LOWE'S OCCUPATIONAL INJURY BENEFIT PLAN

(Effective November 1, 2008)

SUMMARY PLAN DESCRIPTION

NOTICE TO ENGLISH SPEAKING EMPLOYEES: This booklet contains a summary in English of your plan rights and benefits under the Lowe's Occupational Injury Benefit Plan. If you have difficulty understanding any part of this booklet, or would like a Spanish version of this booklet, contact the Manager - Workers' Compensation at 1000 Lowe's Blvd., Mooresville, North Carolina 28117, 704-758-3052. Office hours are from 8:00 a.m. to 5:00 p.m., Eastern time, Monday through Friday.

AVISO A LOS EMPLEADOS QUE NO HABLAN INGLES: Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo el Plan de Lesiones Ocupacionales de Lowe's Occupational Injury Benefit Plan. Si tiene dificultad en entender cualquiera parte de este folleto o quiere obtener una copiadle folleto en español, contacte a Manager - Workers' Compensation en el 1000 Lowe's Blvd., Mooresville, North Carolina 28117, 704-758-3052. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., Hora del este`, de lunes a viernes.

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Dear Lowe’s Employee:

Although safety is a priority at Lowe’s, work-related injuries will occur from time to time. When they do, you want to receive prompt, professional medical treatment without any inconvenience, and salary continuation if you need to recover at home. With these goals in mind, we have developed a program called the Lowe's Occupational Injury Benefit Plan. Under this Plan, Lowe’s pays the entire cost for injury benefit coverage.

This Plan is effective for all eligible on-the-job injuries occurring on or after November 1, 2008.

We sincerely hope you never need to make a claim for benefits due to a work-related injury. However, if you are injured at work, you can rest assured that this valuable benefit plan is available to protect you and your family.

Sincerely,

Valerie Wilhite
Vice President Risk Management

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PLAN BENEFITS

Table-1

Type of Benefit	Amount and Duration of Benefit
Maximum Benefit Limit Maximum amount for all benefits combined payable to you for an injury	**$300,000** per associate **$1,000,000** per occurrence
Medical Benefits Pays for care from approved health care providers if you are injured at work	**100%** of covered charges for up to **120 weeks**
Wage Replacement Benefits Pays you weekly income if you need time at home to recover	Starting on the **first** full day of disability pays **90%** of your "lost wages" for up to **120 weeks**
Death Benefits Provides payment to eligible beneficiaries if death occurs on the job	**$200,000** (20% paid as soon as administratively possible, and remainder paid over 35 months)
Burial Benefit Provides reimbursement for burial expenses	Up to **$6,000**
Dismemberment Benefits Provides a payment for loss or loss of use of a member of the body	Up to **$200,000**, based upon the severity of the injury (20% paid as soon as administratively possible, and remainder paid over 35 months)
Please see the Program Detail section of this booklet for a more complete description of benefits, taxation issues, applicable exclusions and limitations, and requirements you must satisfy in order to receive benefits.	

PROGRAM DETAIL

INTRODUCTION

Lowe's Companies, Inc. is committed to providing loss of income protection and helping you pay medical expenses that might otherwise present a financial burden to you if you are injured on the job. To accomplish this, we have implemented a benefit program called the Lowe's Occupational Injury Benefit Plan (the "Plan"). **The Plan has been adopted for the benefit of the Texas employees of Lowe's Companies, Inc. and Lowe's Home Centers, Inc. (collectively or individually, "Lowe's" or the "Company").** This booklet has been prepared to help you understand your benefits under the Plan. Please read it carefully.

If any conflict arises between the information contained in this booklet and the provisions of the formal Plan document, the Plan document will control. Certain terms used in this booklet are capitalized and defined in the DEFINITIONS section of this booklet.

Benefits described in this booklet are effective for all covered Injuries occurring on or after November 1, 2008.

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NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

The following notice is being provided as required by Texas law:

COVERAGE: Lowe's Companies, Inc. has elected not to obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

This notice also applies to Lowe's Home Centers, Inc.

COBERTURA: Lowe's Companies, Inc. ha elegido no obtener cobertura de compensación para trabajadores. Como empleado de un empleador que ha elegido no obtener seguro de compensación para trabajadores usted no es elegible para recibir beneficios de compensación bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información acerca de la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de "Derecho Común" de Texas, si usted ha sufrido una lesión o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione información acerca de la cobertura, por escrito, cuando es contratado o cuando su empleador obtiene o deje de tener cobertura de seguros de compensación para trabajadores.

LÍNEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea telefónica gratuita las 24 horas, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque él o ella, de buena fe, reporta una presunta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

El presente aviso es aplicable además a Lowe's Home Centers, Inc.

Your Injury Benefit Plan: Lowe's **DOES PROVIDE** to all Texas employees, without cost, the Plan described in this booklet.

Our Safety Program: The success of our Company largely depends upon you following all of our safety rules and procedures and **immediately notifying your supervisor first** of any unsafe working condition, safety violation or on-the-job injury, no matter how minor. As mentioned above, you will not be suspended, terminated, or discriminated against because you in good faith report an unsafe working condition, on-the-job injury or potential occupational health or safety violation.

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ELIGIBILITY

You automatically become a participant in the Plan if you are a Lowe's employee and your employment with Lowe's is principally located within the State of Texas. You must be a person who is employed in the regular business of, and receives his or her pay by means of a salary, wage or commission directly from, Lowe's and for whom Lowe's files a Form W-2 with the Internal Revenue Service. This Plan does not cover an independent contractor or third-party agent.

HOW THE PLAN WORKS

Medical Determinations and Treatment

As explained further below, to receive any benefits under this Plan, all medical care must be **pre-approved by the Claims Administrator** and furnished by or under the direction of an **Approved Physician or Approved Facility (acting within the scope of the physician's or facility's license)**, unless provided in connection with Emergency Care as described below.

Any list of Approved Physicians and Approved Facilities will be furnished to you, without charge, as a separate document. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Physicians or Approved Facilities at any time. **No Approved Physician or Approved Facility is an agent of Lowe's. Although benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care you deem appropriate from any provider of your choice at your own expense. In addition, the Plan is not intended to affect your relationship with your healthcare providers. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of you and your attending Approved Physician and other healthcare providers based on their independent judgment for the provision of health care.**

For purposes of this Plan, all determinations relating to your physical condition and the payment of benefits (for example, inability to return to work or results of a prior injury) must be made by an Approved Physician. You must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Physician, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator will have the right to require you to be examined or reexamined by an Approved Physician as often as they determine to be reasonably necessary or appropriate while you are receiving or claiming benefits under the Plan.

Procedure in Event of Injury

Table-2

	Accident	Cumulative Trauma/ Occupational Disease
When to Report an Injury	Immediately, but no later than 24 hours from the time of the injury. (Report all injuries no matter how minor.)	24 hours after being medically diagnosed, or within 30 days after you should have known you were suffering from a work-related cumulative trauma or occupational disease, whichever comes first.
To Whom Should You Report Your Injury	Your Supervisor	Your Supervisor
Date of Injury Means:	The date the accident occurred which resulted in an injury.	The earlier of (1) the date that the damage, harm, or symptoms were first known to you (or should have been known by you), or (2) the date the approved Physician medically diagnosed you with an occupational disease or cumulative trauma. NOTE: If Lowe's has obtained an insurance contract or policy, to pay in whole or in part Plan benefits to a Participant or reimburse the Company for Plan benefits, then notice must be provided no later than 35 months after the end of the policy period.
Approved Physicians and Facilities	You must use an Approved Physician or Facility to receive	You must use an Approved Physician or Facility to receive benefits under the

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	Accident	Cumulative Trauma/ Occupational Disease
	benefits under the Plan. Upon notice of an injury, your Supervisor will direct you to the Approved Physician or Facility if medical treatment is necessary.	Plan. If you are treating with your personal physician and are advised that your condition is work-related, you must notify your Supervisor and you will be directed to an Approved Physician or Facility.
Exception to Use of Approved Providers and Facilities	Emergency Care – you may use a non-approved Physician or Facility if the treatment was for Emergency Care, meaning the condition was such that failure to receive immediate medical attention would result in: • death, disfigurement, or permanent disability, or • substantial impairment of any bodily organ, part or function	Same as for Accident
What if Medical Treatment is Not Immediately Necessary?	You must receive your first medical treatment (with an approved Provider or Facility) within 14 days after the date of your injury	Not applicable
Drug and Alcohol Testing	You must submit to a drug and alcohol test, in accordance with Lowe's Drug and Alcohol Use Policy (HR Policy # 411), at the time of your initial medical treatment. Failure or refusal to submit to a drug and alcohol test could jeopardize your eligibility for benefits under the Plan.	Not applicable
Pre-Approval of Medical Treatment	You must obtain pre-approval of all medical treatment unless such treatment meets the definition of Emergency Medical Care.	Same as for Accident
Continuing Treatment	You must follow the procedures described in the REQUESTING BENEFITS section and the CONTINUING BENEFITS section of this booklet to ensure that you maintain your eligibility for benefits under the Plan.	Same as for Accident

Funding

Lowe's currently pays the entire cost to provide you coverage under this Plan and pays Plan benefits solely out of its general assets. Lowe's has the right, but no obligation, to obtain insurance contracts or policies to provide funds to it that Lowe's can use to pay all or any portion of a benefit under the Plan; but no benefits under the Plan are guaranteed under any contract or policy of insurance, and Lowe's will be solely responsible for the payment of claims under this Plan. If Lowe's has obtained an insurance contract or policy, the purpose of which (in whole or in part) is to provide funds to Lowe's for Plan benefits or that may be used to reimburse the Company for Plan benefits, then:

- **benefit payments under this Plan shall not be payable or shall immediately cease in the event that benefits coverage is not available to Lowe's or ceases under such policy for any reason; and**

- no such insurance policy or contract proceeds shall be considered "plan assets" for purposes of ERISA. Policy proceeds shall constitute a part of the general assets of Lowe's. Any such insurance contract or policy shall be owned by, and all amounts under the policy shall be payable to Lowe's, and you shall not have any interest in, or right to, any amounts payable under the policy (even though certain benefit payment, reporting or other requirements of this Plan may relate to requirements of such insurance policy).

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COVERED AND NON-COVERED INJURIES

Covered Injuries

The Plan pays benefits only on account of an **"Injury."** An "Injury" means damage or harm to the physical structure of the body resulting from either:

- an **"Accident,"** meaning an event that --
  - was unforeseen, unplanned, and unexpected;
  - occurred at a specifically identifiable time and place;
  - occurred by chance or from unknown causes; and
  - results in physical injury to you;
- an **"Occupational Disease,"** meaning a condition which has affected your normal healthy state, and it is determined that the condition arose out of your assigned duties in the Course and Scope of your employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Course and Scope of Employment); or
- **"Cumulative Trauma,"** meaning damage to the physical structure of your body occurring as a result of rapid, repetitious, physically traumatic activities that occur in the Course and Scope of Employment. "Cumulative Trauma" does not mean fatigue, soreness, strains or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by your Course and Scope of Employment. No benefits will be payable with respect to Cumulative Trauma unless you have completed at least 180 days of continuous, active employment with Lowe's and have been regularly engaged in a Course and Scope of Employment with Lowe's involving rapid, repetitious, physically traumatic activities.).

Any such damage or harm must occur or arise during, and directly and solely result from, the Course and Scope of Employment with Lowe's (see the DEFINITIONS section of this booklet). To be subject to the provisions of this booklet and the Plan, **the date of the Injury must be on or after November 1, 2008.**

Any provision of this Plan to the contrary notwithstanding, if Lowe's has obtained an insurance policy or contract as described above, the purpose of which (in whole or in part) is to pay Plan benefits to a participant or reimburse Lowe's for Plan benefits, then:

- the Accident must have occurred during the policy period;
- your last day of last exposure to the condition causing or aggravating any Occupational Disease must have taken place during the policy period; or
- your last day of last exposure to the condition causing or aggravating the Cumulative Trauma must have taken place during the policy period.

All injuries relating to (1) an Accident or related series of Accidents, (2) exposure to an environmental or physical hazard that causes Occupational Disease, or (3) rapid, repetitious, physically traumatic activities that result in Cumulative Trauma, will be considered a single Injury.

Types of Non-Covered Injuries

Injury," as used in this booklet and under this Plan, does not include:

- Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure, or other body part resulting from:
  - use of a video display terminal or keyboard;
  - poor or inappropriate posture;
  - the natural results of aging;
  - osteoarthritis, arthritis, or degenerative process (including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative diseases of the spine);

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- factors to which the general public is exposed; or
- other circumstances prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment;

➢ Diagnostic labels which imply generalized musculoskeletal aches and pains which cannot be attributed to a specific incident, series of incidents, or exposure (for example, a diagnosis of fibrositis, fibromyalgia, myofascial Pain Syndrome, myositis, or chronic fatigue syndrome);

➢ Except for those circumstances identified in the section entitled "Medical Requiring Specific Approval in Writing or by Electronic Notice," any mental injury, emotional distress, mental trauma or similar injury to your mental or emotional state, including, without limitation:

- any physical conditions resulting from such mental or emotional state; and
- any mental or emotional damage or harm that arises primarily from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment or other disciplinary action;

➢ Damage or harm resulting from airborne contaminants not commonly found in the Company's normal working environment, including, but not limited to, pollen, fungi, and mold;

➢ Damage or harm resulting from job stress;

➢ Any heart attack, stroke, or aneurysm (an "attack"), unless --

- the attack can be identified as –

  ➢ occurring at a definite time and place; and

  ➢ caused by a specific event related to and occurring in the Course and Scope of Employment;

- the preponderance of the medical evidence regarding the attack indicates that your work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing cause of the attack; and
- the attack was not triggered solely by emotional or mental stress factors, unless it was the result of a sudden work-related circumstance;

➢ Hernia, except for inguinal hernia that -

- appeared suddenly and immediately following the Injury;
- did not exist in any degree prior to the Injury; and
- was accompanied by pain; or

➢ Any Preexisting Condition, except to the limited extent (if any) an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that

- coverage for such aggravation will be provided only if and to the extent that the Approved Physician –

  ➢ confirms the Preexisting Condition has been previously repaired or rehabilitated; and

  ➢ prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and

- no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury. See Appendix B for more information regarding limitations of the Preexisting Condition exclusion.

<u>Non-Covered Injury Circumstances</u>

No benefits will be payable under the Plan if:

➢ you are not an employee of the Company or your employment is not principally located in the State of Texas;

➢ the Injury occurred while you were under the influence or in a state of intoxication or had otherwise lost the normal use of your mental

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or physical faculties as a result of the use of a drug or alcohol. For this purpose, you will be considered to have been under the influence or in a state intoxication at the time of the Injury if the drug or alcohol test required by Lowe's finds a violation of Lowe's Drug and Alcohol Use policy (see HR Policy # 411);

- the Injury is treatable by medical care that is reasonable and a type of treatment that an ordinary prudent person in the same or similar circumstances would undergo, and you have not made yourself available or agreed to such treatment;

- the Injury was caused by your willful intention or attempt to injure yourself or another person, whether you were sane or insane;

- the Injury occurred while you were employed in violation of any law;

- your horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;

- your long-term cell phone use, or second-hand smoke was a proximate cause of the Injury;

- the Injury was incurred while you were "on suspension," "laid off" by Lowe's, on a leave of absence for any reason, or otherwise outside of the Course and Scope of Employment;

- the Injury arose out of an act of a third person intended to injure you because of personal reasons and not directed at you as an employee or because of your employment;

- the Injury arose out of your participation in an off-duty recreational, social or athletic activity not constituting part of your work-related duties, except where these activities are expressly required in writing by Lowe's (more than an invitation or request to participate or attend);

- the Injury arose out of an act of God, unless your employment exposes you to a greater risk of Injury from an act of God than ordinarily applies to the general public;

- the alleged Injury is fraudulent or made in an attempt to defraud Lowe's;

- the Injury arose out of your participation in:

  - a riot or act of civil disturbance;
  - a war, declared or undeclared;
  - any act of war or terrorism;
  - any illegal act;
  - a felony or an assault, except an assault committed in defense of Lowe's business or property; or
  - service in the military of any country or any civilian non-combatant unit serving with such forces;

- any damage or harm arising out of the use of or caused by --

  - asbestos, asbestos fibers or asbestos products; or
  - the hazardous properties of nuclear material or biological contaminants;

- the Injury arose out of your participation in the commission, or attempted commission, of any crime;

- the Injury occurred while you were traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if you are:

  - flying in any aircraft that is rocket propelled;
  - flying in any aircraft used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental usage;
  - flying when a special permit or waiver from the proper authority has to be issued;
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

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- riding as a passenger in an aircraft owned, leased, or operated by Lowe's;

- the Injury did not occur during your Course and Scope of Employment; or

- the Injury was not reported timely (or requested information was not provided timely) in accordance with the timeframes specified in the REQUESTING BENEFITS section of this booklet.

WAGE REPLACEMENT BENEFITS

When Wage Replacement Benefits Begin

- **Total Disability.** From the first full day you become Totally Disabled due to a covered Injury, the Plan shall pay Wage Replacement Benefits equal to 90% of your Pre-Injury Pay.

  Please note that if the Approved Physician determines you are subject to permanent work restrictions as a result of your work-related injury, Lowe's will comply with the Americans with Disabilities Act (the "ADA"), if applicable. The ability to provide a Modified Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent modified duty position for purposes of the ADA.

- **Partial Disability.** From the first full day you become Partially Disabled, the Plan shall pay Wage Replacement Benefits equal to 90% of the portion of your Pre-Injury Pay that you are unable to earn (due to the Approved Physician's restrictions) while working Modified Duty.

  - If you have a Partial Disability and are released to Modified Duty, but (i) Lowe's has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment, then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

  - If you have a Partial Disability and have made a good faith effort to comply with the treating Approved Physician's instructions and carry out your responsibilities in the Modified Duty position, but you are either:

    - again determined by an Approved Physician to be Totally Disabled, or
    - the Modified Duty position is no longer available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment,

    then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

  Please note that if the Approved Physician determines you are subject to permanent work restrictions as a result of your work-related injury, Lowe's will comply with the Americans with Disabilities Act (the "ADA"), if applicable. The ability to provide a Modified Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent modified duty position for purposes of the ADA.

- **Payment Terms and Other Limitations.** An Approved Physician must make the determination regarding whether you are Totally Disabled or Partially Disabled, unless such determination is made in conjunction with Emergency Care as determined by the Claims Administrator. Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury). Wage Replacement Benefit payments shall be reduced as described in the "Offset For Other Benefits" section of this booklet.

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When Wage Replacement Benefits Cease

Wage Replacement Benefits will continue until the earliest of:

- the expiration of 120 weeks from the date of the Injury. This 120-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether you qualify as Disabled at all times during such period or receive Wage Replacement Benefits continuously throughout such period;
- the date you are determined by the treating Approved Physician no longer to be Disabled, without regard to whether you return to regular or Modified Duty on that date;
- the date that the Maximum Benefit Limit is met;
- termination of all your employment with Lowe's; unless such termination is due solely to -
    - application of a duration limit in a Lowe's leave of absence policy, or
    - elimination of your employment position;
- the date you are placed in jail, are deported or detained by or at the request of any government agency or foreign government, have left the local area for an extended period of time, or are similarly unavailable for work; provided, however, that this paragraph shall operate to cease Wage Replacement Benefits only for such period of time that you are unavailable for work; or
- as otherwise provided under the CONTINUING BENEFITS section below.

Other Benefit Reductions

Wage Replacement Benefits are generally considered taxable income, and therefore all appropriate amounts will be withheld. Also, amounts legally garnished may be withheld and appropriate Pre-Injury Pay deductions for such items as retirement plan contributions and insurance premiums will continue to be withheld unless you advise otherwise. Make sure to review your retirement plan and insurance program rules and procedures to ensure continued eligibility for such programs.

DEATH AND DISMEMBERMENT BENEFITS

If you die or suffer a loss as described in the Schedule of Losses set forth in this booklet and such death or loss is the direct and sole result of duties performed in the Course and Scope of Employment, the Plan will pay the following benefits:

Table-3

	Death	Dismemberment
Amount of Benefit	$200,000; paid 20% lump sum (as soon as administratively possible) with the remainder paid in 35 equal monthly installments (without interest).	The applicable percentage from the schedule below times $200,000; paid 20% lump sum (as soon as administratively possible) with the remainder paid in 35 equal monthly installments (without interest).
Benefit Paid To:	(a) Eligible Spouse or Eligible Domestic Partner (as identified and certified on Lowe's Important Tax Information Domestic Partner Form); if there is no Eligible Spouse or Eligible Domestic Partner, then (b) equal shares to Eligible Child(ren); if there is no Eligible Child(ren) then (c) Eligible Surviving Dependent (in accordance with the criteria set forth in section 152 of the Internal Revenue Code; if there is no Eligible Spouse, Eligible Domestic Partner, Eligible Child(ren), or Surviving Dependent who is a parent, sibling, or	Participant

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	Death	Dismemberment
	grandparent, then (d) no Death Benefits shall be payable.	
Coordination of Benefits	Death Benefits are in addition to Dismemberment Benefits, Wage Replacement Benefits, and Medical Benefits (no interest in future Dismemberment Benefits survive after your death, and your beneficiary is entitled to Death Benefits).	Benefits may be reduced to avoid exceeding the Maximum Benefit Limit. Dismemberment Benefits will be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of death that results in the payment of Death Benefits.
Timing of Loss	Benefits will be payable should you die within 365 days of sustaining a work-related injury.	Benefits will be payable should you suffer a loss within 365 days from the date of your work-related injury.
Burial Benefits	Reasonable expenses up to $6,000.	Not applicable.

SCHEDULE OF LOSSES

Table-4

Loss of	Benefit Amount
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

- If you suffer more than one Injury described above from any one Accident, related series of Accidents, Occupational Disease exposure or Cumulative Trauma exposure, only one of the applicable Dismemberment Benefits listed above (the largest single amount) will be payable with respect to the Accident or exposure.

- Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Physician for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.

- Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint. Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the total and permanent loss of speech. Loss of Hearing means the total and permanent loss of hearing in both ears.

MEDICAL BENEFITS

Subject to the medical management and other provisions of this Plan, medical services and supplies that are approved by the Claims Administrator (referred to below as "Covered Charges") are covered at 100%, with no co-pays, deductibles or other out-of-pocket expense to you, provided that all applicable Plan requirements are satisfied. The service or supply must be medically necessary, based on the type of Injury sustained, and when provided shall (1) cure or relieve the effects naturally resulting from the Injury; (2) promote recovery; or (3) otherwise enhance your ability to return to or retain employment. Such services and supplies are also subject to the other medical management provisions of the Plan. Coverage also requires satisfaction of the following requirements:

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First and Continuing Treatment

- The first Covered Charge must be incurred within 14 days following the date of your Injury; and

- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days. This section, however, shall not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

Approved Provider and Pre-Authorization Requirements

The cost of a service or supply shall be a Covered Charge only if:

- **Treatment is (1) furnished by or under the direction of an Approved Physician or Approved Facility, acting within the scope of the Approved Physician's or Approved Facility's license, and (2) pre-approved by the Claims Administrator (except when the Claims Administrator determines that prior approval was impossible under the circumstances).** Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility, and must be in writing, or by electronic notice (except as otherwise specified below or in the Plan's claims procedures); or

- **Treatment is <u>provided as Emergency Care</u>** and (1) the Claims Administrator receives notification of the Emergency Care no later than 24 hours from the time you received "Emergency Care" treatment or the next business day after you received "Emergency Care" treatment and the treatment meets the definition of "Emergency Care" set forth in the Plan; and (2) all treatment after receiving Emergency Care, and all treatments following the Emergency Care treatment are provided by, or at the direction of, an Approved Physician or Approved Facility in accordance with the paragraph above.

  "Urgent Care Claims" (as discussed in this booklet's claims procedures) may not rise to the level of Emergency Care. <u>Any decision by you to seek treatment from an urgent care clinic or hospital emergency room does not necessarily involve Emergency Care.</u> An Emergency Care determination shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Physician as the Claims Administrator or Appeals Committee deems appropriate. If you obtain treatment from a non-approved healthcare provider and the Claims Administrator or Appeals Committee determines that your situation has not satisfied all of the above requirements, your claim for benefits may be denied and the expenses associated with treatment by the non-approved provider shall not be paid.

Covered Medical Services and Supplies

Medical Services and Supplies That Can Be Verbally Authorized. Subject to the restrictions and limitations set out elsewhere in this booklet, Covered Charges that can be verbally authorized will include the cost of the following:

- Approved Physician visits - at an Approved Facility (including charges for an emergency room), Approved Physician's office, or in the case of home health care, at your home, including second opinion services requested by the Claims Administrator, and charges for a registered nurse;

- Medical supplies approved by the treating Approved Physician, including the following:

  - Prescription drugs (generic, unless trade name drugs are requested by an Approved Physician) and over-the-counter drugs such as analgesics prescribed by an Approved Physician and approved by the Claims Administrator;
  - Blood and other fluids (other than allergy, insulin, and similar drugs)

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injected into the circulatory system (but only to the extent not available through any refund or allowance by a blood bank or similar organization);
- Oxygen and its administration;
- Upon the written advice or prescription of an Approved Physician and only if obtained from an Approved Facility, rental or purchase of a wheelchair, assisted breathing apparatus, or other mechanical equipment necessary for the treatment of respiratory paralysis, and similar internal or external durable medical equipment designed primarily for therapeutic purposes;
- Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Physician or Approved Facility; and
- Other items approved by the Claims Administrator;

➢ Ambulance services - professional ground ambulance service, or if no other means of transportation can reasonably suffice to deliver the individual to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;

➢ Eyeglasses or contact lenses - one pair per Injury up to $200, inclusive of professional office visit charges, but excluding routine eye examinations; and

➢ External hearing aid - up to $600, inclusive of professional office visit charges.

Medical Services and Supplies Requiring Specific Approval in Writing or by Electronic Notice

Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges shall also include the cost of the following so long as the Claims Administrator specifically approves such charges in advance and in writing or by electronic notice:

➢ Admission to an Approved Facility on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;

➢ Diagnostic testing, including x-ray examinations, laboratory tests, MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;

➢ Speech, occupational and physical therapy provided by an Approved Physician or a speech therapist, licensed occupational therapist or licensed physical therapist; provided, however, that such services shall be subject to case management approval regarding the number of visits, the types, and amount of services provided during such visits;

➢ Inpatient rehabilitation services provided in a medical rehabilitation hospital; provided, however, that such services shall be subject to continued stay review by the Claims Administrator and case management approval regarding the types and amount of services provided;

➢ Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;

➢ Surgery that restores a reasonable, normal pre-Injury functioning;

➢ Services of a dentist or licensed oral surgeon - services for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of teeth (excluding temporomandibular junction dysfunction services) when you seek treatment as soon as possible after the Injury;

➢ Home health care (with respect to physical needs only) up to 75 visits per Plan Year and up to eight (8) hours per visit for the first two (2) weeks of home health care and up to four (4) hours per visit thereafter;

➢ Skilled nursing care, provided that an Approved Physician monitors your progress at least once during each 30-day period of confinement;

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- Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prostheses, or any similar item;

- Organ and tissue transplant services not otherwise covered by some form of expense payment program, excluding the donor's transportation costs, organ procurement costs and the donor's surgical expenses;

- Charges for telephone consultations with you, your family, Approved Physicians or other health care providers;

- Mental health services (to the extent not otherwise covered by the Company's Employee Assistance Program), but only when such services are provided for mental or emotional damage or harm resulting from you being the victim of, or witness to, a traumatic event occurring during your Course and Scope of Employment; and provided, that such services shall not exceed five (5) visits with an Approved Physician or Approved Facility. This coverage applies solely to Medical Benefits coverage and will not result in any payment of Wage Replacement Benefits or other benefits under this Plan;

- Services rendered primarily for training, testing, evaluation, counseling, or educational purposes; and

- Reasonable travel, meal and lodging expenses related to medical treatment that requires travel greater than 20 miles from your residence (one way) as interpreted by the Claims Administrator for application under this Plan and approved by the attending Approved Physician.

<u>Non-Covered Medical Services and Supplies</u>

While the Plan provides benefits for many medical expenses, the following expenses are **<u>not</u>** covered by the Plan:

- Charges incurred prior to your date of participation in the Plan, or prior to your date of Injury;

- Charges rendered after your Medical Benefits under this Plan terminate;

- Expenses which are not medically necessary, as determined by the Claims Administrator;

- Charges incurred more than 60 days after the date of the last Covered Charge (except as otherwise specified in this booklet);

- Expenses that exceed any fee schedule adopted by the Claims Administrator or the usual and customary charge for the same or similar treatment, services or supplies in your geographic area;

- Services or supplies payable by any government or subdivision or agency thereof, or any other applicable third-party payor;

- Services or supplies which are experimental, investigative, or for the purposes of research, including, but not limited to, services and supplies that have not been approved by the American Medical Association, the Food and Drug Administration, the appropriate medical specialty society, or the appropriate governmental agency, all phases of clinical trials, all treatment protocols based upon or similar to those used in clinical trials, or any treatment not generally accepted by the physician's profession in the United States as safe and effective for diagnosis and treatment;

- Services or supplies performed or provided while you are not covered by the Plan;

- Services or supplies for which you are not legally obligated to pay or for which no charge would be made in the absence of the Plan;

- Services for the evaluation or treatment of mental or psychological damage or harm, except to the extent provided above;

- Services or supplies for personal comfort or convenience, such as a private room, television, telephone, radio, guest trays, and similar items;

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- Fraudulent claims or claims not filed in good faith as determined by the Claims Administrator;

- Canceled appointment charges;

- Self-administered services;

- Services or supplies to which your condition is persistently nonresponsive;

- Services or supplies relating to Preexisting Conditions, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; however --

  - coverage for such aggravation will be provided only if and to the extent that the Approved Physician -

    - confirms that the Preexisting Condition has been previously repaired or rehabilitated, and

    - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to your pre-Injury physical condition; and

  - no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury. See Appendix B for more information regarding limitations of the Preexisting Condition exclusion;

- Acupuncture, behavior modification, pain management programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;

- Chiropractic or spinal manipulation services;

- Substance abuse services;

- Services and supplies provided in or out of a rest home, convalescent facility, nursing home, or other institution that only assist with activities of daily living such as bathing, dressing, walking, eating, preparing special diets, or the supervision of taking medications, no matter by whom recommended or furnished;

- Charges for the purchase, rental or repair of bedding or environmental control devices, including, but not limited to, an air conditioner, humidifier, dehumidifier, or air purifier, and charges for jacuzzis, saunas, vans, or structural changes to your residence or moving expenses;

- Charges for services performed by:

  - a person who normally lives with you;
  - your spouse or domestic partner;
  - a parent of you or your spouse or domestic partner;
  - a child of you or your spouse or domestic partner; or
  - a brother or sister of you or your spouse or domestic partner; and

- The cost of any other service or supply not specified above as a Covered Charge.

Initial Treatment and Denial

The rendering of first aid, or the payment by the Plan for Emergency Care, Wage Replacement Benefits or a medical evaluation or treatment, does not prevent the Plan from making a subsequent determination that you have not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

Medical Provider Referrals

If the treating Approved Physician finds it necessary to refer you to another healthcare provider, the treating Approved Physician must notify you and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. **It is your responsibility to contact the Claims Administrator to determine the status of the approval or disapproval of such**

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referral prior to seeking treatment. The expense of services or supplies relating to any disapproved referral will be solely your responsibility.

No Interference with Patient-Provider Relationship

You are entitled to seek any medical care you deem necessary from any provider of your choice at your own expense; **however, any medical expenses incurred for this medical care will not be payable under this Plan and your use of a non-approved physician or facility may result in a complete denial or termination of benefits under this Plan.** Lowe's, the Claims Administrator, the Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other healthcare services provided by any Approved Physician, Approved Facility or other designated healthcare service provider. Healthcare providers are not agents of the Plan, Lowe's, the Claims Administrator, or the Appeals Committee. The Plan, Lowe's, the Claims Administrator, and the Appeals Committee are not liable or responsible for the acts or omissions of any healthcare provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other healthcare providers based on their independent judgment for the provision of healthcare.

Second Medical Opinions

The Plan reserves the right to require a second medical opinion from an Approved Physician selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Plan.

The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Plan. However, if you disagree with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then you may request a second medical opinion. **You must notify the Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Plan.** If you provide advance notice to the Claims Administrator, then you shall have the right to a one-time examination at your own expense by another physician ("Physician B"). This examination by Physician B will be solely for the purpose of evaluating your condition and making a treatment recommendation.

If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Physician for a further medical examination. The diagnosis and/or recommended treatment of the peer review physician or this last Approved Physician will be controlling. The fees and related expenses of the peer review physician and this last Approved Physician will be paid by the Plan (although you will have the option of paying up to one-half of such fees and expenses).

Use and Disclosure of Protected Health Information

See Appendix A located at the back of this booklet.

When Medical Benefits Cease

Medical Benefits will cease upon the earliest of:

- the expiration of 120 weeks from the date of the Injury;
- reaching the Maximum Benefit Limit;
- involuntary termination of your employment with the Company for gross misconduct;
- the date that you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days; or

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- your failure to comply with the requirements specified under the CONTINUING BENEFITS Section of this booklet.

REQUESTING BENEFITS

The following is a summary of the procedures for requesting benefits under this Plan. Also see the DETAILED CLAIM PROCEDURES in the next section of this booklet.

Notice of Injury

See Table 2 entitled "Procedure in the Event of Injury" on page 7 of this booklet.

Providing Required Information

You (or a person acting on your behalf) and your supervisor (or such other person as the Claims Administrator may specify) must complete the Employee Incident Report and authorization forms, file written statements, provide recorded statements (whether sworn or unsworn), and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may require. This information will be delivered to the Claims Administrator or its designated representative as your request for benefits. **The written Employee Incident Report must be provided within 24 hours after the Injury is reported.**

An immediate incident report to your supervisor is essential so that the Claims Administrator can promptly verify the facts regarding your Injury and pay appropriate benefits. **No benefits will be payable under the Plan if:**

- notice of Injury is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner; or

- all required information is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a timely manner.

Medical Examination

You must submit to medical examinations or evaluations as often as the Claims Administrator determines to be reasonably necessary or appropriate.

CONTINUING BENEFITS

Subject to the limitations and other rules and procedures described in this booklet, your benefits under this Plan will begin or continue as long as you –

- submit to any requested drug and/or alcohol testing in accordance with Lowe's Drug and Alcohol Use Policy (see HR Policy # 411), and provide Lowe's with this alcohol and/or drug testing information or authorize Lowe's to gain access to this information;

- receive prior approval for all medical care (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);

- utilize only Approved Physicians and Approved Facilities (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);

- submit to examination by an Approved Physician selected by the Claims Administrator (other than the treating Approved Physician) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Physician for which the Claims Administrator considers a second medical opinion advisable;

- are responsive to treatment. Nonresponsiveness would include, but not be limited to, nonresponsiveness due to the need for participant behavioral modification recommended by the treating Approved Physician;

- provide accurate information to, and follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is

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not limited to, any recommended treatment, therapy, course of action, abstinence or rehabilitation program;

- keep and be on time for all scheduled appointments with health care providers. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment will result in a warning and/or suspension of benefits and a second missed appointment will result in a termination of benefits;

- do not engage in conduct which hinders your recovery;

- report in to your supervisor periodically as directed until you are able to return to work, including notice of expected recovery time after each appointment with the treating Approved Physician;

- immediately inform your supervisor that you have been released by an Approved Physician to return to full or Modified Duty, and timely report to work in accordance with such work release;

- do not receive benefits with respect to the Injury from, and the incident does not create any liability for the Company under, any workers' compensation law (regardless of whether or not any coverage for benefits is actually in force under such law);

- are truthful in regard to every aspect of the required information supplied as part of the Injury reporting or employment process;

- are truthful and otherwise cooperate fully with the Claims Administrator (including, but not limited to, the requirements on providing information), and do not demonstrate bad faith in connection with the administration of the Plan (including, but not limited to, subrogation or coordination of benefits procedures); and

- comply with the provisions of this summary plan description, the Plan, and the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

A claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan will be initiated by you (or a person acting on your behalf) complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS section and other parts of this booklet. The “Claims Review Procedures” chart set forth below shows the time limits for the Claims Administrator to respond to your claim for benefits and the time limit for you to submit an appeal, and for the Appeals Committee to respond to your appeal. **A claim for Death Benefits under the Plan shall be initiated by a beneficiary providing notice of entitlement thereto to the Claims Administrator within 90 days after the date of the participant's death.** If, within two years after any amount becomes payable under this Plan to an individual, but the individual fails to claim such amount and the Claims Administrator has exercised reasonable diligence in attempting to make such payment, the amount shall be forfeited and shall cease to be a liability of this Plan.

- **What is a Claim** -- Each (1) medical service or supply for which payment is requested, (2) Wage Replacement Benefit for a particular payroll period, or (3) claim for Death Benefits or Dismemberment Benefits, will be deemed a separate "claim" for benefits that is subject to a determination under the Plan. The Plan's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

- **Who is a Claimant** -- A claimant or a claimant's authorized representative may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit

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Determination. References in this DETAILED CLAIMS PROCEDURES section to "claimant" may include you, a medical provider seeking payment for a service or supply, or a claimant's authorized representative, as applicable.

- **Information to Submit** -- Claims must include the information required by the REQUESTING BENEFITS section and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement that provides that the amounts requested for payment under this Plan have not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Plan. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet.

- **Submission of Medical Bills for Payment** -- Approved Physicians and Approved Facilities will be requested to invoice all health care-related charges directly to the Claims Administrator (or to Lowe's, which will immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice from an Approved Physician, Approved Facility, or other health care provider (in the case of Emergency Care) for such expenses.

- **Incomplete Claim Submissions** -- If a claim, as originally submitted, is not complete, the Claims Administrator will notify the claimant in the manner described below, and the claimant will have the responsibility for providing the missing information. Subject to the applicable provisions of this DETAILED CLAIMS PROCEDURES section, if the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.

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Claims Review Procedures

Table-5

	Notice of Initial Claim Determination	Appeal of Initial Determination
Urgent Care, Pre-Service Claims	• You'll be notified of determination as soon as possible but no later than 72 hours (24 hours if additional information is needed.) You will be provided not less than 48 hours to provide necessary information. You will be notified of the Plan's initial determination not later than 48 hours after receipt of information, or the expiration of the time allotted to provide such information, whichever is earlier. • No extension periods are permitted for pre-service urgent care claims.	You must appeal a denial of your claim within 180 days of receipt of such denial.
Concurrent Medical Care Decisions (if Claims Administrator approved on-going course of medical treatment to be provided over a period of time or number of treatments)	• Notification to end or reduce treatment will allow time to finalize appeal before the course of treatment is reduced or terminated. • Any request made by you to extend the prescribed course of treatment approved as an Urgent Care Claim will be decided as soon as possible, but no later than 24 hours after receipt of request provided the request is made 24 hours prior to the expiration of the prescribed treatment. If not, the request will be decided as soon as possible, but not later than 72 hours .	You must file an appeal within 15 days receipt of notification to end or reduce course of treatment.
Non-Urgent Care, Pre-Service Medical Claims	• You will be notified of the determination as soon as possible, but no later than 15 days from receipt of claim. • One extension period of 15 days (measured from the end of the original determination due date) is allowed for circumstances beyond the Claims Administrator's control. You must provide the additional information within 45 days of the date of the notice of extension. • For procedurally flawed claims, the Claims Administrator will notify you as soon as possible, but no later than 5 days from receipt of claim.	• You must file an appeal within 180 days from the claim denial. • You will be notified of the appeal determination as soon as possible, but not later than 30 days from receipt of the appeal.
Post-Service Medical Benefit, Wage Replacement, Death Benefit, Dismemberment Benefits	• You will be notified of the claim determination as soon as possible, but no later than 30 days from receipt of claim. • One extension period of 15 days is allowed for circumstances beyond the control of the Claims Administrator. • You must provide any request for additional information within 45 days of the request.	• You must file an appeal within 180 days of the claim denial. • An appeal for Death or Dismemberment Benefits must be filed within 60 days of the claim denial. • You will be notified of the appeal determination as soon as possible, but no later than 45 days from receipt of the appeal.

CLAIMS REVIEW DEFINITIONS:

- **<u>Pre-Service Claim</u>: A claim for healthcare where prior approval for any part of the care is a condition to receiving the care.**
- **<u>Concurrent Care Claim</u>: A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.**

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- **<u>Post-Service Claim</u>: A claim for care that has already been received.**

- **<u>Urgent Care</u>: 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 managed without 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).**

Table-6

Manner and Content of Adverse Benefit Determination	Appeals Committee Consideration
You will be provided written or electronic notice of the Claims Administrator's initial determination of your claim (such notice of the denial of your claim is called an Adverse Benefit Determination). The notice shall satisfy the following requirements: • Any electronic notice shall satisfy ERISA regulations. • Any notice will identify any rule, protocol, or guideline that was relied upon in making the determination (such rule, protocol, or guideline will be provided free of charge upon request). • The notice shall provide the statement that in the event the Appeals Committee upholds an Adverse Benefit Determination, you can pursue your right to bring an action under ERISA Section 502(a). • If the claim is an Urgent Care claim, the notice will provide a description of the applicable expedited review process. • A description of any additional materials or information necessary for you to perfect the claim and a reason as to why such materials or information is necessary. • You will be provided a description of the Plan's review procedures (including applicable time limits).	The Appeals Committee will comply with the following requirements when reviewing an Adverse Benefit Determination: • The Committee will take any written comments, documents, records, or other information related to the claim for benefits under consideration. • You may receive, upon request and free of charge, reasonable access to and copies of, all documents, records or other information relevant to your claim (as determined by the Appeals Committee). • Your appeal will be reviewed without any deference given to the initial Adverse Benefit Determination. • If the appeal is a result of a determination based in whole or in part on a medical judgment, the Appeals Committee will seek the opinion of a physician who has appropriate training and experience in the field of medicine involved in the medical judgment. • The Appeals Committee will, upon your request, identify the names of medical or vocational experts whose advice was obtained and relevant to the determination of your claim.

➢ **Exhaustion of Administrative Remedies**: No legal action can be brought by or with respect to you to recover benefits under the Plan before the foregoing claims procedure has been exhausted. Every ERISA right of action by you, your representative, beneficiary or estate against the Plan or any Plan fiduciary must be brought no later than three (3) years from the date that your employment ended with Lowe's, or from receipt of the Appeals Committee's benefit Determination on review, if earlier, except as otherwise required by ERISA.

FINAL COMPROMISE AND SETTLEMENT

At the Claims Administrator's option within 120 weeks after the date of Injury, and at any time if the Claims Administrator elects to extend such 120-week period after the date of Injury, the Claims Administrator may notify you of the Plan's intention to be released from any further known and unknown benefit and all other injury-related claims by you and pay a final claim settlement to, or with respect to, you in exchange for your agreement to a release of liability in favor of the Plan, Lowe's, the Claims Administrator, the Appeals Committee and other interested parties with respect to such claims. In that event, the Claims Administrator may appoint an actuary, appraiser, and/or Approved Physician to investigate, determine, and capitalize such claims, or use such other valuation method as the Claims Administrator may specify. The payment by the Plan and/or Lowe's of the value of such claims (as finally determined by the Claims Administrator) will be made in such manner as the Claims Administrator may determine. No additional claims will be subsequently accepted with

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respect to such Injury. Any actuary or appraiser will apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Claims Administrator may determine. You must cooperate and provide all information, sign such forms and agreements, and submit to all medical examinations as may be requested by the Claims Administrator to arrive at a valuation and settlement of your claims. No further benefits will be payable to, or with respect to, you if you fail or refuse to accept the Claims Administrator's claim valuation, sign the release agreement presented by the Claims Administrator, or otherwise comply with the requirements of this section or other provisions of the Plan. Prior or subsequent to the Claims Administrator's evaluation and determination of the value of your claims, the Claims Administrator may determine to not capitalize and satisfy any such claim as described above and to instead continue eligibility for benefit payments and defer the above valuation and settlement.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT

Offset For Other Benefits

Benefit payments under this Plan shall be reduced by:

- the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;
- your earnings from any employer after disability begins, amounts legally garnished, and your contributions (through salary reduction or otherwise) to a 401(k) or a 403(b) plan, cafeteria plan, or other pre-tax salary deferral employee benefit plan;
- except as specified in the Plan's "Coordination of Benefits" section, any amount paid or available to you with respect to your Injury under the following: Social Security Act, the Railroad Retirement Act, workers' compensation law, unemployment compensation law, occupational disease law or any other government program or similar law. The Plan shall deduct from Plan benefits the estimated benefit amounts for which you are likely to be eligible under such other deductible sources of income, regardless of whether you actually apply for such other deductible source of income.

Coordination Of Benefits

If you are covered under this Plan and one or more other benefit plans, then (unless otherwise subject to the "Subrogation and Reimbursement Rights" section below) any Medical Benefits and Wage Replacement Benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Plan. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Plan.

- For purposes of this section, "other benefit plans" shall mean any health or disability-type benefits provided under (1) any individual, group, blanket or franchise plan, (2) other prepaid coverage under service plan contracts, or under group or individual Plans, policies or a practice, (3) uninsured arrangements of group or group-type coverage, (4) labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
- Except as specified below, if a person is covered by more than one plan to which this coordination of benefits provision applies,

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then the following rules will determine which plan will be primary:

- With respect to health benefits only, when only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan;

- The plan under which the person is covered other than as a dependent (for example, active employee, former employee, inactive employee, COBRA employee or retiree) will be the primary plan over a plan which covers the person as a dependent;

- The plan under which the person is covered as an active employee will be the primary plan over a plan which covers the person as former employee, inactive employee, COBRA employee or retiree;

- If none of these rules establish an order of benefit determination, then the plan that has covered the person for the longer period of time will be the primary plan.

➢ Unless otherwise provided, Medical Benefits payable under this Plan to or with respect to any participant who is in "current employment status" as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be primary and shall not be reduced by the amount of benefits payable to or with respect to such participant under Medicare, which will be considered the secondary plan. However, Medical Benefits payable under this Plan to or with respect to any participant who is not in "current employment status," as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be secondary and reduced by the amount of all benefits payable to or with respect to such participant under Medicare, which will be the primary plan. In addition, the fact that a participant is eligible for or provided medical assistance under a state plan will not be taken into account in making payments under the Plan.

➢ You must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverages or plans which may be applicable to the Injury, and in (2) completing and returning to the Claims Administrator any questionnaire or forms inquiring about, or assigning rights to recover under, other policies, coverages or plans which may cover or be applicable to you.

Subrogation and Reimbursement Rights

For purposes of "Subrogation and Reimbursement Rights", the "Notice of Legal Proceedings," and "Assignment of Rights" sections of this Plan, the term "Payee" means a participant or beneficiary or a participant's or beneficiary's family members, heirs, estate, or other representative (in an individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery.

➢ **Right of Subrogation -** If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, Lowe's), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee, and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorney fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the

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participant had or has a valid claim against a third party.

- **Written Confirmation -** Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee.

- **Right to Reimbursement –** A Payee's acceptance of benefits from the Plan means that the Payee has agreed to reimburse the Plan—in full—from the net proceeds of any settlement, judgment, insurance, or other payment the Payee or the Payee's attorney receives as a result of an Injury from any source. A Payee's acceptance of payment by the Plan also gives rise to an equitable lien and constructive trust against the net proceeds of any recovery. It does not matter how the amounts the Payee recovers are characterized, why they are paid, or whether these amounts are specified as being for the Payee's Injury. And it does not matter whether the Payee's recovery fully compensates the Payee for any losses, injuries, or damages the Payee has suffered. If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this Section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate, reduce, or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee.

- **Right of Recovery -** The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan. The Plan shall also have the right to bring a lawsuit and assert a constructive trust, equitable lien, or other interest against any and all persons that have assets to which the Plan can claim rights. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole."

- **Attorney Fees and Expenses -** The Plan's subrogation rights and first lien will not be reduced by attorney fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorney fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

Notice of Legal Proceedings

A Payee (whether or not such person has received or may in the future directly or indirectly receive Plan benefits) shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding (for negligence, wrongful death, survival or other cause of action), one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Injury for which Plan benefits have been or may in the future be paid. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future), plus all medical management, investigation, attorney fees, costs of recovery, and other expenses incurred by the Plan.

Assignment of Rights

By participating in this Plan, a participant obligates himself or herself, as well as all other Payees (in both their individual and

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representative capacities), to the provisions of this Plan, including, without limitation, the "Subrogation and Reimbursement Rights, "Notice of Legal Proceedings," and "Assignment of Rights" sections hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in the "Subrogation and Reimbursement Rights" and "Notice of Legal Proceedings" sections, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and the Plan's selected counsel shall have complete control over the conduct of any lawsuit, settlement discussion, or other proceeding without the consent or participation of any Payee. Whenever the Plan intervenes in or institutes any lawsuit or other proceeding as permitted by the provisions of this section, the Plan may pursue the lawsuit or proceeding to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employers, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, consultants, attorneys, and employees from all claims, causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any lawsuit, settlement discussion or other proceeding.

Right To Receive And Release Necessary Information

Subject to Appendix A herein, the Claims Administrator may, without the consent of or notice to any person or organization, release to or obtain from any person or organization, information needed to implement Plan provisions. When you request benefits, you must furnish all information requested by the Claims Administrator.

RESOLUTION OF CERTAIN INJURY-RELATED DISPUTES

Lowe's has adopted a **mandatory policy** requiring you to comply with the following dispute resolution requirements.

This mandatory dispute resolution policy does not apply to any legal or equitable claim under the Employee Retirement Income Security Act of 1974 (as amended) ("ERISA") for benefits, to remedy a fiduciary breach, or for other relief or remdies solely relating to benefits payable under this Plan. If you wish to appeal a denial of benefits under the Plan, you must follow the process described in the "Detailed Claims Procedures" section of this booklet. Only after exhausting the appeal process outlined in the "Detailed Claims Procedures" section, may you bring an action challenging a Plan decision, or any other ERISA right of action.

Dispute Resolution Requirement

All claims or disputes described below that cannot otherwise be resolved between Lowe's and you are subject to mediation, and if necessary, **final and binding** arbitration. **This dispute resolution requirement is the only method for resolving any such claim or dispute**.

Claims Covered By This Requirement

This arbitration requirement applies to:

- any legal or equitable claim or dispute relating to enforcement or interpretation of the arbitration provisions in a Receipt, Safety Pledge, and Arbitration Acknowledgement form or this dispute resolution requirement; and

- any legal or equitable claim by or with respect to you for any form of physical or psychological damage, harm or death which relates to an Accident, Occupational Disease, or Cumulative Trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; and claims for assault, battery, negligent hiring/training/supervision/retention, emotional distress, retaliatory discharge, or violation of any other noncriminal federal,

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state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of the Plan).

This includes all claims listed above that you have now or in the future against Lowe's, its officers, directors, owners, employees, representatives, agents, subsidiaries, affiliates, successors, or assigns.

The determination of whether a claim is covered by these provisions will also be subject to mediation and arbitration under this dispute resolution requirement. **Neither you nor Lowe's will be entitled to a bench or jury trial on any claim covered by this dispute resolution policy. This dispute resolution policy applies to you without regard to whether you have completed and signed a Receipt, Safety Pledge, and Arbitration Acknowledgement form**. These dispute resolution provisions also apply to any claims that may be brought by your spouse, domestic partner, children, stepchildren, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. The dispute resolution provisions of the Plan will be the sole and exclusive remedy for resolving any such claim or dispute.

Mediation Prior to Arbitration

If you have a claim or dispute, you must first seek resolution of the problem through mediation before you request arbitration.

Required Notice of All Claims

- **Mediation:** When you seek to resolve a claim or dispute through mediation, you must give written notice to the other party **and** to the American Arbitration Association. You must send written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas 75240-6620. You must also send written notice to Lowe's, in care of the Manager – Workers' Compensation, Lowe's Companies, Inc., 1000 Lowe's Boulevard, Mooresville, North Carolina 28117 (or such other person or address as the Employer may specify). If Lowe's wishes to seek mediation, Lowe's will give notice to you at the last address recorded in your personnel file.

- **Arbitration:** If your claim or dispute is not resolved through mediation, then you must request arbitration. When you seek to resolve a claim or dispute through arbitration, you must give written notice of any claim to the American Arbitration Association **and** the other party within the applicable statute of limitations. The day upon which the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given, the claim shall be void and deemed waived.

  - You must send written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas 75240-6620. You must also send written notice to Lowe's, in care of the Manager – Workers' Compensation, Lowe's Companies, Inc., 1000 Lowe's Boulevard, Mooresville, North Carolina 28117. If Lowe's wishes to invoke arbitration, it will give notice to you at the last address recorded in your personnel file. The party requesting arbitration must identify specifically and describe in the written notice all claims asserted and the facts on which the claims are based. This written notice shall be sent certified or registered mail, return receipt requested. The responding party shall have the ability to file special exceptions with the arbitrator on the basis that the written notice does not satisfy the requirements of this arbitration requirement.

  - **Judicial Review:** Any party may file an action in a court of competent jurisdiction to compel arbitration, to enforce an award rendered by the arbitrator, or to vacate an arbitration award. In an action to vacate an award, the standard of review applied to the arbitrator's findings of fact and

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conclusions of law will be the same as that applied by an appellate court reviewing a decision of a trial court sitting without a jury.

Procedures

- **Mediation Procedures:** Mediation under this Section will be handled by a mediator appointed by the American Arbitration Association ("AAA") who is skilled in handling conflicts. The goal of mediation is to develop a solution that satisfies both parties in a way that strengthens the working relationship. The mediator will listen to both sides and will offer creative solutions to the problem. If the parties cannot agree to a solution through a mediator, either party may request arbitration.

- **Arbitration Procedures:** Any arbitration under this arbitration requirement will be administered by the American Arbitration Association ("AAA") under its then-current Employment Arbitration Rules and Mediation Procedures.

  - Unless otherwise agreed to in writing by the parties, the arbitrator selected by the parties in accordance with those rules (1) shall be an attorney licensed to practice in the State of Texas with experience in personal injury litigation, and (2) shall be selected from a panel of arbitrators located in Dallas County, Texas. If the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process.

  - The arbitrator will apply the substantive law of Texas (other than the Texas General Arbitration Act), or federal law, or both, depending upon the claims asserted. The arbitrator will provide brief findings of fact and conclusions of law. The arbitrator will have the authority to consider and grant motions consistent with the Texas Rules of Civil Procedure (or Federal Rules of Civil Procedure, if applicable), including, but not limited to, motions for summary judgment. The arbitrator is authorized only to rule on the claims set forth in the original written notice, any counterclaim(s), and the answer(s) made to such claims and counterclaims. The arbitrator is not authorized to modify the powers granted to him or her under this arbitration requirement or to make any award merely on the basis of what he or she determined to be just or fair. **The arbitrator shall also not commingle the standards for state law determinations and remedies (for example negligence claims and special damage awards) with the standards for federal law determinations and remedies that may or may not be subject to this arbitration policy (for example, ERISA benefit eligibility and ERISA benefit awards and other remedies).**

  - The final decision and the arbitration award, if any, shall be made consistent with the remedies available under the state or federal statute, common law, code or regulation that is the subject of the claim. All decisions rendered by an arbitrator under this arbitration requirement will be kept confidential by all parties, and will not serve as binding, legal precedent with respect to subsequent claims or disputes brought under this arbitration requirement. **An arbitrator's decision can be challenged in a state or federal court of law only on such basis as are available under the Federal Arbitration Act or on the basis that the arbitrator's decision constitutes a manifest disregard of the law.**

Payment of Fees and Expenses

- **Mediation:** The AAA filing fee for mediation will be equal to the standard filing fee specified under the then-current AAA Employment Arbitration Rules and Mediation Procedures. Your share of this fee is $50. Lowe's will pay the remainder of the AAA filing fee. Lowe's will also pay the mediator's entire fee and any other AAA administrative expenses. Each party will also be responsible for that party's own attorney fees, if any.

- **Arbitration:** You shall pay a nonrefundable arbitration filing fee equal to the standard employee filing fee specified under then-

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current AAA Employment Arbitration Rules and Mediation Procedures. Your filing fee must be paid when you submit a request for arbitration (or, if this process is challenged by you, when arbitration is compelled by court order). Lowe's shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. Lowe's will also pay the arbitrator's entire fee and any other AAA administrative expenses; provided, however that you may elect to also pay up to one-half of these fees and expenses.

- If the arbitrator finds completely in your favor on all claims, Lowe's will reimburse you for your share of the filing fee.

- If Lowe's requests arbitration (by means other than a motion in court to compel arbitration), you will pay no portion of the AAA or arbitrator fees.

- Either party may arrange for and pay the cost of a court reporter to provide a stenographic record of the proceedings;

- Each party will also be responsible for that party's own attorney fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorney fees to the prevailing party;

- Notwithstanding the above provisions, the arbitrator will assess the AAA filing fee, arbitrator fees and expenses, and attorney fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless; and

➢ If either party pursues a claim covered by this requirement by any means other than the dispute resolution provisions of this Plan, the responding party will be entitled to dismissal of such action, and the recovery of all costs and attorney fees and expenses related to such action.

Interstate Commerce

Lowe's is engaged in transactions involving interstate commerce (for example, purchasing goods and services from outside Texas which are shipped to Texas, and providing goods to customers from other states) and your employment involves such commerce. The Federal Arbitration Act will govern the interpretation, enforcement, and proceedings under this arbitration requirement. Unless contrary to applicable law, any lawsuits seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

Binding Effect of Arbitration

This arbitration requirement for resolving claims and disputes by final and binding arbitration is equally binding upon, and applies to any such covered claims that may be brought by, Lowe's and all employees, including you and your spouse, domestic partner, children, stepchildren, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

➢ **This arbitration policy applies to all employees without regard to whether they have completed and signed a Receipt, Safety Pledge, and Arbitration Acknowledgement form.** Adequate consideration for this arbitration requirement is represented by, among other things, your eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that this policy is mutually binding on both Lowe's and you. Any actual payment of benefits under this Plan to or with respect to you will serve as further consideration for and represent your further agreement to the provisions of this arbitration requirement. This arbitration policy will remain in effect with respect to Lowe's and you even if you refuse or reject benefits under this Plan, you return Plan benefit payments to Lowe's, you become ineligible for benefits or benefits cease under this Plan in accordance with its terms, or your employment with Lowe's is voluntarily or involuntarily terminated.

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- **This arbitration provision is not subject to ERISA requirements or otherwise dependent upon the benefit provisions of this Plan in any way, and is included in this booklet strictly as a matter of convenience in documentation.** This Plan and arbitration requirement also in no way change the "at will" employment status of any employee not covered by a collective bargaining agreement.

AMENDMENT OR TERMINATION OF PLAN

Lowe's presently intends to continue the Plan indefinitely, but Lowe's reserves the right to amend, modify, or terminate the Plan at any time; provided, however, that no such amendment or termination will alter the arbitration provisions incorporated into this booklet with respect to, or reduce the amount of any benefit payable to or with respect to you under the Plan in connection with, an Injury occurring prior to the date of such amendment or termination. In addition, any such amendment or termination of the arbitration provisions incorporated into this booklet shall not be effective until at least 14 days after written notice has been provided to you. Any such amendment or termination will be adopted pursuant to formal written action of a representative authorized to act on behalf of Lowe's.

DEFINITIONS

This section defines specific terms used in this booklet. These definitions should not be interpreted to extend coverage unless specifically provided for in the other sections of this booklet and the Plan document.

Adverse Benefit Determination

A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. For example, this includes denial, reduction or termination of benefits based upon (1) your ineligibility to participate in the Plan, (2) application of any utilization review, (3) a medical service being considered experimental, investigational or not medical necessary, or (4) your no longer being Totally Disabled.

Appeals Committee

The individual or individuals appointed by Lowe's to make determinations on appeal of benefit claims and otherwise administer the Plan on behalf of Lowe's.

The Appeals Committee shall have maximum discretionary legal authority to construe and interpret the terms and provisions of the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to an employee's rights, make factual findings, review referred appeals and uphold or reverse any denials, and, keep and maintain records pertaining to the referred appeals.

Lowe's has appointed ELAP, Inc. ("ELAP") to serve as the Appeals Committee. The mailing address for ELAP is 12 Atkinson Street, Newnan, Georgia 30263, and the telephone number for ELAP is 770-254-8382.

Approved Facility

A hospital, other medical care facility or other medical service or supply provider either expressly approved by the Claims Administrator, included on an approved list of facilities adopted by the Claims Administrator or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

Approved Physician

A person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included in an approved list of physicians adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

Claims Administrator

The individual, individuals or entity appointed by Lowe's to make initial determinations of benefit claims under this Plan on behalf of Lowe's. Lowe's has appointed Specialty Risk Services,

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LLC ("SRS") to serve as the Claims Administrator. The mailing address for SRS is 5801 Tennyson, Plano, Texas 75024, and the telephone number for SRS is 800-677-1412.

Course and Scope of Employment

An activity of any kind or character for which you were hired and that has to do with, and originates in, the work, business, trade or profession of Lowe's, and that is performed by you in the furtherance of the affairs or business of Lowe's. The term includes activities conducted on the premises of Lowe's or at other locations designated by Lowe's. This term does not include:

- transportation to and from your place of employment, unless:
  - the transportation is furnished as part of your employment arrangement or is paid for by Lowe's; provided, however, that this exception does not include commuting to or from your usual place of employment;
  - the means of the transportation are under the control of Lowe's; or
  - you are directed in your employment to proceed from one place to another place. Commuting to the place where you begin Lowe's business and commuting away from the place where you ceased Lowe's business will not be covered if such travel is not paid for by Lowe's or otherwise under the control of Lowe's.
- travel by you in furtherance of the affairs or business of Lowe's if such travel is also in furtherance of personal or private affairs by you, unless:
  - the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs by you to be furthered by the travel; and
  - the travel would not have been made had there been no affairs or business of Lowe's to be furthered by the travel.
- any injury occurring before you clock in or otherwise begin work for Lowe's, or after you clock out or otherwise cease work for Lowe's, unless the Injury occurs in parking lot, common area or other area owned by Lowe's (or for which the Company is responsible for maintenance).
- any injury occurring while you are on a work break, unless (1) the injury occurs while you are on a work break inside a Lowe's facility (for purposes other than eating or smoking), (2) the work break was authorized by your supervisor (or was otherwise permitted consistent with your job description), (3) you are scheduled to return to work that same day following the work break, and (4) you have not clocked out or otherwise ceased work for Lowe's.

Disabled or Disability

A Total Disability or a Partial Disability:

- A "Total Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, which –
  - causes you to be unable to perform the normal duties for which you were employed;
  - causes you to be under the regular care of an Approved Physician; and
  - causes you to be unable to engage in Modified Duty or any other occupation for wage or profit.
- A "Partial Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in your being –
  - unable to fully perform the normal duties for which you were employed;
  - under the regular care of an Approved Physician;
  - released to Modified Duty by such Approved Physician; and
  - working for Lowe's in a Modified Duty position approved by Lowe's.

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Emergency Care

A service or supply provided with respect to a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (1) result in death, disfigurement, or permanent disability, or (2) result in substantial impairment of any bodily organ, part, or function.

Maximum Benefit Limit

The maximum amount of all benefits payable to you under the Plan with respect to an Injury. Payments made for each form of benefit will be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Plan is $300,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, will not exceed $1,000,000. This aggregate amount may reduce proportionally the Maximum Benefit Limit applicable to each participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

Modified Duty

A temporary accommodation that allows you to perform your regular job, or an alternate, temporary job that complies with your work restrictions and Lowe's needs.

Plan

Lowe's Occupational Injury Benefit Plan.

Plan Administrator

Lowe's is the plan administrator of the Plan for purposes of ERISA. The Plan is administered on behalf of Lowe's by the Claims Administrator and Appeals Committee.

Subject to the Plan's claim procedures, both the Claims Administrator and the Appeals Committee have discretionary authority to interpret and implement the provisions of the Plan, including, but not limited to, making all factual and legal determinations, correcting any defect, reconciling any inconsistency and supplying any omission, and making any and all determinations that may affect a claim for benefits under the Plan. The Claims Administrator and Appeals Committee shall perform all of the duties and may exercise all of the powers and discretion that the Claims Administrator and Appeals Committee deem necessary or appropriate for the proper administration of the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination, or other exercise of authority by the Claims Administrator or Appeals Committee will be binding upon all affected parties, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no de novo review by any arbitrator or court of any decision rendered by the Appeals Committee, and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator or Appeals Committee may adopt any rules and procedures it considers necessary or appropriate for the administration of the Plan. The Claims Administrator or Appeals Committee may deny a claim for or suspend the payment of Plan benefits otherwise payable to you if you do not comply with any provision of the Plan or the rules and procedures adopted by the Claims Administrator or Appeals Committee. **Notwithstanding the foregoing, the Appeals Committee shall have final discretionary authority regarding any decision made with respect to the administration of the Plan and benefits available and provided under the Plan.**

Preexisting Condition

Any employee illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the date that you became a participant in the Plan.

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Pre-Injury Pay

- For a salaried participant, regular bi-weekly salary from Lowe's at the time of the Injury; and

- For an hourly participant, the average earnings from Lowe's for the 13 consecutive weeks immediately preceding the date of Injury; provided, however, that if the participant has been employed for less than 13 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator), such 13-week average will be based upon the earnings received over such period by a similar employee of Lowe's.

"Pre-Injury Pay" **will include** pay for overtime and participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. "Pre-Injury Pay" **will not include** any bonuses, benefits (including, but not limited to, Lowe's contributions to any employee benefit plans or matching contributions to a retirement plan) or other extraordinary remuneration.

Receipt, Safety Pledge, and Arbitration Acknowledgement

The form attached to the back of this SPD booklet.

GENERAL INFORMATION

Type of Plan and Administration

The Plan is a welfare benefit plan providing wage replacement, death, dismemberment and medical benefits (including certain dental and vision benefits) due to an Injury. The Plan is administered by the Claims Administrator and Appeals Committee to the extent such duties have been delegated to the Claims Administrator and Appeals Committee by the Plan Administrator.

Name and Address of Primary Plan Sponsor

Lowe's Companies, Inc.
1000 Lowe's Boulevard
Mooresville, North Carolina 28117

Names and Addresses of Participating Employers

Lowe's Companies, Inc.
1000 Lowe's Boulevard
Mooresville, North Carolina 28117

Lowe's Home Centers, Inc.
1000 Lowe's Boulevard
Mooresville, North Carolina 28117

Name, Address, and Telephone Number of Plan Administrator

Lowe's Companies, Inc.
c/o Manager – Workers' Compensation
1000 Lowe's Boulevard
Mooresville, North Carolina 28117
Telephone 704-758-3052

Names and Addresses of Plan Service Providers

Claims Administrator:
Specialty Risk Services, LLC
5801 Tennyson
Plano, Texas 75024

Appeals Committee:
ELAP, Inc.
12 Atkinson Street
Newnan, Georgia 30263

Name and Address of Person Designated as 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

Service of legal process may also be made upon the Plan Administrator.

Employer and Plan Identification Numbers

The employer identification number assigned by the Internal Revenue Service to Lowe's is 56-0578072. The plan number of the Plan is 511.

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Type of Plan Administration

Third-party administration

Plan Year

The Plan operates and keeps its records on the basis of the 12-month period beginning each January 1 and ending the following December 31, except that a period of less than 12 months may be a Plan Year for the initial and final Plan Year, and transition to a different 12 month period for the Plan Year.

COBRA, HIPAA AND USERRA RIGHTS STATEMENT

The Plan shall comply with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The Plan Administrator shall have full power and discretion to interpret the extent to which such requirements are applicable or appropriate to the Plan.

ERISA RIGHTS STATEMENT

As a participant in the 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 Your Plan and Benefits

- 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 (if any), and copies 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 (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue group health coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You 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 an exclusionary period of coverage for Preexisting Conditions under your group health plan if you have creditable coverage from another nonsubscriber 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, 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 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 the Company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without

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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 file suit in 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 Plan 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. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have brought a claim against 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 (866-444-3272), or visiting the Employee Benefits Security Administration's web site, www.dol.gov/ebsa/.
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November 1, 2008

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APPENDIX A
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: NOVEMBER 1, 2008

Lowe's understands that medical information about you is personal. The following information constitutes the Lowe's Welfare Plan Privacy Notice.

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

This notice applies to Lowe's self-insured health plans.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by the Lowe's Occupational Injury Benefit Plan (the Plan) whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the Plan.

For questions about medical information associated with plan eligibility or claims appeal information maintained by the Plan, contact the Plan's privacy official, Kyle Went, Vice President, Benefits, at the number listed on the last page of this notice.

The Plan's Duties with Respect to PHI About You

The Plan is required by law to maintain the privacy of your PHI and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your PHI. It is important to note that these rules apply to the Plan and not to Lowe's 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, such as sick leave records, FMLA leave information, drug and alcohol use testing results, disability, life insurance, and OSHA records. This type of information is not PHI and is not covered by this notice.

Third parties assist the Plan in administering your health benefits. These entities keep and use most of the medical information maintained by the Plan, such as information about your heath condition, the healthcare services you receive, and the payments for such services. They use this information to process your benefit claims. They are required to use the same privacy protections as the Plan.

How the Plan May Use or Disclose Your PHI

The privacy rules generally allow the use and disclosure of your PHI without your permission, known as authorization, for purposes of healthcare treatment, payment activities, and healthcare operations. This section describes how the Plan uses and discloses medical information to administer benefits. Please note that this notice does NOT list every use or disclosure; instead it gives examples of the most common uses and disclosures:

- <u>Treatment</u> includes providing, coordinating, or managing healthcare by one or more healthcare 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 Plan may share your PHI with physicians who are treating you.

- <u>Payment</u> includes activities by this Plan, 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, and utilizing management activities, claims management, and billing as well as behind the scenes plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of your benefits.

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- Healthcare operations include activities by this Plan (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. Healthcare operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development.

The amount of PHI used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The Plan may also 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.

How the Plan May Share Your PHI with Lowe's

The Plan may disclose your PHI to Lowe's without your written authorization for plan administration purposes. Lowe's may need your PHI to administer benefits under the Plan. Lowe's agrees not to use or disclose your PHI other than as permitted or required by the Plan documents and by law. The Lowe's Risk Management staff and, if necessary, your HR Manager will have access to your PHI 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 Plan may disclose summary health information to Lowe's, if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- The Plan may disclose to Lowe's information on whether an individual is eligible or not eligible for benefits under the Plan.

In addition, you should know that Lowe's cannot and will not use PHI obtained from the Plan for any employment related actions. However, as described above, 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 PHI.

Other Allowable Uses or Disclosure of Your PHI

In certain cases, your PHI 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 describing 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'll 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 PHI may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your PHI without your written authorization for the following activities:

- The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human and Services is investigating or determining compliance with HIPAA.
- The Plan will disclose PHI about you when required to do so by federal, state, or local law.
- The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- If you are an organ donor, the Plan may release your PHI to organizations that handle organ procurement; or organ,

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eye, or tissue transplantation; or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- If you are a member of the armed forces, the Plan may release your PHI as required by military command authorities.
- The Plan may release your PHI for workers' compensation or similar programs.
- The Plan may disclose your PHI for public health activities, such as child abuse and neglect, threats to public health and safety, and national security.
- The Plan may disclose your PHI to a health oversight agency for activities authorized by law (e.g. audits, investigations, inspections, and licensure)
- If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request, or other lawful process to someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- The Plan may release your PHI if asked to do so by a law enforcement official.
- The Plan may release your medical information to a coroner or medical examiner.
- The Plan may release your PHI authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your PHI to the correctional institution or law enforcement official.
- The Plan may release your PHI for research purposes, subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding the necessity of using your health information and treatment of the information during a research project.

Except as described in this 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, your revocation will only stop future uses and disclosures that are made after the Plan receives your revocation. It will not have any affect on the prior uses and disclosures of your PHI.

The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal ERISA preemption, the Plan will comply with the stricter law.

Your Individual Rights

You have the following rights with respect to your PHI maintained by the Plan. These rights are subject to certain limitation, as discussed below. This section of the notice describes how you may exercise each individual right. See the **Contact** section at the end of this notice for information on how to submit requests.

Right to Request Restrictions on Certain Uses and Disclosures of Your PHI and the Plan's Right to Refuse

You have the right to ask the Plan to restrict the use and disclosure of your PHI for treatment, payment, or healthcare operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your PHI 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 the Plan to restrict use and disclosure of PHI 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 the Plan must be in writing.

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The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan, including an oral agreement, or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose PHI about you if you need emergency treatment, even if the Plan as agreed to a restriction.

Right to Receive Confidential Communications of Your PHI

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

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

Right to Inspect and Copy Your PHI

With certain exceptions, you have the right to inspect or obtain a copy of your PHI in a Designated Record Set. This may include medical and billing records maintained for a healthcare provider, enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan or, or a group of records the Plan uses to make decisions about individuals. However, you do NOT have a right to inspect or obtain copies of psychotherapy notes of information complied for civil, criminal, or administrative proceedings. In addition, 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 PHI is not accessible onsite), the Plan will provide you with:

- The access or copies your 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 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 PHI, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan does not maintain the PHI but knows where it is maintained, you will be informed of where to direct your request.

Right to Amend Your PHI that is Inaccurate or Incomplete

With certain exceptions, you have a right to request that the Plan amend your PHI 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 PHI 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;
- Provide 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.

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Right to Receive an Accounting of Disclosures of Your PHI

You have the right to a list of certain disclosures the Plan has made of your PHI. This is often referred to as an accounting of disclosures. You generally may receive an accounting of disclosures 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 PHI going back for six years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective).

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 PHI;
- 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 Request that the Plan Disclose Your PHI to Your Personal Representative

You may request that the Plan disclose your PHI to your personal representative. A personal representative is an individual you designate to act on your behalf and make decisions about your medical care. If you want the Plan to disclose your PHI to your personal representative, submit a written statement giving the Plan permission to release your PHI to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney. Submit this request in writing to the Plan Administrator.

Security of Electronic PHI

The Plan shall comply with the "Standards for the Protection of Electronic Protected Health Information" ("HIPAA Security Rules") by complying with the following

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that is created, received, maintained, or transmitted by the Company on behalf of the Plan.
- Ensure that adequate separation exists between the Company and the Plan through the implementation of reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- Report to the Plan any security incident of which it becomes aware.

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Changes to the Information in this Notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice took effect on April 14, 2003. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at anytime, and to make new provisions effective for all PHI that the Plan maintains. This includes PHI that was previously created or received, not just PHI created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice. A revised notice will be mailed to the last known address of the covered employee. A revised notice will also be posted on the Lowe's intranet web sites.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, send your complaint in writing to Kyle L. Wendt, Lowe's Vice President, Benefits. Lowe's Vice President, Benefits has been designated as the Lowe's privacy official. Send your written complaint to the address listed just below in the "Contact" section.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Lowe's privacy official, Kyle L. Wendt, Vice President, Benefits, Lowe's Companies, Inc., 1000 Lowe's Boulevard, Mail Code 2WHR, Mooresville, North Carolina 28117.

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APPENDIX B
NOTICE OF PREEXISTING CONDITION EXCLUSION AND CREDITABLE COVERAGE RIGHTS

The Plan imposes a Preexisting Condition exclusion. This means that you will not be eligible for Medical Benefits coverage for any Preexisting Condition until you have been continuously eligible for the Plan for 12 months. For purposes of this exclusion, a "Preexisting Condition" is considered to be any illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months immediately preceding your first day of Plan coverage.

The Preexisting Condition exclusion will not apply to pregnancy. In addition, you can reduce the length of this exclusion period by the number of days of any prior "creditable coverage" that you have had under any previous similar non-subscriber health coverage. This creditable coverage can be used to reduce the Plan's Preexisting Condition exclusion as long as you have not experienced a break in coverage of at least 63 consecutive days. To reduce the Plan's 12-month Preexisting Condition exclusion period by any creditable coverage that you may have, you must provide a copy of any certificates of creditable coverage you have to the Plan's Claims Administrator. If you do not have a certificate of creditable coverage, but you do have prior non-subscriber health coverage, The Claims Administrator can help you obtain a certificate of creditable coverage from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage towards the Plan's Preexisting Condition exclusion.

Please note, however, that a reduction or elimination of the Preexisting Condition limitation under this Plan does not prevent the Plan from otherwise determining in accordance with the terms of the Plan that Plan benefits are not payable for reasons including, but not limited to, a determination that your Preexisting Condition did not arise from your Course and Scope of Employment with Lowe's.

All questions about the Plan's Preexisting Condition exclusion and creditable coverage requirements should be directed to the Plan Administrator c/o Manager – Workers' Compensation, Lowe's Companies, Inc., 1000 Lowe's Boulevard, Mooresville, North Carolina 28117.

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APPENDIX C
COBRA CONTINUATION COVERAGE NOTICE

The federal law requirements of "COBRA" continuation coverage (as amended from time to time) apply to group health benefits provided under the Plan. This notice is intended to inform you in summary fashion of your rights and obligations.

Please note that group health benefits provided under the Plan are limited to treatment of injuries which are sustained during the Course and Scope of your Employment with Lowe's. Therefore, continuation of group health coverage would not be practical if you experienced a termination of employment with Lowe's for whatever reason.

In addition, if you have a covered injury during your employment with Lowe's, the Plan would continue to provide you with health benefits for that injury following your termination of employment (subject to the terms and limits in the Plan) unless your employment is terminated based upon gross misconduct. Therefore, termination of employment in this situation is not a "qualifying event" under COBRA because it does not result in a loss of coverage under the Plan.

Finally, the Plan does not provide coverage for dependents. Therefore, any continuation coverage provided under COBRA with respect to dependents would not be applicable to this Plan.

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage under the Plan because of a life event known as a "qualifying event." Specific qualifying events are described later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You could become a qualified beneficiary if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

As a Plan participant, you would become a qualified beneficiary if you lost your group health coverage under the Plan because of the following "qualifying event": termination of your employment with Lowe's (other than for gross misconduct). Lowe's is required to notify the Plan Administrator of your termination of employment.

The following information applies only in the situation where there is a qualifying event. The Plan Administrator will, within 14 days of being notified of a qualifying event, advise you of the right to elect continuation coverage under the Plan. You must elect continuation coverage under the Plan within 60 days of the later of the following:

- The date you would lose Plan coverage because of the qualifying event; or
- The date you are advised by the Plan Administrator of the right to continue Plan coverage based on COBRA rules.

If you do not elect continuation coverage within this election period, then the right to COBRA continuation coverage will be lost.

Payment of continuation coverage. You will be required to pay for the cost of continuation coverage in an amount equal to the cost of Plan coverage, plus 2 percent. The contributions must be paid by a check made payable to Lowe's.

Contribution amounts and benefits for continuation coverage are subject to change. You will be notified of any changes in contribution amounts or benefits available under the Plan.

If you elect continuation coverage after the qualifying event, then you will have 45 days from the date of the election to make the required initial contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of your payment. There is no grace period for the initial contribution. Each subsequent contribution payment is due within 30 days after the first day of each month of continuation coverage.

You will not be billed for any contribution payments for continuation coverage. You must make the payments directly to the Plan Administrator. If any contribution payment for continuation coverage is postmarked after the date the payment is due, continuation coverage under the Plan will terminate and will not be reinstated.

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Duration of continuation coverage. If you elect to continue Plan coverage, the maximum continuation period following a qualifying event involving termination of employment is 18 months.

The 18-month period may be extended to 29 months (an additional 11 months) if the Social Security Administration ("SSA") determines that you were disabled at any time during the first 60 days on continuation coverage.

To be eligible for the disability extension, the disabled person must remain disabled and must notify the Plan Administrator:

- Within 60 days after receiving the disability determination from Social Security, and
- Before the original 18-month period to continue Plan coverage ends.

A qualified beneficiary who is entitled to a disability extension may be required to pay up to 150 percent of the cost of his or her COBRA continuation coverage. If the increased cost is required, it will apply to each qualified beneficiary who is entitled to the disability extension. The disabled person must promptly notify the Plan Administrator of any SSA finding that he or she is not longer disabled.

Termination of continuation coverage. The right to continue Plan coverage will end before the maximum period on the earliest of the following:

- The date Lowe's ceases to provide any nonsubscriber health plan coverage for all Texas employees;
- The date you fail to make the required contribution when due;
- The date after you first become, after your COBRA election:
  - Covered under another employer's nonsubscriber health plan, or
  - Entitled to Medicare.

If you elected to extend continuation coverage for up to 29 months due to a finding of disability by the SSA, the first of the month that begins more than 30 days after the date of the final determination by the SSA that the person is not longer disabled. You must inform the Plan Administrator within 30 days of the date of any final determination by the SSA that the person is no longer disabled.

If you become covered by another employer's nonsubscriber health plan and have a Preexisting Condition which is not covered by that plan, then the right to continue Plan coverage (at least for that Preexisting Condition) will not be terminated due to that other coverage.

Your right to COBRA continuation coverage will coordinate with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA limits a group health plan's ability to apply Preexisting Condition exclusions to new employees. COBRA continuation coverage under this Plan will terminate early if you become covered under a new employer's nonsubscriber health plan that has a Preexisting Condition exclusion that does not apply to you because of HIPAA's new requirements.

Notice of address change. Please keep the Plan Administrator informed of any address changes or changes in personal circumstances (such as a change in your marital status) so that we can provide you with any necessary information concerning your rights to continuation coverage.

General information about continuation coverage. Continuation coverage is provided subject to eligibility under the law. The Plan Administrator reserves the right to terminate continuation coverage retroactively if you are determined to be ineligible for continuation coverage.

This notice is only a summary under the law of your rights to continuation coverage. The Company intends to provide continuation coverage only to the extent required by law and will administer continuation coverage according to those requirements. If you have any specific questions, please contact the Plan Administrator, c/o Manager – Workers' Compensation, Lowe's Companies, Inc., 1000 Lowe's Boulevard, Mooresville, North Carolina 28117. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the

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EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional District EBSA offices are available through EBSA's website.)

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Este folleto y forma contiene información importante sobre sus derechos. Por favor dele vuelta a esta forma para obtener la información en español. Si tiene dificultad en entender cualquier parte de este folleto, comuníquese con el Manager - Workers' Compensation a (704) 758-3052.

APPENDIX D-1
RECEIPT, SAFETY PLEDGE, AND ARBITRATION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") and the Highlights Brochure for the Lowe's Occupational Injury Benefit Plan, effective November 1, 2008.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify my Supervisor within 24 hours of the time of the Injury, and receive any medical care from a Plan-approved physician in order to receive benefits under the Plan.

SAFETY PLEDGE. I agree to familiarize myself with the Lowe's safety procedures and rules and to perform my job according to Lowe's general and departmental safety rules. I will also use any personal protective equipment that is provided to me. I also agree to report immediately to my Supervisor any accident that involves another employee, team member, a customer, a vendor, or myself. I will also report immediately any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and participate actively in any Lowe's safety training programs.

ARBITRATION. I also acknowledge that this SPD includes a mandatory company policy requiring that claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between the Lowe's and me) must be submitted to an arbitrator, rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with Lowe's at any time on or after November 1, 2008, I am accepting and agreeing to comply with these arbitration requirements. I understand that Lowe's is also accepting and agreeing to comply with these arbitration requirements. All covered claims brought by my spouse, domestic partner, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns are also subject to the Lowe's Occupational Injury Benefit Plan arbitration policy, and any decision of an arbitrator will be final and binding on such persons and Lowe's.

X ______________________________ | ______________________________
Employee's Signature | Date

______________________________ | ______________________________
Print Employee's Name | Employee's Identification Number

______________________________ | ______________________________
Parent or Legal Guardian Signature (if Employee under age 18) | Date

______________________________ | ______________________________
Print Parent or Legal Guardian Name | Employee's Work Location or Department

X ______________________________ | ______________________________
For the Company | Date

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[To be replaced with Spanish version after translation]

APPENDIX D-2
RECEIPT, SAFETY PLEDGE, AND ARBITRATION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") and the Highlights Brochure for the Lowe's Occupational Injury Benefit Plan, effective November 1, 2008.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify my Supervisor within 24 hours of the time of the Injury, and receive any medical care from a Plan-approved physician in order to receive benefits under the Plan.

SAFETY PLEDGE. I agree to familiarize myself with the Lowe's safety procedures and rules and to perform my job according to Lowe's general and departmental safety rules. I will also use any personal protective equipment that is provided to me. I also agree to report immediately to my Supervisor any accident that involves another employee, team member, a customer, a vendor, or myself. I will also report immediately any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and participate actively in the Lowe's safety training programs.

ARBITRATION. I also acknowledge that this SPD includes a mandatory company policy requiring that claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between Lowe's and me) must be submitted to an arbitrator, rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with Lowe's at any time on or after November 1, 2008, I am accepting and agreeing to comply with these arbitration requirements. I understand that Lowe's is also accepting and agreeing to comply with these arbitration requirements. All covered claims brought by my spouse, domestic partner, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns are also subject to the Lowe's Occupational Injury Benefit Plan arbitration policy, and any decision of an arbitrator will be final and binding on such persons and Lowe's.

X ________________________________ Employee's Signature	________________________________ Date
________________________________ Print Employee's Name	________________________________ Employee's Identification Number
________________________________ Parent or Legal Guardian Signature (if Employee under age 18)	________________________________ Date
________________________________ Print Parent or Legal Guardian Name	________________________________ Employee's Work Location or Department
X ________________________________ For the Company	________________________________ Date

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