The Medical Payment Plan Quick Facts and Quick Links
U.S. Salaried & Full-Time Hourly Associates

Your Medical Payment Plan Option

1 Hospital Only Option

A Quick Look at the Medical Payment Plan

<table>
<thead>
<tr>
<th>If you receive this service:</th>
<th>Hospital Only Your cash payment is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admission*</td>
<td>$1,000 (1 per year for the initial day one hospital stay)</td>
</tr>
<tr>
<td>Daily Hospital Benefit*</td>
<td>$100 (up to 100 days per coverage year)</td>
</tr>
<tr>
<td>Per Biweekly Paycheck Payroll Deduction: Associate-only Coverage</td>
<td>$7.38</td>
</tr>
</tbody>
</table>

* A hospital stay means a period during which a covered person is confined in a hospital, treatment facility, hospice facility, skilled nursing facility or rehabilitation facility and charged for room, board and general nursing services. Stay does not include any period of such a confinement due to custodial or personal needs that do not require medical skills or training. Benefits are payable for pregnancy-related stays, visits and services provided on the same basis as for disease.

Cool Medical Payment Plan Features

• **Cash Benefit Goes Directly to You.** If you are hospitalized with a condition diagnosed with a covered condition after your Medical Payment Plan coverage begins, you will receive a lump-sum cash benefit.

When Do I Enroll in Medical Payment Plan Coverage?

• **New Associates Enrolling for the First Time:** Before your 91st day of employment (29th day for Hawaii associates).
• **All Other Associates:** During annual enrollment and when you have a life event.

Quick Links to Frequently Used Medical Payment Plan Info

• What's covered under the plan?
• What's not covered under the plan?
• I need to file a claim
MEDICAL PAYMENT PLAN
U.S. Salaried & Full-Time Hourly Associates

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Get the Most Value from Your Plan

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<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Get a claim form</td>
<td>Go to <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a> or call Aetna at 1-800-508-4015</td>
</tr>
<tr>
<td>• Submit a claim</td>
<td>Make a copy of your certificate or claim form and documentation and send it to: Aetna Voluntary Claims Department P.O. Box 14079 Lexington KY 40512-4079 You can also fax your information to 1-859-455-8650</td>
</tr>
</tbody>
</table>

The Medical Payment Plan

The Medical Payment Plan Hospital-Only Option provides benefits that can help you pay the cost of a hospital stay. This plan will pay a daily benefit for each day of the stay if you or a covered dependent is admitted to the hospital as an inpatient.

You can enroll yourself and eligible dependents in this plan even if you are not enrolled in the Home Depot medical plan.

Note Plan Limits

This plan has specific limits and other restrictions on the dollar amounts covered under the plan. Once these limits have been reached, the plan will not pay any more toward this coverage. This chapter explains these limits. Please read it carefully so that you understand the limits to what the plan will pay before you enroll. You’ll also find additional information on this plan’s benefits, limits and exclusions in documents on [www.livetheorangelife.com](http://www.livetheorangelife.com).

IMPORTANT INFORMATION ABOUT THE BENEFITS YOU ARE BEING OFFERED: The Medical Payment Plan Hospital-Only Option is a hospital confinement indemnity plan. The plan provides LIMITED BENEFITS and does not provide comprehensive medical coverage. The plan pays you fixed dollar amounts regardless of the amount that the provider charges. You are responsible for making sure the provider’s bills get paid. These benefits are paid in addition to any other health coverage you may have.

This plan does not count as Minimum Essential Coverage (MEC) under the Affordable Care Act (ACA) and does not satisfy the Individual Mandate under the ACA. Failure to have MEC and to satisfy the Individual Mandate may result in a tax penalty for you. The Medical Payment Plan is a supplement to health insurance and is not a substitute for major medical coverage.

This plan does not meet Massachusetts minimum creditable coverage standards.

If you are eligible for Medicare now or in the next 12 months, you should understand that:

• This IS NOT a Medicare Supplement Policy.
• This prescription drug benefit IS NOT creditable coverage under Medicare Part D.

You can get a free Guide to Health Insurance for People with Medicare at [www.medicare.gov](http://www.medicare.gov).

It’s important that you understand these benefits before you decide to enroll. You may reach one of Aetna Voluntary’s Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m. Eastern Time, by calling toll free 1-800-508-4015.

Coverage Categories

You may select one of four coverage categories for the Medical Payment Plan:

- Associate only
- Associate + spouse
- Associate + child(ren)
- Associate + family (children and spouse)
Medical Payment Plan

Benefits

For example, if you are hospitalized in February 2017 for five days, your benefit would be $1,500. If you were hospitalized again in July 2017 for three days, your benefit would be $300.

A hospital stay means a period during which a covered person is confined in a hospital, treatment facility, hospice facility, skilled nursing facility; or rehabilitation facility and charged for room, board, and general nursing services. Stay does not include any period of such a confinement due to custodial or personal needs that do not require medical skills or training.

Benefits are payable for pregnancy-related stays, visits and services provided on the same basis as for disease.

What the Plan Does Not Cover

No benefit is paid for or in connection with the following stays or visits or services:

- Those not medically necessary, as determined by Aetna, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed; recommended; or approved, by the attending physician.
  - Those that are not prescribed, recommended and approved by the person's attending physician.
  - Those for private duty nursing.
  - Those for hospice care, except for services rendered in a hospice facility.
  - Those for visits by a physician for non-surgical medical treatment given to a person during a stay in a hospital, treatment facility, rehabilitation facility or skilled nursing facility. This includes consultation services given to an insured person while confined as an inpatient in such facility. A "consultation" is an exam of the person; a review of his or her x-ray and lab exams; a review of the person’s medical history; and a written report by the consulting physician if the attending physician requests one.
  - Those received outside the United States.
  - Those for or related to sex change surgery or to any treatment of gender identity disorders.
  - Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
  - Those for a voluntary sterilization procedure or the reversal of a sterilization procedure.
  - Those for manipulative treatment or other physical treatment of spinal subluxation.
  - Those for surgery except for any stay, visit or X-ray or lab test related to surgery (including hospital stays or follow up care).
  - Those resulting from an injury or sickness due to working for wage or profit or for which benefits or other services and supplies which improve, alter or enhance appearance (whether or not for psychological or emotional reasons); except to the extent needed to:
    - Improve the function of a part of the body that is not a tooth or structure that supports the teeth;
    - is malformed
    - as a result of a severe birth defect; this includes harelip or webbed fingers or toes;
      - as a direct result of disease or surgery performed to treat a disease or injury.
      - Repair an injury which occurs while the person is covered under this Plan. Surgery must be performed in the Coverage Year of the accident which causes the injury or in the next Coverage Year.
    - Those for or related to sex change surgery or to any treatment of gender identity disorders.
    - Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
    - Those for a voluntary sterilization procedure or the reversal of a sterilization procedure.
    - Those for manipulative treatment or other physical treatment of spinal subluxation.
    - Those for surgery except for any stay, visit or X-ray or lab test related to surgery (including hospital stays or follow up care).
    - Those resulting from an injury or sickness due to working for wage or profit or for which benefits

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Benefit amount</th>
<th>Limit on benefit</th>
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<tbody>
<tr>
<td>Lump-sum benefit</td>
<td>$1,000 per covered individual</td>
<td>For the initial day of one inpatient hospital stay per coverage year</td>
</tr>
<tr>
<td>Daily benefit</td>
<td>$100 per day per covered individual</td>
<td>Up to 100 days that you are an inpatient in a hospital per coverage year.</td>
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are payable under any Workers’ Compensation or Occupational Disease Law.

- Those to treat an injury sustained while the covered person was legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the injury occurred.
- Those to treat an injury sustained while the covered person was voluntarily using any drug, narcotic or controlled substance unless prescribed by a physician.
- Those to treat an illness or injury sustained while flying as a pilot or crew member of any aircraft or travel or flight. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by, for, or under, the direction of any military authority other than the Military Airlift Command of the United States or similar air transport service of any other country.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

### Filing a Claim

You will need to file a claim for your inpatient hospitalization in order to receive benefits under the Medical Payment Plan.

To file a claim:

1. Use the medical claim form found at www.livetheorangeflife.com/MPP. Or, you can get the form by calling us toll-free at 1-800-508-4015; or by writing to the Claims Department address below.

2. Ask your doctor to complete the medical claim form during your follow-up appointment. Please make sure that the hospital bill includes:
   - Date admitted
   - Date released
   - Diagnosis code

3. Please send the completed medical claim form and itemized bill to:

   Aetna Voluntary Claims Department
   P.O. Box 14079
   Lexington, KY 40512-4079
   Or fax to 859-455-8650

Your claim will be processed within 14 to 30 business days after it is received.

### Refund of Overpayments

If benefits are paid by the Medical Payment Plan for expenses incurred on account of a covered person, that covered person must make a refund to the Medical Payment Plan if either of the following apply:

- All or some of the expenses did not legally have to be paid by the covered person.
- All or some of the payment made exceeded the benefits under the Plan.

The refund equals the amount paid in excess of the amount that should have paid under the Medical Payment Plan.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, the amount of any future benefits that are payable under the Medical Payment Plan may be reduced. The reductions will equal the amount of the required refund. The Medical Payment Plan also retains all other rights in addition to the right to reduce future benefits that may be legally available.

### Coordinating With Other Plans

This plan does not coordinate benefits with any other plan.