinement of a covered individual in such a Facility. Such confinement must be needed for the control of acute symptoms, crisis management, or to provide respite for the patient's family. Charges for such confinement that exceed $200 per day or for more than 30 days (five days in any period of three months for respite care) will not be a Covered Medical Expense.

• **Hospital Services:** These include Room and Board and other services and supplies provided by a Hospital. Room and Board charges that exceed the daily maximum shown for them in the Schedule of Insurance will not be covered medical expenses. The maximum benefit payable for services and supplies, other than Room and Board, is also shown in the Schedule of Insurance.

• **Medical Equipment and Supplies:** These include only the items that are specifically listed below, but only if they:
  
  o Are determined by AB to be Medically Necessary for the treatment of a condition covered under the Group Policy; and
  
  o Will not, in whole or in part, serve as a comfort or convenience item for the covered individual.
  
  o Supplies and services to repair medical equipment may be a Covered Medical Expense only if the covered individual owns the equipment or is purchasing the equipment. The Covered Medical Expense for medical equipment is based on the most cost-effective medical equipment that meets the covered individual's needs, as determined by AB. At AB's option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Medical Expense. With respect to durable medical equipment that is purchased, only the initial purchase will be a Covered Medical Expense. The only equipment and supplies that are covered are as follows:

    • **Anesthetics,** surgical dressings, blood, and blood plasma.

    • **Casts,** splints, and braces.
• **Durable Medical Equipment** that includes only canes, crutches, walkers, standard manual or electric wheelchairs, and standard hospital beds.

• **Hemodialysis For Renal Disease**, including the required equipment, and medical supplies, when prescribed by a Physician and provided at hemodialysis clinics and home training centers that are approved by the Joint Commission on the Accreditation of Healthcare Organizations.

• **Oxygen**, including the use of equipment for its administration, when the Medical Necessity for 24-hour usage is certified by a Physician.

• **Prescription Drugs**, dispensed by a licensed pharmacist for which the law requires a Physician's written prescription. In addition, Covered Medical Expenses will include insulin and the needles and syringes required for its administration, if the covered individual has a Physician's authorization for such supplies on record with the pharmacist.

• **Nursing Services**: These are for private duty nursing care by a licensed nurse (R.N. or L.P.N.). They must entail active medical treatment. They must be provided as Home Health Services.

• **Physician Services**: These are for performing Surgery or other medical care and treatment. Each service must be within the scope of the Physician's license to practice.

• **Radiation Therapy Services**: These include chemotherapy, X-rays, radium, and radioactive isotope therapy for the treatment of benign or malignant conditions.

• **Surgical Services**: These are in connection with Surgery performed by a Physician in a surgical facility. Such facility must be duly licensed as such.

• **Therapeutic Services**: These are services of a licensed speech therapist to aid in the restoration of speech loss, resulting from injury, stroke, or surgical procedure; or services provided by a physiotherapist, occupational therapist, respiratory therapist, or inhalation therapist to aid in the restoration of normal physical function that the covered individual once had, but later lost, provided any such loss of speech or physical function occurred while coverage under the Part-time Medical Plan Option was in force.

A charge or fee is considered to be incurred on the date a covered individual receives the service or supply for which the charge is made.

**Special Provisions**

*Mental Illness*
Benefits are provided under the Part-Time Medical Plan Option for care and treatment of mental illness and functional nervous disorders, including alcoholism and drug abuse.

**Contraceptives**

Benefits are payable under the Part-Time Medical Plan Option for Reasonable and Customary charges you or your covered dependents incur for outpatient contraceptive services. Benefits will be based on the Insured Percent and any Deductible or Co-payment that would be applied to expenses for the treatment of Sickness. This includes oral contraceptives and devices that may be dispensed only by prescription. However, RU-486, Preven, or equivalent drugs are not included.

**Screening for Cancer**

Benefits are payable under the Part-Time Medical Plan Option for Reasonable and Customary charges you or your covered dependents incur for low dose screening mammography, pap smear, prostate specific antigen tests or colorectal cancer screening. Benefits will be based on the Insured Percent and any Deductible or Co-payment that would be applied to expenses for the treatment of Sickness.

**Anesthesia and Hospitalization for Dental Procedures**

Charges for general anesthesia and facility charges for care in a Hospital or ambulatory surgical center are covered if the patient: (a) is a child under 9 years of age; or (b) has a serious mental or physical condition; or (c) has significant behavioral problems; and (d) the provider certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure. Benefits will be based on the Insured Percent and any Deductible or Co-payment that would be applied to expenses for the treatment of Sickness.

**Expenses Not Covered**

No benefits will be paid under any section of the Group Policy that provides a type of Health Expense Insurance for any expense incurred by a covered individual:

- On account of or in connection with:
  - An examination not required for care or treatment of a Sickness or Injury, immunizations or other preventive measures, except as may be provided in the provision for Maternity Care, or under any Special Provisions;
  - Care of any person AB determines to be custodial or for maintenance purposes, except as may be provided under the provision for Maternity Care, or under any Special Provisions;
- Injury arising out of or in the course of doing any job or work for which the covered individual is reasonably qualified by education or training, or Sickness covered by any Workers' Compensation Law or Act;

- War or any act of war, whether declared or not, that occurs while the person is insured;

- Injury sustained while participating in a riot or in the act of committing an assault or felony;

- Care or treatment of the teeth, their roots, root sockets, or gums, except:
  - Prompt (within 12 months in the case of an adult) repair of sound natural teeth or other body tissue required as a result of an injury; or
  - Care or treatment of congenital defects in a child who becomes insured at birth;
  - Eye exams, eyeglasses or lenses, or surgery for the correction of errors of refraction in the eye, except the first exam and lens that may be required after cataract surgery;
  - Hearing aids and their fitting, or hearing exams;
  - Cosmetic Surgery, regardless of any psychological or emotional benefits to be gained by it, unless it is required to correct a severe birth defect or the severe scar of an acute Sickness or Injury suffered while insured;
  - The removal of corns, calluses, or toenails, unless the nail roots must be removed too, or the purchase of shoes;
  - Acupuncture (this does not apply if used as a form of anesthesia for which a benefit may be paid);
  - Any type of education or job training of any kind;
  - Therapies that are not otherwise covered, including, but not limited to: primal, educational, megavitamin, bioenergetic, and carbon dioxide therapies, rolfing and psychodrama;
  - Counseling services that are not otherwise covered, including, but not limited to: marriage, family, child, career, social adjustment, pastoral, and financial counseling;
  - A pregnancy of a Dependent Child and the child's birth that may result, or any induced abortion unless the mother's life or health would be endangered if she carried the fetus to term (this exclusion does not apply where there are Complications of Pregnancy);
  - Mental illness, nervous disorders, alcoholism, or drug abuse, except as may be covered under any Special Provisions;
• Drugs or medicines that may be obtained lawfully without a Physician's prescription (this does not apply to insulin);

• Sexual dysfunction or identity, sex change, or procedures to cause a person to be pregnant or aid in such causes;

• Treatment or tests for infertility (unless brought on by Sickness or Injury while insured) or genetic testing;

• Measures to control food intake for purposes of weight control;

• Programs to train and teach people to cope with or manage pain or to retrain for a job;

• Biofeedback and other forms of training for the care of one's self and related testing; or

• A Preexisting Condition, except as provided under the special provisions.

The terms "education" or "training" as used within the above Exclusions, do not include diabetes outpatient self-management training and educational services used to treat diabetes, when such training and services are: (a) certified as necessary by the attending Physician; and (b) provided by the Physician or by a healthcare professional designated by the Physician.

• For care, treatment, services and supplies:
  o That are not Medically Necessary;
  o For which there is no legal obligation for the covered individual to pay, or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in a similar amount by the provider of such to other non-indigent patients, or unless, in either case, AB is required by law to pay to the Government of the United States;
  o Rendered and charged for by a resident intern or Physician;
  o That AB determines to be not necessary for diagnosis, care, or treatment of the Sickness or Injury involved (this applies even if prescribed by a Physician);
  o That could have been done for himself/herself or a member of his/her family; or provided or charged for by one of your relatives.

• When the provider charges a fee for a service he/she does not actively perform (examples of this include, but are not limited to, case management fees and the professional component of automated laboratory procedures); or

• That exceed the Reasonable and Customary charges within the area for the services and supplies furnished.
Preexisting Condition

A Preexisting Condition is a Sickness or Injury for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to the person’s enrollment date. See the definition of “Preexisting Condition” for more information.

No benefits will be payable under the Part-Time Medical Plan Option for a Preexisting Condition for 12 months after the insured’s enrollment date. This exclusion will not apply to an employee’s newborn child, foster child, or adopted child under the age of 19 years, if the child has not had a Significant Break in Coverage since his/her date of birth or placement. If the insured was covered by Creditable Coverage and did not have a Significant Break in Coverage, they will receive credit for that period of Creditable Coverage. To obtain this credit, proof of the previous coverage that is satisfactory to AB must be provided.

Coordination of Benefits

If you are covered by another plan, your benefits under this Part-Time Medical Plan Option will be coordinated with those of any other plan so that no more than 100% of the Allowable Expenses will be reimbursed under all plans combined.

Mothers and Newborns Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician's assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact AB at 1-877-215-0939.
Women’s Health and Cancer Rights Act

The Part-Time Medical Plan Option complies with the Women’s Health and Cancer Rights Act of 1998, providing benefits for mastectomy-related services including Reconstructive Breast Surgery, prosthesis, and complications resulting from a mastectomy.

Important Notice from Lowes Companies, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lowe’s and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Lowe’s has determined that the prescription drug coverage offered by AB is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from AB. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from AB. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Lowe’s, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a
Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Lowe’s.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Lowe’s, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn’t join, if you go 63 continuous days or longer without prescription drug coverage that’s creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lowe’s coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Lowe’s coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the Customer Care Center at Allstate Benefits, 1-877-215-0939. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Lowe’s changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Filing Claims
You should submit your claim for Part-Time Medical Plan Option benefits to AB. Contact the Customer Service Center of AB at 1-877-215-0939 to obtain the necessary claim forms.

When the claim form has been processed by AB, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

Definitions

**Accident:** A sudden, unforeseeable event that causes injury to one or more covered individuals.

**Allowable Expenses:** Charges that are Reasonable and Customary for services and supplies that are Medically Necessary.

**Birthing Center:** A freestanding facility that:

- Is licensed as a Birthing Center in which obstetrical procedures may be performed;
- Is directed by an obstetrician;
- Has a Physician present at all births;
- Has on staff, available at all times, one or more Physicians who practice obstetrics in an area Hospital;
- Provides room and board and around-the-clock skilled nursing services directed by an R.N. or certified nurse midwife;
- Keeps a medical record on each mother and child;
- Is equipped and staffed to handle medical emergencies to sustain life in the event of complications or a child born with an abnormality that threatens life or functional impairment; and
- Has a written agreement with at least one Hospital in the area for emergency transfer of a mother or child.

**Complications of Pregnancy:** A condition that:

- Requires Hospital confinement as an Inpatient during which the pregnancy is not terminated; and
- May be caused or aggravated by the pregnancy, but
- Is a condition that could also be suffered by persons who are not pregnant; and
- Missed abortion, nonelective caesarean section, ectopic pregnancy, and the unplanned end of a pregnancy from which it is not possible to bring forth a newborn that can survive.
Co-payment: The amount of medical expenses incurred by a covered individual for each Physician office visit, before benefits are payable.

Cosmetic Surgery: Surgery performed to change appearance. It does not mean surgery that is Medically Necessary to correct disorders of normal function.

Coverage Year: A consecutive 12-month period during which an employee’s coverage under the Part-time Medical Plan Option is in force. The first Coverage Year begins on the effective date of the employee’s coverage under the group policy and ends after 12 consecutive months of coverage. Dependents added later will have the same coverage year as the employee.

Creditable Coverage: Coverage of a person under any of the following:

- A self-funded employer group health plan under the Employee Retirement Security Act of 1974;
- Group or individual Health Insurance Coverage;
- Medicare (Part A or Part B);
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- Chapter 55 of Title 10, United States Code;
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A health plan offered under chapter 89 of Title 5, United States Code;
- A public health plan (as defined in federal regulations);
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- Title XXI of the Social Security Act (State Children's Health Insurance Program (SCHIP)); or
- Short term, limited duration, health insurance coverage.

Health Expense Insurance: Includes all insurance under the Group Policy that pays benefits to defray, at least in part, loss caused by the expense of healthcare. Healthcare is the care and treatment of a covered individual for Sickness or Injury.

Health Insurance Coverage: Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Hospice: An agency that provides hospice care 24 hours a day, seven days a week for the Terminally Ill. It operates in accordance with law and is licensed as may be required by the jurisdiction in which it is located. It is under the direction of a Physician and has on its staff at least one Physician, one R.N., one licensed or certified social worker, and one pastoral or other counselor. Services provided or arranged for
by such staff include medical and skilled nursing care, medical and/or other social services, psychological and dietary counseling, bereavement counseling for the immediate family, physical or occupational therapy, home health aid services, and Inpatient care in a Hospice Facility. It assesses each patient's medical and social needs and develops a Hospice Care Program to meet those needs. A medical record is maintained on each patient. Its administrator is employed full-time.

**Hospice Care Program:** A plan set forth in writing. It provides care and treatment for a person who is terminally ill. It is under the direction of an attending Physician who, along with appropriate staff of a Hospice, reviews it from time to time. It is designed to give palliative and supportive care to the patient and supportive care to his/her family. It includes an assessment of the patient's medical and social needs and describes the care to be given to meet those needs. For purposes of benefits under the group policy the program ends on the date of the patient's death.

**Hospice Facility:** A facility, or a distinct part of one, that chiefly provides Inpatient care for the Terminally Ill. It makes a charge for such care and meets all licensing or certification standards required by the jurisdiction in which it is located. It is owned by or has working agreements with a Hospice. It has an ongoing quality assurance program that includes reviews by physicians who neither own nor direct it or the hospice. It is run by a staff of Physicians at least one of whom is on call at all times. It provides 24-hour a day nursing services supervised by a R.N.

**Hospital:** An institution that operates as such and is licensed by law to do so, and that:

- Provides continuous room and board and nursing services for its patients;
- Has a staff including one or more Physicians available at all times;
- Is equipped with organized facilities on its own premises or under its control for diagnosis, therapy, and both major and minor surgery; and
- Is not primarily a clinic or nursing, rest, or convalescent home or facility, but
- The requirement for surgical facilities does not apply in the case of care and treatment for mental illness, nervous disorders, alcoholism, or drug abuse. In such case the Hospital must be licensed by the state or be accredited by the Joint Commission on the Accreditation of Hospitals to give such care and treatment for such condition.

**Injury:** An injury to the body that is sustained by Accident.

**Inpatient:** A person who is a resident patient using and being charged for the Room and Board facilities of a Hospital or Skilled Nursing Facility.

**Medically Necessary or Medical Necessity:** Services and supplies that are covered medical expenses and are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease;
- Not for experimental, investigational, or cosmetic purposes, except as provided in Clinical Trials;
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
Within generally accepted standards of medical care in the community; and

Not solely for the convenience of the covered individual, his/her family, or the provider of the services.

**Non-Participating Provider or Non-PPO Provider:** A Physician or other health care provider who has not made an agreement with the Third-Party Network and who is not a Preferred Provider.

**Outpatient:** Care or treatment for Sickness or Injury received while the covered individual is not an Inpatient.

**Physician:** A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). He/she must be licensed to practice as such. The term also means any of the following, who are duly licensed or certified, and provide a covered service, supply, or certification of disability within the scope of practice of their respective license: optometrist, podiatrist, dentist, chiropractor, clinical social worker, substance abuse professional, psychologist, pharmacist, fee-based practicing pastoral counselor, professional counselor, physician assistant, or advanced practice R.N. The license or required certification must be valid at the time.

**Preexisting Condition:** Any Sickness or Injury, other than: pregnancy, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period right before a covered individual's enrollment date. Genetic information is not considered a Preexisting Condition unless there is a diagnosis of the condition to which the genetic information relates. A condition that was first diagnosed while the person was covered under previous health coverage, and for which benefits were payable under that coverage, is also not considered a Preexisting Condition, provided there has been no Significant Break in Coverage. The medical advice, diagnosis, care, or treatment must have been recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

**Preferred Provider:** A provider of services, which are covered by the Group Policy, who has an agreement with the Third-Party Network. Such Third-Party Network will furnish lists of such providers to Insured Persons.

**Reasonable and Customary:** Applies to fees and charges for services and supplies. For services rendered by a Preferred Provider, Reasonable and Customary means the charge contractually negotiated by the network and agreed to between the network and that provider for the particular service or supply. The Insured Person is not responsible for the difference between the billed amount and the Reasonable and Customary amount when services are rendered by a Preferred Provider.

For services rendered by a Non-PPO Provider, the term means the lesser of: (a) the provider's usual charge for the service or supply; or (b) the prevailing charge for a comparable service or supply rendered by a similarly trained and experienced provider, based on available data for the area in which it is furnished. The Insured Person is responsible for the billed amount in excess of the Reasonable and Customary amount when services are rendered by a Non-PPO Provider.

**Reconstructive Breast Surgery:** Surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive Breast Surgery also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the non-diseased breast.
**Room and Board**: The services of a Hospital, Hospice or Skilled Nursing Facility that are charged for by the day or week based on the accommodations furnished. They include bed, room, meals, and general nursing services.

**Service Area**: The geographic area where Preferred Providers are located.

**Sickness**: Sickness or disease. It also means pregnancy, childbirth, and medical conditions that are related to these. As to a child born while the mother is insured, it further includes:

- Infancy, while, as a newborn, the child is confined as an Inpatient in a Hospital; and
- Medically diagnosed birth defects and abnormalities.

**Significant Break in Coverage**: A period of 63 consecutive days during which the person does not have any Creditable Coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a Significant Break in Coverage.

**Surgery**: Manual procedures that:

- Involve cutting of body tissue;
- Debridement or permanent joining of body tissue for repair of wounds;
- Treatment of fractured bones or dislocated joints; and
- Endoscopic procedures.

Surgery also includes:

- Other manual procedures when used in lieu of cutting for purposes of removal, destruction, or repair of body tissue; and
- Reconstructive Breast Surgery due to a mastectomy.

**Terminally Ill**: Those with a medical prognosis of 12 months or less to live.

**Third-Party Network**: A network of hospitals, physicians and other health care providers who have an agreement with a company other than American Heritage Life Insurance Company to deliver health care services to persons insured under the Group Policy at a lower cost.

---

**Outline of Group Voluntary Term Life Insurance Option Benefits**

This program provides Group Voluntary Term Life Insurance for you, your spouse or domestic partner, your dependent child(ren), and/or your domestic partner's dependent child(ren).

You must make an active enrollment election to be covered, and you are not automatically enrolled in the Group Voluntary Term Life Insurance Option.
Life Insurance Benefit

If you elect this option, you will be provided with $20,000 of coverage. In addition, you may also elect to cover your spouse or domestic partner in the amount of $10,000 and your dependent child(ren) or your domestic partner's dependent child(ren) over the age of 6 months, also in the amount of $10,000. You may not elect coverage for your dependents unless you first elect it.

Benefit Cost

The employee pays 100% of the cost, which is in addition to the cost of the Part-Time Medical Plan Option.

Rules Regarding Deferral of Effective Date

If you are not Actively at Work on the date your Life Insurance would have become effective, it will not become effective until the first day you are Actively at Work. If a dependent is confined as an inpatient on the date their insurance would have become effective, such Insurance will become effective the day following discharge from the facility.

Eligibility for Coverage of Dependent Children

A child born to, or adopted by, you or your spouse or domestic partner while you have dependent child coverage will be eligible for coverage the date the child is acquired if a written request is made to the insurance company within 31 days of becoming eligible.

Benefit for Dependent Children

- Children under 15 days old have no coverage;
- Children 15 days but less than 6 months have $2,000 of coverage; and
- Children 6 months to the age limit have $10,000 of coverage.

Late Enrollment

If you do not enroll within 31 days from the start of your initial employment period, you may enroll later only during the annual enrollment period and you must submit Evidence of Insurability with your enrollment form. Your late enrollment will not become effective until approved by AB. Employees should
enroll via the Empowered Benefits website (My Lowe’s Life>My Health) if they want to enroll as a late applicant.

**Family Status Change**

Changes in an employee's Group Voluntary Term Life Insurance are permitted if application is made within 31 days after a family status change. Evidence of Insurability will be required for applications submitted more than 31 days after the family status change and may only be submitted during the next re-enrollment period. A change in family status is defined as birth, death, marriage, divorce or adoption. Employees who have a family change of status should enroll via the Empowered Benefits website (My Lowe’s Life>My Health)

**Termination of Coverage**

Coverage is terminated if the employee ceases to pay a premium after the 31 day grace period; or at termination of employment of the employee. Spouse or domestic partner coverage terminates upon the termination of the employee or the end of the period for which dependent premiums are paid. Reduction in amounts of coverage for employees and spouses or domestic partners apply at age 70 and over as shown under "Benefit Reduction Schedule." Dependent child coverage terminates at termination of employee or as an eligible dependent (see Plan Administration, for more information regarding Eligible Dependents), whichever occurs first. Termination of coverage also occurs if the Group Policy is terminated.

**Exclusion**

This policy does not pay the death benefit if the insured employee, spouse or domestic partner commits suicide within the one year period after the effective date of that person's life insurance under the group policy.

**Continuation of Coverage (Portability)**

You have the option, if you leave Lowe's employment, to continue coverage at group rates up to age 70, so long as the group policy remains in force. You must apply under this option for the portability policy within 31 days after your coverage ends. Contact AB at 1-877-215-0939 for continuation of coverage information.

**Conversion**

You have the option, if you leave Lowe's employment, to convert to an individual permanent life insurance policy without Evidence of Insurability. Your insured spouse or domestic partner and dependent child(ren) have the option to convert at the same time you do. They also may convert if they are no longer eligible
for insurance under the group policy. An example of this would be when a dependent child reaches the age limit. You must apply under this option for the individual policy within 31 days after your coverage ends. Proof of good health is not required. Contact AB at 1-877-215-0939 for conversion information.

**Accelerated Death Benefit**

If you or your insured spouse or domestic partner are diagnosed with a terminal illness (defined as less than 12 months to live), this benefit pays a portion of the total face amount (up to the lesser of 50% or $10,000). The remaining life insurance benefit is paid upon the death of the insured.

**Benefit Reduction Schedule**

Reductions in group insurance amounts will apply at older ages, according to the following schedule:

<table>
<thead>
<tr>
<th>Insured Age</th>
<th>Percent of Original Coverage Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 but less than age 75</td>
<td>65%</td>
</tr>
<tr>
<td>75 but less than age 80</td>
<td>50%</td>
</tr>
<tr>
<td>80 and over</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Waiver of Premium**

If you become disabled prior to age 60 and the disability lasts for 6 months or longer, you will not be required to pay premiums for as long as the disability lasts or until you reach age 65, whichever occurs first, provided the group policy remains in force. Employees should contact AB at 1-877-215-0939 to determine if the Waiver of Premium applies.

**Beneficiary Designation**

You may name anyone as your beneficiary by listing their name or names on the Empowered Benefits enrollment website (My Lowe’s Life>My Health). Any payment made by AB before receipt of notice of such change will fully discharge Lowe’s and AB’s obligation for such payment.

If you name more than one beneficiary, each will share equally unless you indicate otherwise on the form.

If a beneficiary dies before you, his or her share will be paid equally to your surviving beneficiaries, unless you state otherwise. If you do not name a beneficiary, or if no named beneficiary survives you or is disqualified, your death benefits will be paid to one or more of your family members in the following order:
• Your legal spouse or domestic partner;
• Your children;
• Your mother or father; or
• Your siblings.

If none of your family members survive you, your death benefits will be paid to your estate.

You can change your beneficiary designation on the Empowered Benefits enrollment website (My Lowe’s Life> My Health).

Filing Claims

You or your beneficiary should contact the Customer Service Center of AB 1-877-215-0939 to obtain the necessary claim forms.

Written notice of death of a covered person must be sent to AB at which time they will advise the forms needed to certify “proof of death.” These forms include, but are not limited to, a certified copy of the death certificate and Statement of Claim signed by the designated beneficiary.

Any cost incurred as the result of obtaining these items will be the claimant's responsibility.

When the claim form has been processed by AB, you or your beneficiary will be notified of the benefits paid. If any benefits have been denied, you or your beneficiary will receive a written explanation.

Outline of Group Voluntary Short Term Disability Option Benefits

This option provides that, while you are totally disabled, you will receive your monthly benefit amount after the elimination period has been satisfied. Benefits continue while you are disabled up to the benefit period listed on your Certificate of Insurance.

You are totally disabled when, because of sickness or off-the-job injury, you cannot perform the material and substantial duties of your regular occupation and you are not working in any occupation.

For any disability period, you may collect a partial disability benefit or a total disability benefit, but not both. If you are disabled from the same or related cause within 14 days of recovery, it is considered to be the same disability; you will not be required to satisfy a new elimination period.
You must make an active enrollment election to enroll in the Group Voluntary Short-Term Disability Option. You are not automatically enrolled in the Group Voluntary Short-Term Disability Option.

The Benefit

The maximum benefit is $650 per month, prorated to a daily amount of $21.66, less other income benefits.

You will begin receiving Short Term disability benefits after you have satisfied the Elimination Period, which is seven (7) days. The elimination period is the consecutive days of total disability that must pass before benefits start; this period cannot be met if you’re only partially disabled.

Group Voluntary Short Term Disability benefits are payable up to 3 months.

Benefit Cost

The employee pays 100% of the cost.

Preexisting Condition

Group Voluntary Short Term Disability benefits will not be paid for a disability that begins within 12 months of your effective date of coverage, if caused by a preexisting condition.

A preexisting condition is any condition for which you received medical treatment, consultation, care, or services including diagnostic measures, or for which you've taken prescribed drugs or medicines in the 12 months just prior to your effective date of coverage.

Pregnancy is covered as any other illness and may be considered a preexisting condition.

Late Enrollment

If you do not enroll within 31 days after your eligibility date, you may later enroll only during the reenrollment period and you must submit evidence of insurability. To do this you must complete an Evidence of Insurability form, answering health questions. AB may ask you to submit a doctor's statement, provided at your expense. No coverage will become effective until AB approves this evidence of insurability, and AB will have the right to deny the coverage, based on your health history.

Other Income Options

Monthly benefits are reduced by the deductible sources of income listed in your certificate, including, but not limited to:
• State compulsory disability income benefits;
• Other group insurance plans;
• Payments from certain retirement plans; and
• Any other benefit offset as listed on your certificate of coverage.

Exclusions and Limitations

Benefits are not paid for a disability caused by, or resulting from (directly or indirectly) your:

• Loss of professional license, occupational license, or certification; or
• Participation in a felony; or
• Intentionally self-inflicted injuries; or
• Active participation in a riot; or
• Commission of a crime for which you have been convicted under state or federal law; or
• Preexisting condition; or
• Occupational sickness or injury.

Disabilities due to war, declared or undeclared, or any act of war will not be covered. AB will not pay a benefit for any period of disability in which you are incarcerated.

When Benefits End

The monthly benefit amount will end on the earliest of the following:

• The day you fail to provide proof of continued disability;
• The date you are no longer under the regular care of a Physician, refuse to be examined, refuse to seek appropriate available treatment, or fail to provide information or documents needed to determine whether benefits are payable;
• The date you refuse a full-time or part-time job with Lowe's where work modifications or accommodations have been made to allow you to perform the duties of your job;
• The end of the maximum benefit period;
• The date you are no longer disabled; or
• The date you die.

**Filing Claims**

You should submit your claim for Group Voluntary Short Term Disability benefits as soon as you think your absence from work may extend beyond 7 days. You may also submit claims two weeks in advance of a planned disability absence such as childbirth or prescheduled surgery. You should also notify your HR Manager that you will be missing from work, and Key Benefits and Administration (KBA) will send you a bill if you are enrolled in the Part-Time Limited Benefits Health Plan, Part-Tim Term Life Insurance, Part-Time Dental Plan, and/or Part-Time Short Term Disability Plan. Contact the Customer Service Center of AB at 1-877-215-0939 to obtain the necessary claim forms.

When the claim form has been processed by AB, you will be notified of the benefits payable. If any benefits have been denied, you will receive a written explanation.