The Company benefit plans also provide benefits to the following groups of associates of Home Depot U.S.A., Inc. and its affiliates in the U.S., who receive different versions of the Benefits Summary: part-time hourly associates, health care qualifying hours associates and certain associates of our Services and Interline businesses who are paid 100% by commission. The Company benefit plans also provide benefits to full-time hourly, part-time hourly and salaried associates in the Company’s affiliates in Guam, Puerto Rico and U.S. Virgin Islands, who receive different versions of the 2017 Benefits Summary.
**A Quick Look at Life Events/Qualified Status Changes**

<table>
<thead>
<tr>
<th>IF YOU EXPERIENCE ONE OF THE LIFE EVENTS/QUALIFIED STATUS CHANGES BELOW:</th>
<th>TO CHANGE YOUR BENEFITS DUE TO A LIFE EVENT/QUALIFIED STATUS CHANGE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have 30 days from the date of the event to make your benefit changes.*</td>
<td>Log into <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a> or call the Benefits Choice Center at 1-800-555-4954</td>
</tr>
</tbody>
</table>

* If you experience a qualified status change, your requested change in benefits must be consistent with, and correspond to, the qualified status change.

**Quick Links to Life Events/Qualified Status Changes**

- Marriage
- Divorce/Legal Separation/Annulment
- Judgement, Order or Decree, including a Qualified Medical Child Support Order (QMCSO)
- Birth
- Adoption, Placement or Termination of Adoption
- Death
- Gain or Loss of Coverage Due to Moving
- Gain or Loss of Other Coverage
- Change of Employment Status
- Military Leave
- Leaves of Absence
## LIFE EVENTS

**U.S. Part-Time Hourly Associates**

### CHAPTER CONTENTS

<table>
<thead>
<tr>
<th>3</th>
<th>Life Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Marriage</td>
</tr>
<tr>
<td>4</td>
<td>Divorce/Legal Separation/Annulment</td>
</tr>
<tr>
<td>5</td>
<td>Judgement, Order or Decree, including a Qualified Medical Child Support Order (QMCSO)</td>
</tr>
<tr>
<td>5</td>
<td>Birth</td>
</tr>
<tr>
<td>6</td>
<td>Adoption, Placement or Termination of Adoption</td>
</tr>
<tr>
<td>6</td>
<td>Death of...</td>
</tr>
<tr>
<td>6</td>
<td>Gain or Loss of Coverage Due to Moving</td>
</tr>
<tr>
<td>7</td>
<td>Gain or Loss of Other Coverage</td>
</tr>
<tr>
<td>9</td>
<td>Change of Employment Status</td>
</tr>
<tr>
<td>9</td>
<td>Military Leave</td>
</tr>
<tr>
<td>10</td>
<td>Leaves of Absence</td>
</tr>
</tbody>
</table>
Get the Most Value from Your Plan

<table>
<thead>
<tr>
<th>What do you need</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notify the Benefits Choice Center that you have had a qualified status change</td>
<td>Call the Benefits Choice Center at 1-800-555-4954 and speak with a representative</td>
</tr>
<tr>
<td>Make changes in your benefits after qualified status change</td>
<td>Log into <a href="http://www.livetheorangefife.com">www.livetheorangefife.com</a> or call the Benefits Choice Center at 1-800-555-4954</td>
</tr>
</tbody>
</table>

Life Events

When your life changes, chances are your benefits will need to change too. As you learn more about when you are able to change your benefit elections during the year, you’ll find out that marriage, divorce, birth or adoption, or your spouse’s employment change are events that may allow you to make certain changes in your benefits. You’ll also find out that you have 30 days from the date of the event to contact the Benefits Choice Center or to visit www.livetheorangefife.com and make your changes.

Although, due to IRS regulations, you are generally not permitted to make election changes during the year for benefits paid through a cafeteria plan, meaning on a before-tax basis, the IRS does allow election changes to be made during the year on account of and consistent with certain life events (also referred to in this document as qualified status changes). This section outlines the life events which may permit you to make election changes to the benefits provided to you by the Company. Use the charts in this chapter to help guide you through the benefit coverages you may need to change following a particular life event. Absent a qualified status change or rolling 12-month election for life insurance and disability, no mid-year election changes can be made with the exception of the Critical Illness Protection Plan that can be dropped at any time.

Remember that all election changes made as a result of a life event must be made within 30 days after the date of the event unless noted otherwise.

If you experience a qualified status change, your requested change in benefits must be consistent with, and correspond to, the qualified status change. For example, if you are divorced and had been covered under your spouse’s dental plan, it would be consistent to elect coverage under the Company’s Dental Plan. However, if you did not lose coverage as a result of the divorce, it would not be consistent for you to elect dental coverage.

Note: the Plan Administrator may also permit any other changes provided for under the Plan document or IRS regulations in addition to those listed in these charts.
### You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You will be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision¹</th>
<th>Term Life Insurance, Legal Services Plan¹</th>
<th>Disability¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Date of marriage</td>
<td>Can add coverage for spouse and/or children and change option</td>
<td>Can add coverage for self, spouse and/or children</td>
<td>Can drop coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td>You wish to add spouse and/or children</td>
<td>Date of marriage</td>
<td>Can drop coverage for self and/or children, if covered under spouse’s employer’s plan</td>
<td>Can drop coverage for self, spouse and/or children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You wish to drop coverage</td>
<td>Date of marriage or date new coverage gained, whichever is later</td>
<td>Can drop coverage for self and/or children, if covered under spouse’s employer’s plan</td>
<td>Can drop coverage for self, spouse and/or children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Divorce/Legal Separation/Annulment

<table>
<thead>
<tr>
<th>You wish to drop your dependents’ coverage under the plan</th>
<th>Date of decree</th>
<th>Can drop coverage for children with proof of coverage under other parent’s plan</th>
<th>Can add or drop coverage for self and/or children</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must drop coverage for spouse and any stepchildren who cease to be your dependents</td>
<td>Date of decree</td>
<td>Can add or drop coverage for self and/or children if at least one child has lost coverage under spouse’s plan</td>
<td>Must drop coverage for spouse and any stepchildren who cease to be your dependents</td>
<td></td>
</tr>
<tr>
<td>You wish to add self and/or your eligible children under the plan</td>
<td>Date of decree</td>
<td>Can add or change coverage option for self and/or children under spouse’s plan</td>
<td>Can add coverage for self and/or children</td>
<td></td>
</tr>
</tbody>
</table>

¹ Must be actively at work for coverage to take effect.
² Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You will be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision¹</th>
<th>Term Life Insurance, Legal Services Plan¹</th>
<th>Disability¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement, Order or Decree, including a Qualified Medical Child Support Order (QMCSO)²</td>
<td>Requires coverage for your child under this plan</td>
<td>Approved court order, judgement or decree requiring coverage</td>
<td>Issuance of a court order Coverage will start as soon as order is approved</td>
<td>Coverage is automatically added for child(ren) and self, if not enrolled, as specified by the judgement, order or decree</td>
<td>No change permitted</td>
</tr>
<tr>
<td>Requires coverage of your child under spouse’s plan</td>
<td>Approved court order, judgement or decree requiring coverage</td>
<td>Date other employer plan accepts the order</td>
<td>Drop coverage for child(ren) covered by the order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth</td>
<td>You wish to add self, spouse and/or new child</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Date of birth</td>
<td>Can add coverage for new child, self, other children and spouse and/or change coverage option</td>
<td>Can add or increase coverage for self, spouse and/or children</td>
</tr>
<tr>
<td></td>
<td>You wish to drop coverage for self, spouse and/or children and cover under spouse’s plan</td>
<td>Documentation verifying the dependency or status change.</td>
<td></td>
<td>Can drop coverage for self, spouse and/or dependents if you gain coverage under spouse’s plan following birth</td>
<td>No change permitted</td>
</tr>
</tbody>
</table>

¹ Must be actively at work for coverage to take effect.
² A QMCSO may require coverage for your child, but not for your spouse or former spouse.
³ Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
### You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You will be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision</th>
<th>Term Life Insurance, Legal Services Plan</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption, Placement or Termination of Adoption</td>
<td><strong>You wish to add self, spouse and/or new child</strong></td>
<td>Documentation verifying the dependency or status change.</td>
<td>Date of adoption or placement</td>
<td>Can add self, spouse and/or child(ren) and change coverage option</td>
<td>Can add coverage for self, spouse and/or child</td>
</tr>
<tr>
<td><strong>You wish to drop coverage and cover child under spouse's plan</strong></td>
<td></td>
<td></td>
<td></td>
<td>Can drop coverage for self, spouse and/or other dependents if become covered under spouse's plan</td>
<td>No change permitted</td>
</tr>
<tr>
<td><strong>You wish to drop coverage due to termination of adoption proceedings</strong></td>
<td></td>
<td></td>
<td></td>
<td>Must drop coverage for child who ceases to be an eligible dependent</td>
<td>Drop affected child only</td>
</tr>
<tr>
<td><strong>Death of...</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your dependent covered under a Home Depot plan</strong></td>
<td><strong>Your dependent covered under a Home Depot plan</strong></td>
<td>Death certificate or other documentation verifying the dependency or status change.</td>
<td>Date of death</td>
<td>Must drop coverage for dependent who died</td>
<td>Must drop coverage for dependent who died, can drop or decrease your coverage</td>
</tr>
<tr>
<td><strong>Your spouse and you and/or your children lose coverage under your spouse's plan</strong></td>
<td></td>
<td>Date coverage ends with other employer</td>
<td>Can add coverage for self and/or children or change coverage option if you or any child lost coverage under spouse's plan</td>
<td>Can add coverage for self and children</td>
<td></td>
</tr>
<tr>
<td><strong>Gain or Loss of Coverage Due to Moving</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>You have a work site transfer or ZIP Code change resulting in a change to eligibility for coverage under your plan</strong></td>
<td><strong>You have a work site transfer or ZIP Code change resulting in a change to eligibility for coverage under your plan</strong></td>
<td>Address must be updated in payroll system</td>
<td>Your move to a new ZIP code</td>
<td>Can change plan option</td>
<td>No change permitted</td>
</tr>
<tr>
<td><strong>You have a work site transfer or ZIP Code change resulting in no change to your plan eligibility</strong></td>
<td></td>
<td>Address must be updated in payroll system</td>
<td>Your move to a new ZIP code</td>
<td>No change permitted</td>
<td>No change permitted</td>
</tr>
</tbody>
</table>

1. Must be actively at work for coverage to take effect.
2. Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>Gain or Loss of Other Coverage</th>
<th>You will be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision</th>
<th>Term Life Insurance, Legal Services Plan</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain of coverage due to spouse’s employer’s period of coverage differing from Home Depot’s period of coverage</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Effective date of coverage gained</td>
<td>Can drop or decrease coverage for self, spouse and/or children if become covered under spouse’s plan</td>
<td>Can drop coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Loss of coverage due to spouse’s employer’s period of coverage differing from Home Depot’s period of coverage</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Effective date of coverage lost</td>
<td>Can add or increase coverage for self, spouse and/or children if coverage is lost under the spouse’s plan</td>
<td>Can add coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Gain coverage due to change in spouse’s or dependent’s employment</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Date coverage begins with other employer</td>
<td>Can drop or decrease coverage for self, spouse and/or children if covered under newly available plan</td>
<td>Can drop coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Loss of coverage due to child’s loss of eligibility under the Home Depot plans</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Effective date of coverage lost</td>
<td>You must drop coverage for dependent child</td>
<td>Can drop coverage for self, spouse and/or children You must drop coverage for child who lost eligibility</td>
<td>Not applicable</td>
</tr>
<tr>
<td>You, your child or dependent lose coverage under another health plan because it no longer offers benefits to similarly situated individuals</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Effective date of coverage lost</td>
<td>Can add coverage and/or change coverage for you, your spouse or your children</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Loss of coverage due to you, your spouse’s or your dependent’s loss of eligibility under another health plan</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Date coverage ends</td>
<td>Can add or increase coverage for self, spouse and/or children or change coverage option if you add affected dependent</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Loss of coverage due to action of other employer by termination of all plans of the same type or by ceasing all employer contributions of coverage that is not COBRA coverage</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Date other coverage involuntarily ends</td>
<td>Can add or increase coverage for self, spouse and/or children or change coverage option if each had been covered under the spouse’s plan</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

1. Must be actively at work for coverage to take effect.
2. You must notify the Benefits Choice Center after the loss of coverage has occurred but before the 30 days have passed since that loss of coverage.
3. Loss of eligibility does not include loss of coverage due to failure to pay premiums on a timely basis or termination for cause (such as making fraudulent claims).
4. Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
### You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You will be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision*</th>
<th>Term Life Insurance, Legal Services Plan†</th>
<th>Disability†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain or Loss of Other Coverage (continued)</td>
<td>Loss of coverage due to the exhaustion of COBRA coverage†</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Date COBRA coverage ends with other employer</td>
<td>Can add coverage for self, spouse and/or children or change coverage option if covered under the spouse’s plan</td>
<td>No change permitted</td>
</tr>
<tr>
<td>Spouse’s employer eliminates or adds a benefit option</td>
<td>Documentation verifying the dependency or status change.</td>
<td>Effective date of change</td>
<td>If option is eliminated, can add coverage for self, spouse and/or children</td>
<td>If option is added, can drop coverage for self, spouse and/or children if covered under new option</td>
<td></td>
</tr>
<tr>
<td>You, your spouse or your dependent lose coverage under Medicare and you wish to add coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You or your spouse gain coverage by Medicare and you wish to drop coverage</td>
<td></td>
<td></td>
<td></td>
<td>No change permitted</td>
<td>No change permitted</td>
</tr>
<tr>
<td>Gain eligibility under Medicaid or CHIP</td>
<td></td>
<td></td>
<td></td>
<td>No change permitted</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Lose coverage under Medicaid or CHIP</td>
<td></td>
<td></td>
<td></td>
<td>No change permitted</td>
<td></td>
</tr>
</tbody>
</table>

1. Must be actively at work for coverage to take effect.
2. You must notify the Benefits Choice Center after the loss of coverage has occurred but before the 30 days have passed since that loss of coverage.
3. Exhaustion of COBRA means an individual’s COBRA continuation coverage ceases for any reason other than failure to pay premiums on a timely basis, the individual voluntarily drops COBRA coverage or for cause (such as making an intentional misrepresentation of a material fact in connection with the Plan).
4. Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>Change of Employment Status</th>
<th>If you have the following change in status...</th>
<th>You will be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision¹</th>
<th>Term Life Insurance, Legal Services Plan¹</th>
<th>Disability¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part-time to Full-time</td>
<td>Date of employment status change or eligibility date</td>
<td>Coverage, except for Dental, Vision, Medical Payment Plan and Legal Services, ends for self, spouse and/or children. No changes are allowed in the Dental and Vision plans. You may drop or enroll in the Hospital-Only option in the Medical Payment Plan. See the Full-time Benefits Summary for a description of coverage for which you may be eligible following your change in employment status. Full-time hourly associates are automatically enrolled in the full-time hourly Disability Plan. The terms and conditions, including limits, differ for the full-time hourly Disability Plan, so check the Full-time Benefits Summary for more information. Coverage, except Dental, Vision, Medical Payment Plan and Legal Services, ends for self, spouse and/or children. No changes are allowed in the Dental and Vision plans. You may drop coverage or change options in the Medical Payment Plan and you may add or drop coverage in the Legal Services Plan. See this Benefits Summary and the Health Care Qualifying Hours Associates Benefits Summary for a description of coverage for which you may be eligible following your change in employment status. The full-time hourly Life Insurance and Disability plans end (see the Life Insurance chapter for information regarding portability and conversion); however, part-time hourly associates are automatically enrolled in the part-time hourly Disability Plan. The terms and conditions, including limits, differ for the part-time Disability Plan, so check this Benefits Summary for more information.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time to Part-time</td>
<td>Date of employment status change or eligibility date</td>
<td>Can add or increase coverage for self, spouse and/or children</td>
<td>Can add or increase coverage for self, spouse and/or children</td>
<td>Can add or increase coverage for self, spouse and/or children</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

**Military Leave**

| Leaving for and returning from a military leave of absence within the same calendar year | Documentation verifying the dependency or status change. | Date leave begins or date leave ends | Coverage before leave will automatically be reinstated OR Can add coverage and/or change coverage for you, your spouse or your children | Coverage before leave will automatically be reinstated OR Can add coverage and/or change coverage for you, your spouse or your children | Coverage before leave will automatically be reinstated OR Can add coverage and/or change coverage for you, your spouse or your children | Not applicable |
| Leaving for and returning from a military leave of absence in a subsequent year | Documentation verifying the dependency or status change. | Date leave begins or date leave ends | Can add coverage and/or change coverage for you, your spouse or your children | Can add coverage and/or change coverage for you, your spouse or your children | Can add coverage and/or change coverage for you, your spouse or your children | Not applicable |

¹ Must be actively at work for coverage to take effect.

² Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You will be asked to provide the Benefits Choice Center within 30 days after...</th>
<th>You must notify the Benefits Choice Center within 30 days after...</th>
<th>Medical Payment Plan, Critical Illness Protection, Dental &amp; Vision¹</th>
<th>Term Life, Legal Services Plan¹</th>
<th>Disability¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaves of Absence</td>
<td>Date leave begins</td>
<td>Can drop coverage for you, your spouse or children²</td>
<td>Can drop coverage for you, your spouse or children</td>
<td>Can drop coverage</td>
<td></td>
</tr>
<tr>
<td>Going on a leave of absence</td>
<td>Date leave begins</td>
<td>Can drop coverage for you, your spouse or children²</td>
<td>Can drop coverage for you, your spouse or children</td>
<td>Can drop coverage</td>
<td></td>
</tr>
<tr>
<td>Returning from a leave of absence within the same calendar year³</td>
<td>Date leave ends</td>
<td>Coverage before leave will automatically be reinstated.</td>
<td>Coverage before leave will automatically be reinstated.</td>
<td>Coverage before leave will automatically be reinstated.</td>
<td></td>
</tr>
<tr>
<td>Returning from a leave of absence the following calendar year (or any subsequent year, up to five years, for military leave)³</td>
<td>Date leave ends</td>
<td>Coverage you are enrolled in when you return from leave will continue after you return from leave. If you don’t have coverage(s) when you return from leave, you can enroll within 30 days of the date you return from leave</td>
<td>Coverage before leave will automatically be reinstated. If you want to add or stop coverage, see the applicable chapter for requirements (Life Insurance chapter or the Disability chapter). For information on the Legal Services Plan or other Voluntary Benefits, call the Benefits Choice Center.</td>
<td>Coverage before leave will automatically be reinstated. If you want to add or stop coverage, see the applicable chapter for requirements (Life Insurance chapter or the Disability chapter). For information on the Legal Services Plan or other Voluntary Benefits, call the Benefits Choice Center.</td>
<td></td>
</tr>
</tbody>
</table>

¹ Must be actively at work for coverage to take effect.
² Coverage and payroll deductions will automatically be reinstated for the plans you continue to contribute towards through direct billing. If your coverage is dropped during your leave for non-payment of premiums, your coverage will be automatically reinstated upon your return from leave. If you voluntarily drop coverage during your leave, the dropped coverage will not be automatically reinstated upon your return from leave. You will need to call the Benefits Choice Center within 30 days to re-enroll.
³ Associates going on a leave of absence are not allowed to enroll in Medical Payment Plan coverage if the associate is not covered in the Medical Payment Plan prior to the leave. Associates who go on a leave of absence and are enrolled in the Medical Payment Plan prior to the leave of absence are allowed to drop coverage or change to a lower coverage tier during their leave.
⁴ Coverage in the Critical Illness Protection Plan can be added, changed or dropped following a life event.
Eligibility and Enrollment Quick Facts and Quick Links

U.S. Part-Time Hourly Associates

For New Associates Enrolling for the First Time

<table>
<thead>
<tr>
<th>When do I enroll?</th>
<th>Before your 91st day of employment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you don’t enroll by your deadline, you won’t have dental, vision, medical payment plan or critical illness protection plan coverage for the rest of 2017 unless you have a life event.</td>
</tr>
</tbody>
</table>

| How do I enroll? | • Read the New Hire Guide on www.livetheorangelifelife.com |
|                  | • To enroll, log into www.livetheorangelifelife.com or call the Benefits Choice Center at 1-800-555-4954 |

| When does my coverage begin? | Generally, on your 91st day of employment |

For All Other Associates

<table>
<thead>
<tr>
<th>When do I enroll?</th>
<th>During annual enrollment.</th>
</tr>
</thead>
</table>

| How do I enroll? | Log into www.livetheorangelifelife.com or call the Benefits Choice Center at 1-800-555-4954 |

| When does my coverage begin? | Generally, on the following January 1. |

Quick Links to Frequently Used Eligibility and Enrollment Info

- Is my spouse eligible for coverage?
- Are my dependent children eligible for coverage?
- I need to change my coverage due to a life event.
- When does my coverage end?
ELIGIBILITY AND ENROLLMENT
U.S. Part-Time Hourly Associates

CHAPTER CONTENTS

13 Who Is Eligible
13 U.S. Part-time Hourly Associates
13 Temporary Associates, Leased Employees and Independent Contractors
13 Dependent Eligibility
14 Eligibility: Dependent Children
14 Eligibility: Disabled Dependent Children
14 Eligibility: Newborn and Adopted Children
15 Special Enrollment Rights
15 Eligibility: Family Members Who Can’t Participate
16 If You and Your Spouse Both Work for the Company
16 Enrolling as a New Associate
16 Enrolling in Benefits as a New Associate
16 Enrolling or Making Changes After Initial Enrollment
16 Annual Enrollment
17 Qualified Change in Status/Life Events
17 When Changes to Coverage Take Effect
17 When Coverage Begins
18 If You’re Rehired
19 Employment Status Changes
19 Declining Coverage
19 Opting Out of Automatic Enrollment
19 Cost of Coverage
19 About Before-Tax Contributions
19 When Your Coverage Ends
20 Continuing Coverage
20 Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)
**Who Is Eligible**

**U.S. Part-time Hourly Associates**

You are eligible to participate in the Company’s health and welfare benefit plans as described in this Benefits Summary, if you are classified by the Company as a part-time associate and have completed your 90-day waiting period. Coverage under benefits you enroll in generally begins on your 91st day of employment. You may also be eligible for medical benefits if you are a Health Care Qualifying Hours associate. See the Health Care Qualifying Hours Associate Benefits Summary for more details.

The Company also offers Group Benefits, which include the MetLaw Legal Services Plan, Auto and Home Insurance, Roadside Assistance Program, Home Protection Program and MetLife Pet Insurance. For more information on these plans, call the Benefits Choice Center and say “Additional Programs” at the main menu.

When you enroll during Annual Enrollment, your coverage begins on January 1. See When Coverage Begins in this chapter for more information on when coverage begins.

Please note that if the amount of your pay does not cover or only partially covers the payroll deductions for your benefit coverage for two consecutive pay periods, you will be direct billed at active associate rates and must make payments for your coverage. Any unpaid premium amounts for those two pay periods will be collected in future paychecks. In addition, you will not be able to pay for your benefits through payroll deduction for the rest of the calendar year.

Temporary Associates, Leased Employees and Independent Contractors

If you are on the Company’s payroll system as a temporary associate, you are not eligible to participate in health and welfare benefits or other benefit programs except for, in certain cases, the FutureBuilder 401(k) Plan. See the eligibility rules for additional information. Leased employees and independent contractors are also ineligible for these benefits.

If you are working for the Company as a temporary associate and are added to the Company’s payroll system as a part-time hourly associate, your length of employment for eligibility for health and welfare benefits will include your time as a temporary associate. If you are converted from a temporary associate to a part-time hourly associate, you will become eligible for health and welfare benefits as of the later of your 91st day of employment or the date you are converted to part-time status.

If you are working for the Company as a leased employee or independent contractor and are added to the Company’s payroll system, your length of employment for eligibility for health and welfare benefits will not include your time as a leased employee or independent contractor.

**Dependent Eligibility**

The following dependents can participate in the Medical Payment, Dental, Vision, Critical Illness Protection and Term Life Insurance Plans as described in this document:

- Your legal spouse, unless you are legally separated (as defined under applicable law). Your legal spouse is a person of the same or opposite sex to whom you are validly married under the laws of the state or foreign country in which the marriage was performed.
- Common-law spouses are not eligible.
- Domestic partners are not eligible.

---

1 If you are later determined to be an employee of the Company for any reason and become eligible for benefits, you may participate in benefits only from the actual date the determination is made that you are a benefits eligible employee, even if the reclassification becomes effective on an earlier date.
Eligibility: Dependent Children

Eligible dependent children may be covered under the Company Medical Payment, Dental, Vision, Critical Illness Protection and Term Life Insurance Plans through the last day of the calendar year in which the child turns 26. Eligible dependent children include the following:

- Your natural and adopted children, and children placed with you for adoption;
- Children for whom you are appointed legal guardian; and
- Stepchildren.
- Children for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO), but only for coverage under the group health plans as required under the order.
- Dependents for whom state insurance law requires coverage to be extended under a fully insured plan. See the State Exceptions to Dependent Eligibility for Fully Insured Plans chart below. Refer to the Plan Administration Section for a list of the fully insured plans.

### State Exceptions to Dependent Eligibility for Fully Insured Plans

<table>
<thead>
<tr>
<th>State</th>
<th>Coverage available until the end of the calendar year in which eligible participant turns:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>Age 27</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Age 27</td>
</tr>
<tr>
<td>Ohio</td>
<td>Age 28</td>
</tr>
<tr>
<td>Florida</td>
<td>Age 30</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Age 28</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Age 28</td>
</tr>
<tr>
<td>New York</td>
<td>Age 29</td>
</tr>
</tbody>
</table>

Eligibility: Disabled Dependent Children

You may continue to cover a dependent child who is eligible for coverage as defined in Dependent Eligibility previously in this chapter and who is incapable of self-support and primarily depends on you for support and maintenance because of mental retardation or physical disability and such disability existed prior to the last day of the calendar year in which the child turns 26 as long as the child was covered under the Plan before that date. You can continue coverage for your disabled child as long as the mental or physical disability continues. To continue coverage, you must contact the Benefits Choice Center within 30 days after coverage would otherwise end. Documentation will be required.

Eligibility: Newborn and Adopted Children

To enroll a newborn or newly adopted child (or child placed for adoption) for coverage, you must call the Benefits Choice Center or go to www.livetheorangefull.com and enroll them no later than 30 days after the child’s birth, date of adoption or placement for adoption.

If you first become eligible for the benefit plans after the last day of the calendar year in which your disabled child turns 26, you can cover that child if:

- your child meets the definition of a disabled child above; and
- you enroll yourself and that child within your initial eligibility period.

The Company’s Plans reserve the right to have your child examined by a physician of their choice to determine the existence of your child’s disability.

Coverage for your disabled dependent child will end on the first to occur of the following:

- Cessation of the disability.
- Failure to provide proof that the disability continues.
- Failure to have any required exam.
- Termination of dependent coverage as to your child for any reason other than reaching the maximum age under the plan.

Eligibility: Newborn and Adopted Children

To enroll a newborn or newly adopted child (or child placed for adoption) for coverage, you

TO ENROLL, GO TO WWW.LIVETHEORANGELIFE.COM; FOR HELP, CALL 1-800-555-4954
Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Company plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You may also enroll in the plan if you lose Medicaid or CHIP coverage or become eligible to participate in a Medicaid or CHIP premium assistance program. You must request special enrollment in the Company plan within 60 days from the date of loss of coverage or the date of eligibility.

Note: You may at anytime be asked to provide required documentation to verify the eligibility of your eligible dependent children. Failure to provide such documentation within the time frame given will result in your child being ineligible for coverage under the plan.

Eligibility: Family Members Who Can’t Participate
The following family members cannot participate in the Company’s benefit Plans as described in this Benefits Summary:

- Your spouse, if you are legally separated (as defined under applicable law)
- Your ex-husband or ex-wife, if divorced from you
- Your common-law spouse and his or her children
- Your same- or opposite-sex domestic partner and his or her children
- Children as of the last day of the calendar year in which they turn 26 unless they meet the requirements for disabled children
- Foster children, except under the Critical Illness Protection Plan. A foster child can be covered under the Critical Illness Protection Plan if the child is placed with you by an authorized placement agency or by judgement, decree or other order of any court of competent jurisdiction
- Any family member, including yourself, while on active duty in any military service for any country (subject to military leave and continuation of benefits coverage requirements under federal law)

Enrolling for Coverage
By enrolling or making changes to your benefits (including such actions as, but not limited to adding a dependent), you are responsible for providing truthful and accurate information. Providing false information may result in exclusion from (i.e., loss of eligibility for, which could include the recission of coverage) all Company-sponsored health and welfare benefit plans and/or disciplinary action as outlined in the Company’s Standards of Performance.
Enrolling as a New Associate

You will receive benefits enrollment information after you join the company. Refer to the Enrolling in Benefits as a New Associate chart below regarding general enrollment requirements. You must go to www.livetheorangegle.com or call the Benefits Choice Center to enroll within 90 days of your date of hire. If the enrollment information was mailed to the address on the Company records, no exception will be made to the above enrollment deadline. You are responsible for updating your postal address in the Company records. Please contact the Human Resources Service Center at 1-866-698-4347 for details on updating your contact information. Paper enrollments will not be accepted.

If you do not enroll when you are first eligible as a new hire, you will not be able to enroll in Medical Payment, Critical Illness Protection, Vision or Dental benefits until the next Annual Enrollment unless you have a qualified status change during the year. You may enroll in Term Life, Dependent Term Life or Short-Term Disability during any rolling 12-month period; annual enrollment counts for this purpose. You can enroll in the Legal Services Plan, Auto and Home and MetLife Pet Insurance at any time.

### Enrolling in Benefits as a New Associate

<table>
<thead>
<tr>
<th>Plan</th>
<th>Is Enrollment Necessary?</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Payment Plan</td>
<td>Yes.</td>
<td>The Medical Payment Plan Hospital Plus I and Hospital Plus II options are not available to associates who live in HI, MN and ND. The Medical Payment Plan is not available to associates who live and work in New Hampshire.</td>
</tr>
<tr>
<td>Critical Illness Protection Plan</td>
<td>Yes.</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Yes.</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Yes.</td>
<td></td>
</tr>
<tr>
<td>Associate Only Term Life Insurance</td>
<td>Yes.</td>
<td></td>
</tr>
<tr>
<td>Dependent Term Life Insurance</td>
<td>Yes.</td>
<td></td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>No.</td>
<td>Enrollment is automatic for newly eligible associates during their initial eligibility period. If you do not want disability insurance, you can opt out at any time. STD is not available in CA, NJ, NY and RI. You may only opt out if you have not filed a claim for a disability benefit with Aetna within the prior 12 months. Evidence of Insurability will be required to re-enroll.</td>
</tr>
<tr>
<td>Legal Services Plan</td>
<td>Yes.</td>
<td></td>
</tr>
</tbody>
</table>

### If You and Your Spouse Both Work for the Company

If you and your spouse both work for the Company, you have the following enrollment options:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Choice</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| Dental, Vision, Medical Payment and Critical Illness Protection Plan | Each of you can enroll in associate-only coverage | With this choice:  
• Your spouse is covered as a dependent.  
• Your spouse must be enrolled in the same Dental, Vision, Medical Payment and/or Critical Illness Protection Plan option, that you elect. |
|                                           | One of you can enroll in associate + spouse coverage |                                                                 |
| See the Dental, Vision, Medical Payment and Critical Illness Protection Plan chapters for more information40 | One of you can enroll in associate + family (children and spouse) coverage | With this choice:  
• Your spouse and children, if any, are covered as dependents.  
• Your spouse and children must be enrolled in the same Dental, Vision, Medical Payment and/or Critical Illness Protection Plan option, that you elect. |
Enrolling or Making Changes After Initial Enrollment

If you decline coverage for yourself and/or your eligible dependents during your initial eligibility period, or if you do not enroll for coverage when you or your eligible dependents are first eligible, you can enroll during the next Annual Enrollment or if you have a qualified status change, subject to certain restrictions. For more information, see the Life Events chapter.

Federal tax law requires the Company to limit the times that you can change your benefit elections for the Medical Payment, Dental and Vision Plans to:

- Once a year during Annual Enrollment; and
- When you experience a qualified change in status.

Except for these two events, you cannot change your benefits elections during the year.

The Company limits the number of times you can change your elections for the Critical Illness Protection Plan as follows:

- Once a year during Annual Enrollment; and
- When you experience a qualified change in status.

However, you can drop Critical Illness Protection Plan coverage for yourself or your dependents at any time by calling the Benefits Choice Center.

For any change made during a subsequent Annual Enrollment period for Medical Payment, Critical Illness Protection, Dental and/or Vision Plans, coverage will start on January 1 of the new Plan Year, unless otherwise noted in your enrollment communications.

For more information on qualified status changes, see the Life Events chapter.

You may be able to change your benefit elections for Term Life Insurance, Dependent Term Life Insurance and STD:

- Once every rolling 12 months from the date of the election (annual enrollment counts for this purpose); and
- When you experience a qualified change in status (not applicable for STD).

Annual Enrollment

The Company usually holds annual benefits enrollment during the last quarter of each calendar year. Annual Enrollment is the time when you make your benefit elections for the coming year.

Enrolling in Medical Payment, Critical Illness Protection, Dental, Vision and Term Life Insurance Coverage

There may be times when the Company requires you to actively enroll in the Medical Payment, Critical Illness Protection, Dental, Vision and Term Life Insurance plans during Annual Enrollment by going to www.livetheorangelife.com or calling the Benefits Choice Center.

In years that the Company does not require you to actively enroll in Medical Payment, Critical Illness Protection, Dental, Vision and Term Life Insurance coverage during Annual Enrollment and you do not go to www.livetheorangelife.com or call the Benefits Choice Center to add, cancel or change your elections, you will be automatically assigned the same coverage if available in the new Plan Year. If the same coverage is not available, you will be assigned to the coverage that is most similar to the coverage that is no longer available.

Coverage elections made during Annual Enrollment will be effective January 1 of the following year and will continue until December 31 of that year, unless otherwise noted in your Annual Enrollment communications.

Enrolling in Life Insurance and Disability

If you are enrolled in life and/or disability insurance, you do not have to reenroll in these plans during Annual Enrollment—you will keep your coverage for the next calendar year unless you make a change.

Qualified Change in Status/Life Events

You cannot change or cancel your Medical Payment, Critical Illness, Dental or Vision Plan elections mid year except as shown in the Life Events chapter.

However, you can drop Critical Illness Protection Plan coverage for yourself or your dependents at any time by calling the Benefits Choice Center.

When Changes to Coverage Take Effect

Generally, for your election to become effective you must call the Benefits Choice Center, and speak to a representative within 30 days after the qualified change in status occurs. A 60-day election period applies to changes related to Medicaid and CHIP coverage.

For your election change to be effective, the Benefits Choice Center must determine that the requested enrollment change is consistent with the qualified
change in status. If approved, all new coverage will be effective the date of the change in status. If you experience a change in status due to marriage, divorce, birth, adoption, or placement for adoption, you may also go to www.livetheorangelife.com to make your election changes within 30 days after the event occurred.

The Company may request that you provide required documentation of your qualifying change in status. Providing false information may result in exclusion (i.e., loss of eligibility for, which could include the rescission of coverage), for all Company sponsored health and welfare benefit plans and/or disciplinary action as outlined in The Company’s Standards of Performance.

When Coverage Begins
Your coverage begins on the first day after you complete your 90-day waiting period—your 91st day.

When you enroll during Annual Enrollment, your coverage begins on the following January 1.

Exceptions
Coverage may be postponed for all Plans, except dental, vision, critical illness protection and MetLaw coverage, as follows:

- You are not actively working on the day your coverage begins. Coverage for you and your eligible family members will be delayed until you return to work.
- Your dependent is confined at home, in a hospital or elsewhere for medical reasons. Coverage for that individual will be delayed until his or her attending doctor provides a final medical release. (Final medical release refers to a statement from the attending physician that treatment for the condition has been completed and that the patient may return to normal activities.)

If You’re Rehired
If you stop working for the Company and are rehired and are actively working on a regular part-time basis, your enrollment in the Plans will be handled as follows:

- **Within 30 days.** If you were eligible before termination and are re-employed within 30 days and within the same calendar year, you are automatically reinstated in the same coverage. If you experienced a qualified status change, you may make changes to your benefits within 30 days of your rehire. If you were not eligible prior to termination and are re-employed within 30 days, you must complete the 90-day waiting period and enroll by your enrollment deadline. You will receive credit for previous employment. All coverages become effective on the first day after you complete the waiting period—the 91st day—provided you enroll within 30 days of your rehire date.
- **After six months.** If you are rehired more than six months from the date of your termination, you will be considered a new hire for purposes of coverage under the benefit plans and will have to complete the 90-day waiting period to be eligible for benefits. With respect to the FutureBuilder 401(k) Plan, once you have satisfied the eligibility requirements, if you leave the Company and are later rehired you will be able to rejoin the FutureBuilder Plan immediately. See What’s a Break in Service? in the FutureBuilder chapter.

In all cases, if you are eligible and you enroll by your enrollment deadline, all coverages are effective on the date you become eligible.

If you leave the Company due to a reduction in force and are rehired within 30 days and in the same calendar year, the coverage you had before your termination will be reinstated with no lapse. Contact the Benefits Choice Center to verify that your coverage has been reinstated.
**Employment Status Changes**

If your part-time employment status changes to full-time, your enrollment in the Health and Welfare plans will be handled as follows:

- **If you have not completed the waiting period,** you must complete your waiting period and enroll in any full-time plans you become eligible for within 30 days of your employment status change date. All coverages become effective on the first day after you complete your 90-day waiting period—on the 91st day.

- **If you have completed the waiting period:**
  - You can continue the coverage you had before the employment status change under COBRA; or
  - You can enroll in new coverage you become eligible for within 30 days of your employment status change.

If your employment status changes to salaried, you are eligible for salaried health and welfare plans on your employment status change date if you have completed your waiting period. If you have not completed your waiting period, you must complete your waiting period and enroll within 30 days of your employment status change date. All coverages become effective on the first day after you complete your 90-day waiting period—on the 91st day.

---

**Declining Coverage**

Participation in the Company benefit plans is voluntary. When you first become eligible for benefits, if you do not wish to enroll in coverage for yourself and/or your eligible family members (except STD), you do not have to do anything.

---

**Opting Out of Automatic Enrollment**

All newly eligible associates are automatically enrolled in the Company’s Short-term Disability Plan (STD), except in CA, NJ, NY and RI, which have mandatory state programs.

If you do not want STD coverage, you must opt out by going to [www.livetheorangelife.com](http://www.livetheorangelife.com) or calling the Benefits Choice Center before your 91st day of employment.

You may only opt out of disability coverage if you have not filed a claim for a disability benefit with Aetna within the prior 12 months. If you have been approved for a disability benefit by Aetna, you may opt out of coverage during your next 12-month period following your return from medical leave.

If you opt out of STD, you may enroll in STD during any rolling 12-month period. You also may elect this coverage when you experience a qualified status change or at annual enrollment—enrollment in these instances will count as once in a rolling 12-month period. See the Disability chapter for more information. Note that when you re-enroll or enroll after opting out, you will have to provide Evidence of Insurability.

---

**Cost of Coverage**

The benefit Plans, including the Medical Payment, Critical Illness Protection, Vision, Dental, Disability Insurance and Term Life Insurance Plans, require contributions from you.

As a convenience to you, if you enroll in any of these Plans, your contributions will be deducted from your paycheck.

---

**About Before-Tax Contributions**

By enrolling in the Medical Payment, Vision and/or Dental Plans, you authorize the Company to reduce your gross pay with before-tax dollars for the required premiums. This means you will not pay Social Security taxes, federal income taxes and, in most cases, state income taxes on the money deducted from your paycheck for Medical Payment, Vision and Dental. While you pay less in current taxes, the amount of your pay used to determine Social Security benefits at retirement may be reduced slightly.

---

**When Your Coverage Ends**

All coverage (in the Medical Payment, Critical Illness Protection, Dental, Vision, STD, Term Life, Dependent Term Life, and MetLaw Legal Services Plans) will end on the first to occur of the following:

- On midnight on the last day in the pay period in which your employment with the Company ends.
- At midnight on the date that you or any member of your family (dependents) no longer meet the eligibility requirements for participation in the Plans.

See [Who is Eligible](#) and [Dependent Eligibility](#) in this chapter for more information.
ELIGIBILITY AND ENROLLMENT

• If you are on a medical leave of absence, your eligibility to file a new disability claim ends on the day your leave begins.
• If you are on a leave of absence, see the HR SOP applicable to you for information on when coverage ends for your specific type of leave.
• When you experience an employment status change (for example, full-time to part-time or part-time to full-time), your coverage ends at midnight on the date of the employment status change.
• When your payment grace period has expired after you stop making the required contributions for coverage, your coverage in all Plans will be ended on your paid through date.
• The date amendments to the Plans terminate certain benefits or terminate the Plans.
• When you or any covered dependent has received the maximum basic benefit amount payable under the Critical Illness Protection Plan.

Continuing Coverage

In some cases, you may continue Medical Payment, Critical Illness Protection, Vision and Dental coverage for you and your eligible family members after your coverage would typically end. See the COBRA Coverage chapter for more information. Coverage in Care Solutions for Life EAP and the on-site medical clinic will continue automatically for 36 months.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. You should contact your state for further information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
<table>
<thead>
<tr>
<th>STATE</th>
<th>WEBSITE</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA: Medicaid</td>
<td><a href="http://www.myalhipp.com">www.myalhipp.com</a></td>
<td>1-855-692-5447</td>
</tr>
<tr>
<td>ALASKA: Medicaid</td>
<td>The AK Health Insurance Premium Payment Program:</td>
<td>1-866-251-4861</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid Eligibility:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
</tr>
<tr>
<td>COLORADO: Medicaid</td>
<td><a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td>Medicaid Customer Contact Center: 1-800-221-3943</td>
</tr>
<tr>
<td>FLORIDA: Medicaid</td>
<td><a href="http://www.fimedicaidplrecovery.com/hipp/">http://www.fimedicaidplrecovery.com/hipp/</a></td>
<td>1-877-357-3268</td>
</tr>
<tr>
<td>GEORGIA: Medicaid</td>
<td><a href="http://dch.georgia.gov/medicaid-">http://dch.georgia.gov/medicaid-</a> Click on Health Insurance Premium Payment (HIPP)</td>
<td>404-656-4507</td>
</tr>
<tr>
<td></td>
<td>All other Medicaid: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
<td>1-800-403-0864</td>
</tr>
<tr>
<td>IOWA: Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a></td>
<td>1-888-346-9562</td>
</tr>
<tr>
<td>KANSAS: Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
<td>1-785-296-3512</td>
</tr>
<tr>
<td>KENTUCKY: Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-635-2570</td>
</tr>
<tr>
<td>LOUISIANA: Medicaid</td>
<td><a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>1-888-695-2447</td>
</tr>
<tr>
<td></td>
<td>TTY: Maine relay 711</td>
<td></td>
</tr>
<tr>
<td>MASSACHUSETTS: Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>1-800-462-1120</td>
</tr>
<tr>
<td>MINNESOTA: Medicaid</td>
<td><a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a></td>
<td>1-800-657-3739</td>
</tr>
<tr>
<td>MISSOURI: Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>MONTANA: Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>1-800-694-3084</td>
</tr>
<tr>
<td>NEBRASKA: Medicaid</td>
<td><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a></td>
<td>1-855-632-7633</td>
</tr>
<tr>
<td>NEVADA: Medicaid</td>
<td><a href="http://dhsw.nv.gov/">http://dhsw.nv.gov/</a></td>
<td>1-800-992-0900</td>
</tr>
<tr>
<td>NEW JERSEY: Medicaid CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmabs/clients/medicaid/">http://www.state.nj.us/humanservices/dmabs/clients/medicaid/</a></td>
<td>609-631-2392</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td>1-800-701-0710</td>
</tr>
<tr>
<td>NEW YORK: Medicaid</td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td>NORTH CAROLINA: Medicaid</td>
<td><a href="http://www.ncdhhs.gov/mana/">http://www.ncdhhs.gov/mana/</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td>NORTH DAKOTA: Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>844-854-4825</td>
</tr>
<tr>
<td>OKLAHOMA: Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org/">http://www.insureoklahoma.org/</a></td>
<td>1-888-365-3742</td>
</tr>
<tr>
<td>OREGON: Medicaid</td>
<td><a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a></td>
<td></td>
</tr>
</tbody>
</table>
## ELIGIBILITY AND ENROLLMENT

<table>
<thead>
<tr>
<th>STATE</th>
<th>WEBSITE</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PENNSYLVANIA: Medicaid</td>
<td><a href="http://www.dhs.state.pa.us/hipp">http://www.dhs.state.pa.us/hipp</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>RHODE ISLAND: Medicaid</td>
<td><a href="http://www.eohhs.ri.gov">http://www.eohhs.ri.gov</a></td>
<td>401-462-5300</td>
</tr>
<tr>
<td>SOUTH CAROLINA: Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
</tr>
<tr>
<td>SOUTH DAKOTA: Medicaid</td>
<td><a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>1-888-828-0059</td>
</tr>
<tr>
<td>TEXAS: Medicaid</td>
<td><a href="http://www.gethipptexas.com">http://www.gethipptexas.com</a></td>
<td>1-800-440-0493</td>
</tr>
<tr>
<td></td>
<td><a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
<td></td>
</tr>
<tr>
<td>VERMONT: Medicaid</td>
<td><a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>1-800-250-8427</td>
</tr>
<tr>
<td>VIRGINIA: Medicaid and CHIP</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-800-432-5924</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-855-242-8282</td>
</tr>
<tr>
<td>WASHINGTON: Medicaid</td>
<td><a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administra-">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administra-</a></td>
<td>1-800-562-3022 ext. 15473</td>
</tr>
<tr>
<td></td>
<td>tion/premium-payment-program</td>
<td></td>
</tr>
</tbody>
</table>
The Medical Payment Plan Quick Facts and Quick Links

U.S. Part-Time Hourly Associates

Your Medical Payment Plan Options

1 Hospital Only  2 Hospital Plus I*  3 Hospital Plus II*

* Not available to associates who live in HI, MN and ND. Also not available to associates who live and work in NH.

A Quick Look at the Medical Payment Plan

<table>
<thead>
<tr>
<th>Service</th>
<th>Hospital Only</th>
<th>Hospital Plus I*</th>
<th>Hospital Plus II*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admission</td>
<td>$1,000 (1 per year)</td>
<td>$1,000 (1 per year)</td>
<td>$700 (2 per year)</td>
</tr>
<tr>
<td>Daily Hospital Benefit: Non-Intensive Care Unit</td>
<td>$100 (100 day limit)</td>
<td>$100 (2 stays per year)</td>
<td>$500 (2 stays per year)</td>
</tr>
<tr>
<td>Daily Hospital Benefit: Intensive Care Unit</td>
<td>$100 (100 day limit)</td>
<td>$200 (2 stays per year)</td>
<td>$1,000 (2 stays per year)</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>—</td>
<td>$200 (2 per year)</td>
<td>$275 (2 per year)</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>—</td>
<td>—</td>
<td>$450 (2 per year)</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>—</td>
<td>—</td>
<td>$450 (2 per year)</td>
</tr>
<tr>
<td>Outpatient Lab and X-ray</td>
<td>—</td>
<td>—</td>
<td>$90 (3 per year)</td>
</tr>
<tr>
<td>Services Resulting from an Accident</td>
<td>—</td>
<td>$200 (2 per year)</td>
<td>$300 (2 per year)</td>
</tr>
<tr>
<td>Doctor Office Visits</td>
<td>—</td>
<td>$50 per day (5 days per year)</td>
<td>$70 per day (7 days per year)</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>—</td>
<td>$35 per day (12 days per year)</td>
<td>$45 per day (12 days per year)</td>
</tr>
<tr>
<td>Per Biweekly Paycheck Payroll Deductions: Associate-only Coverage</td>
<td>$6.69</td>
<td>$19.40</td>
<td>$34.53</td>
</tr>
</tbody>
</table>

Note: Only one payment per day per service. For full plan details, go to livetheorangefife.com > Benefit Summaries. *Not available to associates who live in HI, MN and ND. Also not available to associates who work and live in NH.

Cool Medical Payment Plan Features

- **Benefits When You Need it Most!** When you receive a covered service, your MPP benefit could be paid directly to you or to your health care provider, depending on the plan you select and your provider.
- **If you are enrolled in the Hospital Plus I or Hospital Plus II Option You:**
  - **Pay Less for Care from Network Providers.** Lower your medical expenses by seeing participating providers in the Aetna Open Choice® PPO network.
  - **Have Access to Registered Nurses 24/7 through Aetna's Informed Health® Line.**
  - **Get Discounts on Fitness Centers, Jenny Craig and More.**

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

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.
# The Medical Payment Plan

## U.S. Part-Time Hourly Associates

**Chapter Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Medical Payment Plan (MPP)</td>
<td>25</td>
</tr>
<tr>
<td>MPP Options</td>
<td>25</td>
</tr>
<tr>
<td>Note Plan Limits</td>
<td>25</td>
</tr>
<tr>
<td>Coverage Categories</td>
<td>26</td>
</tr>
<tr>
<td>ID Cards</td>
<td>26</td>
</tr>
<tr>
<td>Examples of How the MPP Pays Benefits</td>
<td>26</td>
</tr>
<tr>
<td>Hospital Only</td>
<td>26</td>
</tr>
<tr>
<td>Hospital Plus II</td>
<td>26</td>
</tr>
<tr>
<td>Getting the Most Value out of the Hospital Plus I and Hospital Plus II Options Providers</td>
<td>26</td>
</tr>
<tr>
<td>Medical Payment Plan Summary of Benefits</td>
<td>27</td>
</tr>
<tr>
<td>Filing a Claim</td>
<td>28</td>
</tr>
<tr>
<td>Aetna Programs Available to MPP Participants</td>
<td>28</td>
</tr>
<tr>
<td>Aetna Vision Discounts</td>
<td>28</td>
</tr>
<tr>
<td>Prescription Drug Discount Program</td>
<td>28</td>
</tr>
<tr>
<td>Aetna's Informed Health® Line: Hospital Plus I and Hospital Plus II Options</td>
<td>29</td>
</tr>
<tr>
<td>Aetna Resources For Living: Hospital Plus I and Hospital Plus II Options</td>
<td>29</td>
</tr>
<tr>
<td>What the Plan Does Not Cover</td>
<td>29</td>
</tr>
<tr>
<td>Refund of Overpayments</td>
<td>30</td>
</tr>
<tr>
<td>Coordinating With Other Plans</td>
<td>30</td>
</tr>
</tbody>
</table>
The Medical Payment Plan (MPP)
The Medical Payment Plan (MPP) pays a fixed amount for eligible covered services that, depending on the plan you select, include:

- Inpatient hospital stays
- Inpatient and outpatient surgical procedures
- Emergency room visits
- Outpatient doctors’ office visits—including walk-in clinics and urgent care centers
- Outpatient laboratory and x-ray services
- Prescription drugs, equipment and supplies

If you receive a covered service, the plan pays a fixed cash benefit. You may have the option of having the benefits paid directly to you depending on the plan you select and your health care provider; otherwise the MPP will make the payment directly to your health care provider on your behalf. See Filing a Claim for more information. The MPP pays benefits regardless of any other insurance coverage you may have. You can enroll yourself and eligible dependents in this plan.

MPP Options
As a part-time associate, you have three MPP coverage options:

- Hospital Only
- Hospital Plus I*
- Hospital Plus II*
  * Not available to associates who live in HI, MN and ND. Also not available to associates who live and work in NH.

The Hospital-Only option pays benefits for inpatient hospital stays only. The Hospital Plus I and Hospital Plus II options pay benefits for inpatient hospital stays, outpatient doctors’ office visits, prescription drugs and more. For more information on benefits, see the Medical Payment Plan Summary of Benefits chart in this chapter.

The Hospital Plus I and Hospital Plus II options also offer access to the Aetna Open Choice PPO network.

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.livetheorangefl.com.

IMPORTANT INFORMATION ABOUT THE BENEFITS YOU ARE BEING OFFERED:

Medical Payment Plan Hospital Only Option is a hospital confinement indemnity plan. The Hospital Plus and Hospital Plus I options are hospital confinement indemnity plans with other fixed indemnity benefits. 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.

This chapter provides a brief description of the important features of the benefits. It is not an insurance contract and only the actual policy provisions...
will control. The specific dollar limits are described in this chapter. If the costs of services exceed these specific dollar amounts, you are responsible for the payment of any excess amounts.

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.

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)

ID Cards
Once you become covered under the Home Depot Hospital Plus I or II option, you will receive an identification (ID) card(s). Keep your ID card with you at all times, and show it at your doctor’s office each time you receive medical treatment. It will help your doctor verify your benefits. Please note that the possession of an ID card does not entitle you to benefits. Your enrollment in a plan must be effective when medical services are received for you to be entitled to benefits.

Examples of How the MPP Pays Benefits
The MPP pays a fixed cash benefit for covered services. For information on benefits for each of the options, see the Medical Payment Plan Summary of Benefits chart in this chapter.

Hospital Only
This example shows how the Hospital Only option pays benefits for a three-day hospital stay in February 2017 and a four-day hospital stay in June 2017.

Please note that under the Hospital Only option, the benefit is paid directly to you; you will need to submit a claim form to Aetna. Please refer to Filing a Claim for more information.

### Hospital Plus II

This example shows how the Hospital Plus II option pays benefits for a sports injury—a torn ACL—which required a visit to the emergency room, a one-day inpatient hospital stay, surgery and follow-up care.

The Hospital Plus I and Hospital Plus II plans pay benefits directly to network providers; however you may have the option of having your benefit paid directly to you—just let the provider know when you complete the paperwork. Please refer to Filing a Claim for more information.

<table>
<thead>
<tr>
<th>Service</th>
<th>Hospital Plus II benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visit</td>
<td>$275</td>
</tr>
<tr>
<td>Initial day of inpatient hospital stay (lump-sum benefit)</td>
<td>$700</td>
</tr>
<tr>
<td>One-day inpatient hospital stay (daily benefit)</td>
<td>$500</td>
</tr>
<tr>
<td>Surgery</td>
<td>$450</td>
</tr>
<tr>
<td>Doctors’ visits (6 days at $70 for each visit)</td>
<td>$420</td>
</tr>
<tr>
<td>Prescription drugs (3 days at $45 per day)</td>
<td>$135</td>
</tr>
<tr>
<td><strong>Total Hospital Plus II benefit</strong></td>
<td><strong>$2,480</strong></td>
</tr>
</tbody>
</table>

### Getting the Most Value out of the Hospital Plus I and Hospital Plus II Options Providers

MPP benefits are paid for care you receive anywhere. However, participants in the Hospital Plus I and Hospital Plus II options can lower their medical expenses by seeing participating providers in the Aetna Open Choice® PPO network. To locate a participating provider, call toll-free 1-888-772-9682 or visit http://www.aetna.com/docfind/custom/avp.
## Medical Payment Plan Summary of Benefits

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Hospital Only</th>
<th>Hospital Plus I**</th>
<th>Hospital Plus II**</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Inpatient hospital stay</em> – lump sum benefit (includes maternity)</em>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays for per initial day of an inpatient stay</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$700</td>
</tr>
<tr>
<td>Maximum number of stays per coverage year</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><em><em>Inpatient hospital stay</em> – daily benefit (includes maternity)</em>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day in a private or semi-private room</td>
<td>$100</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Plan pays per day in Intensive Care Unit (ICU)</td>
<td>$200</td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td>Maximum number of days per stay</td>
<td>Not applicable</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Maximum number of stays per coverage year</td>
<td>Unlimited</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>100</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Inpatient surgical procedure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day on which a surgical procedure is performed</td>
<td>Not covered</td>
<td>Not covered</td>
<td>$450</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>2</td>
</tr>
<tr>
<td><strong>Accident – additional benefit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per initial day for an accident</td>
<td>Not covered</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Emergency room</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day on which an emergency room visit occurs</td>
<td>Not covered</td>
<td>$200</td>
<td>$275</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Outpatient doctors’ office visits–Includes doctors’ services in the office, home, walk-in clinic or urgent care clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day on which doctors’ services are provided</td>
<td>Not covered</td>
<td>$50</td>
<td>$70</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td><strong>Outpatient laboratory and x-ray services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day on which lab or x-ray services are provided</td>
<td>Not covered</td>
<td>Not covered</td>
<td>$90</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>3</td>
</tr>
<tr>
<td><strong>Outpatient surgical procedure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day on which a surgical procedure is performed</td>
<td>Not covered</td>
<td>Not covered</td>
<td>$450</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>2</td>
</tr>
<tr>
<td><strong>Prescription drugs, equipment and supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays per day on which a prescription drug, equipment or supply is obtained.</td>
<td>Not covered</td>
<td>$35</td>
<td>$45</td>
</tr>
<tr>
<td>Maximum number of days per coverage year</td>
<td>Not applicable</td>
<td>12</td>
<td>12</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.

**Only one payment per day per service.
Be sure to show your ID card to doctor each time you receive medical treatment. The doctor’s office will file a claim on your behalf. You may be able to assign your benefits to be paid directly to you by Aetna. You will need to discuss having benefits paid directly to you with the provider when you complete the paperwork; otherwise the benefit is paid directly to the provider on your behalf. Please refer to Filing a Claim for more information. If you do not present your ID card when you visit your service provider you will need to complete a paper claims form. Use the medical claim form found at www.livetheorangelife.com/MPP. Or, you can get the form by calling Aetna Voluntary toll-free at 1-800-508-4015.

Filing a Claim
You will need to file a claim for your covered service in order to receive benefits under the Medical Payment Plan.

To file a claim:

1. Use the medical claim form found at www.livetheorangelife.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.

Aetna Programs Available to MPP Participants
The MPP offers participants a variety of valuable discount programs, including the Natural Products and Services Program, Fitness Program, reduced rates for natural therapy professional services and discounts to over 2,000 fitness clubs and Jenny Craig products. For more information about these discount programs, visit www.livetheorangelife.com/MPP. Discount programs provide access to discounted prices and are not insured benefits and you are responsible for the full cost of the discounted services.

Aetna VisionSM Discounts
Aetna VisionSM Discounts uses the nationwide EyeMed Select Network of vision care providers to offer you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at discounted prices. Plus, you can receive discounts on eye exams and LASIK eye surgery. For exams and eyewear call 1-800-793-8616. For contacts call 1-800-391-5367. For LASIK customer service call 1-800-422-6600. You can also locate a local provider by visiting www.livetheorangelife.com/MPP. This discount arrangement may not be available to Illinois residents.

Prescription Drug Discount Program
The prescription drug discount program gives you and your family access to over 65,000 retail pharmacies nationwide. You can also use our Aetna Rx Home Delivery® service; a fast, easy way to fill the prescriptions you take regularly. To locate a participating pharmacy, call 1-888-772-9682 or visit www.livetheorangelife.com/MPP.
Aetna’s Informed Health® Line: Hospital Plus I and Hospital Plus II Options

Aetna’s Informed Health® Line gives you and your family access to registered nurses 24 hours a day, 7 days a week. This toll-free line connects you to a team of nurses experienced in providing information on a variety of health topics. The nurses give you the information you need to help you make smarter health care decisions. They can also help improve the communication and relationships with your doctors. Nurses are available through a toll-free telephone number at: 1-800-556-1555. You may also e-mail a nurse by clicking on the “Talk to a Nurse” link on Aetna Navigator, our secure member website. Nurses respond to these online member inquiries within 24 hours.

While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Aetna Resources For Living: Hospital Plus I and Hospital Plus II Options

Aetna Resources For Living helps you and your family manage stress and balance work and life. Resources related to emotional support, childcare, and legal and financial guidance are available by telephone and online. Services also include consultation, information, education and referral services in connection with:

- Parenting
- Adoption
- Grandparent as parent
- Childcare and summer care
- Temporary back-up care
- Special needs
- High-risk adolescents
- Adult care and elder care
- Mental health
- Academic services
- Home improvement
- Pet care
- Consumer information
- Legal services
- Financial counseling
- Child safety information
- Pre-natal information

These services are convenient and confidential, available 24 hours a day, 7 days a week by calling 1-800-599-7158 or visiting www.resourcesforliving.com. Log in with username MY123EAP and password MY123EAP.

What the Plan Does Not Cover

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

- 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 outpatient rehabilitation therapy such as cognitive, speech, physical or occupational.
- 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 experimental or investigative procedures, as determined by Aetna.
- Those for services of a resident physician or intern rendered in that capacity.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for custodial care.
- Those for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for stays in connection with plastic surgery; reconstructive surgery; cosmetic surgery; 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 hare lip 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 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 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 as 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.

**Refund of Overpayments**

If benefits are paid by the Medical Payment Plan for expenses incurred on account of a covered person, that covered person, or any other person or organization that was paid, 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 refund is due from another person or organization, the covered person agrees to help the Medical Payment Plan get the refund when requested.

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.
The Critical Illness Protection Plan Quick Facts and Quick Links

U.S. Part-Time Hourly Associates

Your Critical Illness Protection Plan Options

1. $5,000 benefit amount  
2. $10,000 benefit amount  
3. $20,000 benefit amount  
4. $30,000 benefit amount

A Quick Look at the Critical Illness Protection Plan Covered Conditions

<table>
<thead>
<tr>
<th>Plan pays 100% of your benefit amount for these covered conditions:</th>
<th>Plan pays 25% of your benefit amount for these covered conditions:</th>
<th>Plan pays $75 per calendar year if you have one of the following:</th>
</tr>
</thead>
</table>
| • Heart attack  
• Stroke  
• Invasive cancer  
• Certain transplants  
• Alzheimer’s disease  
• …and more | • Coronary artery bypass surgery  
• Cerebral palsy  
• Cystic fibrosis  
• …and more | • Physical exam  
• Biopsy for skin cancer  
• Oral cancer screening  
• Immunizations  
• …and more |

Cool Critical Illness Protection Plan Features

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

• **Benefits for Travel and Lodging Expenses.**

• **Wellness Service Benefit of $75 per Covered Person.** In some cases, that $75 could cover the cost of your Critical Illness Protection Plan coverage.

Quick Links to Frequently Used Critical Illness Protection Plan Info

• Which conditions are covered under the plan?  
• What's not covered under the plan?  
• I need to file a claim

When Do I Enroll in Critical Illness 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.
# The Critical Illness Protection Plan

## Coverage Categories
- The Critical Illness Protection Plan
- Coverage Categories
- When Benefits Are Paid
- Wellness Benefit
- Transportation Benefit
- Lodging Benefit
- Recurrence Benefit
- Critical Illness Protection Plan Summary of Benefits
- Waiver of Premium Due to Disability
- Critical Illnesses Covered Under the Plan
- What the Plan Does Not Cover
- Filing a Claim
- Payment of Claims
- Appealing a Denied Claim
- Continuing Critical Illness Protection Plan Coverage When Coverage Ends
- COBRA (Continuing Coverage After Termination)

TO ENROLL, GO TO WWW.LIVETHEORANGELIFE.COM; FOR HELP, CALL 1-800-555-4954
The Critical Illness Protection Plan pays a lump-sum benefit for specific conditions, such as heart attack, stroke, cancer, transplant, Alzheimer’s disease and paralysis and benefits for eligible travel and lodging expenses. The plan also pays an annual benefit of $75 for wellness services per covered person. The Critical Illness Protection Plan is administered by Allstate Benefits.

The lump-sum benefit paid for covered conditions is based on the benefit amount you choose when you enroll for this plan. Your Critical Illness Protection Plan basic benefit amount options are:

- $5,000
- $10,000
- $20,000
- $30,000

Your cost for Critical Illness Protection Plan coverage is based on your basic benefit amount, the number of dependents you cover and your tobacco-user status. To view your rates, select the Critical Illness Protection Plan during your enrollment session and enter your information (for example, tobacco-user status and number of dependents covered).

Under the Critical Illness Protection Plan, benefits for covered conditions are paid at either 25% of your basic benefit amount or 100% of your basic benefit amount, depending on the condition. The Critical Illness Protection Plan Summary of Benefits chart located in this chapter shows the conditions payable at 100% and the conditions payable at 25%.

You may discontinue your Critical Illness Protection Plan coverage at any time by calling the Benefits Choice Center.

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 Critical Illness Protection Plan is a supplement to health insurance and is not a substitute for major medical coverage.

Coverage Categories
You may select one of four coverage categories:

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

When Benefits Are Paid
The Critical Illness Protection Plan will pay a benefit when a covered person is diagnosed with a critical illness if:

- The date of diagnosis is after the covered person’s effective date of coverage; and
- The date of diagnosis for the critical illness is while the covered person is insured under the policy; and
- The critical illness is listed in the Critical Illness Protection Plan Summary of Benefits chart located in this chapter and matches the specific description in this chapter.

A covered person can receive a benefit for each critical illness only once, unless the critical illness is named in the Recurrence Benefit section of this chapter.
A covered person can receive benefits for different covered critical illnesses if the dates of diagnosis for each critical illness are separated by at least 90 days.

The maximum basic benefit amount payable for all critical illnesses is the lesser of four times your basic benefit amount or $250,000 for each covered person. All benefits paid contribute toward the maximum basic benefit amount unless otherwise noted. Critical Illness Protection Plan coverage will end when you or any covered dependent has received the maximum basic benefit amount.

Each critical illness must be diagnosed by a physician in the United States or its territories. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States or its territories may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States or its territories.

**Wellness Benefit**

The plan pays $75 per calendar year per covered person for covered wellness services. Covered wellness services are listed in the Critical Illness Protection Plan Summary of Benefits chart in this chapter. Documentation must be provided for the service rendered.

The wellness benefit does not count toward the maximum basic benefit amount.

**Transportation Benefit**

The plan pays the actual cost, up to $1,500 per calendar year, for round trip transportation coach fare on a common carrier; or a personal vehicle allowance of $0.50 per mile, up to $1,500 per calendar year, when travel is required by a covered person to receive treatment of a covered critical illness at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic or any other specialized free-standing treatment center. Mileage is measured from the covered person’s home to the treatment facility as described above. The treatment facility must be more than 100 miles from the covered person’s home.

The plan does not pay for transportation for someone to accompany or visit the covered person receiving treatment, visits to a physician’s office or clinic or for other services. If the treatment is for a covered child and common carrier travel is necessary, the plan will pay this benefit for up to two adults to accompany the child.

“Common carrier” means the following: commercial airlines; passenger trains; inter-city bus lines; trolleys; or boats. It does not include taxis; intra-city bus lines; or private charter planes.

The transportation benefit does not count toward the maximum basic benefit amount.

**Lodging Benefit**

The plan pays $60 per day when a covered person receives treatment for a covered critical illness on an outpatient basis. The benefit is for lodging at a motel, hotel or other accommodations acceptable to the plan. This benefit is limited to 60 days per calendar year. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person’s home.

The lodging benefit does not count toward the maximum basic benefit amount.

**Recurrence Benefit**

The plan will pay a recurrence benefit if a covered person is diagnosed for a second time with a heart attack, stroke, coronary artery by-pass surgery, transplant, invasive cancer or carcinoma in situ, for which a benefit was previously paid if:

- The second date of diagnosis is more than 12 months after the first date of diagnosis for the critical illness; and
- The second date of diagnosis is while the covered person is covered under the plan; and
- For the cancer critical illness benefits, the covered person had no symptoms and did not receive any treatment during the 12 months after the prior occurrence.

The benefit amount is equal to the benefit amount previously paid for that critical illness. A covered person can receive a recurrence benefit only once for each critical illness.

For the purposes of the cancer critical illness benefits, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.
## Critical Illness Protection Plan Summary of Benefits

<table>
<thead>
<tr>
<th>Plan pays 100% of benefit amount for:</th>
<th>Plan pays 25% of benefit amount for:</th>
<th>Plan pays up to $75 per calendar year for each covered person for one of the following eligible wellness services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Heart attack</td>
<td>• Coronary artery bypass surgery</td>
<td>• Pre Biopsy test for skin cancer</td>
</tr>
<tr>
<td>• Stroke</td>
<td>• Carcinoma in situ</td>
<td>• Biopsy for skin cancer</td>
</tr>
<tr>
<td>• Invasive cancer</td>
<td>• Amyotrophic lateral sclerosis (Lou Gherig’s disease)</td>
<td>• Oral cancer screening</td>
</tr>
<tr>
<td>• Heart transplant</td>
<td>• Adrenal hypofunction (Addison’s disease)</td>
<td>• Blood test for triglycerides</td>
</tr>
<tr>
<td>• Lung transplant</td>
<td>• Bone marrow donor</td>
<td>• Bone marrow testing</td>
</tr>
<tr>
<td>• Liver transplant</td>
<td>• Cerebral palsy</td>
<td>• Colonoscopy</td>
</tr>
<tr>
<td>• Pancreas transplant</td>
<td>• Cystic fibrosis</td>
<td>• Echocardiogram</td>
</tr>
<tr>
<td>• Kidney transplant</td>
<td>• Hemophilia</td>
<td>• Electrocardiogram (EKG, including stress EKG)</td>
</tr>
<tr>
<td>• Bone marrow transplant</td>
<td>• Huntington’s chorea</td>
<td>• Flexible sigmoidoscopy</td>
</tr>
<tr>
<td>• End stage renal failure</td>
<td>• Meningitis</td>
<td>• Hemocult stool analysis</td>
</tr>
<tr>
<td>• Paralysis</td>
<td>• Multiple sclerosis</td>
<td>• Lipid panel (total cholesterol count)</td>
</tr>
<tr>
<td>• Complete blindness</td>
<td>• Muscular dystrophy</td>
<td>• Mammography, including breast ultrasound</td>
</tr>
<tr>
<td>• Complete loss of hearing</td>
<td>• Myasthenia gravis</td>
<td>• Pap Smear, including ThinPrep Pap Test</td>
</tr>
<tr>
<td>• Coma</td>
<td>• Necrotizing fasciitis</td>
<td>• PSA (prostate specific antigen—blood test for prostate cancer)</td>
</tr>
<tr>
<td>• Benign brain tumor</td>
<td>• Osteomyelitis</td>
<td>• Serum Protein Electrophoresis (test for myeloma)</td>
</tr>
<tr>
<td>• Alzheimer’s Disease</td>
<td>• Scleroderma</td>
<td>• Stress test on bike or treadmill</td>
</tr>
<tr>
<td>A covered person can receive benefits for each of the above critical illnesses if the dates of diagnosis for each critical illness are separated by at least 90 days.</td>
<td>• Sickle cell anemia</td>
<td>• Annual physical examination (only for covered persons over 18 years of age)</td>
</tr>
<tr>
<td></td>
<td>• Systemic lupus</td>
<td>• Immunizations</td>
</tr>
<tr>
<td></td>
<td>• Tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>

### Transportation Benefit
- Actual cost, up to $1,500, for round trip coach fare on a common carrier; or $.50 per mile for personal vehicle travel, up to $1,500, to a facility if more than 100 miles from place of residence.

### Lodging Benefit
- $60 per day up to 60 days if facility is more than 100 miles from residence. Only applies to lodging occurring within 24 hours of, and including days of treatment.

### Recurrence Benefit
- A benefit of 100% of the previously paid amount will be paid if a covered person is diagnosed for a second time with a heart attack, stroke, coronary artery bypass surgery, transplant, invasive cancer or carcinoma in situ. The second date of diagnosis must be more than 12 months after the first date of diagnosis for the critical illness, and for the cancer critical illness benefits, the covered person must have had no symptoms nor received any treatment during the 12 months after the prior occurrence.
“Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemoprevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

“Symptoms” mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

**Waiver of Premium Due to Disability**

Your premiums for this coverage will be waived if you:

- Become totally disabled due to a sickness or injury; and
- Remain disabled for at least 180 consecutive days.

After the 180th day, your premiums will be waived until the earliest of:

- The date you are no longer totally disabled; or
- The date you reach age 65; or
- The date coverage ends.

“Disabled” means you are under the continuous care of a physician and unable to perform all of the essential functions of your regular job or any gainful employment for which you are reasonably qualified based on your education, training or experience. “Gainful employment” means the performance of any occupation for wages, remuneration or profit, for which you are qualified by education, training or experience on a full-time or part-time basis.

This benefit is payable only for the disability of the covered associate. It does not apply to covered dependents.

**Critical Illnesses Covered Under the Plan**

The Critical Illness Protection Plan covers the specific conditions listed in *The Critical Illness Protection Plan Summary of Benefits* chart.

**Heart Attack**

“Heart attack” is the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on both:

- New electrocardiographic changes; and
- Elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

The date of diagnosis for heart attack is the date of death (infarction) of a portion of the heart muscle.

**Stroke**

“Stroke” is the death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA’s), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

**Coronary Artery By-Pass Surgery**

“Coronary artery by-pass surgery” is the surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary artery by-pass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of diagnosis for coronary artery by-pass surgery is the date the actual coronary artery by-pass surgery occurs.

**Transplant**

“Transplant” is the surgical transplantation of a heart, lung, liver, pancreas, kidney or bone marrow. The transplanted organ/tissue must come from a human donor.

The date of diagnosis for transplant is the date the actual surgery occurs for the covered transplant.

**End Stage Renal Failure**

“End stage renal failure” is the irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.
End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for end stage renal failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

**Paralysis**

“Paralysis” is the total and permanent loss of voluntary movement or motor function of 2 or more limbs as the result of a sickness or injury.

The date of diagnosis for paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

**Complete Blindness**

“Complete blindness” is a clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6.60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for complete blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

**Complete Loss of Hearing**

“Complete loss of hearing” is the total and irreversible loss of hearing in both ears.

Complete loss of hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for complete loss of hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

**Coma**

“Coma” is a continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

**Benign Brain Tumor**

A “benign brain tumor” is a non-cancerous brain tumor:

- Confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
- Resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- Tumors of the skull; or
- Pituitary adenomas; or
- Germanomas.

The date of diagnosis for a benign brain tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

**Alzheimer’s Disease**

“Alzheimer’s Disease” is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer’s Disease, which causes the covered person to be incapacitated.

“Incapacitated” means that, due to Alzheimer’s Disease, the covered person:

- Exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
- Requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined below.

As used in this benefit, the “activities of daily living” are:

- Bathing – to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – to get on and off the toilet and maintain personal hygiene.
- Bladder and Bowel Continence – to manage bowel and bladder function with or without protec-
tive undergarments or surgical appliances so that a reasonable level of hygiene is maintained.

- Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

The date of diagnosis for Alzheimer’s Disease is the date a physician first diagnoses the covered person as incapacitated due to Alzheimer’s Disease.

**Cancer: Carcinoma In Situ**

A “carcinoma in situ” is a cancer where the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in situ includes:

- Early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
- Melanoma not invading the dermis.

**Carcinoma in situ does not include:**

- Other skin malignancies; or
- Pre-malignant lesions (such as intraepithelial neoplasia); or
- Benign tumors or polyps.

**Cancer: Invasive Cancer**

“Invasive cancer” is a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Invasive cancer includes Leukemia and Lymphoma.

**Invasive cancer does not include:**

- Carcinoma in situ; or
- Tumors in the presence of any human immunodeficiency virus; or
- Skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
- Early prostate (stages A, I or II) cancer.

**Cancer Diagnosis Requirements**

A cancer critical illness must be diagnosed in one of two ways:

- **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.
- **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms.

The plan will pay benefits for a clinical diagnosis only if:

- A pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- There is medical evidence to support the diagnosis.

The date of diagnosis for cancer critical illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based. The “first diagnosis of cancer” includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned. “Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

For purposes of this benefit, “symptoms” means the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

**What the Plan Does Not Cover**

The plan will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from:

- War, declared or undeclared, participation in a riot, insurrection or rebellion.
- Intentionally self-inflicted injury or action.
- Illegal activities or participation in an illegal occupation.
- Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.
Filing a Claim

You can obtain a claim form by calling Allstate Benefits at 1-866-828-8766 or visiting Allstate Benefits’ website at http://allstatevoluntary.com/homedepot to print the claim form. You must complete all applicable sections of the claim form and then give it to your attending physician. The physician will need to complete his or her section statement of the form. Once the form and supporting documentation is collected, all documents need to be mailed or faxed to Allstate Benefits.

Mail to:
Allstate Benefits
P.O. Box 41189
Jacksonville, Florida 32203-1189

Electronic submission through:
http://allstatevoluntary.com/homedepot/
Fax to: 1-877-652-2979

Written proof of your claim must be furnished to Allstate Benefits within 90 days of each critical illness or payable loss. If it is not reasonably possible to provide written proof in the time required, Allstate Benefits will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to Allstate Benefits no later than one year from the time specified unless you are legally incapacitated.

Allstate Benefits has the right, at Allstate Benefits’ expense, to have you examined by a physician of Allstate Benefits’ choosing, as often as may be reasonably required while a claim is pending. Allstate Benefits may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

Payment of Claims

Allstate Benefits will send notice to you within 15 working days of receiving written proof of claim. If Allstate Benefits does not pay the loss within 15 working days upon receipt, this notice will state the reasons for failing to pay the claim, either in whole or in part. It will also provide an itemization of any documents or other information needed to process the claim.

When all the requested information needed to process the claim has been received, Allstate Benefits will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving the reasons for denying such claim or any portion of it.

Any amounts unpaid at your death may, at Allstate Benefits’ option, be paid to a person who is related to you and who survives you, in the following order:

1. to your spouse or domestic partner, if living; otherwise
2. to the covered person’s children including your domestic partner’s children, in equal shares, if living; otherwise
3. to the covered person’s parents, in equal shares, if living; otherwise
4. to the covered person’s siblings, in equal shares, if living; otherwise
5. to the covered person’s estate.

You may name a beneficiary by contacting Allstate Benefits at 1-866-828-8766 to request a beneficiary designation form or get the form online at http://allstatevoluntary.com/homedepot. Once you return the form to Allstate Benefits, your beneficiary designation will take effect on the date you signed it.

Allstate Benefits has the right to recover any overpayments due to fraud or any error made in processing a claim. You must reimburse Allstate Benefits in full. Allstate Benefits will work with you to develop a reasonable method of repayment if you are financially unable to repay in a lump sum.

Appealing a Denied Claim

For information on appealing denied claims, see the Claims and Appeals chapter.

Continuing Critical Illness Protection Plan Coverage When Coverage Ends

When your Critical Illness Protection Plan coverage through the Company ends, you may elect to continue your coverage through portability by sending Allstate Benefits a written request and payment of the first premiums for the portability coverage not later than 30 days after your coverage ends.
No portability coverage will be provided if your Critical Illness Protection Plan coverage ends due to your failure to make required premium payments.

The benefits, terms and conditions of the portability coverage will be the same as those provided under the plan when the insurance terminated except portability coverage will not have a waiver of premium provision. Portability coverage may include any eligible dependents covered under the plan.

Portability coverage will be effective on the day after insurance under the policy terminates.

For information about portability, call 1-866-828-8766.

**COBRA (Continuing Coverage After Termination)**

You and your eligible dependents will be offered the opportunity to purchase a temporary extension of coverage under the Critical Illness Protection Plan at group rates in certain instances where coverage under the Critical Illness Protection Plan would otherwise end. This coverage is referred to in this Benefits Summary as COBRA coverage. For more information, see the COBRA Coverage chapter.
Dental Plan Quick Facts and Quick Links

U.S. Part-Time Hourly Associates

Your Dental Plan Options
1. MetLife $500 Max
2. MetLife $1,000 Max
3. MetLife $2,000 Max

A Quick Look at the Dental Plan

<table>
<thead>
<tr>
<th></th>
<th>MetLife $500 Max</th>
<th>MetLife $1,000 Max</th>
<th>MetLife $2,000 Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covers Preventive Care</td>
<td>100%*</td>
<td>100%*</td>
<td>100%*</td>
</tr>
<tr>
<td>Covers Restorative Care (fillings, oral surgery, root canals, periodontics)</td>
<td>Yes, you pay 30%*</td>
<td>Yes, you pay 25%*</td>
<td>Yes, you pay 20%*</td>
</tr>
<tr>
<td>Covers Major Care (crowns, bridges)</td>
<td>No</td>
<td>Yes, you pay 60%*</td>
<td>Yes, you pay 50%*</td>
</tr>
<tr>
<td>Covers Orthodontia (braces)</td>
<td>No</td>
<td>Yes, you pay 50%*</td>
<td>Yes, you pay 50%*</td>
</tr>
<tr>
<td>Per-biweekly Paycheck Payroll Deduction—Associate-only Coverage</td>
<td>$6.19</td>
<td>$12.91</td>
<td>$16.00</td>
</tr>
</tbody>
</table>

* You pay this percentage of the PDP (Preferred Dentist Program) charge if you use a MetLife dentist or the reasonable and customary charge if you use a non-MetLife dentist.

Cool Dental Plan Features
- **FREE Dental Check-Ups.** Two cleanings and checkups each calendar year are free (subject to your option’s maximum annual benefit) with no deductible if you use a dentist in the MetLife PDP network.
- **15% to 45% Discount for Care from MetLife PDP Dentists.** You can use any dentist; however, you will pay less if you use a MetLife network dentist.
- **Discounts on Cosmetic Dentistry from MetLife PDP Dentists.**

When Do I Enroll in Dental 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 Dental Plan Info
- I want to find a MetLife PDP dentist
- My child needs braces
- What’s covered under the plan?
- What’s not covered under the plan?
CHAPTER CONTENTS

43 Dental Plan Options
43 Coverage Categories
43 How the Dental Plan Options Work
44 Maximum Benefits
45 Special Rule for Orthodontia: Maximum Lifetime Orthodontia Benefit When Treatment Begins Applies Throughout Orthodontia Treatment
45 Selecting a MetLife PDP Dentist
45 Scheduling Appointments with Your MetLife PDP Dentist
45 Pretreatment Estimate of Benefits
45 Pretreatment Estimate of Benefits Does Not Guarantee Payment
45 The Alternate Benefit Provision Allows for Suitable Dental Treatment
45 Filing Claims for Out-of-Network Services
46 Limitations
46 Changing Your Dental Option
46 Benefits for In-Network Services
46 Benefits for Out-of-Network Services
46 Examples of How the Plan Pays Benefits
47 What's Covered
47 Preventive and Diagnostic
47 Basic Restorative
47 Major Restorative
48 What's Covered Under the Plan
49 What's Not Covered
50 Coordinating Benefits with Other Plans
50 How Benefits Are Paid Through COB
51 Right to Recover Payment
51 Subrogation
51 COBRA (Continuing Coverage After Termination)
51 Appealing a Denied or Reduced Claim
52 Which Plan is the Primary Plan When Coordination of Benefits Applies?
Get the Most Value from Your Plan

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find a MetLife PDP dentist</td>
<td>Go to <a href="http://www.metlife.com/dental">www.metlife.com/dental</a> and click “Find a PDP dentist” or call 1-800-638-9909</td>
</tr>
<tr>
<td>Get a claim form for out-of-network services</td>
<td>Go to <a href="http://www.metlife.com/dental">www.metlife.com/dental</a> to download a claim form or call 1-800-638-9909</td>
</tr>
<tr>
<td>Submit a claim form</td>
<td>Take a claim form with you to your dentist. Mail to: MetLife P.O. Box 981282 El Paso, TX 79998-1282</td>
</tr>
<tr>
<td>• Track your claims online and receive e-mail alerts when a claim has been processed.</td>
<td>Log into <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a> or go to <a href="http://www.metlife.com/dental">www.metlife.com/dental</a> and set up a user ID and password.</td>
</tr>
<tr>
<td>• Find out the approximate in-network (PDP) fees and out-of-network fees in your area for many dental services</td>
<td></td>
</tr>
</tbody>
</table>

Dental Plan Options
The Dental Plan offers you three dental options:

- **MetLife $500 Max**—covers only preventive and basic restorative care
- **MetLife $1,000 Max**—high level of coverage including orthodontia
- **MetLife $2,000 Max**—highest level of coverage including orthodontia

Coverage Categories
You may select one of four coverage categories for the dental plan options:

- associate only
- associate + spouse
- associate + child(ren)
- associate + family (children and spouse)

How the Dental Plan Options Work
All three dental options are MetLife Preferred Dentist Program (PDP) plans that let you use any dentist you want, but offer negotiated discounts when you go to a MetLife PDP network dentist. Your dental options provide you with comprehensive dental coverage for the majority of preventive, diagnostic and basic dental services, but vary in deductibles, maximum benefits, coinsurance and coverage of certain benefits.

All of the dental options offer:

- **Preventive dental care covered at 100%.** Dental cleanings and checkups are covered at no cost if you use a dentist in the MetLife PDP (Preferred Dentist Program) network—you don’t have to meet the deductible for preventive care benefits to begin. All dental benefits—including preventive care benefits—are subject to the per-covered individual annual maximum benefit that applies to your dental option.

- **Lower costs when you go to MetLife PDP network dentist.** You can use any dentist; however, you will pay less if you use a MetLife PDP network dentist because PDP network negotiated fees typically range from 15% to 45% less than average fees for the same or similar services charged by dentists in your area. In addition, MetLife PDP dentists have agreed to accept MetLife’s negotiated fees as payment in full for services performed (subject to any deductibles, co-payments, coinsurance, exclusions and benefit maximums).

- **Access to large network of providers.** To find a MetLife PDP network dentist near you, go to www.metlife.com/dental. If your dentist is not part of the network, he or she can apply to become a MetLife PDP network dentist by going to www.metdental.com, a website for dentists only or calling 1-877-638-3379.

- **Same coverage for non-network dentists.** You’ll have the same level of coverage—the same
deductible, coinsurance and annual maximum—for dental services regardless of whether you use a MetLife PDP network or non-network dentist. However, when you use a MetLife PDP network dentist, you’ll pay the negotiated fee, which is typically 15% to 45% lower than non-network dentists’ fees. For out-of-network charges, you pay any amount above the reasonable and customary charge.

- **MetLife discounts on cosmetic dentistry and other non-covered dental services.** You’ll receive the MetLife PDP dentist negotiated rate on cosmetic procedures and other services not covered by the dental options when you use a PDP dentist. You also will continue to receive the negotiated rate after you have reached your annual maximum benefit.

**The MetLife $500 Max option** covers only preventive and basic restorative care and offers a lower payroll deduction. This option is designed to encourage good dental health for associates and covered family members that may need only preventive and basic restorative dental services. This option has no coverage for major services or orthodontia. Preventive care and diagnostic services are covered at 100% when you use a MetLife PDP network dentist or covered at 100% of the reasonable and customary charge for non-network dentists. See *What’s Covered, Preventive and Diagnostic* later in this chapter for a list of covered services. Basic and major restorative dental services and orthodontia are subject to the deductible and coinsurance. All preventive/diagnostic and basic and major restorative dental benefits are subject to the annual maximum benefit. This option has an annual maximum benefit of $1,000 per covered individual and a separate lifetime orthodontia maximum benefit of $750.

**The MetLife $2,000 Max option** covers preventive, basic restorative and major restorative care as well as orthodontia for covered dependent children under age 19 with a payroll deduction that is higher than the MetLife $500 Max option. Preventive care and diagnostic services are covered at 100% when you use a MetLife PDP network dentist or covered at 100% of the reasonable and customary charge for non-network dentists. See *What’s Covered, Preventive and Diagnostic* later in this chapter for a list of covered services. Basic and major restorative dental services and orthodontia are subject to the deductible and coinsurance. All preventive/diagnostic and basic and major restorative dental benefits are subject to the annual maximum benefit. This option has an annual maximum benefit of $2,000 per covered individual and a separate lifetime orthodontia maximum benefit of $1,500.

See *What’s Covered* for complete information on the services covered under the options.

### Maximum Benefits

Each Dental Plan option pays a maximum annual benefit for you and each of your covered family members as follows:

- **MetLife $500 Max**—$500 for each covered individual
- **MetLife $1,000 Max**—$1,000 for each covered individual
- **MetLife $2,000 Max**—$2,000 for each covered individual

All preventive/diagnostic and basic and major restorative dental benefits are subject to the annual maximum benefit. Orthodontia has a separate lifetime maximum, as follows:

- **MetLife $500 Max**—No orthodontia coverage
- **MetLife $1,000 Max**—$750 lifetime maximum for each covered dependent child
- **MetLife $2,000 Max**—$1,500 lifetime maximum for each covered dependent child

The maximum is based on orthodontic services and procedures, whether in-network or out-of-network. Orthodontic services are available only for your child(ren) under age 19.
Special Rule for Orthodontia: Maximum Lifetime Orthodontia Benefit When Treatment Begins Applies Throughout Orthodontia Treatment

The lifetime maximum orthodontia benefit that will apply is based on the option in which the covered dependent child is enrolled when orthodontia services began. The maximum orthodontia benefit will not change throughout that dependent’s orthodontia treatment regardless of the option chosen in subsequent years.

For example, if you are enrolled in the $500 Max option when orthodontia treatment begins, no orthodontia benefits are paid for any orthodontia treatment even if a benefit option is chosen in subsequent years that covers orthodontia treatment. If you are enrolled in the $1,000 Max option when the orthodontia treatment begins, the $750 lifetime maximum benefit will apply throughout the orthodontia treatment regardless of whether you enroll in the $2,000 Max option or $500 Max option in subsequent years.

Selecting a MetLife PDP Dentist

A MetLife PDP dentist is a general dentist or specialist who has agreed to accept MetLife’s negotiated fees as payment in full for services provided to plan participants. PDP fees typically range from 15-45% below the average fees charged in a dentist’s community for the same or substantially similar services.

To get a list of participating MetLife PDP dentists:

- Go to www.metlife.com/dental, and click “Find a PDP dentist”; or
- Call 1-800-638-9909 to have a list faxed or mailed to you.

If your current dentist does not participate in the MetLife PDP network and you’d like to encourage him or her to apply, tell your dentist to go to www.metdental.com, or call 1-877-638-3379 for an application. The website and phone number are designed for use by dental professionals only.

Scheduling Appointments with Your MetLife PDP Dentist

To set up an appointment with your MetLife PDP dentist:

- Confirm with MetLife that the specific provider and location is participating
- Call the dental office you selected.

Pretreatment Estimate of Benefits

Whenever extensive dental work is proposed involving charges of $300 or more, your dentist can request a Pretreatment Estimate of Benefits from the Dental Plan. Your dentist should submit a detailed description of planned treatment and expected charges, including those for diagnostic x-rays, before dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to your dental claims office.

After reviewing the description of the planned treatment and expected charges, the Dental Plan will determine the services the Dental Plan may cover and advise your dentist.

Pretreatment Estimate of Benefits Does Not Guarantee Payment

The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed. You must provide proof on or after the date the dental service is received before the Dental Plan will pay benefits.

The Alternate Benefit Provision Allows for Suitable Dental Treatment

When more than one dental service could provide suitable treatment based on common dental standards, MetLife will determine the dental service on which benefits will be based and the expenses that will be considered as covered expenses. Benefits will be provided for treatment you receive in accordance with accepted dental standards for adequate and appropriate care.

You and your dental provider are free to apply this benefit payment to the treatment of your choice; however, you are responsible for any expenses that exceed covered expenses. To avoid any surprises, use the Pretreatment Estimate of Benefits process so that you and your dentist know in advance what the Dental Plan will cover before any treatment begins.

Filing Claims for Out-of-Network Services

Your dentist may file your claims for you, which means you have little or no paperwork. Bring a claim form with you to your appointment. If you need a claim form, you can find one online at www.metlife.com/dental, or request one by calling 1-800-638-9909. You don’t have to speak with a live representative to order a claim form—the MetLife
automated voice response system is available 24 hours a day, 7 days a week.

If your dentist does not file claim forms for you, you must complete a claim form and send it to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Be sure to fill out a separate form for each covered family member, even if more than one family member visited the same dentist on the same day. You can include more than one bill (with the same or different dates) on a single claim form if all expenses are for the same family member.

If you or a covered family member are covered under another employer’s group health plan that is the primary payer of dental benefits, submit your claim to that plan first. After you receive payment, send a copy of the explanation of benefits along with copies of the itemized bills to MetLife for processing. See Coordinating Benefits with Other Plans in this chapter for more details on coordinating benefits with other plans.

Limitations
You should file all claims within 12 months of the date services are provided. The Dental Plan does not consider a claim form until the claims office receives all required information relating to the service or benefit provided. Claims filed more than 12 months following the date services were provided may not be eligible for benefits.

If you have questions about any of the MetLife dental options, call MetLife at 1-800-638-9909 and follow instructions to speak to a representative.

**Changing Your Dental Option**
You may change your dental option only during Annual Enrollment or when you have a qualified change in status. See the Life Events chapter for more information.

**Benefits for In-Network Services**
Payment for in-network services under each of the dental options is limited to the PDP negotiated charge. The PDP negotiated charge refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any deductibles, copayments, coinsurance, exclusions and benefit maximums. You are responsible for paying the deductible and any other charges that the Dental Plan does not cover.

**Benefits for Out-of-Network Services**
Payment of benefits for out-of-network services under each of the dental options is limited to the reasonable and customary (R&C) allowance. You are responsible for charges above R&C. The deductible, annual maximum and orthodontia lifetime maximum are combined for all in-network and out-of-network procedures and services.

Certain limitations and exclusions apply to all three dental options for both in-network and out-of-network services. For further explanation of your dental coverage, call MetLife at 1-800-638-9909.

**Examples of How the Plan Pays Benefits**
Here are some examples of how the MetLife dental options pay benefits when you go in-network or out-of-network. These examples assume that you have met your deductible.

**Example A:** You are enrolled in MetLife $1,000 maximum option and go to your dentist for a filling (a basic restorative service):

- the in-network MetLife PDP negotiated fee is $245
- the out-of-network R&C cost is $400
- the dentist’s usual fee is $475

<table>
<thead>
<tr>
<th>In-Network</th>
<th>When you receive care from a participating PDP dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDP fee</td>
<td>$245.00</td>
</tr>
<tr>
<td>$1,000 MetLife Max dental option pays: 75% x $245 PDP fee</td>
<td>- $183.75</td>
</tr>
<tr>
<td>Your out-of-pocket cost</td>
<td>$61.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Network</th>
<th>When you receive care from a non-participating dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist’s usual fee</td>
<td>$475.00</td>
</tr>
<tr>
<td>$1,000 MetLife Max dental option pays: 75% x $400 R&amp;C fee</td>
<td>$300.00</td>
</tr>
<tr>
<td>Your out-of-pocket cost</td>
<td>$175.00</td>
</tr>
</tbody>
</table>
Example B: You are enrolled in MetLife $2,000 maximum option and go to your dentist for a crown (a major restorative service):

- the in-network MetLife PDP negotiated fee is $375
- the out-of-network R&C cost is $500
- the dentist’s usual fee is $600

**In-Network**
When you receive care from a participating PDP dentist

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDP fee</td>
<td>$375.00</td>
</tr>
<tr>
<td>$2,000 MetLife Max dental option pays: 50% x $375 PDP fee</td>
<td>- $187.50</td>
</tr>
<tr>
<td>Your out-of-pocket cost</td>
<td>$187.50</td>
</tr>
</tbody>
</table>

**Out-of-Network**
When you receive care from a non-participating dentist

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist’s usual fee</td>
<td>$600.00</td>
</tr>
<tr>
<td>$2,000 MetLife Max dental option pays: 50% x $500 R&amp;C fee</td>
<td>$250.00</td>
</tr>
<tr>
<td>Your out-of-pocket cost</td>
<td>$350.00</td>
</tr>
</tbody>
</table>

What’s Covered
Here is a list of primary covered services and limitations under each of the dental options.

**Preventive and Diagnostic**
- oral exams twice per calendar year
- full mouth or panoramic x-rays once every 60 months
- cleaning of teeth (oral prophylaxis), twice per calendar year
- bitewing x-rays, one set in a calendar year for adults and children
- topical fluoride treatment for a child under age 19, twice per calendar year
- intraoral-periapical and extraoral x-rays
- pulp vitality and bacteriological studies for determination of bacteriologic agents
- diagnostic cast, twice per calendar year
- emergency palliative treatment to relieve tooth pain
- space maintainers for a covered child under age 14 once per location
- Sealants for a child under age 19, once per tooth every five years

**Basic Restorative**
- amalgam or resin fillings limited to once per 24-month period on the same tooth and surface
- consultations, but not more than once in a 12-month period
- root canal treatment, but not more than once in any 24-month period for the same tooth
- periodontal scaling and root planing, but not more than once per quadrant in any 24-month period
- simple extractions
- periodontal maintenance where periodontal treatment (including scaling, root planing and periodontal surgery such as osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during the current calendar year
- pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- pulp therapy and apexification/recalcification
- re-cementing of cast restorations or dentures
- simple repairs of cast restorations or denture
- occlusal adjustments, once per 12 months

**Major Restorative**
- general anesthesia or intravenous sedation in connection with oral surgery, extractions or other covered services, when anesthesia is determined as necessary in accordance with generally accepted dental standards
- initial installation of full or partial dentures or implants once per 84 months:
  - when needed to replace congenitally missing teeth; or
  - when needed to replace natural teeth that are lost while you or a dependent is covered under the dental plan
- replacement of a non-serviceable denture if such denture was installed more than five years prior to replacement
- replacement of an immediate, temporary full denture with a permanent full denture if the immediate, temporary full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full denture
- relinings and rebasings of existing removable dentures:
  - if at least six months have passed since the installation of the existing removable denture; and
  - not more than once in any 36 month period
## What’s Covered Under the Plan
The following charts summarize services and costs under the MetLife dental options. For more information, see What’s Covered and What’s Not Covered.

<table>
<thead>
<tr>
<th>Dental Services</th>
<th>MetLife $500 Max</th>
<th>MetLife $1,000 Max</th>
<th>MetLife $2,000 Max</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Annual Deductible (individual/family)</td>
<td>$25/$75</td>
<td>$25/$75</td>
<td>$50/$150</td>
</tr>
<tr>
<td>Annual Maximum Benefit' (per covered individual)</td>
<td>$500</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Preventive and Diagnostic Care (deductible does not apply)</td>
<td>Covered at 100%</td>
<td>Covered at 100%²</td>
<td>Covered at 100%²</td>
</tr>
<tr>
<td>Basic Restorative Care (fillings, root canals)</td>
<td>You pay 30%</td>
<td>You pay 30%²</td>
<td>You pay 25%</td>
</tr>
<tr>
<td>Major Restorative Care (bridges, dentures, crowns)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>You pay 60%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>No coverage</td>
<td>No coverage</td>
<td>50% up to $750 lifetime maximum per covered dependent child</td>
</tr>
</tbody>
</table>

1 All preventive/diagnostic and basic and restorative dental benefits are subject to the annual maximum benefit.
2 Plan pays this percentage of the reasonable and customary (R&C) charge if you use a non-MetLife dentist.
—adjustments of dentures, if at least six months have passed since the installation of the denture

• initial installation of cast restorations but only when the tooth is fractured or has major decay that cannot be restored with regular filling

• replacement of any cast restoration with the same or a different type of cast restoration but no more than one replacement for the same tooth within 84 consecutive months of a prior replacement

• prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 84 months

• crowns, inlays and gold fillings to restore teeth, but only when the tooth is fractured or has major decay that cannot be restored with regular fillings once per 84 months per tooth

• core buildup, but no more than once per tooth in a period of 84 months

• posts and cores, but no more than once per tooth in a period of 84 months

• labial veneers, but no more than once per tooth in a period of 84 months

• oral surgery except as mentioned elsewhere in this chapter

• periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36-month period

• surgical extractions

• implants, but no more than once for the same tooth position in an 84-month period

• repair of implants, but not more than once in a 12-month period

• implant supported prosthetics, but no more than once for the same tooth position in an 84-month period

• Occlusal guard which typically treats the effects of bruxism or grinding of teeth and other occlusal factors

What’s Not Covered

The Dental Plan will not reimburse you for expenses relating to the following:

• services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which are deemed experimental in nature

• services for which you would not be required to pay in the absence of dental coverage

• services or supplies received by you or your covered family member before the dental coverage starts for that person

• services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
  — scaling and polishing of teeth; or
  — fluoride treatments

• services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn child

• services or appliances which restore or alter occlusion or vertical dimension

• restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease

• restorations or appliances used for the purpose of periodontal splinting

• counseling or instruction about oral hygiene, plaque control, nutrition and tobacco

• personal supplies or devices including, but not limited to: water piks, toothbrushes or dental floss

• initial installation of a denture or implant to replace one or more teeth which were missing before such person was insured for dental insurance, except for congenitally missing teeth

• decoration or inscription of any tooth, device, appliance, crown or other dental work

• missed appointments

• services:
  — covered under any workers’ compensation or occupational disease law;
  — covered under any employer liability law;
  — for which the employer of the person receiving such services is not required to pay; or
  — received at a facility maintained by the Company, labor union, mutual benefit association or VA hospital

• services covered under other coverage provided by the Company
- temporary or provisional restorations
- temporary or provisional appliances
- prescription drugs
- services for which the submitted documentation indicates a poor prognosis
- the following when charged by the dentist on a separate basis:
  - claim form completion;
  - infection control such as gloves, masks and sterilization of supplies; or
  - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide
- dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- caries susceptibility tests
- sedative fillings
- local chemotherapeutic agents
- modification of removable prosthodontic and other removable prosthetic services
- injections of therapeutic drugs
- application of desensitizing agents
- precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics
- adjustment of a denture made within six months after installation by the same dentist who installed it
- duplicate prosthetic devices or appliances
- replacement of a lost or stolen appliance, cast restoration or denture
- repair or replacement of an orthodontic device
- diagnosis and treatment of temporomandibular joint disorders
- intra- and extra-oral photographic images
- fixed and removable appliances for correction of harmful habits

**Coordinating Benefits with Other Plans**

If you or a covered family member is participating in this Dental Plan and is also covered under another employer’s group health/dental plan, MetLife will coordinate coverage with that plan. Coordination of benefits (COB) is the process used to determine how claims for eligible Dental Plan expenses should be paid when you and a covered family member are covered under two or more dental plans—for example, if you and your spouse (or same sex domestic partner) both work and are covered by each other’s employer-provided dental plan. The term “plan” refers to:

- a group insurance plan
- an HMO
- a blanket plan
- uninsured arrangements of group or group type coverage
- a group practice plan
- a group service plan
- a group prepayment plan
- any other plan that covers people as a group
- motor vehicle No Fault coverage if the coverage is required by law
- any other coverage required or provided by any law or any governmental program, except Medicaid
- Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Coordination of benefits applies only when the Dental Plan is the secondary plan. If the Dental Plan is the primary plan (for example, if the expense was incurred by you, as a Company associate), COB does not apply.

**How Benefits Are Paid Through COB**

When the Dental Plan is the secondary plan, the total amount payable under the Dental Plan, when added to the amount or value of the benefits or services provided by all other plans, will not exceed the amount or value of the allowable expense which is incurred. In no event will the amount the Dental Plan pays be more than the Dental Plan would pay if there were no other plan.

When the Home Depot Dental Plan is secondary, the Home Depot Dental Plan will pay whatever is lower:

- The Home Depot Dental Plan’s normal liability; or
- The part of the allowable expenses that were not paid by the primary plan (the remaining balance).

If the reasonable and customary charge amount is different for the Home Depot Dental Plan and the other plan, the higher amount of reasonable and customary charge will be used as the COB allowable expense to calculate benefits.
The allowable expense is any necessary, reasonable, and customary service or expense, including deductibles or coinsurance, covered—in whole or in part—by any one of the plans that cover the person for whom claim is made. When the benefits are in the form of services, the reasonable cash value of each service is the allowable expense and is a benefit paid. The “reasonable cash value” is an amount which a duly licensed provider of dental care services usually charges patients and which is within the range of fees usually charged for the same service by other dental care providers located within the immediate geographic area where the dental care service is rendered under similar or comparable circumstances.

If you have any questions about the COB rules for the Dental Plan, call MetLife at 1-800-638-9909.

Right to Recover Payment

If the Dental Plan makes a payment by mistake, the Plan has the right to recover the amount of the overpayment from any person, insurance company or other organization to whom the payment was made.

Subrogation

There is no subrogation provision within the Dental Plan. Subrogation is the right of the insurance company to recoup benefits paid to a participant through legal suit, if the action causing the disability and subsequent dental expenses was the fault of another individual.

COBRA (Continuing Coverage After Termination)

Federal law requires that you and your eligible dependents be offered the opportunity to purchase a temporary extension of coverage under the Dental Plan at group rates in certain instances where coverage under the Dental Plan would otherwise end. This coverage is referred to as COBRA coverage. For more information, see the COBRA Coverage chapter.

Appealing a Denied or Reduced Claim

For information on appealing a denied or reduced claim, see the Claims and Appeals chapter.
**Which Plan is the Primary Plan When Coordination of Benefits Applies?**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you (the The Home Depot associate) are the patient…</td>
<td>The Home Depot Dental Plan is the primary plan.</td>
</tr>
<tr>
<td>When your spouse is the patient…</td>
<td>His or her plan is primary and the The Home Depot Dental Plan is secondary.</td>
</tr>
<tr>
<td>When your child is the patient…</td>
<td>The “birthday” rule is followed. This means that when both plans covering your child follow the birthday rule, the plan of the parent whose birthday occurs earlier in the year (regardless of the ages of the parents) is primary for the child. The birthday rule is an insurance industry standard. If one of the plans is issued out of the state whose laws govern this policy and determines the order of benefits based upon the gender of the parent, the plan with the gender rules shall determine the order of benefits.</td>
</tr>
<tr>
<td>If you are legally separated or divorced (or were never married)…</td>
<td>If a court decree states that one parent is responsible for the child’s healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge. The primary plan is determined in this order:</td>
</tr>
<tr>
<td>benefits for a child will be determined in this order:</td>
<td>The plan of the parent with custody of the child.</td>
</tr>
<tr>
<td></td>
<td>The plan of the spouse of the parent with custody of the child.</td>
</tr>
<tr>
<td></td>
<td>The plan of the parent not having custody of the child.</td>
</tr>
<tr>
<td></td>
<td>The plan of the spouse of the parent not having custody of the child.</td>
</tr>
<tr>
<td>If the above rules do not establish the order…</td>
<td>The plan covering the claimant for the longest period of time will be primary except:</td>
</tr>
<tr>
<td></td>
<td>The plan covering the claimant as an active associate is primary over a plan covering the claimant as a laid-off or retired associate. If the other plan does not have this rule, it will not apply.</td>
</tr>
<tr>
<td></td>
<td>The plan covering the claimant as an active participant is primary over a plan covering the claimant under a right of continuation provided by federal or state law. If the other plan does not have this rule, it will not apply.</td>
</tr>
</tbody>
</table>
Vision Plan Quick Facts and Quick Links

U.S. Part-Time Hourly Associates

Your Vision Plan Options

1. **EyeMed Select $120**
2. **EyeMed Select $150**

A Quick Look at the Vision Plan

<table>
<thead>
<tr>
<th></th>
<th>EyeMed Select $120 (in-network)</th>
<th>EyeMed Select $150 (in-network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposable Contact Lenses</td>
<td>Plan pays first $120, then you pay balance over $120</td>
<td>Plan pays first $150, then you pay balance over $150</td>
</tr>
<tr>
<td>Frames</td>
<td>Plan pays first $120, then you pay 80% of balance over $120—frame benefit available once every 24 months</td>
<td>Plan pays first $150, then you pay 80% of balance over $150—frame benefit available once every 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>$15 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Lens Options Coverage</td>
<td>Some covered, others available at a discount</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Per-biweekly Paycheck Payroll Deduction—Associate-only Coverage</td>
<td>$2.19</td>
<td>$8.04</td>
</tr>
</tbody>
</table>

Cool Vision Plan Features

- **FREE Vision Exams.** The plan covers one eye exam every 12 months and its FREE when you use an EyeMed Select network provider.
- **Pay Less for Glasses and Contacts at EyeMed Select Providers.** Lenscrafters, Sears Optical, Target Optical, JC Penny Optical and most Pearle Vision locations are all EyeMed Select providers.
- **Discounts on Laser Vision Correction.**

When Do I Enroll in Vision 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 Vision Plan Info

- I want to find an EyeMed Select provider
- I want to get a discount on laser vision correction
- What's covered under the plan?
- What's not covered under the plan?
## CHAPTER CONTENTS

<table>
<thead>
<tr>
<th>55</th>
<th>Vision Plan Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>Coverage Categories</td>
</tr>
<tr>
<td>56</td>
<td>Using EyeMed Select Network Providers</td>
</tr>
<tr>
<td>56</td>
<td>Online In-Network Options</td>
</tr>
<tr>
<td>56</td>
<td>Using Out-of-Network Providers</td>
</tr>
<tr>
<td>56</td>
<td>What's Covered Under the Vision Plan</td>
</tr>
<tr>
<td>56</td>
<td>Eye Exams</td>
</tr>
<tr>
<td>56</td>
<td>Eyeglasses</td>
</tr>
<tr>
<td>57</td>
<td>Contact Lenses</td>
</tr>
<tr>
<td>57</td>
<td>Additional Discounts on Eyeglasses and Contact Lenses</td>
</tr>
<tr>
<td>57</td>
<td>Discounts on Laser Vision Correction Surgery</td>
</tr>
<tr>
<td>58</td>
<td>The EyeMed Select Vision Options</td>
</tr>
<tr>
<td>60</td>
<td>What's Not Covered</td>
</tr>
<tr>
<td>60</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>60</td>
<td>Filing Claims</td>
</tr>
<tr>
<td>60</td>
<td>Appealing a Denied or Reduced Claim</td>
</tr>
<tr>
<td>60</td>
<td>Member Grievance Procedure</td>
</tr>
<tr>
<td>60</td>
<td>Timely Filing Limitation</td>
</tr>
<tr>
<td>61</td>
<td>Subrogation</td>
</tr>
<tr>
<td>61</td>
<td>COBRA (Continuing Coverage After Termination)</td>
</tr>
<tr>
<td>61</td>
<td>EyeMed Vision Discount Program</td>
</tr>
<tr>
<td>61</td>
<td>Limitations and Exclusions for the EyeMed Vision Discount Program</td>
</tr>
<tr>
<td>62</td>
<td>EyeMed Vision Discount Program</td>
</tr>
</tbody>
</table>
Vision Plan Options

The EyeMed Vision Plan offers you two options:

• EyeMed Select $120 option; and
• EyeMed Select $150 option.

Both options offer:

• **No cost for eye exams.** Eye exams are covered at no cost when you use EyeMed Select network providers. Annual eye exams are important to all ages, as an eye exam not only detects vision correction needs, but can reveal the signs of health conditions including diabetes and high blood pressure.

• **Pay less for eyeglasses and contact lenses when you use EyeMed Select network providers.**

• **Large network of retail and independent providers!** The EyeMed Select network includes thousands of independent optometrists, ophthalmologists and opticians.

• **Large network of leading optical retailers.** Lenscrafters, Sears Optical, Target Optical, JC Penny Optical and most Pearle Vision locations are all EyeMed Select providers.

• **Discounts on laser vision correction.** EyeMed offers vision plan participants a laser vision correction discount of 5% off any promotional price or 15% off the retail price for treatments performed through the U.S. Laser Network, owned and operated by LCA vision.

• **Unlimited additional discounts on eyeglasses and contact lenses.** Vision plan participants get a 40% discount off complete pairs of eyeglasses and a 15% discount off conventional contact lenses once your frame, lens and contact lens benefits have been used.

Coverage Categories

For the Vision Plan, you may select one of four coverage categories:

• associate only
• associate + spouse
• associate + child(ren)
• associate + family (children and spouse)
**Using EyeMed Select Network Providers**

To find an EyeMed Select network provider, go to [www.eyemed.com](http://www.eyemed.com) (be sure to look at “Select” network providers) or call EyeMed’s Home Depot Member Services Department at 1-888-203-7447. Before you go to an EyeMed Select network provider, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Select ID card. If you don’t have your card, say that you are participating in the Home Depot vision care plan so your eligibility can be verified. You can also go to [www.eyemed.com](http://www.eyemed.com) to print an ID card or call EyeMed’s Home Depot Member Services Department at 1-888-203-7447 to request a new ID card.

When you receive services by an EyeMed Select network provider, you won’t have to file a claim form. You will have to pay the cost of any services or eyewear that exceeds your allowances and any applicable copayments (see [The EyeMed Vision Plan Options](#) chart later in this chapter). You will also owe state tax, if applicable, and the cost of non-covered expenses (see [What’s Not Covered](#) later in this chapter). Your EyeMed Select network provider arranges eyewear fabrication and delivery.

**Online In-Network Options**

In addition to the EyeMed Select network of independent providers and optical retailers, you can receive in-network benefits online through Glasses.com and ContactsDirect. You’ll need a valid prescription from your eye doctor to get started.

- **ContactsDirect** ([www.contactsdirect.com](http://www.contactsdirect.com))
  - Use your vision benefits online to make shopping more convenient and contacts more affordable
  - Order contact lenses and have them shipped straight to your door
  - Your contact lenses will ship for free, once the prescription is verified
- **Glasses.com**
  - Members can apply in-network vision benefits to their transaction
  - Access the award-winning 3D virtual try-on app
  - Choose from a large selection of high quality frames and lenses, including some of the world’s leading brands
  - Free in-store fitting available at LensCrafters
  - Easy return policies

**Using Out-of-Network Providers**

If you visit an out-of-network provider, you are responsible for paying the provider in full at the time of service and then submitting the claim and receipts to EyeMed/FAA for reimbursement. You will be reimbursed for eligible services received from an out-of-network provider as shown in [The EyeMed Vision Plan Options](#) chart later in this chapter.

To receive care from an out-of-network provider:

- **Request an Out-of-Network Claim Form:** To ensure timely payment of your claim, get an out-of-network claim form at [www.eyemed.com](http://www.eyemed.com) before you see the provider. You can also call EyeMed’s Home Depot Member Services Department at 1-888-203-7447 and the form will be mailed to you within 24 hours. Forms can also be emailed or faxed.
- **Schedule an Appointment:** Make an appointment with the out-of-network provider of your choice.
- **Pay for all Services:** Pay for all services at the point of care and ask the provider for an itemized receipt.
- **Submit Out-of-Network Claim Form:** Fill out and submit the out-of-network claim form with paid receipts to EyeMed/FAA for processing. Out-of-network reimbursements are sent directly to you. Payment will include an Explanation of Benefits (EOB).

See the [Filing Claims](#) section for more information on using out-of-network providers.

**What’s Covered Under the Vision Plan**

**Eye Exams**

The EyeMed Select $120 option and the $150 option provide benefits for one eye exam every 12 months. If you use an EyeMed Select network provider, there is no cost to you. If you use an out-of-network provider, you will be reimbursed up to $40 of the amount charged.

**Eyeglasses**

The EyeMed Select $120 option provides benefits for frames once every 24 months and the EyeMed Select network $150 option provides benefits for frames once every 12 months. If you use an EyeMed
Select network provider and choose a frame that exceeds your option’s allowance, you pay 80% of the balance over the allowance. Your provider will assist you in determining which frames are within your allowance and what the additional charges, if any, will be. If you use an out-of-network provider, you will be reimbursed up to the out-of-network frame allowance for your option.

The lens benefit is available once every 12 months in both options. The options differ in the amount you pay for the lenses and lens options.

Elective or medically necessary contact lenses may be provided instead of eyeglass lenses once every 12 months. You cannot receive benefits for contact lenses and eyeglass lenses in the same year.

For information on frame and lens coverage, see The EyeMed Vision Plan Options chart later in this chapter.

Contact Lenses

The Vision Plan covers disposable, non-disposable or medically necessary contact lenses instead of eyeglass lenses. The contact lens fit and follow-up coverage depends on the type of contact lens you will be receiving:

- Standard Contact Lenses include spherical clear contact lenses in conventional wear and planned replacement (for example, disposable and frequent replacement).
- Premium Contact Lenses include all lens designs, materials and specialty fittings other than Standard Contact Lens (for example, toric and multifocal).

Contact lenses are considered to be medically necessary only if one of the following exists:

- To correct extreme vision problems that can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses
- Keratoconus when the member’s vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- Anisometropia of 3D in meridian powers
- High ametropia exceeding -10D or +10D in meridian powers

Your eye doctor determines if your vision needs qualify. If your vision needs do not qualify, you may receive the elective contact lens allowance.

For information on contact lens fit and follow-up and contact lens coverage, see The EyeMed Vision Plan Options chart later in this chapter.

Additional Discounts on Eyeglasses and Contact Lenses

Once your frame, lens and contact lens benefits have been used for that calendar year, Vision Plan participants get a:

- 40% discount off complete pairs of eyeglasses
- 15% discount off conventional contact lenses
- 20% discount on items not covered by the plan. This cannot be combined with any other discounts or promotional offers and does not apply to EyeMed provider’s professional services or contact lenses.

These discounts are available through EyeMed.

Select network providers only. Pursuant to Maryland and Texas law, discounts may not be available at all participating providers. Prior to your appointment, please confirm with your provider that discounts are offered.

For more information on the additional discounts available to EyeMed members, call EyeMed’s Home Depot Member Services Department at 1-888-203-7447.

Discounts on Laser Vision Correction Surgery

As a participant in an EyeMed vision option, you can save money on laser vision correction surgery. You will receive a 15% discount off regular pricing or a 5% discount off promotional pricing on LASIK, PRK and e-LASIK procedures through the US Laser Vision Network, which is owned and administered by LCA-Vision, the leading provider in the industry. For more information about this discount, visit www.EyeMedLasik.com or call 1-877-552-7376. This service is separate from your standard plan benefit.

To access the laser vision discount:

1. Call the U.S. Laser Network at 1-877-552-7376 to find the laser correction provider most convenient for you.
2. Schedule a consultation with the provider. When making the appointment, tell the office that you are an EyeMed member.
3. During your consultation, you and your provider will determine whether or not you are a good candidate for the procedure.
The EyeMed Select Vision Options

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam (once every 12 months)</td>
<td>$0 copay</td>
<td>Up to $40</td>
<td>$0 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Eyeglasses (frames and lenses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>Plan pays first $120 then you pay 80% of balance over $120—frame benefit available once every 24 months</td>
<td>Up to $45—available once every 24 months</td>
<td>Plan pays first $150 then you pay 80% of balance over $150—frame benefit available once every 12 months</td>
<td>Up to $53—available once every 12 months</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision (once every 12 months)</td>
<td>$15 copay</td>
<td>Up to $35</td>
<td>$0 copay for all</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Bifocal (once every 12 months)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trifocal (once every 12 months)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenticular (once every 12 months)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard progressive (once every 12 months)</td>
<td>$80 copay</td>
<td>Up to $55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium progressive (once every 12 months)</td>
<td>fixed pricing list</td>
<td>Up to $55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Lens Options*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Coating</td>
<td>$0 copay</td>
<td>Up to $11</td>
<td>$0 copay for all</td>
<td>Up to $11</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$0 copay</td>
<td>Up to $11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Scratch-Resistance</td>
<td>$0 copay</td>
<td>Up to $11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$40 ($0 copay for dependents under age 19)</td>
<td>N/A for adults (Up to $28 for dependents under age 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photochromatic</td>
<td>80% of charge</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitions</td>
<td>80% of charge</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edge Coating</td>
<td>80% of charge</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The EyeMed Select Vision Options—continued

<table>
<thead>
<tr>
<th>Item</th>
<th>EyeMed Select $120</th>
<th>Non-EyeMed Select Providers Reimbursement After You Submit Claim</th>
<th>EyeMed Select $150</th>
<th>Non-EyeMed Select Providers Reimbursement After You Submit Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Lens Fit and Follow-up (once comprehensive eye exam has been completed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard (examples include conventional, disposable, frequent replacement)</td>
<td>$0 fit and two follow-up visits</td>
<td>Up to $40</td>
<td>$0 fit and two follow-up visits</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Premium (examples include toric, multifocal)</td>
<td>You get 10% off retail price, Plan pays first $40, then you pay 100% of balance over $40</td>
<td>Up to $40</td>
<td>You get 10% off retail price, then you pay balance over the plan’s $40 allowance</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Contact Lenses (once every 12 months instead of eyeglasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>Plan pays first $120, then you pay 85% of balance over $120</td>
<td>Up to $96</td>
<td>Plan pays first $150, then you pay 85% of balance over $150</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Disposable</td>
<td>Plan pays first $120, then you pay 100% of balance over $120</td>
<td>Up to $96</td>
<td>Plan pays first $150, then you pay balance over $150</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 copay</td>
<td>Up to $210</td>
<td>$0 copay</td>
<td>Up to $210</td>
</tr>
</tbody>
</table>
4. If you choose to proceed with the treatment, call the U.S. Laser Network to request an authorization for your discount. A refundable deposit will also be requested at this time. The authorization will be sent to you and the laser provider.

5. Schedule your procedure. After your appointment be sure to follow all post-operative instructions carefully.

What’s Not Covered
Benefits are not provided for services or materials arising from:

- Orthoptic or vision training
- Subnormal vision aids and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Services provided as a result of any Workers’ Compensation law, or similar law
- Lost or broken materials
- Eye or vision exam, or corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under the plan
- Two pair of glasses in lieu of bifocals
- Aniseikonic lenses
- Non-prescription lenses and/or contact lenses
- Certain frames where the manufacturer imposes a no-discount policy.

Coordination of Benefits
There is no coordination of benefits provision for the Vision Plan. If elected, benefits described in this Benefits Summary are provided regardless of whether or not you are covered by another plan, such as an HMO with a vision exam provision. In addition, you may also receive full discounts that may be available through vision care discount programs offered through your Medical Plan.

Filing Claims
When you receive services from an EyeMed Select network provider, you will not have to file a claim form. If you visit an out-of-network provider, you are responsible for paying the provider in full at the time of service and then submitting the claim and receipts to EyeMed/FAA for reimbursement. “FAA” (First American Administrators) is a wholly-owned subsidiary of EyeMed. FAA manages the claim payment and adjudication process for all EyeMed plan members. Mail, fax or e-mail the completed form along with the itemized paid receipts for services and materials to:

EyeMed Vision Care/FAA
Attn: OON Claims
P.O. Box 8504
Mason, Ohio 45040-7111
Fax: 1-866-293-7373
oonclaims@eyemedvisioncare.com

Appealing a Denied or Reduced Claim
If a claim for reimbursement or benefits is reduced or denied, in whole or in part, and you want the claim reconsidered, a written request for reconsideration must be submitted in accordance with the procedures set forth in the Claims and Appeals chapter.

Member Grievance Procedure
If you are dissatisfied with the services provided by an EyeMed network provider, you should either write to EyeMed at the address indicated above or call EyeMed’s Home Depot Member Services Department at 1-888-203-7447. The EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues you raised.

If a resolution is not able to be reached during the telephone call, the concern will be addressed through the complaints and appeals process. The member will receive an acknowledgement letter from a Quality Assurance Specialist within three days that includes a resolution or a description of the appeal procedure and time line. If you are not satisfied with the resolution, the member may file a formal appeal in accordance with the procedures set forth in the Claims and Appeals chapter.

Timely Filing Limitation
For the Vision Plan, all claims must be received within 12 months of the date services are rendered. Claims filed after 12 months will not be considered for payment.
**Subrogation**

There is no subrogation provision within the Vision Plan. Subrogation is the right of the insurance company to recoup benefits paid to a participant through legal suit, if the action causing the disability and subsequent medical expenses was the fault of another individual.

**COBRA (Continuing Coverage After Termination)**

Federal law requires that you and your eligible dependents be offered the opportunity to purchase a temporary extension of coverage under the Vision Plan at group rates in certain instances where coverage under the Vision Plan would otherwise end. This coverage is referred to as COBRA. For more information, see the COBRA Coverage chapter.

**EyeMed Vision Discount Program**

The EyeMed Vision Discount Program is available to all Home Depot associates who are not enrolled in an EyeMed vision option. For information on this program, see the EyeMed Vision Discount Program chart later in this chapter.

Member will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this Discount Program. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider’s professional services, or contact lenses. Retail prices may vary by location. Pursuant to Maryland and Texas law, discounts may not be available at all participating providers. Prior to your appointment, please confirm with your provider that discounts are offered.

The EyeMed Vision Discount Program is available through EyeMed Select network providers only.

**Limitations and Exclusions for the EyeMed Vision Discount Program**

Discount is not provided for services or materials arising from:

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Services provided as a result of any Workers’ Compensation law
- Discount is not available on those frames where the manufacturer prohibits a discount
EyeMed Vision Discount Program

The EyeMed Vision Discount Program is available to all Home Depot associates who are not enrolled in an EyeMed vision option.

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with Dilation as Necessary:</td>
<td>$5 off comprehensive exam</td>
</tr>
<tr>
<td></td>
<td>$10 off contact lens exam</td>
</tr>
</tbody>
</table>

**Complete Pair of Glasses Purchase**: frame, lenses and lens options must be purchased in the same transaction to receive full discount.

<table>
<thead>
<tr>
<th>Standard Plastic Lenses:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Single Vision</td>
<td>$50</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$70</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>$105</td>
</tr>
<tr>
<td>• Standard Progressive</td>
<td>$135</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frames:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any frame available at provider location</td>
<td>35% off retail price</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lens Options:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>• Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>• Standard Scratch-Resistance</td>
<td>$15</td>
</tr>
<tr>
<td>• Standard Polycarbonate</td>
<td>$40</td>
</tr>
<tr>
<td>• Standard Anti-Reflective Coating</td>
<td>$45</td>
</tr>
<tr>
<td>• Other Add-Ons and Services</td>
<td>20% discount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Lens Materials: (Discount applied to materials only)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Disposable</td>
<td>0% off retail price</td>
</tr>
<tr>
<td>• Conventional</td>
<td>15% off retail price</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laser Vision Correction**:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lasik or PRK</td>
<td>15% off retail price - or - 5% off promotional price</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Examination</td>
<td>Unlimited</td>
</tr>
<tr>
<td>• Frame</td>
<td>Unlimited</td>
</tr>
<tr>
<td>• Lenses</td>
<td>Unlimited</td>
</tr>
<tr>
<td>• Contact Lenses</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

* Item purchased separately will be discounted 20% off the retail price.

** Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6.

Pursuant to Maryland and Texas law, discounts may not be available at all participating providers. Prior to your appointment, please confirm with your provider that discounts are offered.

This is not Insurance

---

1 Uses EyeMed Select Network

---

U.S. PART-TIME HOURLY ASSOCIATES

TO ENROLL, GO TO WWW.LIVETHEORANGELIFE.COM; FOR HELP CALL 1-800-555-4954
Term Life Insurance Quick Facts and Quick Links

When Do I Enroll in Life Insurance?

• You can enroll or make changes in your life coverage during annual enrollment, once during any 12-month rolling period or when you experience a life event change by calling the Benefits Choice Center at 1-800-555-4954.

Quick Links to Frequently Used Term Life Insurance Info

• How do I designate or change my life insurance beneficiary?
• What's not covered under the life insurance plan?
• I need to file a claim

Your Term Life Insurance Options

| Associate Coverage | • $20,000 coverage amount
|                    | • If your death is the result of an accident, your beneficiary will receive an additional $20,000
| Spouse or Same-Sex Domestic Partner Coverage | • $2,500 coverage amount
| Child Coverage     | • $2,500 coverage amount for each eligible child age six months and older
|                    | • $500 coverage amount for a child under six months

Term Life Insurance Contacts
## CHAPTER CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>Term Life Insurance</td>
</tr>
<tr>
<td>65</td>
<td>Coverage for You</td>
</tr>
<tr>
<td>65</td>
<td>Coverage for Your Family</td>
</tr>
<tr>
<td>65</td>
<td>Enrolling in Term Life Insurance</td>
</tr>
<tr>
<td>65</td>
<td>What's Not Covered Under the Life Insurance Plans</td>
</tr>
<tr>
<td>65</td>
<td>Accidental Death Benefit</td>
</tr>
<tr>
<td>66</td>
<td>What's Not Covered Under the Accidental Death Benefit</td>
</tr>
<tr>
<td>66</td>
<td>Converting to an Individual Life Policy</td>
</tr>
<tr>
<td>66</td>
<td>Filing Claims for Benefits</td>
</tr>
<tr>
<td>66</td>
<td>Appealing a Claim</td>
</tr>
<tr>
<td>66</td>
<td>Designating a Beneficiary</td>
</tr>
</tbody>
</table>
Get the Most Value from Your Plan

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll in coverage</td>
<td>Go to <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a> or call the Benefits Choice Center at 1-800-555-4954</td>
</tr>
<tr>
<td>Designate your beneficiaries</td>
<td>Call the Benefits Choice Center at 1-800-555-4954</td>
</tr>
<tr>
<td>Get additional information on converting term life insurance coverage after employment at the Company ends</td>
<td>Call Aetna Voluntary 1-800-508-4015</td>
</tr>
</tbody>
</table>

**Term Life Insurance**

Depending on your family’s financial situation, you may decide to purchase protection for yourself under the Term Life Insurance coverage through the Aetna Voluntary Plans and for your eligible family members under the Dependent Term Life Insurance coverage.

You can find information related to your Term Life Insurance plan benefits, exclusions and limitations and other important information in your Plan Documents. Your Plan Documents are available 24 hours a day, 7 days a week on [www.livetheorangelife.com](http://www.livetheorangelife.com).

**Coverage for Your Family**

You can purchase Dependent Term Life Insurance to provide coverage for dependent family members. You may purchase coverage for your spouse only, your eligible children only, or your spouse and eligible children together. The coverage for your spouse is $2,500. Coverage is $2,500 for each eligible child from six months after birth or $500 for children under six months. You must be actively at work for any Term Life Insurance coverage to become effective.

**Enrolling in Term Life Insurance**

To enroll in term life insurance for yourself and/or your family, call the Benefits Choice Center. You may make changes in your life coverage once during any 12-month rolling period or when you experience a qualified status change.

**What’s Not Covered Under the Life Insurance Plans**

Term Life benefits are not paid under the Term Life and Dependent Term Life Plans if you (or your dependent) commits suicide, while sane or insane, during the first two years of coverage under the Plan.

If a suicide occurs within two years of the effective date of any coverage, that coverage will not be payable.

If death on account of suicide occurs after two years of your effective date of coverage, while you are insured, but within two years of the date that any increase in coverage becomes effective, no life insurance benefit will be payable for any such increase.

**Accidental Death Benefit**

If you die as the result of an event described below, the Plan will pay the amount of insurance that applies. Your beneficiary must provide the Aetna Life Insurance Company with proof that:

- Death occurred while the insurance was in force;
- The injury which caused your death began while you were insured under the Plan;
- The death occurred within 365 days after the injury; and
- Death was due to the injury independent of all other causes.

The accidental death benefit does not apply to Dependent Term Life Insurance.
What's Not Covered Under the Accidental Death Benefit

Benefits will not be paid for a death caused or contributed by:

- Disease, ptomaine, or bacterial infection, bodily or mental infirmity, or medical or surgical treatment of these other than an infection which results directly from the injury or surgery needed because of the injury
- Suicide or intentionally self-inflicted injury, while sane or insane
- War or any act of war, declared or undeclared
- Use of alcohol, any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a physician
- Driving while intoxicated, as defined by the applicable state law where the loss occurred
- Voluntary inhalation of poisonous gases or voluntary taking of poison
- Travel in, travel on, fall from or descent from any aircraft (including a hang glider) while such aircraft is in flight unless you are traveling solely: as a fare paying passenger on a licensed, commercial regularly scheduled nonmilitary aircraft; or in a civil aircraft having current and valid “Standard Federal Aviation Agency Airworthiness Certificate” and is piloted by a person with a current and valid pilot’s certificate with proper ratings for the type of flight and aircraft involved.
- Bodily or mental infirmity*
- Medical or surgical treatment*

*These do not apply if the loss is caused by:
- An infection which results directly from the injury
- Surgery needed because of the injury
- Intended or accidental contact with nuclear or atomic energy

Converting to an Individual Life Policy

If you or your eligible family members lose coverage under the Term Life Insurance coverage (not including the matching accidental death benefit), you may be eligible to obtain an individual life insurance policy customarily issued by Aetna for conversions. The amount of coverage will equal your coverage level under the Company’s Term Life and/or Dependent Term Life Plans.

To convert your term life insurance to an individual policy, you must follow these steps:

- Apply within 31 days after the qualifying event that caused you to lose coverage. You can obtain the proper forms from the Benefits Choice Center. Your individual policy will become effective at the end of the 31 day period, after Aetna has processed your completed application and premium payment.
- Pay the required premium within 31 days following the date on which your insurance with the Company ended. Aetna will base the premium for the individual policy on the covered person’s age on the policy’s effective date, the class of risk to which you belong, and the type and amount of the policy.

If you die during the 31 days following the date of a qualifying event, the Plan will pay your life benefits, according to plan provisions, whether or not you have applied for an individual policy.

Filing Claims for Benefits

The Benefits Choice Center must be notified if you or a family member dies while covered by the Term Life and/or Dependent Term Life Plans. Upon notification, the Benefits Choice Center will provide the beneficiary with the appropriate claim forms. Your beneficiaries must complete and return the forms, along with other required information, to Aetna Voluntary for processing:

Aetna Voluntary
Attn: Claims Department
PO Box 14079
Lexington, KY 40512-4079

Aetna has the right to have an autopsy performed by doctors of Aetna’s choice.

Appealing a Claim

If your claim is denied as described in the Claims and Appeals chapter of this book, you will receive a formal letter that states the reasons for the denial and outlines the process you must follow if you choose to appeal the denial. To appeal, you must request a review of the claim in writing to:

Aetna Voluntary
Attn: Appeals Resolution Team
PO Box 14463
Lexington, KY 40512-4463

Designating a Beneficiary

To designate or change beneficiaries, you must go to www.livetheorangelife.com and complete the online Beneficiary Designation Form. You can change your beneficiary(ies) at any time.
You may want to change the designation of your beneficiary if you divorce or are legally separated from your spouse. Please note that Aetna will pay the beneficiary listed on your latest form, even if you subsequently changed your will, separated or divorced. To change your beneficiary designation, go to the www.livetheorangelife.com website.

If there is no designated beneficiary at your death, any benefits for these plans will be paid in the following manner:

- Your legal spouse if there is no spouse,
- Natural or legally adopted children in equal shares; if there are no children,
- Parents, equally or to the survivor; if there are no parents,
- Equal shares to your brothers and sisters; if none of the above survives,
- Your estate.
Your Part-time Hourly Disability Option

**Short-term Disability**
Not available to associates working in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island—these states have state disability plans

### A Quick Look at the Disability Plan

<table>
<thead>
<tr>
<th>When benefits begin:</th>
<th>Your disability benefit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term disability:</td>
<td>50% of your current weekly base pay (up to $125 per week) for an approved disability up to 26 weeks (your 14-day elimination period plus your 24 weeks of coverage)</td>
</tr>
<tr>
<td>After an illness or injury has kept you unable to work for 14 consecutive calendar days</td>
<td></td>
</tr>
</tbody>
</table>

### Important Enrollment Information

- **New Associates Enrolling for the First Time:** You are automatically enrolled in the Short-term Disability Plan. If you do not want this coverage, you must decline it before your 91st day of employment or payroll deductions will begin. To decline, call the Benefits Choice Center at 1-800-555-4954.

- **All Other Associates:** You can enroll in the disability plan once during any 12-month rolling period or when you experience a life event. To enroll, call the Benefits Choice Center at 1-800-555-4954.

### Quick Links to Frequently Used Disability Info

- How do I qualify for short-term disability benefits?
- What’s not covered under the disability plan?
- How do I file a claim for benefits?
### CHAPTER CONTENTS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td><strong>Short-Term Disability Coverage</strong></td>
</tr>
<tr>
<td>70</td>
<td><strong>Enrolling in STD Coverage</strong></td>
</tr>
<tr>
<td>70</td>
<td><strong>Paying for Your Coverage</strong></td>
</tr>
<tr>
<td>70</td>
<td><strong>How the Short-term Disability Plan Works</strong></td>
</tr>
<tr>
<td>70</td>
<td><strong>Qualifying for Benefits</strong></td>
</tr>
<tr>
<td>71</td>
<td><strong>How the Plan Pays Benefits</strong></td>
</tr>
<tr>
<td>71</td>
<td><strong>Recurring Disabilities</strong></td>
</tr>
<tr>
<td>71</td>
<td><strong>Total Disability</strong></td>
</tr>
<tr>
<td>71</td>
<td><strong>What's Not Covered Under the Disability Plan</strong></td>
</tr>
<tr>
<td>71</td>
<td><strong>Termination of Benefits</strong></td>
</tr>
<tr>
<td>71</td>
<td><strong>Filing Claims for Benefits</strong></td>
</tr>
<tr>
<td>72</td>
<td><strong>Information Checklist</strong></td>
</tr>
<tr>
<td>72</td>
<td><strong>How Your Claims Are Handled</strong></td>
</tr>
<tr>
<td>72</td>
<td><strong>Appealing a Claim</strong></td>
</tr>
</tbody>
</table>

---

**Note:** The Disability Plan is not available to THD At-Home Services 100% commission associates with under one year of service.
Get the Most Value from Your Plan

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>File an STD claim</td>
<td>Aetna Voluntary 1-800-508-4015</td>
</tr>
<tr>
<td>Check the status of an STD or LTD claim</td>
<td>Call Aetna Voluntary 1-800-508-4015</td>
</tr>
</tbody>
</table>

**Short-Term Disability Coverage**

To help your financial protection if you become disabled and are unable to work because of illness or injury, the Company offers you the Short-term Disability (STD) Insurance Plan (not available to associates working in California, New Jersey, Rhode Island, Hawaii, New York and Puerto Rico.)


You can find information related to your Disability plan benefits, exclusions and limitations and other important information in your Plan Documents. Your Plan Documents are available 24 hours a day, 7 days a week on livetheorangelife.com. To access your Plan Documents, go to www.livetheorangelife.com.

**Enrolling in STD Coverage**

You are automatically enrolled in the Short-term Disability coverage after completing your 90th day of service. Payroll deductions begin with your first paycheck after you complete your 90th day.

If you do not want the coverage, you must opt out through www.livetheorangelife.com or by calling the Benefits Choice Center. If you opt out of the Plan, you may enroll in STD once during any rolling 12-month period and/or upon a qualified status change. You may only opt out if you have not filed a claim for a disability benefit with Aetna within the prior 12 months.

If you have filed a claim for a benefit, you may opt out of coverage during your next rolling 12-month period following your return from medical leave. Depending on your personal circumstances, the benefits you may receive from sources other than the STD coverage may significantly reduce any benefit that the Company’s STD coverage might provide.

**Paying for Your Coverage**

Since you pay the premium for short-term disability coverage with after tax dollars, you do not have to pay federal income and FICA taxes on the benefits you receive.

**How the Short-term Disability Plan Works**

After 14 consecutive calendar days of an illness or injury during which you are unable to work, the Short-term Disability coverage will pay 50% of your covered weekly base pay, up to a maximum of $125 per week for an approved period of disability, not to exceed 26 weeks (your 14-day elimination period plus your 24 weeks of coverage). The 14-day elimination period is waived if you are confined to a hospital at any time during the elimination period.

Base pay means your regular hourly pay rate in effect as of the date of disability and does not include overtime, bonuses, premiums, incentive pay or any other form of pay from the Company. These benefits are paid on a weekly basis, and you do not pay federal income or FICA taxes on the benefits received.

**Qualifying for Benefits**

You must be actively at work on the day your coverage begins. If you become disabled during the first seven consecutive calendar days of coverage under the Short-term Disability Plan, you must have been actively working your normally scheduled hours during the seven calendar days immediately before the disability occurred to qualify for benefits.

In addition, to qualify for short-term disability benefits, you must meet all of the following requirements:

- The disability period must be expected to last more than 14 consecutive calendar days;
- You must be under the care of a qualified doctor (qualified doctors include legally licensed...
physicians and practitioners who are not related to you and are performing services within the scope of their licenses);

- You must not be able to perform the material and substantial duties of your regular occupation; and

- Aetna must receive certification accompanied by appropriate medical documentation of a disability from your attending doctor before benefits are considered for payment.

**How the Plan Pays Benefits**

During the first 14 consecutive calendar days that you are disabled, you can use any sick or vacation days you have available to receive pay for normally scheduled hours. After the first 14 consecutive calendar days, if approved, you will receive 50% of your base pay up to a maximum of $125 per week for the period of short-term disability, not to exceed 26 weeks (14 day elimination period plus 24 weeks of coverage).

**Recurring Disabilities**

If you have been receiving disability benefits and return to work for less than 14 days, and then go out on disability again for the same or related cause, the disability, if approved, is considered to be recurring. In this case, the benefit continues through the balance of the 26-week period, from the original date of disability (the 14-day waiting period plus the approved period of disability up to 24 weeks). You do not have to complete another 14-day waiting period.

If you have been receiving disability benefits and return to work for 14 days or more, and then go out on disability again, regardless of the disability reason, a new 26-week period (the 14-day waiting period plus the approved period of disability up to 24 weeks) begins, if approved. You must satisfy the 14-day waiting period before the benefit payment would begin.

If you have been receiving disability benefits and return to work for at least one day, and become disabled due to a different or unrelated cause, the disability is considered to be different. If approved, a new 26-week period (the 14-day waiting period plus the approved period of disability up to 24 weeks) begins. You must satisfy the 14-day waiting period before the benefit payment can begin.

**Total Disability**

You are disabled when Aetna determines that you are unable to perform all of the material and substantial duties of your regular occupation due to your sickness or injury.

**What’s Not Covered Under the Disability Plan**

The Short-term Disability Plan does not cover a disability caused by or resulting from:

- An act or accident of war, declared or undeclared;
- Attempted suicide;
- Intentionally self-inflicted injuries (while sane or insane);
- Insurrection, rebellion or active participation in a riot;
- Committing or attempting to commit a criminal act;
- An occupational sickness or injury except in the case of sole proprietors or partners who cannot be covered by worker’s compensation;
- Operating a motor vehicle under the influence of alcohol; or
- Is caused by alcoholism, drug abuse or substance abuse.

**Termination of Benefits**

Your payments and your claim will end on the earliest of:

- The date you are no longer disabled according to the terms of the Plan;
- The date you reach the end of the maximum benefit period;
- The date you fail to provide proof of continuing disability;
- The date you are able to increase your disability earnings by increasing the number of hours you work or the number of duties you perform, but choose not to do so;
- The date you refuse to be examined by a physician, if such an exam is requested by the Plan;
- The date you refuse to be interviewed by a Plan representative;
- The date you cease to be under the regular care of a physician or refuse recommended treatment designed to cure, correct or limit your disability; or
- The date you die.

**Filing Claims for Benefits**

If you are out of work for more than four days and expect your disability to last more than 14 days, or if you know in advance that you will be out of work for more than 14 days due to an injury, illness or pregnancy (e.g., a scheduled surgery), call Aetna.
Voluntary 1-800-508-4015 immediately.

How do I file a claim? Obtain a claim form by:

- Logging on to www.aetna.com
  - Log In in the center of the page
  - Click on Employees
  - Click on Aetna Voluntary Plans Log In
  - Enter the 6-digit group ID number and password:
    — User ID: 360420
    — Password: AAHC
  - Click on Document Library on the left
  - Calling Claims Customer Service at 1-800-508-4015 Monday through Friday, 8:00 a.m. to 8:00 p.m. ET
  - Writing to:
    Aetna Voluntary
    Attn: Claims Department
    PO Box 14079
    Lexington, KY 40512-4079

These claim forms contain instructions on how to fill them out. Send completed forms to Aetna Voluntary, Attn: Claims Department, PO Box 14079, Lexington, KY 40512-4079. If you have a claim, you must send in a signed claim form of the type utilized by this plan. This will help ensure prompt processing of your claim.

For Customer Service call 1-800-508-4015, Monday through Friday, 8:00 a.m. to 6:00 p.m.

Information Checklist
You will need to provide the following information when you call Aetna:

- Employer’s name and location
- Aetna Voluntary group number, which is 360420
- Policy number, which is ASA 113010570
- Name and Social Security number
- Complete address and phone number
- Date of birth
- Marital status and number of dependents
- Occupation (or job title)
- Supervisor’s name and phone number
- Physician’s name, address and phone number
- Date and description of injury (if applicable)
- A brief description of your medical condition
- Cause of your medical condition (illness, injury, whether it is work related)
- Dates of your first visit, your most recent visit and your next scheduled visit with your physician for this condition
- Last day you worked and first day you were absent from work due to this condition
- Date you expect to return to work (if you know) or the actual date (if you have already returned to work at the time you call)

Please Note: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information, may be subject to legal action. In certain states, other consequences may apply.

How Your Claims Are Handled
Aetna disability claims management unit will handle all STD claims for the Company associates.

Here is a quick summary of important numbers and addresses:

<table>
<thead>
<tr>
<th>If you need to</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check the status of an existing claim</td>
<td>1-800-508-4015</td>
</tr>
<tr>
<td>Send a fax to the claims unit</td>
<td>1-859-455-8650</td>
</tr>
<tr>
<td>Mail information to Aetna</td>
<td>Aetna Voluntary</td>
</tr>
<tr>
<td></td>
<td>Attn: Appeals Resolution Team</td>
</tr>
<tr>
<td></td>
<td>PO Box 14463</td>
</tr>
<tr>
<td></td>
<td>Lexington, KY 40512-4079</td>
</tr>
</tbody>
</table>

Appealing a Claim
If your claim is denied as described in the Claims and Appeals chapter, you will receive a formal letter that states the reasons for the denial and outlines the process you must follow if you choose to appeal the denial.

To appeal, you must request a review of the claim in writing to:

Aetna Voluntary
Attn: Appeals Resolution Team
PO Box 14463
Lexington, KY 40512-4463

For more information, see the Claims and Appeals chapter.
FutureBuilder 401(k) Plan Facts and Quick Links

U.S. Part-Time Hourly Associates

Your FutureBuilder Option

<table>
<thead>
<tr>
<th>You can contribute:</th>
<th>Up to a maximum of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% to 50%* of your pay as:</td>
<td>$18,000 (in 2016)</td>
</tr>
<tr>
<td>• Before-tax contributions; and/or</td>
<td></td>
</tr>
<tr>
<td>• Roth after-tax contributions.</td>
<td></td>
</tr>
</tbody>
</table>

Cool FutureBuilder Features

• You Contribute to FutureBuilder through Convenient Payroll Deductions.
• You Can Have Your Contribution Automatically Increased by 1% (or More) Each Year.
• You’ll Lower Your Tax Bill When You Make Before-Tax Contributions. You also can make Roth after-tax contributions.
• The Company Match Puts Free Money in Your FutureBuilder Account. Once you’ve completed one year of service with The Home Depot (at least 1,000 hours in a 12-month period) or two years of service (regardless of hours worked), you’ll begin receiving matching contributions on the first 5% of pay you save through FutureBuilder.
• You Invest Your Account Your Way. You can:
  —Let the professionals invest your account by choosing a LifePath Portfolio based on your projected retirement age; or
  —Make your own investment decisions among the plan’s core funds or through the self-directed brokerage window.
• Get Professional Investment Advice.

* Limits may apply.

When Do I Enroll in FutureBuilder?
To enroll, log into www.livetheorangelifelife.com and select Save & Protect. Or, call the Benefits Choice Center at 1-800-555-4954. You can enroll anytime, but you must take action to enroll.

Quick Links to Frequently Used FutureBuilder Info

• How do I enroll in FutureBuilder?
• What investment funds are available through FutureBuilder?
• How do I change my investments?
• How does the Company match work?
• Can I withdraw money from my FutureBuilder account?
• I’m retiring and want a final distribution of my account.
CHAPTER CONTENTS

75 What Is FutureBuilder?
75 Who's Eligible?
76 How to Enroll
76 What Is Considered Eligible Compensation?
77 Changing Your Contribution Rate and Investment Elections
77 Choosing a Beneficiary
77 Investment Advisory Services
78 Contributions to FutureBuilder
78 Your Contributions
78 Before-Tax Contributions
78 Tax Savings Comparison
78 Roth After-Tax 401(k) Contributions
79 Catch-up Contributions If You Are Age 50 or Older
79 Comparison of Traditional Before-Tax 401(k) Contributions and Roth After-Tax 401(k) Contributions
80 How the Company’s Matching Contribution Works
81 Rollover Contributions
81 Calculating the Company Match
82 If You Are on Military Leave
82 How Your Contributions and Company Matching Contributions are Invested
82 FutureBuilder Vesting Schedule
83 Savings Limitations
83 What Is Vesting?
83 What Is a Break in Service?
84 Your Investment Options

85 BlackRock LifePath® Portfolios
85 LifePath® Retirement Portfolio
86 LifePath 2020® Portfolio
86 LifePath 2025® Portfolio
87 LifePath 2030® Portfolio
87 LifePath 2035® Portfolio
87 LifePath 2040® Portfolio
88 LifePath 2045® Portfolio
88 LifePath 2050® Portfolio
89 LifePath 2055® Portfolio
89 FutureBuilder Core Funds
90 Stable Value Fund
90 Bond Fund
90 Balanced Fund
91 Large Cap Value Fund
91 Large Cap Index Fund
92 Large Cap Growth Fund
92 Mid Cap Value Fund
92 Mid Cap Growth Fund
93 International Fund
93 Small Cap Value Fund
94 Small Cap Growth Fund
94 Home Depot Stock Fund
94 Notice of Your Rights Concerning Employer Securities
94 Your Rights Concerning Home Depot Stock
94 The Brokerage Window: Schwab PCRA

95 Different Investments Carry Different Risk and Return
96 FutureBuilder Investment Expenses as of July 1, 2016
97 Trading Restrictions
97 Notice of Importance of Diversification
97 Keeping Track of Your Account
97 FutureBuilder Statements
98 Confirmation of Your Transaction
98 Accessing Your Plan Balance
98 Loans from Your Account
100 Hardship Withdrawals
100 In-Service Withdrawals
101 Military Leave Distributions
101 Final Distributions of Your Account
103 Tax Considerations
103 Home Depot Stock
103 Rollovers
104 How to Obtain Additional Information
104 Dividends
104 Forfeitures
104 When Benefits Are Not Paid
105 Right to Amend or Terminate the Plan
105 Implied Promises
105 Limiting Liability
105 Your Rights Under ERISA
108 Glossary of Investment Terms
What Is FutureBuilder?

The sooner you begin contributing to FutureBuilder, the longer your money has to grow. Through the Plan, you can generally save anywhere from 1% to 50% of your pay, subject to certain limitations.

For 2017, the IRS considers an associate who earned $120,000 in 2016 to be a highly compensated employee (HCE). HCEs can contribute between 1% and 11%. The Plan’s Administrative Committee may adjust the maximum contribution percentage from time to time. This contribution limit will be referred to as the “HCE limit” subsequently in this chapter. For more information, log into www.livetheorangelife.com > Save & Protect or call the Benefits Choice Center.

As an incentive to save, the Company adds $1.50 to your account for every $1 you save on the first 1% of your pay, and 50 cents for every additional $1 you save from 2% to 5% of your pay. Company matching contributions begin the first day of the calendar quarter beginning on or after the earlier of (a) the date you complete one year of employment during which you worked at least 1,000 hours in the previous 12-month period; or (b) the date you complete two years of employment (regardless of the number of hours worked), if you enrolled in FutureBuilder.

You make the investment decisions for your account. You can invest your account in the following three tiers to develop your investment portfolio:

- **Tier One**: BlackRock LifePath® portfolios;
- **Tier Two**: FutureBuilder’s core funds; and
- **Tier Three**: The Schwab Personal Choice Retirement Account (PCRA), a self-directed brokerage window.

You have direct access to your account information by logging into www.livetheorangelife.com > Save & Protect or by calling the Benefits Choice Center. Contact Schwab for information about your brokerage account.

If you leave the Company, you’re entitled to the vested balance you’ve earned in FutureBuilder. You always have ownership of the money you put into FutureBuilder, including your before-tax, Roth after-tax 401(k) and rollover contributions.

Who’s Eligible?

Associates (other than those classified by the Company as temporary employees) are eligible to participate in the Plan after completing 90 days of service. If you are employed by the Company when 90 days have passed since your first day of work, you are eligible to make before-tax and/or Roth after-tax contributions, without regard to any intervening termination, leave of absence, reemployment, etc.

Company matching contributions begin the first day of the calendar quarter beginning on or after the date you complete one year of service (at least 1,000 hours in a 12-month period), if you have enrolled in FutureBuilder.

If you do not work at least 1,000 hours during your first 12 months of employment with the Company, your (other than those classified as temporary associates) Company matching contributions will begin the first day of the calendar quarter following the earlier of (a) 1,000 hours of service during any plan year (January 1 – December 31) or (b) two years of employment (regardless of the number of hours worked) after you become employed by the Company.
For purposes of calculating the two years of service in subsection (b) above, service is measured beginning with your date of hire and includes all periods you were paid including sick time, vacation time and approved leaves of absence. It does not include periods you were classified as terminated by the Company.

You are credited with hours of service for the calendar year in which you receive compensation for those hours. For example, you were not paid for some of the hours you worked in December 2016 until the January 2017 payroll. Because you were paid for those hours in January 2017, you will receive credit for those hours in 2017, even though you worked those hours in 2016.

Once eligible, you can begin participating at any time. If you don’t enroll once you become eligible, you can enroll anytime thereafter.

If you are classified by the Company as a temporary employee, you will be eligible to participate in the Plan and will also become eligible to receive matching contributions on the first day of the calendar quarter beginning on or after the date you complete one year of service (at least 1,000 hours in a 12-month period).

How to Enroll
You must enroll in FutureBuilder to start saving in the plan. To enroll, you can:

• Log into www.livetheorangelife.com > Save & Protect
• Call the Benefits Choice Center, and speak to a representative.
• Sign and return the Quick Enrollment Form mailed to you.

If you enroll by phone, a confirmation statement will be mailed to your home. If you enroll through the website, you should print a copy of your enrollment as your confirmation.

When you enroll in FutureBuilder, you will need to choose:

• Your contribution rate. This is the percentage of pay that will be deducted from each of your paychecks. You can save anywhere from 1% to 50% of your pay, in whole percentages unless you are subject to the HCE limit.

You also can choose to have your contribution percentage automatically increased through automatic escalation. If you choose automatic escalation, your FutureBuilder contribution percentage will automatically be increased by 1% each year up to a maximum target rate of 15% through the Quick Enrollment Process, or you can choose your own automatic contribution percentage increase and maximum target rate (up to 50%, unless you are an HCE). If you make your contribution rate escalation election by October 5th, your rate will be increased the following January 5th. You will receive a reminder notification of your escalation election in December should you want to make changes prior to the escalation in January. You can change your contribution rate at any time.

• Your investment elections. You choose where you want contributions invested. See Your Investment Options. If you don’t make an investment election, your contributions will be invested in the appropriate LifePath fund based on your age. You can change your investment election at any time.

• Company match investment. The Plan allows you to choose where you want your matching contributions invested. If you don’t make an investment election, your matching contributions will be invested using the same investment approach you have chosen for your own contributions.

What Is Considered Eligible Compensation?
For purposes of determining your contributions to the Plan, eligible compensation is defined as:

• Your Form W-2 wages; plus
• Any before-tax deferrals you make under a cafeteria plan (such as your premiums for health and dental coverage), a qualified commuter benefits program and the 401(k) portion of the Plan; minus
• All reimbursements, expense allowances, fringe benefits, moving expenses, welfare benefits, and other similar amount; minus
• Wages paid before you become eligible for the Plan; minus
• Amounts paid as settlements and judgments; minus
• Amounts paid as in-kind awards or prizes and gross-ups on those amounts; minus
• Income attributable to stock options, restricted stock or other equity awards

Please note that the IRS specifies a limit on the amount of annual compensation that may be taken into account when determining your payroll deductions to FutureBuilder. This dollar limit is an indexed amount and may change from time to time to reflect inflation. In 2016, the amount is $265,000.
Changing Your Contribution Rate and Investment Elections

Once you have made your enrollment decisions, you can change your contribution rate or investment elections by logging into www.livetheorangelife.com > Save & Protect or calling the Benefits Choice Center. If you change your contribution rate before 1 a.m. (Eastern Time) on any Friday the week before your next payday, your change should generally be effective for your next paycheck. Make your investment elections carefully. Although you can change your election with respect to future pay, under federal tax rules, once your pay is put into the Plan, it can generally only be withdrawn when you have a distributable event such as an employment termination or hardship.

You will get a written confirmation in the mail if you make your changes over the phone. If you make your changes by logging into www.livetheorangelife.com > Save & Protect, you should print a copy as your confirmation. A confirmation will always be mailed for investment election changes no matter how the election is made.

Transactions involving FutureBuilder are subject to the Company’s Insider Trading Policy. Changes in your investment elections or contribution rates, including investments within the brokerage window, must be made in compliance with the policy.

Keep in mind that when you save through FutureBuilder, there is flexibility. In fact, you can stop contributing to the Plan by logging into www.livetheorangelife.com > Save & Protect or calling the Benefits Choice Center and changing your contribution rate to 0%. You can always resume contributions at any time.

Choosing a Beneficiary

As a participant of FutureBuilder, you have the right to designate the beneficiary(ies) to receive your account balance in the event of your death. You can designate one or more individuals, a trust, or your estate as your beneficiary. You can designate your beneficiary(ies) by logging into www.livetheorangelife.com > Save & Protect.

You should be sure that FutureBuilder has up-to-date beneficiary designation information at all times.

If you are married and designate anyone other than your legal spouse as beneficiary, a Beneficiary Authorization Form will be sent to you. Any non-spousal designation will not be valid unless your spouse consents in writing on the Beneficiary Authorization Form. Your spouse’s consent must be notarized. If you marry and have previously designated a beneficiary other than your spouse, your beneficiary will automatically be your spouse unless he or she consents to a non-spouse beneficiary. If you divorce, you should review your beneficiary designation. Note that your former spouse is not automatically removed.

If you do not have a valid Beneficiary Designation on file when you die, or if your designated beneficiary does not survive you or cannot be located, your account will be paid to your surviving legal spouse, if any, or to your estate if you do not have a surviving legal spouse. No benefits are paid to any person responsible for a participant’s death.

Investment Advisory Services

The Home Depot offers investment advisory services to help you meet your financial goals for retirement and make the most of the FutureBuilder’s features. This service can recommend an investment strategy based on your personal goals and the funds available through FutureBuilder. The team of retirement experts offer independent investment advice and discretionary management—they don’t sell investments and they don’t receive commissions.

Two services are available depending on your needs:

- Online Advice is available at no additional cost to FutureBuilder participants. Online Advice provides investment recommendations and forecasts based on the investment funds available through FutureBuilder. This online tool allows you to explore different investment scenarios and fine-tune your strategy. Then you can implement the advice for your FutureBuilder investment portfolio yourself.

- Professional Management provides a savings and investing strategy tailored to your specific needs, and then provides ongoing investment fund monitoring and management. Under Professional Management you turn over actual investment decision making and control of your account. You also can speak with an advisor representative when you have questions. Your account will be charged a monthly fee for Professional Management services. For more information about this fee, log into www.livetheorangelife.com.

Both services provide recommendations for investing in the FutureBuilder funds based on your personal retirement needs. You can find out more
Contributions to FutureBuilder

Your account may consist of your own before-tax contributions, Roth after-tax contributions, Company matching contributions, ESOP contributions previously made, and any rollover contributions you may make.

Your Contributions

You can contribute from 1% to 50% of your pay in before-tax and/or Roth after-tax contributions to the Plan, in any whole percentage, unless you are subject to the HCE limit. Contributions are deducted automatically from your paycheck.

Before-Tax Contributions

When you save with before-tax dollars, you reduce your current year’s income taxes. Your contributions to the plan do not count as current income on your tax return, which means you do not pay current income taxes on what is set aside in the Plan. As a result, you defer paying federal and, in most cases, state and local income taxes on your FutureBuilder savings until you withdraw them or receive a distribution from the Plan.

In the following example, if you save on a before-tax basis through FutureBuilder, you have an extra $375 in take-home earnings compared to savings on an after-tax basis. The example is simplified by excluding deductions and exemptions and assumes you are single, that your eligible compensation is $25,000 and you contribute 10% of that amount to FutureBuilder as before-tax savings. The estimated federal taxes are based on the IRS 2016 tax table.

Tax Savings Comparison

<table>
<thead>
<tr>
<th></th>
<th>Before-tax Savings</th>
<th>Roth After-tax Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Compensation</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Before-tax Contribution</td>
<td>- $2,500</td>
<td>N/A</td>
</tr>
<tr>
<td>Taxable Compensation</td>
<td>$22,500</td>
<td>$25,000</td>
</tr>
<tr>
<td>Estimated Federal Taxes</td>
<td>- $2,914</td>
<td>- $3,289</td>
</tr>
<tr>
<td>Eligible Compensation after Taxes</td>
<td>$19,586</td>
<td>$21,711</td>
</tr>
<tr>
<td>After-Tax Savings</td>
<td>N/A</td>
<td>- $2,500</td>
</tr>
<tr>
<td>Remaining Take-Home Earnings</td>
<td>$19,586</td>
<td>$19,211</td>
</tr>
</tbody>
</table>

Tax Credit for Before-Tax FutureBuilder Contributions

You may be eligible to receive a federal tax credit equal to 10%, 20% or 50% of your annual FutureBuilder contribution, up to $2,000 if for 2016 you file a:

- Single return and have annual income of $30,750 or less
- Joint return and have annual income of $61,500 or less
- Head-of-household return and have annual income of $46,125 or less

The percentage that applies is determined by your income level. Your spouse is able to do the same thing, so your family could receive a total tax credit of as much as $4,000.

Roth After-Tax 401(k) Contributions

Roth after tax 401(k) contributions are deducted from your net paycheck after Federal, state, and other employment taxes are withheld. Although contributions are subject to these taxes, they are not calculated based off of your net paycheck. Roth after-tax contributions are calculated based off of eligible compensation.

The investment earnings on Roth contributions grow tax-free and remain tax-free even when you withdraw them during retirement, provided it’s a qualified withdrawal (generally, if you’re age 59½ or older and the withdrawal is made at least five years after making your first Roth contribution to FutureBuilder). Investment earnings on any other type of contribution to the FutureBuilder Plan (before-tax and Company matching contributions) are tax-deferred while in the Plan, but those earnings will be taxed when you make a withdrawal.

Generally speaking, if you expect to be in a higher tax bracket in retirement than you are now (whether you expect higher taxable income or increased tax rates), Roth contributions might be a good choice. Roth contributions won’t reduce your taxable income today, but after you retire and receive a qualified withdrawal, the Roth contributions, as well as earnings on those contributions, will be tax-free. If you expect to be in a lower tax bracket in retirement than you are now, before-tax contributions, in general, might be the better option. Consult your tax advisor.
The Roth In-Plan Conversion option is available beginning January 1, 2017. This provision allows FutureBuilder account holders (excluding non-spousal accounts) with eligible vested balances to convert, or reclassify, their before-tax money to a Roth account. Any before-tax and vested company match money is eligible for conversion. Schwab PCRA and loan fund balances as well as QNEC and ESOP accounts are not eligible for conversion. The minimum conversion amount is $500 and two in-plan conversions are allowed per calendar year. If you elect the Roth in-plan conversion, you are subject to taxation on any before-tax amounts converted. This could create a substantial tax impact which must be paid with assets from outside the plan unless you are eligible for distribution from the Plan. The Roth in-plan conversion election is not reversible. If this Roth money or other Roth amounts remain in the Plan for at least 5 years, you will benefit from tax-free earnings and will not be subject to applicable mandatory withholding. To avoid triggering a 10% early withdrawal penalty if you have not attained age 59 1/2 at the time of distribution, each Roth conversion must remain in the plan for 5 years.

Before you elect a Roth in-plan conversion, carefully consider your personal tax situation. Remember, you are subject to tax on the amounts converted and these taxes generally must be paid from assets outside of the plan. Choosing to convert assets to Roth doesn’t on its own create a right to obtain a distribution. The amount you convert to Roth will be reported to you and the IRS on a form 1099-R. Check to see if you need to increase your withholding from other sources, such as your pay, or to make estimated tax payments to help avoid an underpayment penalty. Once you elect a Roth in-plan conversion, it is not reversible, so plan carefully and consider consulting your tax advisor.

### Catch-up Contributions

**If You Are Age 50 or Older**

Catch-up contributions may allow associates who are age 50 or older to save even more in their FutureBuilder accounts than they normally could due to IRS or plan contribution limits. This can help you save even more as you approach retirement.

---

### Table: Comparison of Traditional Before-Tax 401(k) Contributions and Roth After-Tax 401(k) Contributions

<table>
<thead>
<tr>
<th></th>
<th>Traditional 401(k) Contributions</th>
<th>Roth 401(k) Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How are your contributions deducted from your pay?</strong></td>
<td>Contributions are deducted from before-tax pay</td>
<td>Contributions are deducted from after-tax pay. They are subject to income tax withholding and are calculated based off of eligible compensation.</td>
</tr>
<tr>
<td><strong>How do your contributions affect your current taxes?</strong></td>
<td>Current taxable income is reduced so your current tax bill is lower</td>
<td>Current taxable income is not reduced so there is no effect on your current tax bill</td>
</tr>
<tr>
<td><strong>Do contributions count toward the 2016 annual contribution limit of $18,000? (See IRS Limits)</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Are contributions eligible for Company matching contributions?</strong></td>
<td>Yes, up to FutureBuilder limits (up to 3.5% on your first 5% of pay)</td>
<td>Yes, up to FutureBuilder limits (up to 3.5% on your first 5% of pay)</td>
</tr>
<tr>
<td><strong>Are contributions available for loans and hardship withdrawals?</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>When will you pay taxes on your contributions?</strong></td>
<td>Income taxes are paid on your contributions when you receive a distribution, unless your distribution is rolled over into an IRA or another qualified employer-sponsored plan</td>
<td>You have already paid taxes on your contributions, so no taxes are due if you receive a qualified distribution (Note: Does not apply to Company-matching contributions)</td>
</tr>
<tr>
<td><strong>When will you pay taxes on your investment earnings?</strong></td>
<td>Income taxes are paid on investment earnings when you receive a distribution, unless your distribution is rolled over into an IRA or another qualified employer-sponsored plan—but taxes are paid when you finally withdraw your funds.</td>
<td>No taxes are due on earnings from your Roth after-tax contributions if the withdrawal is a qualified distribution or if your distribution is rolled over into an IRA or another qualified employer-sponsored plan. Earnings on before-tax Company matching contributions will be taxed since those contributions have not yet been taxed.</td>
</tr>
</tbody>
</table>
Who Can Make Catch-up Contributions
You are eligible to contribute catch-up contributions if you will be age 50 or over by the end of the current year. For example, you may start making catch-up contributions for 2017 even if you are not yet age 50 as long as you will turn age 50 by the end of 2017.

What is Considered Eligible Compensation
In general, eligible compensation for catch-up contributions is the same as FutureBuilder eligible compensation. See What Is Considered Eligible Compensation earlier in this chapter.

How to Elect Catch-up Contributions
In order to make catch-up contributions, you have to be enrolled in FutureBuilder. You then can elect the amount you wish to contribute in catch-up contributions. You can choose to make catch-up contributions as before-tax and/or Roth after-tax contributions. Unlike your regular contribution elections that you make in percentages, you must elect a whole dollar amount, such as $200, for your catch-up contribution election. That amount will be contributed out of each regular paycheck.

Once you have made a catch-up contribution election, you won't have to elect a new catch-up contribution amount each year, unless you want to increase or decrease your contribution. Your catch-up election automatically will be carried over to the next year.

Catch-up Contributions Limit
For 2016, the catch-up contribution limit is $6,000. For example, you could elect to make catch-up contributions each pay period that would result in an annual amount of $3,500 in before-tax contributions and $2,500 in Roth after-tax contributions. It's a good idea to annually review your contributions and make any changes that are appropriate. Make your election carefully—remember the dollar amount you elect will be contributed out of each regular paycheck.

How Catch-up Contributions Are Made
Like regular FutureBuilder contributions, you make catch-up contributions through convenient, automatic payroll deductions.

Generally, catch-up contributions can only be made if you reach the IRS limit on contributions to FutureBuilder. For example, in 2016 the IRS contribution limit is $18,000. However if you qualify for catch-up contributions, you are allowed to contribute up to an additional $6,000, meaning that you could contribute a total of $24,000 to your FutureBuilder account in 2016.

In addition, if you are subject to the HCE limit and you contribute the maximum amount you are allowed under the HCE limit, you can make catch-up contributions (as long as you meet the catch-up contribution age restriction). For example, if in 2016, you contribute the HCE maximum and you qualify for catch-up contributions, you could contribute up to an additional $6,000 to your FutureBuilder account in 2016.

You also may contribute catch-up contributions if, as a result of the Plan’s non-discrimination testing, a portion of your regular contributions would be refunded to you. If you are eligible to receive a refund, the amount of the refund (or a portion of the amount) needs to be reclassified as a result of the testing, you do not need to elect the catch-up contribution. The catch-up contribution, in this case, will be made automatically.

Catch-up Contributions and Company Match
Catch-up contributions are not eligible to be matched, even if the catch-up contributions are reclassified as regular contributions. For more information on the Company match, see How the Company’s Matching Contribution Works in this chapter.

How the Company’s Matching Contribution Works
For most associates, the Company will contribute $1.50 for every $1 you contribute on the first 1% of your pay, and 50 cents for each additional $1 you save from 2% to 5% of your pay. That means that if you save 5% to 50% of your eligible compensation, then the Company will contribute an amount equal to 3.5% of your eligible compensation. The Company match is determined and made on the same frequency as your regular, before-tax and/or Roth after-tax contributions, typically on a biweekly basis throughout the year. There is no end-of-the-year “true-up”. Here’s a snapshot of the boost you can get:
This example shows how the Company’s matching contribution is calculated for an associate with an annual eligible compensation of $20,000 who is contributing 7% of eligible compensation to FutureBuilder. This assumes that the associate begins making contributions on January 1 on a biweekly basis and continues making contributions to December 31 of the same year.

**Calculating the Company Match**

<table>
<thead>
<tr>
<th>Calculating the contributions for</th>
<th>Associate Contribution</th>
<th>Company Match</th>
<th>Total Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first 1% of pay</td>
<td>$200</td>
<td>$300</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td>$20,000 x .01 = $200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The next 4% of pay</td>
<td>$800</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td></td>
<td>$20,000 x .04 = $800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 2% of pay</td>
<td>$400</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$20,000 x .02 = $400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total = 7% of Pay</td>
<td>Associate Contribution = $1,400</td>
<td>Company Match = $700</td>
<td>Total Contributions = $2,100</td>
</tr>
</tbody>
</table>

**The Company Match in Action**

Here is an example to show how matching contributions can add up at various contribution levels for an associate with an annual eligible compensation of $20,000, assuming you make contributions starting January 1 on a biweekly basis and continuing to December 31 of the same year.

**Rollover Contributions**

If you are an active associate and eligible to participate in the Plan, on or after your eligibility date, generally after completing 90 days of service, you may roll over any eligible distribution you receive from another eligible employer retirement plan sponsored by a previous employer or from an Individual Retirement Account (IRA). You may also roll over amounts distributed from a Section 403(b) or a Section 457 plan or amounts you contributed directly to an IRA. However, with the exception of Roth Rollovers, the Plan will not accept any amounts representing after-tax contributions you made to a prior employer’s plan or an IRA. Only direct Roth rollovers will be accepted from qualified plans with Roth accounts. Indirect Roth rollovers and rollovers from Roth IRAs are not permitted. You may obtain more information about rollovers or request a rollover contribution form by logging into www.livetheorangelife.com > Save & Protect or calling the Benefits Choice Help Center.
Center and speaking to a representative. Rollover contributions are subject to the same distribution rules as other plan contributions; meaning absent your termination of employment, attaining age 59-1/2 or other distributable event, you cannot withdraw your rollover contributions.

If You Are on Military Leave

If you are on Military Leave and you are eligible to receive supplemental pay, your contributions to FutureBuilder will be made at the same percentage rate of participation you had elected before going on leave, unless you change the election, which can be done at any time. Corresponding Company matching contributions will continue to be deposited into your account.

Upon re-employment after Military Leave, you may:

• Make up missed contributions that could have been made during the period of military service, and
• Receive Company matching contributions to the extent that you make up missed contributions that could have been made during the period of military service.

The period allowed for make-up contributions may be up to three times the length of military leave, but the make-up period may not exceed five years.

The amount of your make-up contributions cannot exceed the amount that you would have been allowed to make had you remained continuously employed, reduced by the contributions you made from supplemental pay.

FutureBuilder Vesting Schedule

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Your Contributions and Earnings</th>
<th>Matching Contributions and Earnings</th>
<th>ESOP Contributions and Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3</td>
<td>Always 100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>100%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>40%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>5 or more*</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

* Effective January 1, 2010, associates with five years of employment will be vested in the Company’s matching and ESOP contributions.

How Your Contributions and Company Matching Contributions Are Invested

You decide how to invest the Company’s and your contributions. You, not the Company, are in charge of investing your personal account balance. If you change your mind, you can always log into www.livetheorangelifecom > Save & Protect or call the Benefits Choice Center to change how your future contributions will be invested, how your current balance is invested, or both. Information regarding the various investment choices is available on the website or by calling the number below. The investment elections you choose for your own contributions will apply to both before-tax and Roth contributions.

How Your Catch-up Contributions Are Invested

Any catch-up contributions you make will be invested using the same investment approach that you have chosen for your own contributions. You can change how your contributions are invested at any time.

How Your Company Matching Contributions Are Invested

The Plan allows you to choose where you want your matching contributions invested. If you don’t make an investment election, your matching contributions will be invested using the same investment approach you have chosen for your own contributions.

Automatic Rebalancing

If you choose the same investment elections for your own contributions and the company matching contributions, you may elect to have your account automatically rebalanced. Auto rebalancing is functionality that allows your FutureBuilder balances to be automatically reallocated for your choice % every 90 days, every 180 days, or annually to your targeted fund elections. Your targeted fund elections are those you have selected for your future contributions. Automatic rebalance elections are available on the website or with a benefits choice center representative. The rebalance triggering will continue as long as a balance resides in the Plan or you select only one fund for future contributions unless you choose to cancel it and/or choose to receive investment advice. Any changes to your investment elec-
tions will apply to any future rebalance transactions. Any Home Depot Stock Fund balances are excluded from the automatic rebalance activity.

Savings Limitations

Plan Limits
For 2017, the IRS considers an associate who earned $120,000 or more in 2016 to be a highly compensated employee (HCE). HCE’s contributions are subject to certain limitations. Effective July 28, 2016, HCE’s contributions are limited to 11% of eligible compensation.

IRS Limits
The IRS places the following restrictions on contributions to FutureBuilder:

- The combined amount of before-tax and Roth after-tax contributions you make each calendar year is limited to a specific dollar amount. This amount, which the IRS adjusts to reflect inflation from time to time, in 2016 is $18,000, less any contributions you made to another eligible employer-sponsored retirement plan in the same year.

- If your combined contributions under FutureBuilder and another employer’s sponsored plan exceed this combined limit of $18,000 for a given year, you must notify the Benefits Choice Center no later than March 1 of the next year in order to obtain a corrective distribution.

- There is also a limit on the amount of your compensation used in determining your contributions to the Plan. The dollar limit on annual compensation is an indexed amount and may change from time to time. In 2016, this amount is $265,000.

- Your FutureBuilder contributions will be stopped once you have made contributions that reach the IRS-determined annual contribution limit of $18,000 or the dollar limit on annual compensation of $265,000 or higher, whichever happens first.

- To ensure that contributions to the Plan are balanced between associates at lower and higher pay levels, the IRS rules could place further restrictions on the amount higher paid associates may contribute to the Plan. You will be notified if this applies to you.

- If you’re affected by total annual contribution limits under federal law, the amounts you and the Company contribute on your behalf may be limited. Total annual contributions to certain benefit plans like FutureBuilder cannot exceed 100% of your compensation or $53,000 for 2016, whichever is less, under federal law. If you’re affected by these limits, you’ll be notified.

What Is Vesting?
You earn ownership of Company matching contributions and the investment earnings on those amounts based on how long you’ve worked for the Company and its affiliates. This is called vesting. The vesting chart shows when you become vested for each type of contribution based on your years of service.

For vesting purposes, a year of service is any calendar year in which you complete at least 1,000 hours of service.

Keep in mind that all years of service from the date you start working at the Company are considered for vesting, even if you were not enrolled in FutureBuilder.

You always have ownership of the money you put into FutureBuilder, including your before-tax, Roth after-tax, catch-up, and rollover contributions and all investment earnings on your contributions. This money is yours to take from the plan if you leave the Company and its affiliates.

You should be aware, however, that if you take a distribution of the money from your account, you will have to pay taxes unless you roll over your distribution to an IRA or another employer’s plan. This will not apply to your Roth after-tax contributions and the earnings on your Roth after-tax contributions—this money will not be taxed if you take a qualified distribution (generally, if you’re age 59½ or older and the withdrawal is made at least five years after making your first Roth contribution). However, unless you rollover these contributions, you will pay taxes on any company matching contributions that apply to your Roth after-tax contributions.

You will become 100% vested in your Company matching contributions when you complete three years of service in which you complete at least 1,000 hours of service.

In addition, regardless of your service, you automatically become 100% vested in all Company contributions and earnings if, while you are employed by the Company and its affiliates:

- you reach five years of employment;
- you reach age 65;
- you become permanently and totally disabled; or
- you die.

What Is a Break in Service?
You will incur a break in service if you are not credited with at least one hour of service in the calendar year.
If this happens for five consecutive calendar years, you will incur a five-consecutive-year break in service for vesting purposes.

If you leave the Company and its affiliates after you become a participant in the Plan, but later return to work, the following break in service rules will apply:

If you return before a one-year break in service:
• you will be eligible to rejoin the Plan immediately
• you will retain the years of service you had before your termination, and
• any amounts forfeited from your account at termination will be restored.

If you return after a one-year break in service, but before a five-consecutive-year break in service:
• you will be eligible to rejoin the Plan immediately
• your FutureBuilder account will be reinstated and any amount forfeited from your account at termination will be restored, and
• once you have completed one year of service following your rehire date, all years of vesting service accumulated prior to the break in service will be recognized for vesting purposes.

If you return after more than a five-consecutive-year break in service:
• you will be eligible to rejoin the Plan immediately
• any amounts forfeited from your account at termination will not be restored, and
• all years of vesting service accumulated prior to the break in service will be recognized for vesting purposes once you have completed one year of service following your rehire date, if you made contributions to the Plan prior to your break in service or received any vested employer contributions.

Your Investment Options
FutureBuilder offers a wide variety of investment options allowing you to tailor a savings approach that suits your individual needs. The three-tiered investment structure contains LifePath® Portfolios in Tier One, FutureBuilder core funds in Tier Two and a self-directed brokerage account in Tier Three.

This investment structure allows you to:
• Choose a single LifePath fund; or
• Invest in FutureBuilder core funds only or the self-directed brokerage account only; or
• Use a combination of FutureBuilder core funds and the self-directed brokerage account to develop your investment portfolio; or use any combination of all, but note that LifePath is intended to be a one-source solution.

A note about fees: one consideration when choosing among investment options are the fees that are charged to your account. These fees are detailed in the Your Funds Have Fees chart. Note that certain funds, called index funds, are designed to mirror the performance of a particular investment index. These funds, the Large Cap Index Fund, Balanced Fund, Bond Fund and the LifePath portfolios, consist of one or more index funds and have lower fees as a result. Actively managed funds have portfolio managers determining specific securities to invest in and therefore will generally have larger investment fees.

The FutureBuilder Investment Committee monitors the performance of each FutureBuilder core and LifePath fund and may eliminate or add funds or change investment managers at any time. The following descriptions represent the FutureBuilder investment funds when this Benefits Summary was published but you should log into www.livetheorangelife.com > Save & Protect for the most up-to-date information on your investment fund options including fee information.

Please remember, the Company and its affiliates make no guarantee of the performance of any of the investment options offered through FutureBuilder. Sometimes unfavorable market conditions can affect even the most conservative funds. None of the options are guaranteed not to lose money. No person with the Company or representing the Company is authorized to make any statement or give any assurance otherwise.

For an explanation of many common investment terms, see the Glossary later in this chapter.

Tier One: BlackRock LifePath® Portfolios—The LifePath Portfolio is designed so that to invest you can simply determine the target year when you would like retirement funds available.
want to start withdrawing your FutureBuilder savings. Based on the answer to that question, you can determine which LifePath Portfolio is the right starting point for you. Once you do that, you will not need to take any action to change LifePath Portfolios as you pass through the different stages of life, unless you choose to do so. Your portfolio is managed by a team of investment professionals and these professionals will change the portfolio’s asset mix for you over time. This option works well for individuals who do not have the time or interest needed to manage their own investments.

**Tier Two: Core Funds**—In addition to the LifePath Portfolios, you can invest in any combination of FutureBuilder’s core funds in 1% increments. Each of the core funds represents a different kind of investment (asset class) and has a different objective. Therefore, each offers a different level of risk and return potential. This option works well for individuals who prefer to construct their own portfolio, and are willing to commit more time to managing their own investments. This requires that you know your objectives, understand the risks involved in investing, periodically review your strategy and investments and make any adjustments needed to rebalance your account. If you choose this approach, you may want to take advantage of the FutureBuilder financial advisory service, see Financial Engines Investment Advisory Services earlier in this chapter, to help you make your decisions, or consult a professional financial advisor of your own.

**Tier Three: Self-Directed Brokerage Account**—Through the Schwab PCRA brokerage account, you can customize your portfolio even more than the Tier Two option by selecting from a wide variety of mutual funds and from most publicly traded stocks and bonds. This option works well for individuals who are experienced, knowledgeable investors, are willing to commit a significant amount of time managing their investments, and are comfortable paying applicable brokerage transaction fees that will be charged to their account.

**BlackRock LifePath® Portfolios**
The BlackRock LifePath portfolios are designed to be complete investment solutions for individual investors. You choose a LifePath portfolio based on the year you expect to need your money—generally, the year you plan to retire. The LifePath portfolios are diversified among many different asset classes (stocks, bonds, real estate, commodities and money market instruments) and adjusted over time to gradually become more conservative as your target retirement year approaches. You won’t need to change LifePath portfolios as you become older (unless you choose to do so)—the portfolio’s mix of investments will change for you over time.

Each LifePath portfolio has a year in its name (such as 2020 in LifePath 2020®) that represents the approximate year you plan to start withdrawing your money. As you get closer to this year, the investment mix is gradually shifted from a greater concentration of higher-risk investments (stock funds) to a greater concentration of lower-risk investments (bond funds and money market instruments). This shift is designed to reduce but does not eliminate fluctuations in the value of your investment as the time that you will need your money approaches.

One portfolio—LifePath Retirement—does not include a year because it is designed for people currently withdrawing their money or very close to retirement.

The percentages of holdings for these funds are subject to change. Log into www.livetheorangeline.com > Save & Protect for the most current percentage information.

<table>
<thead>
<tr>
<th>Date of Birth*</th>
<th>LifePath Portfolio Default</th>
</tr>
</thead>
<tbody>
<tr>
<td>On or after 1988</td>
<td>LifePath 2055</td>
</tr>
<tr>
<td>On or between 1983 &amp; 1987</td>
<td>LifePath 2050</td>
</tr>
<tr>
<td>On or between 1978 &amp; 1982</td>
<td>LifePath 2045</td>
</tr>
<tr>
<td>On or between 1973 &amp; 1977</td>
<td>LifePath 2040</td>
</tr>
<tr>
<td>On or between 1968 &amp; 1972</td>
<td>LifePath 2035</td>
</tr>
<tr>
<td>On or between 1963 &amp; 1967</td>
<td>LifePath 2030</td>
</tr>
<tr>
<td>On or between 1958 &amp; 1962</td>
<td>LifePath 2025</td>
</tr>
<tr>
<td>On or between 1953 &amp; 1957</td>
<td>LifePath 2020</td>
</tr>
<tr>
<td>On or before 1952</td>
<td>Retirement Fund</td>
</tr>
</tbody>
</table>

* Assumes retirement at age of 65.

**LifePath® Retirement Portfolio**

**Official Fund Name: LifePath® Index Retirement Portfolio**

**Investment Objective**
The LifePath Retirement Portfolio is designed to provide an investment solution for investors who are retired or close to retirement by diversifying among many asset classes, with the largest percentages in U.S. fixed income and smaller holdings in U.S. equities. Although achieving reasonable levels of income generation is important for investors in retirement, it makes sense to have some of the portfolio’s assets...
in stocks, as most investors will still need some protection against inflation and longevity risk during their retirement years.

**Asset Allocation**
The portfolio is diversified among many asset classes, with the largest percentage in U.S. fixed income (bonds) and U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 49% U.S. bonds and 30% U.S. stocks, with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2020. When it reaches its target year (2020), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fees:** See FutureBuilder Investment Expenses.

**LifePath 2020® Portfolio**

**Official Fund Name:** BlackRock LifePath Index 2020® Portfolio

**Investment Objective**
The LifePath 2020 Portfolio is designed to be an investment solution for investors who expect to retire between 2018 and 2022. The portfolio is generally weighted toward investments with higher growth potential (such as stocks), while still using diversification to moderate the price fluctuations that these investments typically incur over the short to medium term.

**Asset Allocation**
The portfolio is diversified among many asset classes, with the largest percentage in U.S. fixed income (bonds) and U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 60% U.S. bonds and 25% U.S. stocks, with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2020. When it reaches its target year (2020), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fees:** See FutureBuilder Investment Expenses.

**LifePath 2025® Portfolio**

**Official Fund Name:** BlackRock LifePath Index 2025® Portfolio

**Investment Objective**
The LifePath 2025 Portfolio is designed to be an investment solution for investors who expect to retire between 2023 and 2027. The portfolio is generally weighted toward investments with higher growth potential (such as stocks), while still using diversification to moderate the price fluctuations that these investments typically incur over the short to medium term.

**Asset Allocation**
The portfolio is diversified among many asset classes, with the largest percentages in U.S. fixed income (bonds), U.S. equities (stocks) and international equities. As of June 30, 2016, the percentage of holdings in these three asset classes was roughly 38% U.S. bonds and 35% U.S. stocks, with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2025. When it reaches its target year (2025), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fees:** See FutureBuilder Investment Expenses.
LifePath 2030® Portfolio

Official Fund Name: BlackRock LifePath Index 2030® Portfolio

Investment Objective
The LifePath 2030 Portfolio is designed to be an investment solution for investors who expect to retire between 2028 and 2032. The portfolio is weighted toward investments with higher growth potential (such as stocks), while being less concerned with the inevitable price fluctuations that these investments typically incur over the short to medium term.

Asset Allocation
The portfolio is diversified among many asset classes, with the largest percentages in U.S. equities (stocks), U.S. Fixed Income (bonds) and non-U.S. equities. As of June 30, 2016, the percentage of holdings in these asset classes was roughly 39% U.S. stocks and 27% U.S. bonds with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2030. When it reaches its target year (2030), it will be at its most conservative asset mix.

Risk and Return Characteristics

All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2030 has a balanced asset mix as it has approximately 13 years to go before reaching its most conservative asset mix in 2030.

Fees: See FutureBuilder Investment Expenses.

LifePath 2035® Portfolio

Official Fund Name: BlackRock LifePath Index 2035® Portfolio

Investment Objective
The LifePath 2035 Portfolio is designed to be an investment solution for investors who expect to retire between 2033 and 2037. The portfolio is weighted toward investments with higher growth potential (such as stocks), while being less concerned with the inevitable price fluctuations that these investments typically incur over the short to medium term.

Asset Allocation
The portfolio is diversified among many asset classes, with the largest percentages in U.S. and non-U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 44% U.S. stocks and 17% in U.S. bonds with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2035. When it reaches its target year (2035), it will be at its most conservative asset mix.

Risk and Return Characteristics

All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2035 portfolio has a moderately aggressive asset mix as it has approximately 18 years to go before reaching its most conservative asset mix in 2035.

Fees: See FutureBuilder Investment Expenses.

LifePath 2040® Portfolio

Official Fund Name: BlackRock LifePath Index 2040® Portfolio

Investment Objective
The LifePath 2040 Portfolio is designed to be an investment solution for investors who expect to retire between 2038 and 2042. The portfolio is heavily weighted toward investments with higher growth potential (such as stocks), while being less concerned with the inevitable price fluctuations that these investments typically incur over the short to medium term.

Asset Allocation
The portfolio is diversified among many asset classes, with the largest percentages in U.S. and non-U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 44% U.S. stocks and 17% in U.S. bonds with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2035. When it reaches its target year (2035), it will be at its most conservative asset mix.

Risk and Return Characteristics

All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2040 portfolio has an aggressive asset mix as it has approximately 20 years to go before reaching its most conservative asset mix in 2035.
The diagram below shows how the BlackRock LifePath portfolios compare to each other in terms of risk and return potential.

### Asset Allocation
The portfolio is diversified among many asset classes, with the largest percentage in U.S. and non-U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 48% U.S. stocks and 8% in U.S. bonds with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2040. When it reaches its target year (2040), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

### Risk and Return Characteristics
All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2045 Portfolio has an aggressive asset mix as it has approximately 28 years to go before reaching its most conservative asset mix in 2045.

### LifePath 2045® Portfolio
**Official Fund Name:** BlackRock LifePath Index 2045® Portfolio

**Investment Objective**
The LifePath 2045 Portfolio is designed to be an investment solution for investors who expect to retire between 2043 and 2047. The portfolio is heavily weighted toward investments with higher growth potential (such as stocks), while being less concerned with the inevitable price fluctuations that these investments typically incur over the short to medium term.

**Asset Allocation**
The portfolio is diversified among many asset classes, with the largest percentage in U.S. and non-U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 49% U.S. stocks and 2% U.S. bonds with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2045. When it reaches its target year (2045), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

**Risk and Return Characteristics**

All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2045 Portfolio has an aggressive asset mix as it has approximately 28 years to go before reaching its most conservative asset mix in 2045.

**Fees:** See FutureBuilder Investment Expenses.
Asset Allocation
The portfolio is diversified among many asset classes, with the largest percentage in U.S. and non-U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 50% U.S. stocks and 1% U.S. bonds, with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2050. When it reaches its target year (2050), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

Risk and Return Characteristics
All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2055 Portfolio has an aggressive asset mix as it has approximately 33 years to go before reaching its most conservative asset mix in 2055.

LifePath 2055® Portfolio
*Official Fund Name: BlackRock LifePath Index 2055® Portfolio*

Investment Objective
The LifePath 2055 Portfolio is designed to be an investment solution for investors who expect to retire after 2052. The portfolio is heavily weighted towards investments with higher growth potential (such as stocks), while being less concerned with the inevitable price fluctuations that these investments typically incur over the short to medium term.

Asset Allocation
The portfolio is diversified among many asset classes, with the largest percentage in U.S. and non-U.S. equities (stocks). As of June 30, 2016, the percentage of holdings in these two asset classes was roughly 50% U.S. stocks and 1% U.S. bonds, with the balance of the portfolio in non-U.S. stocks, real estate and commodities. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2055. When it reaches its target year (2055), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended into the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

Risk and Return Characteristics
All LifePath Portfolios slowly reduce their risk and return profile over time, to respond to the changing needs of their investors as they age. The LifePath 2055 Portfolio has an aggressive asset mix as it has approximately 38 years to go before reaching its most conservative asset mix in 2055.

FutureBuilder Core Funds
In addition to the LifePath Portfolios, you can invest in any combination of FutureBuilder's core funds in 1% increments.

Each of the core funds represents a different kind of investment (asset class) and has a different objective. Higher risk investments may provide higher returns over the long term, but there’s also a greater chance that you might lose a portion of your investment. On the other hand, if you put too much of your savings in safer investments, your return may be more stable but may not be great enough to meet your retirement income needs.

Before choosing FutureBuilder funds, you need to decide how much risk you’re willing to accept and the number of years you have to invest before you’ll need your money.
The diagram below shows how the FutureBuilder core funds compare to each other in terms of risk and return potential.

**Stable Value Fund**

*Official Fund Name: JPMorgan Stable Value Fund*

**Investment Objective**
The Stable Value Fund seeks to preserve the value of money invested, provide an opportunity to perform better than the average money market fund and earn consistent, reliable returns.

**Asset Allocation**
The fund invests in a high quality fixed income portfolio generally consists of investment grade fixed income securities, primarily U.S. Treasury, agency, corporate, agency mortgage-backed and commercial mortgage-backed as well as short-term investment instruments.

**Risk and Return Characteristics**
Overall, this fund is the most conservative core fund offered through FutureBuilder. Due to its structure, the fund tends to earn interest with low price fluctuation. However, under certain conditions, the fund's return may lag behind alternatives like money market funds which tend to reflect rising interest rates more quickly.

**Comparison Index Performance**
Performance of the Stable Value Fund is compared to the CitiGroup 3 Month Treasury Bill Index, which has a similar risk profile.

**Fees**: See FutureBuilder Investment Expenses.

**Bond Fund**

*Official Fund Name: BlackRock U.S. Debt Index Fund*

**Investment Objective**
This fund seeks to match the performance of the Barclays Capital US Aggregate Bond Index by investing in a diversified sample of the bonds that make up the Barclays measure of the U.S. investment-grade bond market.

**Balanced Fund**

*Official Fund Name: BlackRock Balanced Fund*

**Investment Objective**
The BlackRock Balanced Fund seeks to achieve total return through capital appreciation and current income.

**Asset Allocation**
The fund is made up of bonds including U.S. Treasury and federal agency bonds, corporate bonds, residential and commercial mortgage-backed securities, and asset-backed securities.

**Risk and Return Characteristics**
This fund is expected to experience a low to moderate range of price fluctuations. It is intended for investors seeking moderate returns by investing in a diversified portfolio of high-quality fixed income securities. As with any security, an investment in bonds is subject to risk.

**Comparison Index Performance**
Performance of the Bond Fund is compared to the Barclays Capital US Aggregate Bond Index, which has a similar investment style.

**Fees**: See FutureBuilder Investment Expenses.
**Asset Allocation**

The fund invests approximately 60% of assets in the BlackRock Equity Index Fund (which invests in equity securities—stocks to track the returns of the S&P 500) with the remainder of the fund in the BlackRock U.S. Debt Index Fund (which invests in fixed income securities—bonds to track the returns of the BlackRock Capital U.S. Aggregate Bond Index).

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
</table>

This fund is expected to experience a moderate range of price fluctuations. However, the fund may experience larger or smaller price declines or price increases depending on different market conditions. The fund is more diversified than some of the other fund options since it is invested in two different asset classes.

**Comparison Index Performance**

Performance of the Balanced Fund is compared to a Custom Index which is a blended index comprised of 60% return of the S&P 500 Index and 40% return of the BlackRock Capital US Aggregate Bond Index.

**Fees**: See FutureBuilder Investment Expenses.

---

**Large Cap Value Fund**

**Official Fund Name**: Dodge & Cox Stock Fund

**Investment Objective**

The Large Cap Value Fund seeks to provide the opportunity for above-average, long-term growth of your savings by investing in common stocks of companies that the fund’s managers believe to be temporarily undervalued by the stock market but have favorable long-term growth prospects.

**Asset Allocation**

The companies invested in are typically larger, well-established organizations, though the fund also invests in mid-sized companies. Under normal circumstances, the Fund will invest at least 80% of fund assets in common stocks, including those of foreign issuers which are included in the S&P 500 Index. In addition, the fund may also invest up to 20% of its assets in securities of foreign issuers traded in the U.S. that are not included in the S&P 500 Index.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
</table>

This fund is riskier than the Bond, Balanced and Stable Value Funds since it invests exclusively in stocks. While stocks can go up and down dramatically over short time periods, they have traditionally outperformed other types of investments over longer periods and have outpaced inflation as well. Given the short-term risks associated with equity investing, investors should consider this fund a long-term investment.

**Comparison Index Performance**

Performance of the Large Cap Value Fund is compared to the Russell 1000 Value Index, which has a similar investment style.

**Fees**: See FutureBuilder Investment Expenses.

---

**Large Cap Index Fund**

**Official Fund Name**: BlackRock Equity Index Fund

**Investment Objective**

This fund seeks to provide growth and modest income on your savings by investing in each stock that makes up the S&P 500 Index.

**Asset Allocation**

The fund is made up of 500 stocks within major U.S. industries, such as manufacturing, finance, utilities and transportation.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
</table>

This fund is riskier than the Bond, Balanced and Stable Value Funds since it invests exclusively in stocks. While stocks can go up and down dramatically over short time periods, they have traditionally outperformed other types of investments over longer periods and have outpaced inflation as well. Given the short-term risks associated with equity investing, investors should consider this fund a long-term investment.
Comparison Index Performance
Performance of the Large Cap Index Fund is compared to the return of the S&P 500 Index.

**Fees**: See FutureBuilder Investment Expenses.

Large Cap Growth Fund
*Official Fund Name: T. Rowe Price Large Cap Growth Equity Separate Account*

**Investment Objective**
The Fund seeks to provide long-term capital appreciation primarily through investments in common stocks of large capitalization growth companies.

**Asset Allocation**
Normally at least 80% of the Fund’s total market value is invested in the common stocks of large-capitalization companies. The investment manager seeks to invest in companies believed to offer above average rates of earnings and cash flow growth and believed to have the ability to sustain earnings momentum even during times of slow economic growth. The Fund is diversified across issuers and industries.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Fund is subject to the volatility inherent in common stock investing, and may experience fluctuations more than a strategy investing in non-growth oriented stocks. Diversification cannot assure a profit or protect against loss in a declining market. As with all equity funds, the share price can fall because of weakness in the broad market, a particular industry or specific holdings.

Comparison Index Performance
Performance is compared to the Russell 1000 Growth Index.

**Fees**: See FutureBuilder Investment Expenses.

Mid Cap Value Fund
*Official Fund Name: WEDGE Capital Management Mid Cap Value Fund*

**Investment Objective**
The Fund strives to outperform the benchmark Russell Mid Cap Value Index from a total return perspective over a full market cycle. WEDGE Capital Management L.L.P.’s research-driven approach to value investing and portfolio construction defines WEDGE’s Traditional Equity platform. The process first utilizes systematic quantitative analysis to evaluate companies and industries believed to have favorable value and return characteristics. WEDGE’s equity research teams then perform company and industry analysis.

**Asset Allocation**
The Fund’s initial investible universe consists of stocks traded on US equity exchanges within a market capitalization range of $1.0 billion to $20.0 billion. The Fund invests in approximately 30 – 45 securities and seeks to be well diversified among market sectors. WEDGE strives to remain fully invested at all times. The Fund is permitted to invest in ADRs and publicly traded REITs.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This fund may be suitable for investors with a long-term investment time horizon and who are willing to accept a higher degree of risk for the opportunity of higher long-term potential returns.

Comparison Index Performance
Performance of the WEDGE Capital Management Mid Cap Value Fund is compared to the total return of the Russell Midcap Value Index.

**Fees**: See FutureBuilder Investment Expenses.

Mid Cap Growth Fund
*Official Fund Name: TimesSquare Mid Cap Growth Strategy Fund*

**Investment Objective**
The Mid Cap Growth Fund seeks to provide capital appreciation by investing in the common and preferred stock of U.S. mid-capitalization companies. The portfolio management team uses a bottom-up, research-intensive approach to identify mid-capitalization growth stocks that it believes have the greatest potential to achieve significant price appreciation over a 12- to 18-month horizon.

**Asset Allocation**
The fund’s managers target U.S. firms that are believed to have exceptional management, distinct, sustainable competitive advantage, and strong, consistent growth. The fund may also invest up to 10% of its assets in foreign securities.

**Risk and Return Characteristics**

<table>
<thead>
<tr>
<th>Conservative</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This fund may be suitable for investors with a long-term investment time horizon and who are willing to accept a higher degree of risk for the opportunity of higher long-term potential returns.

Comparison Index Performance
Performance of the Mid Cap Growth Fund is compared to the total return of the Russell Mid Cap Growth Index.

Fees: See FutureBuilder Investment Expenses.

International Fund
Official Fund Name: Dodge & Cox International Stock Fund

Investment Objective
The International Stock Fund seeks to provide long-term growth of principal and income by investing primarily in a diversified portfolio of equity securities issued by non-U.S. companies from at least three different foreign countries, including emerging markets. Securities for the fund are primarily those that are believed to have positive prospects for long-term growth in principal and income not reflected in the current price.

Asset Allocation
Under normal circumstances, the Fund will invest at least 80% of its total assets in common stocks, preferred stocks, securities convertible into common stocks and securities that carry the right to buy common stocks of non-U.S. companies. The Fund also invests in American, European and Global Depository Receipts.

Risk and Return Characteristics
The Fund could under-perform other investments for any of the following reasons: the stock markets in the countries in which the Fund invests go down, markets continue to undervalue the stocks in the Fund’s portfolio, Dodge & Cox’s opinion about the intrinsic worth of a company or security is incorrect. Since the Fund invests primarily in securities of foreign companies, there is a greater risk that the Fund’s share price will fluctuate more than if the Fund invested in U.S. issuers.

Non-U.S. currency risk. Non-U.S. currencies may decline relative to the U.S. dollar, which reduces the unhedged value of securities denominated in those currencies. Dodge & Cox may not hedge or may not be successful in hedging the Fund’s currency exposure. The Fund also bears transaction charges for currency exchange.

The practice of short-term or excessive trading, often referred to as market timing, is prohibited by the Dodge & Cox International Stock Fund. Excessive trading by associates could interfere with the efficient management of the fund's portfolio, increase the fund's transaction costs, administrative costs and taxes, and/or impact the fund's performance.

Comparison Index Performance
Performance of the International Fund is compared to the total return of the Morgan Stanley Capital International All Countries World Index ex. U.S. (MSCI ACWI ex. U.S.).

Fees: See FutureBuilder Investment Expenses.

Small Cap Value Fund
Official Fund Name: Thompson, Siegel & Walmsley (TS&W) Small Cap Value

Investment Objective
The Small Cap Value Fund seeks to provide investors with long-term capital growth primarily by investing in U.S. small capitalization companies. The long term investment objective is to consistently outperform the Russell 2000 Value Index over a complete market cycle. The portfolio will hold generally 85 names or less.

Asset Allocation
The fund will typically be fully invested in publicly traded U.S. companies and seeks to hold less than 5% cash. It will generally be diversified among the nine Russell economic sectors, maintaining sector weights of +/-10% of the Russell 2000 Value Index, with an emphasis on those it deems more favorable. Additionally, the fund will focus on small capitalization stocks, maintaining a weighted average market capitalization of +/-50% of the benchmark.

Risk and Return Characteristics
This fund poses a higher risk and is potentially subject to more variation in its returns than the prior funds listed, since it invests predominantly in smaller companies. Smaller companies are subject to higher risks because they often have more limited product lines, markets or financial resources. This fund is intended to offer the possibility of higher long-term returns through investing in small companies with
the potential for significant long-term growth. Given the risks associated with equity investing, investors should consider this a long-term investment.

**Comparison Index Performance**

Performance of the Small Cap Value Fund is compared to the total return of the Russell 2000 Value Index.

**Fees:** See FutureBuilder Investment Expenses.

**Small Cap Growth Fund**

**Official Fund Name:** Stephens Small Cap Growth Fund

**Investment Objective**

The Small Cap Growth Fund seeks to provide long-term growth of capital by constructing an equity portfolio with small market capitalization designed to fluctuate with market trends and outperform the Russell 2000 Growth Index over a full market cycle, based on a disciplined growth philosophy and using bottom-up fundamental analysis.

**Asset Allocation**

The Fund’s investment team invests primarily in common stock of small capitalization U.S. companies with growth characteristics.

**Risk and Return Characteristics**

This fund poses a relatively higher risk and is potentially subject to more variation in its returns than the prior funds listed, since it invests predominantly in smaller companies. Smaller companies are subject to higher risks because they often have more limited product lines, markets or financial resources.

This fund is intended to offer the possibility of higher long-term returns through investing in small companies with the potential for significant long-term growth. Given the risks associated with equity investing, investors should consider this a long-term investment.

**Comparison Index Performance**

Performance of the Small Cap Growth Fund is compared to the total return of the Russell 2000 Growth Index.

**Fees:** See FutureBuilder Investment Expenses.

**Home Depot Stock Fund**

**Official Fund Name:** The Home Depot, Inc. Common Stock Fund

**Investment Objective**

The objective of the Home Depot Stock Fund is to allow FutureBuilder participants to share in ownership of the Company.

**Risk and Return Characteristics**

Since it invests in only one stock, this fund is subject to greater risk than any of the other funds in the plan.

**Fees:** See FutureBuilder Investment Expenses.

**About the Home Depot Stock Fund**

As of September 16, 2008, the Home Depot Stock Fund is no longer an available investment option for additional contributions through FutureBuilder. If you had an existing balance in the Home Depot Stock Fund as of that date, you can keep that balance in the fund; however, you can no longer contribute or transfer money into the fund after September 16, 2008.

**Notice of Your Rights Concerning Employer Securities**

**Your Rights Concerning Home Depot Stock**

At anytime and from time to time you can elect to move any portion of your account that is invested in company stock from that investment into any other investment alternatives under the Plan. This right extends to all your Home Depot stock under the Plan. If you have been notified that you are a designated associate, you can only change your investments in the Home Depot Stock Fund during designated window periods. You can contact the Benefits Choice Center for information about this right, including how to make an election.

In deciding whether to exercise the right to move your balance out of the Home Depot Stock Fund to other more diversified investments, you will want to give careful consideration to the benefits of a well-balanced and diversified investment portfolio. See Notice of Importance of Diversification.

**The Brokerage Window: Schwab PCRA**

The Schwab PCRA (Personal Choice Retirement Account) is a brokerage account that gives you the ability to invest your FutureBuilder account in a much wider range of investment choices. By
expanding your choices beyond the LifePath portfolios and the core investment funds, you have the opportunity to custom-tailor your investment portfolio according to your needs and investment objectives. For example, through the brokerage window, you can invest in:

- An expanded selection of no-load, no transaction-fee mutual funds from hundreds of leading fund companies.
- Stock listed on some of the major exchanges, including over-the-counter issues, so you can invest in companies you follow.
- Exchange-traded funds that seek to keep investment costs low.
- Individual bonds, CDs and other fixed income investments that seek to help preserve capital or add stability to your portfolio.

If you establish a self-directed brokerage window account within the Plan, you will be charged a one-time $50 open account fee. A maintenance fee of $10 per quarter will also apply. These fees will be deducted from other assets you have in the Plan rather than directly from your self-directed brokerage window account. If there are not enough assets to deduct the maintenance fees, funds will be transferred from your brokerage account to cover the fee and meet the $200 core fund requirement. A minimum amount of $200 must remain in the Target Retirement Date and/or Core Funds.

The Schwab PCRA account is subject to the requirements and limitations applicable to assets held in a qualified plan, like FutureBuilder. This is true regardless of anything to the contrary in documents provided to you by Schwab.

Once your Schwab account is established, you fund your PCRA by transferring money from your retirement plan’s other investments in a three-step process:

- Determine from which of your other investments you want to transfer money.
- Decide on the amount to transfer.
- Log into www.livetheorangelife.com > Save & Protect and follow the steps to initiate a transfer. If you do not have internet access, you can also initiate a transfer by contacting the Benefits Choice Center.

Money transferred from your retirement plan’s other fund choices into your PCRA will be automatically allocated to your Schwab sweep money market fund within two business days. Use these assets to purchase other investments in your PCRA.

Due to the existing contractual agreement with JPMorgan, you will NOT be able to transfer money directly from the Stable Value Fund to the PCRA. You CAN transfer money out of the Stable Value Fund into any FutureBuilder fund EXCEPT the PCRA. You must wait for a period of 90 days before you can again transfer that money into the PCRA. You CAN move money directly into the PCRA from any fund EXCEPT the Stable Value Fund.

For more information on the Schwab PCRA log into www.livetheorangelife.com > Save & Protect and access PCRA Brokerage Account or call Schwab at 1-888-393-7272. You can also go to www.schwabpcra.com. Click “Open Your PCRA Brokerage Account.”

Different Investments Carry Different Risk and Return

As you choose your investments, keep in mind that the different investment options offered carry different levels of risk. Higher risk investments may provide higher returns over the long term, but there’s also a greater chance that you might lose a portion of your investment. On the other hand, if you put too much of your savings in safer investments, your return may be more stable but may not be great enough to meet your retirement income needs.

By mixing high-risk and low-risk investments, you can achieve a balance that helps protect against an investment loss. Higher risk investments also tend to provide higher returns over the long term, while lower risk investments typically yield more stable, but lower returns. Generally, the risk of any investment tends to decline the longer you hold it.

The ratio of high to low risk investments you choose should depend on how many years you have until retirement and your personal risk tolerance. The longer you have, the more aggressively you could invest because you have time to ride out the market’s highs and lows. The closer you are to retirement age, the more conservatively you may want to invest because there is less time to recover from market swings.
### FutureBuilder Investment Expenses* as of July 1, 2016

<table>
<thead>
<tr>
<th>Generic Fund Name</th>
<th>LifePath Portfolios</th>
<th>Stable Value Fund</th>
<th>Bond Fund</th>
<th>Balanced Fund</th>
<th>Large Cap Value Fund</th>
<th>Large Cap Index Fund</th>
<th>Large Cap Growth Fund</th>
<th>Mid Cap Value Fund</th>
<th>Mid Cap Growth Fund</th>
<th>International Fund</th>
<th>Small Cap Value Fund</th>
<th>Small Cap Growth Fund</th>
<th>Home Depot Stock Fund</th>
<th>Schwab PCRA Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Fee</strong></td>
<td><strong>Investment Management</strong></td>
<td><strong>Distribution, Service &amp; Administration Fees</strong></td>
<td><strong>Total Investment-related Fees</strong></td>
<td><strong>Recordkeeping Add-on Fees</strong></td>
<td><strong>Total Investment Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.070%</td>
<td>0.140%</td>
<td>0.020%</td>
<td>0.014%</td>
<td>0.420%</td>
<td>0.001%</td>
<td>0.476%</td>
<td>0.350%</td>
<td>0.613%</td>
<td>0.540%</td>
<td>0.917%</td>
<td>0.695%</td>
<td>0.000%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.020%</td>
<td>0.000%</td>
<td>0.020%</td>
<td>0.020%</td>
<td>0.000%</td>
<td>0.020%</td>
<td>0.000%</td>
<td>0.000%</td>
<td>0.000%</td>
<td>0.000%</td>
<td>0.000%</td>
<td>0.000%</td>
<td>0.000%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.090%</td>
<td>0.140%</td>
<td>0.040%</td>
<td>0.034%</td>
<td>0.420%</td>
<td>0.030%</td>
<td>0.476%</td>
<td>0.350%</td>
<td>0.613%</td>
<td>0.540%</td>
<td>0.917%</td>
<td>0.695%</td>
<td>0.000%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td>0.080%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.170%</td>
<td>0.220%</td>
<td>0.120%</td>
<td>0.114%</td>
<td>0.500%</td>
<td>0.110%</td>
<td>0.556%</td>
<td>0.430%</td>
<td>0.693%</td>
<td>0.620%</td>
<td>0.997%</td>
<td>0.775%</td>
<td>0.080%</td>
<td></td>
</tr>
</tbody>
</table>

* A dditional fees which are intrinsic to the value of the assets, including stable value insurance wrapper costs, transaction and commission costs (including bid-ask spreads, market impact and opportunity costs), may apply. These fees will vary and are embedded in the earnings of the applicable fund.

---

1 The JPMorgan Stable Value Fund, TS&W Domestic Small Cap Value Fund, the Stephens Small Cap Growth Fund, the T. Rowe Price Large Cap Growth Fund and the TimesSquare Mid Cap Strategy Fund are offered through a separate account structure. The investment management fee will vary based upon total Home Depot assets invested in each of the funds. The reported fee represents an estimate based upon current participant assets invested in each fund. The investment management fee for the JPMorgan strategy is 0.14% on the first $600 million and 0.10% on the balance. The investment management fee in the TS&W strategy is 0.90% on first $100 million and 0.80% on the balance. The investment management fee schedule for the Stephens strategy is 0.72% on the first $50 million and 0.65% on the balance. The investment management fee schedule for the TimesSquare strategy is 0.47% on the first $50 million and 0.45% on the balance. The investment management fee schedule for the T. Rowe Price Large Cap Growth Fund strategy is 0.50% on the first $50 million and 0.45% on the balance. The investment management fee schedule for the Dodge & Cox strategy is 0.47% on the first $50 million, 0.45% on the balance.

2 The BlackRock Balanced is a 60% allocation to the BlackRock Equity Index Fund and a 40% allocation to the BlackRock U.S. Debt Index Fund. The reported fees represent a pro rata allocation of the investment management fees associated with each fund.

3 Each BlackRock LifePath Portfolio, the BlackRock U.S. Debt Index Fund, the BlackRock Balanced Fund, the BlackRock Equity Index Fund and the Wedge Mid Cap Value Fund is offered through a commingled investment fund structure. Commingled funds are charged for additional administrative fees incurred and include: fund accounting, auditing, tax reporting, operational reporting, proxy costs and litigation fees (if any). Actual administrative fees for each BlackRock fund will vary but have been capped at 0.02%. The investment management fee for the Dodge & Cox Mid Cap Value Fund is 0.35%.

4 Distribution and 12b-1 service fees are included in a mutual fund expense ratio and are used to cover distribution expenses. “12b-1 fees” get their name from the SEC rule that authorizes their payment. “Distribution fees” include fees paid for marketing and selling fund shares, such as compensating brokers and others who sell fund shares, and pay for advertising, printing and mailing prospectuses to new investors, and the printing and mailing of sales literature. The SEC does not limit the size of 12b-1 fees that funds may pay. But under NASD rules, 12b-1 fees that are used to pay marketing and distribution expenses (as opposed to shareholder service expenses) cannot exceed 0.75% of a fund’s average net assets per year. For Dodge & Cox, there is a 12b-1 charge of 10 basis points, however this fee is netted to zero by a revenue sharing credit of 10 basis points.

5 Total investment-related fees represent estimated investment management, distribution, 12b-1 service and administration fees as of July 1, 2016, and actual fees may vary. Mutual fund fees can change periodically; therefore, investors should consult the fund prospectus before investing. Additional fees may be incurred in the management of each portfolio, including trading and/or transaction fees. Trading/transaction fees will vary by fund based upon actual fund activity and are deducted from performance.

6 This fee is used to pay all external administrative expenses such as recordkeeping fees, consulting fees, legal fees, communication fees, trustee fees and advice fees incurred by the plan on an annual basis. Prior to October 23, 2014, a $50 open account fee and $10 quarterly maintenance fee apply to the Schwab PCRA. The recordkeeping add-on fees in the FutureBuilder Plan decreased from 10 basis points to 8 basis points as of July 1, 2016.

7 Fees associated with the Schwab Personal Choice Retirement Account will vary based on the personal investment choices of each participant. Therefore, fee information must be obtained from Schwab. Effective October 23, 2014, a $50 open account fee and $10 quarterly maintenance fee apply to the Schwab PCRA.
Periodically, you should review your investment choices to ensure they are still in line with your savings goals. When necessary, reallocate your fund choices to meet your changing needs.

**Trading Restrictions**
Trading restrictions and/or fees may be placed on certain funds because of excessive and/or short-term trading, which can negatively impact the funds’ performance. This means you may be required to wait a certain period of time before making reallocations or transfers. These time periods are known as purchase blocks. During a purchase block, you’re still able to sell any amount you wish. Restrictions are not applicable to new contributions, loan payments, loans, withdrawals, distributions or rollovers.

Currently, you are not able to transfer money directly from the Stable Value Fund to the Schwab PCRA. Money can be transferred out of the Stable Value Fund into any FutureBuilder fund except the Schwab PCRA, but you must wait for a period of 90 days before transferring those funds into the PCRA.

**Notice of Importance of Diversification**
To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform very well often cause another asset category, or another particular security, to perform poorly. If you invest more than 20% of your retirement savings in any one company or industry, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk.

In deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of FutureBuilder. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk. Therefore, you should carefully consider the rights described in this notice and how these rights affect the amount of money that you invest in Home Depot stock through FutureBuilder. It is also important to periodically review your investment portfolio, your investment objectives, and the investment options under FutureBuilder to help ensure that your retirement savings will meet your retirement goals.

If you have questions about your rights described in this notice, including how to make this election, contact the Benefits Choice Center at 1-800-555-4954.

**FutureBuilder Statements**
If you have an account balance in the Plan, you will receive a FutureBuilder account statement in the mail every quarter. This statement shows your Plan account’s activity for the quarter. It helps you keep track of the contributions to your account, investment results, fund transfers, and distributions. You can also find this information at any time by logging into www.livetheorangelife.com > Save & Protect.

You can also request a copy of the most recent quarterly statement by contacting the Benefits Choice Center.

**www.livetheorangelife.com and the Benefits Choice Center**
The www.livetheorangelife.com website and the Benefits Choice Center give you the ability to obtain information about your account, request forms, and make Plan transactions.

You can log into www.livetheorangelife.com > Save & Protect or call the Benefits Choice Center to do the following:

- Check your account balances—find out your total account balance, balances by fund, and your current vested balances.
- Change your contribution rate—adjust how much you are contributing into FutureBuilder; you can suspend contributing anytime by electing to contribute 0%.
- Change your future investment elections—redirect how your contributions will be invested as they are deducted from future paychecks.
- Transfer existing fund balances—move around
the money that is already in the Plan and elect automatic rebalancing every 90 or 180 days or annually.

- Change your Company match investment election—choose one or more of the Plan investment options.
- Obtain investment fund returns—obtain one-, five-, and ten-year returns.
- Obtain a fund sheet or a fund prospectus that includes information about the fund, such as top portfolio holdings
- Access Lipper fund information (online only)
- Obtain information on a fund’s investment expenses
- Request a loan—find out the amounts you have available for a loan and the rules regarding loans, model a loan, or request a loan.
- Request hardship withdrawal—review the amounts you have available for a hardship withdrawal, the rules regarding hardship withdrawals and the requirements for each hardship reason; you can then request your hardship withdrawal online.
- Request an age 59½ in-service withdrawal—obtain information regarding in-service withdrawals.
- Following your termination of employment or other distributable event, request a final distribution—obtain final distribution information.
- Request forms—select one or more administrative forms to be mailed to your home. A few select forms can be sent to your secured participant mailbox on www.livetheorangelife.com > Save & Protect if you prefer.

- Speak to a Benefits Choice representative—whenever you need help working your way through www.livetheorangelife.com > Save & Protect, or need personal assistance. Representatives are available weekdays (excluding holidays) from 9 a.m. to 7 p.m. (Eastern Time).
- Chat with a Benefits Choice representative—Live web chat representatives are available weekdays (excluding holidays) from 9 a.m. and 11 p.m. (Eastern Time) on www.livetheorangelife.com > Save & Protect.

**Confirmation of Your Transaction**

Each time you request a transaction through a Benefits Choice representative, a confirmation statement will be delivered to you. Be sure to read each confirmation to make sure the transaction processed is what you intended.

Confirmation statements for transactions made on www.livetheorangelife.com > Save & Protect will not always be mailed. It is a good idea to print your requests and confirmations for requests made on the website. However, Confirmations of Investment Election Change will always be sent regardless of how the transaction was made.

If you have any questions about a transaction you made, call the Benefits Choice Center.

**Accessing Your Plan Balance**

The goal of FutureBuilder is to help you save for the long term. However, there may be times during your working years when you will need to access the money in your Plan account. If you do, you may be able to take a loan, hardship or age 59½ in-service withdrawal.

**Loans from Your Account**

If you are an active associate, you may be able to borrow money from your Plan funds. The proceeds of a loan are not taxable. However, you repay the loan with after-tax dollars and interest. Also, as you repay the loan, both your principal and interest payments are credited back to your own account. You may only have one loan outstanding at any time.

**How to Initiate a Loan**

To initiate a loan from your FutureBuilder account, log into www.livetheorangelife.com > Save & Protect or call the Benefits Choice Center to learn how much money you have available for a loan. You can also use the modeling option to determine the amount and repayment period that best fits your situation.

Once you’ve decided the amount you wish to borrow, log into www.livetheorangelife.com > Save & Protect or speak to a Benefits Choice representative to request the loan.

Generally, you should receive your loan check approximately two to three weeks from the date of your request. If you authorize payment to be electronically transferred to a specified bank account, the proceeds will be deposited within three to five business days from the date your request is processed.

**You are responsible for ensuring the bank account number you provide is correct.**

**Amount You Can Borrow**

The amount you are permitted to borrow is determined, in part, by the vested value of your account. You must have a total vested balance of at least $2,100 in your rollover, before-tax, Roth after-tax and/or matching accounts to be eligible for the mini-
mum loan amount. The minimum you can borrow is $1,000. The maximum is the lesser of:

• 50% of the value of your before-tax contributions, Roth after-tax contributions, vested Company match, and rollover contribution minus a $50 loan administrative fee; or
• $50,000 minus your highest outstanding loan balance in the preceding 12 months minus a $50 loan administrative fee.

**Interest Rate for Your Loan**

When you repay your Plan loan, you will also pay a fixed rate of interest. Both the interest and principal will go into your FutureBuilder account. Once the rate for your loan is determined, the rate is fixed for the term of the loan.

**Loans from your PCRA Account**

Loans may only be taken in an amount up to your balance in the core investment options and LifePath portfolios. If you wish to take a loan from your FutureBuilder account in an amount greater than that, you may need to transfer money from your PCRA account to the other investment options. Money cannot be taken directly from your PCRA account for loans. The amount available reflected on your statements and on www.livetheorangelifecom for Save & Protect excludes the balance in the PCRA when displaying the amount available for a loan.

**Repayment of Your Loan**

Loan repayments will be made over the term of the loan (12 to 48 months) through automatic payroll deductions. As long as you still have four or more loan repayments left, you can request to pre-pay the outstanding balance of a loan without penalty. **You must wait at least 90 days after paying off your loan before you can request a new loan from the Plan.** You also have the option to make partial loan repayments on your loan (minimum amount of partial repayment is $500). The partial loan repayment will pay down principal owed on your loan (if you are behind on your loan, it will pay down past due principal and interest first). With the partial loan repayment process, you may be eligible to have your loan term or loan repayment amount decreased. All payments of principal and interest are invested according to your investment elections at the time of repayment.

If you terminate employment, have a vested account balance that is greater than $1,000 and have a loan with a scheduled loan end date more than 90 days following termination, you will have the option to continue monthly loan repayments following termination using loan coupons and avoid defaulting on your loan and incurring taxes and penalties. For more information, call the Benefits Choice Center.

**Defaulting on a Loan**

Your loan will be considered a distribution (withdrawal) from the plan and will be subject to applicable taxes and penalties if:

• your employment with the Company terminates for any reason and payment of the outstanding balance of your loan is not received within two months following the month of your termination or if eligible for monthly repayments following termination, and monthly repayment is not received when due; or
• you fail to pay the loan within its terms. If you have missed two consecutive scheduled repayments, your loan will be defaulted at the end of the quarter following the quarter in which the first scheduled repayment was missed unless the loan is paid off or completely caught up. You will receive notification if your loan is delinquent and subject to default and will have the opportunity to avoid default by sending in the past due repayments and making all future scheduled repayments.

**Loans While on Leave of Absence**

If you are on an approved leave of absence, your loan repayments will be suspended. The maximum period that payments will be suspended is 12 months, unless you are on Military Leave.

When you return from leave, the interest that accrued while your payments were suspended will be added to your loan balance. Your payroll deductions and/or repayment period will be adjusted for the repayment of this additional amount.

**Loans While on Military Leave**

If you are on Military Leave:

• you will have your payments resumed and reamortized upon returning to active status;
• the loan period will be extended by the length of your leave period not to exceed five years; and
• the remaining balance will be reamortized to include interest accrued during the leave period.

Interest will accrue at the rate applicable to your original loan agreement capped at 6% for the length of your military leave.

The loan period will never extend beyond the IRS limit of five years. The time you are on Military Leave is not considered part of the loan period, and it does not count against the five-year limit (e.g., participants will pick up where they left off regardless of the length of military service with the exception that their
repayments will be reamortized to include accrued interest).

**Hardship Withdrawals**

To qualify for a hardship withdrawal, you must be actively employed, and you need to prove that you are experiencing a financial hardship and need a distribution from your Plan account for one of the following reasons:

- to pay for unreimbursed medical expenses previously incurred by you or your dependents;
- to purchase your principal residence (not including mortgage payments);
- to pay for tuition, books, room and board, and other education-related fees for the next 12 months for post-secondary education for yourself or your dependents;
- to cover the immediate need to prevent foreclosure or eviction from your principal residence;
- to pay funeral expenses for members of your immediate family;
- to pay federal income taxes (including penalties and interest) for the two most recently ended tax years;
- to pay for uninsured costs for repairs to your principal residence for damages caused by a natural disaster or accident; or
- to pay for legal fees and expenses incurred as a direct result of the adoption of a child.

To qualify for a hardship withdrawal, you must provide documentation in support of your financial hardship, and **you must have exhausted all other sources of funds to meet your needs.**

If you qualify, you may receive up to 50% of the vested Company contributions, all of the rollover contributions, and all of the before-tax and Roth after-tax contributions from your Plan funds, excluding earnings.

In any event, the amount of your distribution may not exceed:

- the actual amount of your expenses plus;
- an estimated amount to cover the federal income taxes you will have to pay on your distribution.

The minimum hardship withdrawal allowed is $1,000 and you are limited to two hardship withdrawals every rolling 12 months. **You will pay a $25 fee when a hardship withdrawal is processed on your account.** The fee will be deducted from your Plan assets when the payment is processed.

Generally, you should receive your check approximately two to three weeks from the date your request is approved and processed. If you authorize payment to be electronically transferred to a specified bank account, the proceeds will be deposited within three to five business days from the date your request is processed. **You are responsible for ensuring the bank account number you provide is correct.**

Qualified non-elective contributions made to your FutureBuilder account are not available for hardship withdrawals.

If you qualify, you may receive up to 50% of the vested Company contributions, all of the rollover contributions, and all of the before-tax and Roth after-tax contributions from your Plan funds, excluding earnings.

In any event, the amount of your distribution may not exceed:

- the actual amount of your expenses plus;
- an estimated amount to cover the federal income taxes you will have to pay on your distribution.

The minimum hardship withdrawal allowed is $1,000 and you are limited to two hardship withdrawals every rolling 12 months. **You will pay a $25 fee when a hardship withdrawal is processed on your account.** The fee will be deducted from your Plan assets when the payment is processed.

**Tax Considerations**

Your hardship distribution is subject to income tax (as well as the 10% additional tax unless you have attained age 59-1/2). On any hardship withdrawal, 10% will automatically be withheld. You may waive this 10% withholding, if you choose. However, it is important to note that the taxes you may owe on the distribution could be higher than what is automatically withheld, depending on your tax bracket. Consult a tax advisor for more information on your personal situation.

**In-Service Withdrawals**

Once you reach age 59½, if you are actively employed, you may request a withdrawal of the vested portion of your FutureBuilder account.

For Roth after-tax contributions, you will not pay taxes on your Roth after-tax contributions’ earnings if your distribution is qualified. A distribution of your Roth after-tax contributions and their earnings is qualified if you are age 59½ or older and the withdrawal is made at least five years after making your first Roth contribution to the Plan.

You may request up to two withdrawals during a
Military Leave Distributions

If you are on active duty in the uniformed services for more than 30 days and are less than age 59½, you will be treated as separated from service for purposes of being able to receive a distribution of your before-tax and Roth 401(k) contributions and associated earnings excluding the Schwab PCRA fund. If you elect such a distribution, you will be restricted from making up contributions to the plan for a period of six months from the date of the distribution and the 10% penalty tax applies on distributions if you have not attained age 59 ½.

If you are on military leave for more than 179 days, you may request a qualified reservist distribution. You will not have your contributions suspended if you elect this withdrawal and can elect to receive 100% of your vested balance in the core funds. If you take a qualified reservist distribution prior to age 59½, a 10% penalty tax will apply on the total amount of the payment excluding before-tax contributions and earnings (before-tax contributions and earnings are not be subject to the 10% penalty tax).

Final Distributions of Your Account

You may receive a final distribution of the vested portion of your FutureBuilder account in a lump-sum payment when you:

- terminate employment with the Company for any reason; or
- become totally and permanently disabled.

Your beneficiary may receive a final distribution of the vested portion of your FutureBuilder account in the event of your death.

You or your beneficiary may request payment in one of the following forms:

- 100% cash; or
- cash and if you already own Home Depot stock through FutureBuilder, Shares of The Home Depot, Inc. common stock which you can receive as an in-kind transfer or as a stock certificate.

You may request payment to be paid as a:

- Rollover to an IRA or another eligible employer-sponsored retirement plan or to a 403(b) or 457 plan; or
- Taxable distribution; or
- Combination of both.

Your beneficiary may request payment to be paid as a:

- Rollover to an IRA (excluding ineligible trusts and estates) or to another eligible employer-sponsored retirement plan or to a 403(b) or 457 plan (only if your beneficiary is your spouse); or
- Taxable distribution to himself or herself; or
- Combination of both.

Your beneficiary may receive a final distribution of the vested portion of your FutureBuilder account in the event of your death.

If you have funds in a PCRA account, you or your beneficiary may request payment of the assets in the PCRA account in one of the following forms:

- Cash;
- An in-kind rollover to an IRA; or
- A rollover in cash to an IRA or other eligible employer-sponsored retirement plan, a 403(b) plan or a 457 plan.
Requesting a Final Distribution

To request a final distribution, log into www.livetheorangelifelife.com > Save & Protect or call the Benefits Choice Center.

- Provided that your separation from service has been processed by the Company, if you make a request prior to 30 days following the termination of your employment, your request will be processed as of the market close coinciding with or immediately following your termination date plus 30 days. Note that if the day of your distribution (your termination date plus 30 days) is not a business day, your distribution will be made on the first business day following.

- If you make a request prior to market close on or after 30 days following the termination of your employment, your request will be processed as of the date your request is made. Your balances remain active in the market through the market close date on the day your distribution processes. Once your request is processed, your stock certificate and/or check will be mailed to you, generally within two to three weeks. If you authorize payment in cash to be electronically transferred to a specified bank account, the proceeds will be deposited within three to five business days from the date your request is processed. **You are responsible for ensuring the bank account number you provide is correct.**

- You will pay a $25 fee when a total distribution is processed on your account. The fee will be deducted from your Plan assets when the payment is processed.

Deferring Your Final Distribution

After you leave the Company, as long as your vested balance is greater than $1,000, you may elect to defer receiving the value of your FutureBuilder account. The latest you may defer taking payment is up to age 70½.

If you are still working at the Company or one of its affiliates when you reach age 70½, you will not be required to start taking payments until your separation from employment. For further information, call and speak to a Benefits Choice representative.

If You Leave the Company

Once you have left the Company and its affiliates, you may request to receive the vested balance of your FutureBuilder account. If you return to work for the Company before receiving a distribution, your balance will remain in your account. Please see What Is a Break in Service? for rules that apply if you leave the Company.

If you do not request a distribution after leaving the Company and your vested account balance (including any rollover account) is or grows to greater than $1,000 before the end of the second full month following your separation from service, the funds will remain in your FutureBuilder account until the time you request a distribution.

The Home Depot helps you save for retirement with the FutureBuilder 401(k) Plan. When you retire, if your vested account balance is greater than $1,000, you may choose to leave your money in the Plan, roll over to an IRA, receive a lump sum distribution, receive steady payments from the Plan (must be enrolled in Financial Engine Managed Accounts), or roll over to an income annuity IRA (such as Hueler Income Solutions). The Benefits Choice Center can help you understand your options, provide information about tools that can help you manage your income in retirement and take the next steps.

If your vested account balance is $1,000 or less, you cannot defer payment. Your balance will be distributed to you automatically at the end of the second full month after your separation from employment has been processed by the Human Resources Service Center. Or, you may call the Benefits Choice Center and speak to a representative to request a rollover to your IRA or other specific payout option to be made at least 30 days following your separation from service.

If You Are Totally and Permanently Disabled

You are considered totally and permanently disabled if you are wholly prevented from engaging in your regular duties for the Company or an affiliate by reason of a medically determinable physical or mental impairment that can be expected to result in death or to be of long-continued and indefinite duration as determined by the Administrative Committee or its designee. If you are actively employed and become disabled as determined by the Social Security Administration, you will be automatically considered to be totally and permanently disabled. If you are actively employed by the Company when you meet these qualifications, you will become 100% vested and may elect to receive the entire balance in your FutureBuilder account anytime thereafter.

In the Event of Your Death

If you die while you are employed by the Company or one of its affiliates, your FutureBuilder account will become 100% vested and will be paid to your designee.
nated beneficiary or in accordance with the Plan’s default rules if you haven’t designated a beneficiary. Federal law requires that the Plan pay benefits to your surviving spouse, unless you have received your spouse’s written, notarized consent allowing you to designate someone else. See Choosing a Beneficiary.

Tax Considerations
Your before-tax contributions, Company matching contributions, ESOP contributions and investment earnings (not including investment earnings on Roth after-tax contributions if your distribution is qualified) in your account are not taxable until you receive a distribution. At that point, special tax rules may apply. You should consult your tax advisor for specific help. Following is a description of some of the tax considerations.

Your Roth after-tax contributions are not taxable and you will not pay taxes on your Roth after-tax contributions’ earnings if your distribution is qualified. A distribution of your Roth after-tax contributions and their earnings is qualified if you are age 59½ or older and the withdrawal is made at least five years after making your first Roth contribution to the plan.

The IRS stresses that 401(k) plans like FutureBuilder should be for retirement income. Under current tax law, if you terminate employment and receive a final distribution of your account before you reach age 55, or if you receive a hardship withdrawal or default on a loan before age 59½, the IRS imposes a 10% penalty tax on your before-tax contributions, Company matching contributions, ESOP contributions and investment earnings (not including investment earnings on Roth after-tax contributions if your distribution is qualified) in addition to your regular income tax.

This 10% additional tax does not apply if:
- your employment with the Company ends after you reach age 55;
- your account is paid after you reach age 59½ or because of death or total permanent disability;
- the money is paid out under a court-ordered qualified domestic relations order;
- you roll over the money into another eligible employer-sponsored retirement plan or IRA; or
- you use your distribution to pay unreimbursed deductible medical expenses.

Home Depot Stock
Under special tax rules that relate to lump-sum distributions of employer stock, if you receive a lump-sum taxable distribution in Home Depot common stock, the original cost basis of the stock (i.e., the value when it was invested in stock in the plan) and any cash for a fractional share will be taxable income in the year the stock is received. When you later sell the stock, you will be taxed at capital gains rates based on any increase or decrease in the stock’s value over the original cost basis of the stock distributed to you. If you hold shares in The Home Depot Stock Fund, you should discuss these rules with your tax advisor.

Rollovers
In addition, current tax rules enable you to instruct the Company to make a direct rollover of all or part of your distribution (other than a hardship withdrawal) into an IRA or another eligible employer-sponsored retirement plan that accepts rollovers. Rollovers allow you to continue to defer taxation of your account balance. If you elect a direct rollover of Home Depot stock, it is important that you first verify whether the receiving institution will accept the stock in kind.

Unless you elect a direct rollover, the Trustee will automatically withhold 20% of the total cash amount you receive (not including Roth after-tax contributions and the investment earnings on the Roth contributions if the distribution is qualified) for federal income tax, as required by the IRS. The amount withheld goes directly to the IRS, and will be considered a credit when you file your income tax return. In some states, state tax withholding also is required. You can avoid this mandatory withholding by electing to have your eligible rollover distribution directly rolled over to an IRA or another eligible employer’s retirement plan. With a direct rollover, you instruct the Trustee to make the check and/or Shares for your distribution payable to the plan or IRA that you intend to roll into.

If you do not elect a direct rollover, the law requires the Trustee to withhold 20% of the taxable portion of your distribution. You can generally maintain the tax-deferred status of your distribution by rolling over all or a portion of the distribution into an IRA or eligible employer-sponsored retirement plan within 60 days after distribution, but you may still be taxed on the 20% withheld. You can roll over the total amount of your distribution if you replace the 20% with your own money, and then claim that amount as a credit on your annual tax return. If you deposit only a portion of the taxable distribution, you will owe current income tax on the remaining taxable distribution. Note that the IRS limits this indirect tax-free rollover to one time per year.

The tax laws are complicated and subject to change, and the Company cannot provide individual tax
advice. The Company suggests you seek advice from a qualified tax advisor or financial planner to be sure your personal circumstances are considered carefully if you make a withdrawal or when you receive a final distribution.

Hardship withdrawals are not eligible to be rolled over into another plan or an IRA, and you may elect that income tax not be withheld from your hardship withdrawal.

How to Obtain Additional Information

The information in this book summarizes only the federal (but not state and local) tax rules that might apply to your payment. The rules described here are complex and contain many conditions and exceptions that are not included in this information. Information on federal income tax consequences on FutureBuilder payments can be found in the FutureBuilder plan prospectus and Payments Rights Notice, available online or by calling the Benefits Choice Center. You may obtain more specific information on the tax treatment of payments from eligible employer-sponsored retirement plans in IRS Publication 575, Pension and Annuity Income, and IRS Publication 590, Individual Retirement Arrangements. These publications are available from the Internet on the IRS website at www.irs.ustreas.gov/formspubs/index.html, by calling 1-800-TAX-FORM (1-800-829-3676) or from your local IRS office.

Dividends

Dividends on the Shares of Company stock paid to your Home Depot Stock Fund account will be used to acquire additional Shares of Home Depot stock. On a quarterly basis you will be able to elect to have your dividends remain in the plan or paid to you. The dividend payments, if elected, will occur on an annual basis within 90 days of the end of the year. Dividend payout elections are only valid for the year in which they are made. You must make an active election each year to receive a cash payout. If you own Home Depot stock in your PCRA account, you will not have the option to have the dividend paid directly to you.

Forfeitures

Forfeitures are generally Company matching contributions left in the plan by terminated associates who were not 100% vested. If you leave the Company before you are 100% vested, the amount forfeited will be used as a credit toward Company matching contributions for all active participants or to pay plan expenses.

When Benefits Are Not Paid

It’s important that you understand the conditions under which benefits could be less than expected or not paid at all or limited, including:

• **Qualified Domestic Relations Order (QDRO)**—If, as the result of a divorce, you’re responsible for child support, alimony, or marital property rights payments, all or a portion of your benefits could be assigned to meet these payments if a court issues a qualified domestic relations order (QDRO). If your account becomes subject to a QDRO, the expenses incurred by the plan in determining whether the QDRO meets applicable legal requirements may be charged against your account. You can obtain a free copy of the QDRO determination procedures by contacting the plan administrator. **A fee of $500 will be charged when each domestic relations order is processed.** This fee will be deducted from the Plan Participant’s account before the order is applied.

  • If the investment funds you choose experience losses, the value of your contributions can decrease.

  • If the Plan does not pass required nondiscrimination tests, all or a portion of the contributions made on behalf of highly compensated employees may be reduced and refunded. Nondiscrimination tests are required by law to ensure a fair mix of contributions from employees at certain income levels. If you’re affected by these limits, you’ll be notified.

  • If you do not notify the Plan Administrator of your new address following a move, payment of your FutureBuilder distribution can be delayed or even lost if you, or your beneficiary, spouse or estate, in the event of your death, do not come forward. Your account may be forfeited if you or your beneficiary cannot be located. If your account is forfeited because you cannot be located, it will be restored, however earnings may be lost.
Right to Amend or Terminate the Plan
The Company reserves the right to change, suspend, amend or terminate this Plan at any time, in whole or in part. Generally, account balances cannot be reduced except for investment losses, even by a Plan amendment. Termination of the Plan is unlikely, but if the Plan is terminated, your account automatically will become 100% vested. If any material changes are made to the Plan in the future, you’ll be notified.

Implied Promises
Nothing in this book says or implies that participation in this Plan is a guarantee of continued employment with the Company, nor is it a guarantee that contribution levels will remain unchanged in the future.

Limiting Liability
FutureBuilder is intended to meet the provisions of Section 404(c) under ERISA and Labor Reg. § 2550.404c-1. This means that plan fiduciaries (those responsible for administering the plan) will be relieved of liability for losses resulting from a participant’s investment instructions and decisions.

For FutureBuilder claims, any lawsuit or legal action must be brought the earlier of one (1) year after denial of appeal by the Plan Administrator or its designee or two (2) years following (a) in the case of any payment, the date such payment was made, or (b) the date your claim arose.

Any legal action regarding the Plan may only be brought or filed in the Federal District Court for the Northern District of Georgia, Atlanta Division.

Your Rights Under ERISA
For information about your rights under the Employee Retirement Income Security Act (ERISA) and other important information, see the Plan Administration chapter.
<table>
<thead>
<tr>
<th>Request</th>
<th>Deadline</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution rate change</td>
<td>1 a.m. (Eastern Time) on any Friday the week</td>
<td>Contributions at your newly elected rate begin with your next paycheck once you</td>
</tr>
<tr>
<td></td>
<td>before your next payday</td>
<td>are eligible for the plan.</td>
</tr>
<tr>
<td>Investment election change</td>
<td>4 p.m. (Eastern Time) or market close on any</td>
<td>All your future contributions after the day you call are invested according to</td>
</tr>
<tr>
<td></td>
<td>business day</td>
<td>your request.</td>
</tr>
<tr>
<td>Fund transfer/reallocation (limited to 1 per day)</td>
<td>4 p.m. (Eastern Time) or market close on any</td>
<td>Your request will be processed as of the day you make the request at the closing</td>
</tr>
<tr>
<td></td>
<td>business day</td>
<td>prices on the day of your request. Transfers requested for the Schwab PCRA or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>through a financial advisory service will be processed as soon as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administratively possible (within three to five business days of your request).</td>
</tr>
<tr>
<td>Hardship withdrawal request</td>
<td>Return your signed documentation to the</td>
<td>Your request is processed based on the value of your account on the day your</td>
</tr>
<tr>
<td></td>
<td>Benefits Choice Center. When you call or log</td>
<td>completed documentation is received and approved; generally, you will receive</td>
</tr>
<tr>
<td></td>
<td>into <a href="http://www.livetheorangeflife.com">www.livetheorangeflife.com</a> &gt; Save &amp;</td>
<td>your check within two to three weeks after approval or within three to five</td>
</tr>
<tr>
<td></td>
<td>Protect to request this transaction, the</td>
<td>business days if you authorize payment to be direct deposited into a specified</td>
</tr>
<tr>
<td></td>
<td>appropriate paperwork will be mailed to you.</td>
<td>bank account. For more information, see Final Distributions of Your Account.</td>
</tr>
<tr>
<td>Final distribution request (after your employment</td>
<td>4 p.m. (Eastern Time) or market close on any</td>
<td>If you request a final distribution prior to 30 days following the termination</td>
</tr>
<tr>
<td>ends)</td>
<td>business day</td>
<td>of your employment, your request is generally processed based on the value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of your account as of market close coinciding with or immediately following</td>
</tr>
<tr>
<td></td>
<td></td>
<td>your termination date plus 30 days. If you make a request prior to market close</td>
</tr>
<tr>
<td></td>
<td></td>
<td>on or after 30 days following the termination of your employment, your request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>will generally be processed as of the date your request is made. Your balances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>remain active in the market through the market close date on the day of your</td>
</tr>
<tr>
<td></td>
<td></td>
<td>distribution processes. Generally you will receive your check within two to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>three weeks or within three to five business days if you authorize payment to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>be direct deposited into a specified bank account. For more information, see</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Final Distributions of Your Account.</td>
</tr>
<tr>
<td>Force-Out (vested account balances equal to or less</td>
<td>4 p.m. (ET) as applicable or market close on</td>
<td>If you request a final distribution prior to 30 days following the termination</td>
</tr>
<tr>
<td>than $1,000)</td>
<td>last business day of second month following</td>
<td>of your employment, your request is generally processed based on the value of</td>
</tr>
<tr>
<td></td>
<td>termination of your employment. If you do not</td>
<td>your account as of market close coinciding with or immediately following your</td>
</tr>
<tr>
<td></td>
<td>request a final distribution by this deadline,</td>
<td>termination date plus 30 days. If you make a request prior to market close on</td>
</tr>
<tr>
<td></td>
<td>your balance will be paid to you automatically</td>
<td>or after 30 days following the termination of your employment, your request</td>
</tr>
<tr>
<td></td>
<td>as a taxable distribution.</td>
<td>will be processed as of the date your request is made. Your balances remain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>active in the market through the market close date on the day of your</td>
</tr>
<tr>
<td></td>
<td></td>
<td>distribution processes. Generally you will receive your check within two to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>three weeks or within three to five business days if you authorize payment to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>be direct deposited into a specified bank account. For more information, see</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Final Distributions of Your Account.</td>
</tr>
<tr>
<td>Loan</td>
<td>4 p.m. (Eastern Time) or market close on any</td>
<td>Your request is generally processed as of the day you call, and the check</td>
</tr>
<tr>
<td></td>
<td>business day</td>
<td>should be received two to three weeks after your initial loan request is made</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or within three to five business days if you authorize payment to be direct</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deposited into a specified bank account.</td>
</tr>
<tr>
<td>In-service withdrawal</td>
<td>4 p.m. (Eastern Time) or market close on any</td>
<td>Your request will generally be processed as of the day you call at the closing</td>
</tr>
<tr>
<td></td>
<td>business day</td>
<td>prices on the day you call. You should receive your check within approximately</td>
</tr>
<tr>
<td></td>
<td></td>
<td>two to three weeks from the date your request is processed or within three to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>five business days if you authorize payment to be direct deposited into a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>specified bank account.</td>
</tr>
<tr>
<td>Rollover contribution</td>
<td>Return your signed documentation with</td>
<td>Generally, your request is processed as of the day your completed documentation</td>
</tr>
<tr>
<td></td>
<td>rollover proceeds to the Benefits Choice</td>
<td>is received and approved.</td>
</tr>
<tr>
<td></td>
<td>Center. When you call or log into <a href="http://www.livethe">www.livethe</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>orangethinglife.com &gt; Save &amp; Protect to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>request this transaction, the appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>paperwork will be mailed to you.</td>
<td></td>
</tr>
<tr>
<td>Rollover distribution</td>
<td>4 p.m. (Eastern Time) or market close on any</td>
<td>If you request a rollover distribution to an IRA, another qualified plan, 403(b)</td>
</tr>
<tr>
<td></td>
<td>business day</td>
<td>plan, or 457 plan, following the termination of your employment, the timing of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the distribution will mirror the final distribution effective date description</td>
</tr>
<tr>
<td></td>
<td></td>
<td>noted above. In-kind rollovers of Home Depot stock from the Home Depot Stock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fund are available if the receiving institution accepts Shares. If you have a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Schwab PCRA fund balance, you may request a direct in-kind rollover to an IRA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For more information on the Schwab IRA Rollover, please contact Schwab.</td>
</tr>
<tr>
<td>Request</td>
<td>Deadline</td>
<td>Effective Date</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Loan pre-payment, partial payoff or full payoff</td>
<td>Return your invoice with a money order for the loan payment amount to the Benefits Choice Center. When your employment ends or if you request an early payoff, the appropriate paperwork will be mailed to you.</td>
<td>Generally, your request is processed as of the day your payment is received.</td>
</tr>
<tr>
<td>Payment of a benefit or request for a transaction that has been denied</td>
<td>Contact the Benefits Choice Center at 1-800-555-4954 to request a review of your denied request.</td>
<td>Your request will be reviewed and you’ll be informed when you’ll receive a timely response. See the Claims and Appeals chapter for more information.</td>
</tr>
<tr>
<td>Filing a formal claim for benefits and rights under the Plan.</td>
<td>You must file a claim for benefits under FutureBuilder within (i) two years of the date on which your benefits were paid or for all other claims not related to the payment of benefits, within two years from the date on which the action or omission complained of occurred or (ii) one year following issuance of a denial of an appeal (if no denial is issued, one year following the longest permissible period to render a decision).</td>
<td>You must appeal in writing to: Home Depot FutureBuilder Administrative Committee Benefits Department, Building C-18 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-9211</td>
</tr>
</tbody>
</table>
Glossary of Investment Terms

Asset Allocation—the process of dividing investments among different kinds of assets, such as stocks, bonds, real estate and cash, to optimize the risk/reward trade off based on an individual’s specific situation and goals.

Asset Class—a category of investments. Stable value investments, bonds and stocks are three asset classes.

Balanced Fund—a fund that invests in both stocks and bonds in an attempt to achieve higher returns than all-bond funds, but with less risk than all-stock funds.

Benchmark—a standard against which an investment fund’s performance is measured.

Bond—essentially an IOU for a loan that you make to a corporation, bank or government. The bond issuer, or borrower, promises to pay you back the amount of the loan plus interest after a number of years.

Collective/Commingled Funds—collective funds are “pooled” vehicles that commingle the assets of multiple individuals or organizations with the goal to cost effectively invest in a diversified portfolio. These funds are organized as group trusts and are exempt from registration requirements.

Diversification—spreading your savings among more than one investment. It helps reduce market risk and protects against the volatility that can result from putting your money in just one investment.

Dividend—a payout to shareholders based on the company’s earnings. The size and frequency of the dividend is determined by the board of directors.

Growth Funds—funds that invest in companies with strong earnings and growth prospects. The stocks of these companies usually have high price/earnings ratios.

Index Funds—funds that attempt to mirror the performance of a particular investment index, such as the S&P 500. They typically have lower fees than actively managed funds.

International Funds—funds that seek capital appreciation by investing primarily in common stocks of companies outside the United States. Currency fluctuations and political developments could add risk to the fund.

Mutual Fund—a mutual fund is made up of investments selected by fund managers to match the stated objective of the fund. Mutual funds must be registered as investment companies under local securities laws. The mutual funds offered in FutureBuilder are the Dodge & Cox Stock Fund (ticker symbol DODGX) and the Dodge & Cox International Stock Fund (DODFX). Although you can track these funds and their prices in a newspaper’s financial pages or on-line, keep in mind that the net asset values (NAVs) and share prices may differ from those listed due to administrative fees.

Price Earnings Ratio—ratio calculated by dividing the current price of a stock by the earnings per share.

Prospectus—a disclosure document required by the Securities and Exchange Commission for mutual funds and company stocks.

Rate of Return—the amount your investment changes in value (gains or losses) over a period of time, expressed as a percentage of your initial investment.

Risk—the chance that an investment’s value will go up or down over time, or that it won’t stay ahead of inflation.

Separate Account—large institutional investors are able to negotiate and establish an account directly with investment managers. Separate account structures allow plan sponsors to control investment guidelines and reduce total costs. The investment account is not registered with the Securities and Exchange Commission (SEC), and performance is not reported in a newspaper’s financial pages. The TimesSquare Mid Cap Growth, the TS&W Domestic Small Cap Value and the Stephens Small Cap Growth strategies are all offered in a separate account structure.

Stocks—also referred to as equities. Stocks represent ownership in an individual company. Investors typically buy and hold Shares of a company’s stock.

Time Horizon—the number of years you have to invest your money before you’ll need to start withdrawing it.

Value Funds—funds that invest in under-priced companies that show signs of improvement. The stocks of these companies usually have low price/earnings ratios.

Volatility—the ups and downs of the value of an investment. Stock investments tend to have higher volatility than bond or stable value (income) investments.
Employee Stock Purchase Plan Facts and Quick Links

U.S. Part-Time Hourly Associates

The Employee Stock Purchase Plan

<table>
<thead>
<tr>
<th>You can contribute:</th>
<th>Up to a maximum of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% to 20% of your eligible earnings</td>
<td>$21,250</td>
</tr>
</tbody>
</table>

Cool Employee Stock Purchase Plan Features

- You Buy Stock Through Convenient Payroll Deductions.
- Stock Will Be Purchased for You at a 15% Discount. The price you pay is 15% off the closing price of Home Depot stock on the last day of the plan.

When Do I Enroll in ESPP?

The ESPP has two “plans” each year—January 1-June 30 and July 1-December 31. To enroll (or change your investment percentage), log into www.livetheorangefife.com > Save & Protect:

- January 1 through June 30—you must enroll by December 17, 2016; and
- July 1 through December 31—you must enroll by June 16, 2017.

Quick Links to Frequently Used Employee Stock Purchase Plan Info

- How do I enroll in the ESPP?
- How many shares of stock will my account receive?
- How do I manage my ESPP account?
- How do I sell my ESPP shares?
- Will participation in the ESPP affect my tax situation?
CHAPTER CONTENTS

111 The Employee Stock Purchase Plan
111 Terms to Know
111 How the ESPP Works
112 ESPP Administration
112 Participating in the Plan
112 Eligibility and Participation
112 Enrolling in the Plan
112 Automatic Rollover
112 Discounted Stock Purchase Price
112 Your Total Shares
113 ESPP Payroll Deductions
113 Calculating Your Payroll Deduction
113 Limitations on Your Contributions
113 Changing Your Payroll Deduction
114 Special Circumstances
114 Termination of Employment
114 Leave of Absence
114 Additional Special Circumstances
114 Foreign Associates
114 Stock Ownership
114 Your ESPP Account at Computershare
115 Ownership of Shares
115 Stockholder Privileges
115 Cash Dividends & Reinvestment
115 Account Statements
115 Importance of Diversification
115 Stock Transactions
115 Accessing Your Computershare Account
116 Selling Your Shares
116 Receiving Your Stock Sale Proceeds
116 Certificate Withdrawals and Share Transfers
116 Computershare Fees
117 Computershare Contacts
117 Taxes and the ESPP
117 Tax Benefits
117 Tax Consequences
117 Holding Period
117 Dividends
117 Reporting Capital Gains on the Sale of ESPP Shares
118 Backup Withholding (W-9) Certification
118 ESPP Supplemental Information
118 Available Shares
118 Amendment and Termination
118 Rights Not Transferable
118 Restrictions on Resale of Common Stock Acquired under the Plan and Prohibition on Hedging
119 Applicable Laws
119 Incorporation of Documents by Reference
119 Available Information
120 Company Financial Statements
**EMPLOYEE STOCK PURCHASE PLAN**

Get the Most Value from Your Plan

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll in ESPP (Jan. 1 - June 16) (July 1 - Dec. 17)</td>
<td>Log into <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a> &gt; Save &amp; Protect</td>
</tr>
<tr>
<td>Change or stop your payroll deductions</td>
<td>Log into <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a> &gt; Save &amp; Protect</td>
</tr>
<tr>
<td>If you don’t understand your payroll deduction or the amount isn’t correct</td>
<td>Call MYTHDHR (1-866-698-4347); if you work for a subsidiary, call your payroll department</td>
</tr>
<tr>
<td>Sell your ESPP Shares and receive proceeds</td>
<td>Call Computershare at 1-800-843-2150, or visit their website at www-us.computershare.com/employee. See Stock Transactions for more information on selling Shares and payment delivery options.</td>
</tr>
<tr>
<td>Withdraw or transfer Shares</td>
<td>Call Computershare at 1-800-843-2150, or visit their website at www-us.computershare.com/employee to get the appropriate forms.</td>
</tr>
<tr>
<td>If you want to confirm that Shares have been purchased for your account after a Plan has ended</td>
<td>Call Computershare at 1-800-843-2150 and speak with a representative, or go online at www-us.computershare.com</td>
</tr>
<tr>
<td>Get answers to your questions</td>
<td>Call the Home Depot Stock Administration department toll-free at 1-800-654-0688 x13777 or email <a href="mailto:Stock_Administration@homedepot.com">Stock_Administration@homedepot.com</a>.</td>
</tr>
</tbody>
</table>

The Employee Stock Purchase Plan

At The Home Depot, we’re all working together to build success. Our Employee Stock Purchase Plan (ESPP) is designed to give you the opportunity to acquire ownership interest in The Home Depot, Inc. (the “Company”) by purchasing Company Common Stock (“Shares”—going forward, referred to as “stock” in this chapter) at a discount, and represents a key component of the total value you receive from the Company.

This Employee Stock Purchase Plan chapter constitutes a part of a prospectus covering securities that have been registered under the Securities Act of 1933 (the “Securities Act”). ESPP participants, as well as those associates who are considering enrolling in the ESPP, are encouraged to read this chapter and the documents incorporated by reference listed in Incorporation of Documents by Reference. The date of this prospectus is September, 2016.

**Terms to Know:**
- Plan ‘End Date’ (June 30 or Dec 31)
- Plan ‘Pay Period End Date’ (June 16 or Dec 17)

How the ESPP Works

Your participation in the ESPP is voluntary, through convenient after-tax payroll deductions, in an amount that is comfortable for you. While there are no guarantees that the value of any stock will increase, investing can be an important part of your overall financial plan.

Each calendar year, there are two opportunities to participate in The Home Depot’s ESPP. Each opportunity is called a Plan. Each Plan runs for six months: one Plan begins January 1, and the next on July 1. **A Plan in progress is referred to as a Current Plan, and the one to follow is referred to as the Next Plan.**
During an open enrollment period before a Plan begins, you decide how much money you wish to have deducted from each paycheck for that Plan. Your payroll deductions are a percentage (between 1%-20%) of your eligible earnings for each pay period.

At the end of a Current Plan, the Company issues you as many Shares (including fractional Shares) of The Home Depot stock as can be purchased with the total of your payroll deductions (no interest or earnings accumulate on your contributions during the Plan. If you do not have an existing account, however, your payroll deductions must be sufficient to purchase at least one (1) share. Shares are purchased for you after the Plan ends.

**ESPP Administration**

The ESPP is administered by the Leadership Development and Compensation Committee of the Company’s Board of Directors (the “Committee”). The Committee is vested with authority to set the number of Shares to be included in any given Plan, to set the subscription (enrollment) and purchase periods, and to interpret and enforce the provisions of the ESPP.

**Participating in the Plan**

**Eligibility and Participation**

You are eligible to participate in the ESPP if you are employed by The Home Depot or a subsidiary company on the beginning day (Offering Date) of a Plan and have been added into all required administrative systems. To receive Shares you purchased through payroll deductions, you must be an active associate on the last day of the Current Plan End Date (June 30 or Dec 31). See Special Circumstances for exceptions to this rule.

To participate in a Plan, you must enroll during the open enrollment period for that Plan. The enrollment deadline for the January 1 Plan is December 17 and the enrollment deadline for the July 1 Plan is June 16.

**Limitation on Participation**

You are not eligible to participate in The Home Depot ESPP if you own, or will own after the ESPP purchase, 5% or more of the Company’s outstanding Shares, including options to purchase Shares as a result of ESPP participation.

**Enrolling in the Plan**

To participate in the ESPP, you must enroll during the open enrollment period by logging into www.livetheorangefi.com > Save & Protect, or by accessing the automated phone system available through The Home Depot Benefits Choice Center. To enroll, you need the same password you use for FutureBuilder 401(k) and health benefits. During the enrollment process, you will be asked for the percentage of your eligible earnings that you wish to have deducted each pay period (between 1% - 20%).

To enroll online, log into www.livetheorangefi.com > Save & Protect. **You must confirm your selection before the transaction is complete.**

**Automatic Rollover**

The automatic rollover feature for the ESPP is available for the Current Plan. This means that the same percentage amount elected for the Current Plan will be deducted for the Next Plan, unless you elect to change your rate during the open enrollment period for the Next Plan.

If you want to participate in the Next Plan and are not currently enrolled, you must take action to enroll online or through the automated phone system before the applicable enrollment deadline.

See Eligibility and Participation, Enrolling in the Plan and Changing Your Payroll Deduction for more information.

**Discounted Stock Purchase Price**

The price of stock purchased through the ESPP is set with a 15% discount off the closing stock market price on the last day of the Plan. The Home Depot common stock is traded on the New York Stock Exchange (NYSE).

**Example:**

<table>
<thead>
<tr>
<th>$130.00</th>
<th>NYSE closing price</th>
</tr>
</thead>
<tbody>
<tr>
<td>-$19.50</td>
<td>ESPP discount (15% of $130)</td>
</tr>
<tr>
<td>$110.50</td>
<td>ESPP purchase price</td>
</tr>
</tbody>
</table>

**Your Total Shares**

To determine the number of Shares you will receive for a given Plan, divide the total amount deducted from your paycheck during the Plan by the stock purchase price. If your paycheck dollars are in a currency other than U.S. dollars, you must first convert the amount deducted using the conversion rate on the date the Plan ends.
If The Home Depot declares a stock split or has similar capital adjustments, the purchase price of the Current Plan and the number of Shares your payroll deductions purchase will be adjusted accordingly.

**ESPP Payroll Deductions**

**Calculating Your Payroll Deduction**

Your ESPP payroll deductions are taken after taxes. The amount of your payroll deduction is a percentage of your eligible earnings for each pay period.

**Example:**

| $923 | Eligible earnings per pay period (Based on 26 pay periods per year; eligible annual pay of approximately $24,000, or about $12 per hour) |
| $46.15 | Payroll deduction per pay period |
| $599.95 | Total payroll deductions for Plan |

If your hours, pay rate or salary change during the Current Plan, your payroll deductions will be adjusted accordingly. In other words, the percentage rate of your payroll deduction will stay the same, unless you elect to change it as described in the next section. However, the dollar amount of your payroll deductions will change.

**What is Considered Eligible Pay?**

For purposes of determining your contributions to the ESPP, eligible pay is generally your taxable wages, plus your payroll deductions to the FutureBuilder 401(k) Plan and any before-tax payroll deductions for health and welfare benefit plans, minus reimbursements, expense allowances, fringe benefits, moving expenses, welfare benefits income attributable to Restricted Stock or other Equity Awards and other similar amounts.

**Limitations on Your Contributions**

Under the rules of the ESPP, there are limitations to your contributions, as follows:

- Your payroll deductions may not exceed the lesser of 20% of your eligible earnings (including bonuses), or $21,250.
- The maximum value of the stock you can purchase through the ESPP in a calendar year may not exceed $25,000, based on the closing stock price on the first day of a Plan.

If you reach the maximum value of stock you can purchase in the current calendar year ($25,000), then you cannot participate in the ESPP for the remainder of the current year. However, you will automatically be enrolled in the Next Plan for the new calendar year at your Current Plan participation rate, unless you elect to change your rate before the Pay Period End Date (June 16 or Dec. 17).

**Changing Your Payroll Deduction**

Anytime before the Pay Period End Date (June 16 or Dec 17), you may change your ESPP payroll deduction, according to the following rules:

1. Once the Current Plan has started, you cannot increase your payroll deduction percentage.
2. You may reduce your payroll deduction percentage only once during the Current Plan period.
3. You may stop your participation in the Current Plan at any time before the Pay Period End Date (June 16 or Dec. 17). If you choose to stop participating, future payroll deductions will be cancelled. You have two options if you stop participating in the Current Plan:
   - Receive a refund by withdrawing the money that has already been deducted from your paycheck for that Plan. You will not receive any shares of stock at the end of the Plan. Since your ESPP payroll deductions are taken after taxes, no additional tax is withheld. You will receive a full refund for the amount that has been deducted from your pay for that Plan.
   - Stop future deductions and leave the amount already withheld from your paycheck in that Plan. At the end of the Plan, The Home Depot will issue you as many shares of stock as the money deducted from your pay will allow.

**If you stop participating in a current Plan before it ends, there is no automatic enrollment in the Next Plan.** You may change your ESPP payroll deduction by accessing the ESPP online or through the automated phone system. Prompts will lead you through each step to make your change. See Get The Most Value From Your Plan in the front of this section for more information.
If you withdraw from the Current Plan, you must actively enroll in the Next Plan if you want to participate.

After a Current Plan End Date (June 30 or Dec. 31), the total amount of your payroll deductions during the Current Plan will be used to purchase shares of stock. After a Pay Period End Date (June 16 or Dec. 17), you cannot receive a refund for your payroll deductions and you will receive Shares.

Special Circumstances
Your participation in the ESPP and purchase of stock through a Current Plan will be affected by certain special circumstances including termination of employment, leave of absence, retirement, disability, and death.

Termination of Employment
If your employment termination date is on or before the last day of the Current Plan End Date (June 30 or Dec. 31), your rights to purchase Shares under the ESPP will be cancelled. Your contributions to the Current Plan will be automatically refunded to you within 2-3 pay cycles after your termination date.

Leave of Absence
If you are on Leave of Absence during the open enrollment period for the ESPP, you may enroll in the Next Plan while you are still on leave. Your contributions to the Plan start when your pay resumes after you return from leave.

On the 91st day of a Leave of Absence, you lose your eligibility to participate in the Current Plan and your accumulated payroll deductions are automatically refunded to you approximately 2-3 pay cycles following 114 days from your leave of absence begin date. If the Current Plan has not ended when you return to work, you cannot make up missed contributions.

This loss of eligibility, which is determined by tax laws that govern the ESPP, applies unless your re-employment with the Company is guaranteed either by contract or by law (for example, under the provisions of FMLA or certain Military Leaves).

Additional Special Circumstances
Retirement, disability, and death also affect participation in the ESPP. For the purposes of the ESPP, these circumstances are defined as follows:

- **Retirement**—You are terminating employment within three months before the end of a Current Plan End Date and satisfy the requirements of the Company’s ESPP retirement provision (you are at least age 60 and have completed at least five years of continuous employment with the Company or one of its subsidiaries).

- **Disability**—You are terminating employment within three months of the end of a Current Plan and are eligible for permanent and total disability benefits under The Home Depot long term disability plan as defined in the Disability chapter.

- **Death**—You die anytime while actively employed or you die while participating in a Current Plan under the retirement or disability provisions.

If any of the special circumstances listed (retirement, death or disability) apply, and if you or the administrator of your estate do not make a timely election for a refund of your contributions, the monies in your account will be used to purchase stock at the end of the Current Plan.

Foreign Associates
The Committee may adopt rules or procedures to accommodate the requirements of local laws of foreign jurisdictions with respect to participants who are foreign nationals or who are employed by the Company or any subsidiary outside the United States of America, as the Committee may consider necessary or appropriate to accommodate differences in local law, tax policy or custom.

Stock Ownership
Your ESPP Account at Computershare
Soon after a Plan ends, a personal account will be established with Computershare, The Home Depot’s ESPP service provider. The Shares will be allocated into a book entry account established in your name.

After your Shares are allocated to your account, you will receive personal account information, including a PIN (personal identification number) from Computershare. For more information about your PIN, see Accessing Your Computershare Account.

After your Shares are deposited in your personal account, you will also receive an annual statement from Computershare. The statement will show 1) your total deduction amount, 2) the purchase price of the Shares, and 3) the actual number of Shares deposited into your account. **Keep this statement for your tax records!**

Like any service provider, there are fees associated with doing transactions through Computershare. For more information, see Computershare Fees.
Ownership of Shares

You may not transfer ownership or pledge your right to receive Shares through an ESPP Plan to anyone else. However, once the Shares are purchased for you and are deposited in your Computershare account, you may generally sell or transfer the Shares without any restriction. However, refer to Restrictions on Resale of Common Stock Acquired under the Plan for certain insider trading restrictions.

In the case of your death, certain legal documents are required before the stock can be re-registered to anyone. Contact Computershare for more information.

You may not designate a beneficiary for your ESPP account. For more information, see Special Circumstances.

Stockholder Privileges

Once you own at least one whole share of stock, you will receive notices of stockholder meetings, proxy statements, annual reports, and other literature sent to stockholders. As a stockholder, you will also benefit from any stock splits and cash dividends.

Cash Dividends & Reinvestment

The Home Depot has, in the past, paid a cash dividend each quarter (the Company reserves the right to change its dividend policy in the future). If your Shares are being held at Computershare, any dividends will be automatically used to purchase additional Shares of The Home Depot common stock. The Shares purchased will be credited to your Computershare account. If you have your stock in certificate form, the dividend will be mailed to your home address. The chart shows the fees charged by Computershare for processing your dividend reinvestment.

<table>
<thead>
<tr>
<th>Dividend Amount</th>
<th>Fee*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.01–$100</td>
<td>4%</td>
</tr>
<tr>
<td>$100.01–$500</td>
<td>the greater of 2% or $4</td>
</tr>
<tr>
<td>$500.01 +</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

* Percentage of the dividend payment

If you do not wish to have your dividends reinvested, you must write Computershare and ask to be removed from the Dividend Reinvestment Plan. You must include your Computershare account number or Global ID (Canada/Mexico), The Company Name “Home Depot,” and your current address so that Computershare can begin mailing your dividend checks.

If you hold Shares with any other brokerage account, any dividends on your Shares will be credited to your account with this broker. Contact your broker for information about reinvesting these dividends.

Account Statements

Computershare will mail you an annual statement in January. This statement will include your current transaction or activity, your previous share balance, and your current share balance. You will also receive an IRS Form 3922 for each year that you receive an allocation of Shares. It is very important that you keep these statements. You will need the information when you file your income tax return.

Importance of Diversification

A well-balanced and diversified investment portfolio is important to the long-term financial security of you and your beneficiaries. Broadly defined, diversification means having an investment portfolio mixed among different asset classes, such as stocks, bonds, and cash. The stock of a single company, such as The Home Depot, is subject to greater risk than diversified portfolios such as mutual fund investments. The value of an individual stock is subject to volatility and may decline over time. Most financial planners agree that having more than 10 to 20% of your total investment portfolio in any individual stock results in unnecessary risk-taking and wouldn’t be considered adequate diversification. You may want to take this opportunity to evaluate your total investment portfolio allocations, including the stock you acquire under the ESPP, the investments in your FutureBuilder 401(k) account and any personal investments and savings you may have.

Stock Transactions

Accessing Your Computershare Account

After you are allocated Shares from a Plan, Computershare will send you a letter containing your five-digit PIN (personal identification number). You may change the PIN to another five-digit number at any time.

You may access your ESPP account at www-us.computershare.com/employee.

If you forget your PIN, you may contact Computershare by phone at 1-800-843-2150 to obtain a new one.
Selling Your Shares
Once your Shares have been deposited into your Computershare account, you may instruct Computershare to sell any or all of the Shares in your account. Refer to Restrictions on Resale of Common Stock Acquired Under the Plan for certain insider trading restrictions.

If available, market order, Day Limit Order and Good-Til Cancelled (GTC) Limit Order Sale requests received online or via telephone will be placed promptly upon receipt during market hours (normally 9:30 a.m. to 4:00 p.m. EST). Any orders placed after 4:00 p.m. will be placed promptly on the next day the market is open.

Computershare charges a commission for selling your stock. See Computershare Fees for more information.

Receiving Your Stock Sale Proceeds
Computershare offers you two options to receive payment for Shares that you sell:

1. A check sent via first-class mail on “settlement day,” which is the third business day after the sale of stock. This is the standard method for receiving payment. You pay only the regular transaction fee. See Computershare Fees for the current rate.

2. A wire transfer to your bank account on settlement day. You must transmit the following wire transfer information to Computershare: your name, address, Computershare account number or Global ID Number, ABA/bank routing number, bank account number, corresponding bank information (if outside the U.S.), and day and evening telephone numbers.

If you sell your stock and don’t choose a delivery option, a check for your proceeds will be mailed to you (option 1).

Certificate Withdrawals and Share Transfers
Computershare cannot withdraw or transfer your Shares until they have first been deposited to your account. You may obtain withdrawal/transfer forms by calling Computershare at 1-800-843-2150 or through the web at www-us.computershare.com.

After Computershare receives your Shares from The Home Depot, you may have them withdrawn from your account and a certificate issued in your name or the name of someone you designate. Or, you may instruct Computershare to electronically transfer Shares to an investment account that you designate. If you request that a certificate be transferred to a minor (a person under 18 years of age), the certificate must be registered in the minor’s name and must include the name of an adult as custodian. You should discuss the impact of a gift or transfer on your personal situation with your tax/financial advisor.

If you request a certificate, it will arrive approximately three weeks after Computershare receives your request. If another person is taking ownership of the Shares, the certificate will be mailed to that person, unless you request otherwise.

There is a transaction fee for each certificate issued and for electronic share transfers. See Computershare Fees for more information.

Computershare Fees
The following fees are subject to change at any time without notice. To confirm the current fees, visit the Computershare website at www-us.computershare.com.

Selling The Home Depot Stock
- $0.03 per Share
- $25 minimum charge per transaction
- $5.35 confirmation charge per transaction
- Other fees may apply

Payment of Proceeds by Wire Transfer
Your proceeds can be wired directly to your checking account on the third business day following the sale of your stock, provided that Computershare has received the wire instructions to your bank.

- Wire transfer fee ($15 U.S.). Your bank may also charge you a fee to receive the wire into your account.
- Certificate Issuance and Electronic Transfer Fees ($15 U.S.). The fee is waived for transfers to a Merrill Lynch account.

Buying The Home Depot Stock
To purchase stock through Computershare on the open market, you may join Depot Direct by accessing and completing an enrollment form online at http://www.computershare.com/Investor. Separate fees will apply.
Computershare Contacts
You will need your Computershare account number and PIN to access your Computershare portfolio online or through the automated phone system.

Phone
Call 1-800-843-2150. Automated system available 24/7.

Representatives available as follows:
8 a.m.–7 p.m., Eastern Time
7 a.m.–6 p.m., Central Time
6 a.m.–5 p.m., Mountain Time
5 a.m.–4 p.m., Pacific Time

Mail
Computershare Inc.
Attn: ESPP/SOP
250 Royall Street
Canton, MA 02021

Online
www-us.computershare.com/employee

Taxes and the ESPP
The information in this section provides only a brief explanation of some of the tax consequences associated with purchasing and selling Shares of stock through the Employee Stock Purchase Plan. Be sure to consult your tax advisor for a full explanation.

Tax Benefits
When you purchase The Home Depot stock through the ESPP, you are not taxed on the 15% discount you receive off the market price. The difference is called the “spread.” You are taxed, however, when you sell your Shares.

Tax Consequences
When you sell your ESPP Shares, you are responsible for paying federal and any applicable state and local income taxes on your net gain from the sale of your Shares. The purchase price, the date your Shares are purchased, and the date you sell the Shares all figure into the amount of tax you owe.

If you sell Shares, you will receive a transaction history and 1099-B form in January of the following year. Depending on the country where you live, you will be required to complete a W-9 (US) form or a W-8 (NonUS) BEN form.

Holding Period
Each Plan has a Holding Period. The Holding Period extends for two years after the first day of the Plan (the Offering Date).

Qualified Disposition
If you sell your Shares after the Holding Period expires, your Shares are considered to be “qualified.” When you sell the qualified Shares, the sale is considered a “Qualified Disposition.” If you hold the Shares after the expiration of the Holding Period or you die while holding the Shares, you will generally recognize ordinary income upon sale or other disposition of the Shares equal to (a) the difference between the purchase price of the Shares (amount you paid) and the fair market value (closing price of the Shares on the New York Stock Exchange) of the Shares on the date you sold or otherwise disposed of them; or if less (b) 15% of the fair market value of the Shares on the offering date (closing price of the Shares on the first day of the Plan). Any additional gain will generally be taxed as long-term capital gain.

Long-term capital gains tax rates are generally (but not always) lower than your personal income tax rate. Consult your tax advisor for information on your personal situation.

Disqualified Disposition
If you sell before the end of the Holding Period, The Home Depot will report the difference between the stock closing price when the Plan ends less your purchase price for those Shares as taxable wages on your Form W-2. You may have additional gain (for example, if the stock price has gone up since you purchased it). This gain is not included in your W-2 wages, but you must report the gain as a capital gain on your tax return. Consult your tax advisor for information on your personal situation.

Dividends
Any dividends you receive on your ESPP Shares are taxable to you in the year during which they are paid.

Reporting Capital Gains on the Sale of ESPP Shares
The gross proceeds on the sale of your Shares are reported to you by Computershare on a Form 1099-B. When you complete your tax return, you should deduct the cost of your stock and any gain reported on your W-2 from the gross proceeds and calculate taxes on the new profit of your sale.
Backup Withholding (W-9) Certification

The IRS requires Computershare to certify your name and Social Security number. The W-9 certifies, under penalty of perjury, that you gave Computershare your correct name and Social Security number and that you do not owe the IRS any taxes from prior years.

If Computershare does not have your W-9 certification on file, they will withhold 30% from the proceeds when you sell your stock. They will also withhold 30% from the dividends paid by The Home Depot on your Shares of stock. You may certify the required information electronically through Computershare’s automated phone system, online, or by submitting a completed W-9 form, which you may obtain by speaking with a Computershare representative. After you complete the form, you may fax or mail it to Computershare according to instructions provided by the representative.

If Computershare is where you will hold your Shares, you need to provide W-9 certification only once for your ESPP account. If Computershare receives your W-9 certification late, you must file for a refund on “Form 1040” when you file your tax return with the IRS the following year.

ESPP Supplemental Information

Available Shares

A total of 24,124,668 Shares are authorized under the ESPP as of July 31, 2014 and are available for future issuance. The number of authorized Shares for issuance under the ESPP is subject to increase or decrease as the result of changes in The Home Depot stock such as stock splits, stock dividends, and similar events. Shares acquired under the ESPP are purchased from The Home Depot and may be newly issued Shares, treasury Shares, or Shares that have been reacquired by The Home Depot.

Amendment and Termination

The Board of Directors may, at any time, amend the ESPP in any respect. The Home Depot’s stockholders must approve any amendment that would increase the number of Shares that may be issued under the ESPP (other than an increase merely reflecting a change in The Home Depot’s capitalization) or a change in the designation of any corporations (other than a subsidiary of The Home Depot) whose employees may participate in the ESPP.

The Plan and all rights of participants under the ESPP will terminate when all available Shares have been purchased under the ESPP, or upon any earlier date determined by the Board of Directors. If necessary, the number of Shares that may be purchased in a Plan will be prorated based on contributions.

Rights Not Transferable

The rights of ESPP participants may not be assigned or transferred and are not subject to lien.

Restrictions on Resale of Common Stock Acquired under the Plan and Prohibition on Hedging

Federal law prohibits trading in securities on the basis of material non-public information and provides for substantial civil and criminal penalties for violations of these prohibitions. These prohibitions and penalties apply to the Company generally and to associates who participate in the ESPP. Moreover, the Company’s Securities Laws Policy may impose additional limits on transactions in the Company’s common stock. You should refer to the Securities Laws Policy, which is available on the Company’s intranet or in hard copy by request from the Company’s Legal Department.

The federal securities laws also limit the circumstances under which persons who are “Affiliates” can sell securities. “Affiliates” generally include the Company’s executive officers, directors and stockholders who own more than 5% of the Company’s common stock. You may contact the Company’s Legal Department if you are uncertain as to whether or not the Company considers you to be an Affiliate. Non-Affiliate associates who purchase Shares of common stock under the ESPP may generally resell the Shares through a stockbroker in the customary manner or to third persons without the use of a stockbroker. Associates who are Affiliates may resell their Shares of common stock in accordance with the requirements of Rule 144 under the Securities Act stock-broker. In addition, Affiliates and other associates who are “Designated Associates” under the Securities Laws Policy may only sell their Shares of common stock during open window periods under the Policy. You should contact the Company’s Legal Department if you are uncertain as to whether or not the Company considers you to be a Designated Associate.

Certain officers are also subject to potential short-swing profit liability under Section 16(b) of the Securities Exchange Act of 1934 (the “Exchange Act”) with respect to purchases and sales (or sales and purchases) of Shares of the Company’s common stock within a six-month period. For example, if an
officer subject to Section 16 sells Shares in the open market, he or she must ensure that at least six months passes before making any direct or indirect purchases of Company securities, because the sales could be “matched” with the purchases, and the officer might be required to disgorge certain gains from the matched transactions. In addition, persons covered by Section 16 must report purchases and sales of ESPP Shares within two business days after they occur. Directors and officers subject to Section 16 must pre-clear any transactions in the Company’s securities with the Company’s General Counsel.

The Company’s Securities Law Policy prohibits also all associates and directors from entering into hedging or monetization transactions that are designed to limit the financial risk of ownership of the ESPP Shares. These include prepaid variable forward contracts, equity swaps, collars, exchange funds and other similar transactions, as well as speculative transactions in derivatives of the Shares, such as puts, calls, options or other derivatives.

**Applicable Laws**

The ESPP is not subject to the requirements of the Employee Retirement Security Act of 1974 (“ERISA”) nor is it intended to be a qualified plan under Section 401(a) of the Internal Revenue Code of 1986.

**Incorporation of Documents by Reference**

The following documents are incorporated by reference into this summary of the ESPP:

1. The Company’s latest annual report on Form 10-K;
2. All other reports filed pursuant to Section 13(a) or 15(d) of the Exchange Act since the end of the Company fiscal year covered by the Company’s latest annual report on Form 10-K (other than information deemed to be furnished and not filed under SEC rules); and

All documents filed by the Company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Exchange Act (other than, in each case, documents or information deemed furnished and not filed under SEC rules) after the date of this summary and prior to the filing of a post-effective amendment which indicates that all securities offered hereby have been sold or which deregisters all securities then remaining unsold, will be deemed to be incorporated by reference in the summary and be a part hereof from the date of filing of such documents.

The Company will provide without charge, upon written or oral request, the above documents which are incorporated by reference. Written or telephone requests should be directed to:

*Investor Relations Department*
*The Home Depot, Inc.*
*2455 Paces Ferry Road, N.W.*
*Atlanta, Georgia 30339-4024*
*770-433-8211*

**Available Information**

The Company is subject to the information requirements of the Exchange Act and consequently files reports, proxy statements and other information with the SEC. Participants can inspect or copy reports, proxy statements and other such information filed by the Company at the public reference facility maintained by the SEC at:

*SEC*
*100 F Street, N.E.*
*Washington, D.C. 20549*
Copies of such materials (at prescribed rates) may be obtained from this facility. These materials are also available to the public from the SEC’s website at www.sec.gov. The Company’s common stock is listed on the NYSE, and certain of its reports, proxy statements and other information may be inspected at the offices of the NYSE:

NYSE
20 Broad Street
New York, New York 10005

The Company may provide additional updating information with respect to the common stock in the future to participants by means of appendices to this prospectus or delivery of other documents.

The Company has filed with the SEC a Registration Statement on Form S-8 (including all amendments thereto, the “Registration Statement”) with respect to the securities offered under the plans. This prospectus does not contain all of the information set forth in the Registration Statement and its exhibits and schedules. For further information about the Company and the securities offered through the plans, participants should consult the Registration Statement and its exhibits, which may be examined at the SEC’s public reference facility or through the SEC’s website.

Participants may obtain information about their ESPP account and Shares by contacting:

Stock Plan Administration Department
The Home Depot, Inc.
2455 Paces Ferry Road
Atlanta, Georgia 30339
1-800-654-0688, Ext. 13777

Participants receive reports showing the status of account annually. Participants should direct any questions regarding the Plan (other than requests for incorporated documents) to the Stock Plan Administration Department.

Company Financial Statements
ESPP participants and associates eligible to participate in the ESPP may obtain a copy of the Company's latest Form 10-K in any of the following ways:

- access through “Investor Relations” portals of the Company’s website at http://ir.homedepot.com;
- request a copy from your Human Resource Manager;
- Write to request a copy from:
  The Home Depot, Inc.
  Investor Relations Department
  2455 Paces Ferry Road, N.W.
  Atlanta, Georgia 30339-4024
  call to request a copy from the Investor Relations Department at 1-770-384-4388
- request a copy online through the Company’s website at www.homedepot.com (choose Investor Relations)

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of the securities or passed upon the adequacy or accuracy of this prospectus. Any representation to the contrary is a criminal offense.

The Company has not authorized anyone to give any information or make any representation about the Company or the ESPP that is different from, or in addition to, that contained in this prospectus, the related registration statement or in any of the materials incorporated by reference. Therefore, if given information of this type, you should not rely on it. If you are in a jurisdiction where offers to sell, or solicitations of offers to purchase, the securities offered by this document are unlawful, or if you are a person to whom it is unlawful to direct these types of activities, then the offer presented in this document does not extend to you. The information contained in this document speaks only as of the date of this document unless the information specifically indicates that another date applies.

This is an unpublished work containing confidential and proprietary information of The Home Depot. © 2006 Home TLC, Inc. All rights reserved. The Home Depot stock is traded on the New York Stock Exchange (NYSE). Past performance does not guarantee future performance.
## WORK/LIFE BENEFITS

**U.S. Part-Time Hourly Associates**

### CHAPTER CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>Your Home Depot Work/Life Benefits</td>
</tr>
<tr>
<td>122</td>
<td>Care Solutions for Life</td>
</tr>
<tr>
<td>123</td>
<td>Contacting Care Solutions for Life</td>
</tr>
<tr>
<td>123</td>
<td>Health Advocate</td>
</tr>
</tbody>
</table>
Your Home Depot Work/Life Benefits

The Company offers many programs to enhance the quality of your life at work and at home. The following benefits may be available to you. Please refer to the information about each benefit at www.livetheorangelife.com for additional details, including eligibility and rules for each program. If you do not have access to a computer, you can contact the Benefits Choice Center at 1-800-555-4954 for additional information.

- Adoption Assistance Program
- Associate Discount Program
- Associate Home Purchase Program
- Auto and Home/Renters Insurance
- Back-Up Dependent Care Advantage Program®
- Building Better Health Program
- CARE Direct
- Care Solutions for Life Employee Assistance Program
- College Coach®
- Commuter Benefits
- Health Advocate
- Home Depot Health Challenge
- Home Protection Program
- Homer Fund
- Identity Theft Protection
- Matching Gift Program
- Merrill Lynch Financial Life Management
- MetLaw Legal Services Program
- My Health Chat
- On-site Flu Shots
- Purchasing Power Program
- Quit for Life Tobacco Cessation Program
- Roadside Assistance Program
- Team Depot
- The MetLife Center for Special Needs Planning℠
- Tuition Reimbursement Program
- Veterinary Pet Insurance

Each of these programs is delivered under a written document or SOP. In the event of a conflict between this chapter and the program document or SOP, the program document or SOP will govern.

On the following pages, you will find more information about Care Solutions for Life, our free Employee Assistance Program, and Health Advocate.

Care Solutions for Life

Care Solutions for Life is The Home Depot’s free EAP (Employee Assistance Program) and Work/Life resource designed to help associates successfully manage challenges in their personal and work lives. The program is available to all Company associates, spouses, household members and domestic partners, same or opposite sex.

Experienced professionals are available 24 hours a day, seven days a week to provide assistance for a wide range of issues that may impact the quality of your life. Care Solutions for Life will listen to your concerns, answer questions and provide referrals to programs or agencies that offer the best assistance for your particular situation.

Information you share with the EAP is confidential. (Exceptions to confidentiality are required by law when there is danger to the associate or another individual). Each year all associates may receive up to three face-to-face counseling sessions per concern with a local provider free of charge. You can choose to see a counselor in person, with tele-video or over the phone. You can easily access tele-video by calling the dedicated EAP line.

Care Solutions for Life also may refer associates to community organizations for additional services. You are responsible for any fees these agencies may charge. Counseling can help resolve relationship/family conflicts, and address problems with stress, anxiety or depression.

Care Solutions for Life is a valuable resource when you have concerns related to any of the following:

- **Alcohol/Depression**—my-Strength online and mobile emotional wellness tools help mild or moderate depression and anxiety through: personalized eLearning programs, simple tools, trusted resources and daily motivation.

- **Return to Work Job Coaching**—Care Solutions for Life assists in reducing the duration of short- and long-term disability by assisting in the increase of personal functioning and recovery.

- **Elder-Care**—To help you better manage family responsibilities, you can immediately receive cus-
tomized dependent care consultation and referral services. All work-life referrals are to child/elder-care providers that are regulated. Depending upon the state, regulation may be through licensing or certification.

• Financial Counseling and Legal Services—If you could benefit from financial or legal services, you can receive advice from a financial advisor or attorney in 30-minute telephonic or face-to-face attorney and financial consultations. There is a 25% discount with an attorney or mediator beyond the initial 30 minutes, and the consultations can vary in nature allowing up to three sessions per issue per year.

• Adoption—Information on adoption to help you understand the process; referrals to agencies and attorneys.

• Child Care—Referrals to child care including family-operated centers and in-home services and after-school care centers.

• Parenting Resources—Resources and referrals to help you be the best parent you can be.

• Summer Care—Details on available day care, day camps and sleep-away camps to meet your child’s needs.

• School Programs—Information for students of all ages on tutoring, public and private schools, and schools for children with special needs.

• Colleges and Universities—Information on certificate and degree programs, grants, scholarships and financial aid.

Care Solutions for Life also offers:

• Active Adult Work-life Kit—Health and safety are primary concerns in your adult years. This kit is perfect for yourself or someone in your household who is tackling new challenges.

• Elder Caregiving Work-life Kit—If you’re caring (or expecting to provide care) for an elderly relative or friend, you’ll appreciate the educational materials in this kit including data sheets on home safety, managing medications and nutrition for elders.

• Pregnancy/New Baby Work-life Kit—Expecting? This kit includes practical and personal care items for parents-to-be, as well as educational materials about furnishings and equipment for babies, tax considerations for family “additions,” family medical leave and more. Now that you’re a parent, you’ve got lots of new responsibilities. This kit includes educational materials and a variety of items to help you as you care for your new baby.

• Child Safety Work-life Kit—As children grow, they find unique ways of getting into trouble! This kit contains information on managing safety issues for toddlers and young children.

• Personal Concierge Services—Convenience services help with a variety of concerns and save time because Care Solutions for Life does the research for you. Get information about entertainment, shopping, personal services, travel, recreation, household services, pet services and more.

Coverage under Care Solutions for Life extends automatically for 36 months under COBRA following any COBRA qualifying event at no cost to you or your eligible family members. See the COBRA chapter for more information about qualifying events and your notice obligations.

Contacting Care Solutions for Life

For Internet access log on to www.CareSolutionsforLife.com and access educational information and referrals.

To speak with a Care Solutions for Life counselor anytime 24/7, call 1-800-553-3504. Asistencia telefónica y sitio web disponibles en español.

The Care Solutions for Life mobile app is just another way for you to access the tools and services you need — on your schedule. This mobile app is available for free on all smart phones.

Health Advocate

The Company provides all associates with a free service, Health Advocate, to help you deal with benefit claims and billing issues, find an appropriate doctor, schedule specialized treatments as well as other types of assistance. Health Advocate will help you navigate the complexities of the healthcare system.

When you call Health Advocate, you’ll speak with a Personal Health Advocate (PHA). Your PHA typically is a registered nurse who is supported by medical directors and claims and benefits specialists.
He or she will work with you one-on-one to help find solutions to your healthcare or health insurance related issues.

Whatever your healthcare need, your PHA will do the legwork and work with you through the entire process. Health Advocate covers your entire family—you, your spouse, dependent children, your parents and your parents-in-law. Health Advocate can serve you by:

- Assisting with benefit claims and billing issues
- Helping you with eldercare issues
- Locating and researching current treatments for a medical condition
- Identifying “best-in-class” medical institutions for serious illnesses or injuries
- Complementing your basic health insurance coverage by helping your interactions with healthcare providers and claims administrators
- Helping you understand your benefit plan provisions and features
- Providing independent, confidential assistance and information. Health Advocate is not affiliated with any of the Plans’ claims administrators or any specific provider.

You can call Health Advocate toll-free at 1-800-519-6689 Monday through Friday between 8:00 a.m. and 9:00 p.m. Eastern Time.
For information on time-off benefits see the Time-Off Benefits – US SOP.
To find this SOP, go to myapron.homedepot.com or call the HR Service Center at 1-866-698-4347.
For information on leaves of absence, see the Leaves of Absence SOP.

To get a copy of this SOP, call the HR Service Center at 1-866-698-4347.
COBRA Continuation Coverage Quick Facts and Quick Links

U.S. Part-Time Hourly Associates

Your COBRA Continuation Coverage Option

<table>
<thead>
<tr>
<th>IF YOU ARE COVERED UNDER THESE PLANS:*</th>
<th>YOU, YOUR SPOUSE AND/OR YOUR CHILDREN MAY BE ABLE TO CONTINUE COVERAGE UNDER COBRA IF YOU EXPERIENCE ONE OF THESE QUALIFYING EVENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dental</td>
<td>• You terminate employment</td>
</tr>
<tr>
<td>• Vision</td>
<td>• Your child loses eligibility</td>
</tr>
<tr>
<td>• Medical Payment Plan</td>
<td>• You divorce or become legally separated from your spouse</td>
</tr>
<tr>
<td>• Critical Illness Protection Plan</td>
<td>• You go on a personal or military leave</td>
</tr>
<tr>
<td></td>
<td>• You die</td>
</tr>
<tr>
<td></td>
<td>• click for a complete list of COBRA qualifying events</td>
</tr>
</tbody>
</table>

Quick Links to Frequently Used COBRA Info

- Do I qualify for COBRA continuation coverage?
- Does my spouse and/or children qualify for COBRA continuation coverage?
- How do I apply for COBRA coverage?
- How much does COBRA coverage cost and how do I pay for it?
- How long does COBRA coverage last?
CHAPTER CONTENTS

129  Continuation Coverage Rights Under COBRA
129  You May Have Other Options Available to You When You Lose Group Health Coverage
129  What is COBRA Continuation Coverage?
130  Who is Entitled to Elect COBRA Continuation Coverage?
130  Notifying the Company About a COBRA Qualifying Event
130  You Must Give Notice of Some Qualifying Events
130  If You Are on a Leave of Absence
130  USERRA Continuation Coverage
130  How is COBRA Continuation Coverage Provided and How is it Elected?
131  When Does COBRA Continuation Coverage Begin?
131  How Long Does COBRA Coverage Last?
131  Disability extension of 18-month period of COBRA continuation coverage
132  Second qualifying event extension of 18-month period of COBRA continuation coverage
132  Status Changes and COBRA
132  New Spouse
132  Newborn and Adopted Children
132  Are There Other Coverage Options Besides COBRA Continuation Coverage?
132  Cost and Paying for COBRA Coverage
133  When COBRA Continuation Coverage Ends
133  If You Have Questions
134  Keep Your Plan Informed of Address Changes
134  For More Information
135  COBRA Qualifying Events (which result in loss of Plan coverage)
Continuation Coverage Rights Under COBRA

Associates and qualified beneficiaries participating in The Home Depot Vision and Dental Plans, Care Solutions for Life and the on-site medical clinic (collectively, the “Plans”) have the right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plans under certain circumstances when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, your spouse and your dependent children when group health coverage under the Plans would otherwise end. This chapter explains COBRA continuation coverage, when it may become available to you, your spouse, and your dependent children and what you need to do to protect your right to receive it.

COBRA (and the description of COBRA continuation coverage contained in this chapter) applies only to the group health plan benefits offered under the Plans. The Plans provide no greater COBRA rights than what COBRA requires. Nothing in this Benefits Summary or this chapter is intended to expand the rights beyond COBRA’s requirements.

You may continue your Medical Payment and Critical Illness Protection Plan coverage, whether or not they are subject to COBRA. COBRA coverage will continue under the same terms that apply to medical coverage.

You May Have Other Options Available to You When You Lose Group Health Coverage

When you become eligible for COBRA, you also may become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. For more information, see the section entitled Are There Other Coverage Options Besides COBRA Continuation Coverage? later in this chapter.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this chapter. Also, please also refer to the chart at the end of chapter entitled COBRA Qualifying Events (which result in loss of Plan coverage). After a qualifying event occurs and any required notice of that event is properly provided to the Benefits Choice Center, COBRA continuation coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plans is lost because of the qualifying event. Certain newborns, newly adopted children and alternate recipients under a QMSCO may also be qualified beneficiaries. This is discussed in more detail later in this chapter under the section entitled Newborn and Adopted Children. Under the Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
Who is Entitled to Elect COBRA Continuation Coverage?

If you are an associate, you will become a qualified beneficiary and be entitled to COBRA if you lose your group health coverage under the Plans because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an associate, you will become a qualified beneficiary and be entitled to elect COBRA if you lose your group health coverage under the Plans because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If you are the dependent child of the associate, you will become a qualified beneficiary and be entitled to elect COBRA if you lose group health coverage under the Plans because of the following qualifying events:

- Your parent-associate dies;
- Your parent-associate’s hours of employment are reduced;
- Your parent-associate’s employment ends for any reason other than his or her gross misconduct;
- Your parent-associate becomes entitled to Medicare benefits (Part A, Part B, or both); or
- Your parents become divorced or legally separated;
- You stop being eligible for coverage under the Plans as a “dependent child.” See the Eligibility and Enrollment chapter on details regarding who is a dependent child.

Notifying the Company About a COBRA Qualifying Event

The Plans will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Choice Center has been notified that a qualifying event has occurred. The Home Depot will notify the Benefits Choice Center of the following qualifying events:

- The associate’s end of employment or reduction of hours of employment;
- Death of the associate; or
- The associate becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the associate and spouse or a dependent child losing eligibility for coverage as a dependent child), you or a family member must notify the Benefits Choice Center (including providing all required documentation) within 60 days after the qualifying event occurs. You may contact the Benefits Choice Center at 1-800-555-4954. The representative will ask you to mail any required documentation to the address of the Benefits Choice Center listing in the Get the Most Value From Your Plan chart at the beginning of this chapter. If notice is not provided to the Benefit Choice Center during the 60-day notice period, all qualified beneficiaries will lose their right to elect COBRA coverage under the Plans.

If You Are on a Leave of Absence

If you are on medical or family leave of absence, your COBRA coverage begins at the end of your FMLA period.

USERRA Continuation Coverage

Associates participating in the Plans have the right to choose continuation coverage as provided under the Uniformed Services Employment and Reemployment Rights Act (USERRA) while on a military leave of absence.

An election of COBRA coverage will be deemed to be an election of USERRA coverage and both coverages will run concurrently. The cost of USERRA coverage will be the same as the cost of COBRA coverage, and USERRA coverage continues for 24 months from the date your active coverage ends.

How is COBRA Continuation Coverage Provided and How is it Elected?

Once the Benefits Choice Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation cover-
age. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The Benefits Choice Center will send the qualified beneficiaries written notification of the right to choose COBRA continuation coverage. This information will be provided in a personalized Enrollment Worksheet with instructions on how to enroll.

Each qualified beneficiary must enroll no later than 60 days after the date on the notification letter; otherwise, all qualified beneficiaries will lose their right to elect COBRA coverage.

Continuation coverage is not available to non-resident aliens who do not receive any U.S. income or to relatives of non-resident aliens with no U.S. income.

When Does COBRA Continuation Coverage Begin?

Provided you have complied with all the requirements outlined in this chapter, COBRA continuation coverage begins:

- For termination of the associate’s employment, on the date following the last day of his or her final pay period; or
- At the end of the first 12 weeks of any medical or family leave under FMLA; or
- For all other qualifying events, from the date of the qualifying event.

How Long Does COBRA Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to termination of employment or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive up to a maximum of 36 months of coverage. Coverage is continued for Care Solutions for Life and the on-site medical clinic for up to 36 months from the date of the qualifying event at no additional cost.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If a qualified beneficiary (including newborn and newly adopted children) is determined by the Social Security Administration to be disabled and the Benefits Choice Center is notified in a timely fashion, all of the qualified beneficiaries in your family may be entitled to get up to an additional 11 months of COBRA continuation coverage at a higher premium, for a maximum of 29 months if:

- The original qualifying event was due to the covered associate’s termination of employment or reduction of hours;
- The qualified beneficiary or anyone in the family covered under the Plans (including newborn and newly adopted children) is determined to be disabled by the Social Security Administration prior to the qualifying event or during the first 60 days of COBRA continuation coverage;
- The notice of the Social Security Administration’s disability determination is provided to the Benefits Choice Center before the end of the disabled individual’s 18 months of COBRA continuation coverage;
- The disability must last at least until the end of the 18-month period of COBRA continuation coverage; and
- The Benefits Choice Center is provided the notice of the Social Security Administration’s disability determination within 60 days of the later of:
  - The date the letter from the Social Security Administration was issued (the issue date of the Social Security Notice of Award Letter);
  - The date of the qualifying event (the associate’s termination of employment or reduction of hours); or
  - The date on which the qualified beneficiary loses (or would lose) coverage under the Plans as a result of the qualifying event.

To notify the Benefits Choice Center of the disability determination, call 1-800-555-4954. If notice is not provided to the Benefits Choice Center during the 60-day notice period, no extension will be granted.

To submit the documentation establishing disability, mail or fax to:

Benefits Choice Center
4 Overlook Point
P.O. Box 1493
Lincolnshire, IL 60069-1493
Fax: 1-847-883-8269
The Benefits Choice Center must also be notified within 30 days of the date the Social Security Administration makes a final determination that the disabled individual is no longer disabled.

Second qualifying event extension of 18-month period of COBRA continuation coverage

If your family experiences another qualifying event (referred to as a “second qualifying event”) during the initial 18 months of COBRA continuation coverage, the spouse and dependent children in your family who are qualified beneficiaries and who previously elected COBRA coverage may get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plans are properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the associate or former associate dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plans as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plans had the first qualifying event not occurred. This extension is not available under the Plans when a covered associate becomes entitled to Medicare after his or her termination of employment or reduction of hours.

The Benefits Choice Center must be notified within 60 days after the second qualifying event occurs in order to receive this extension of coverage. To notify the Benefits Choice Center of the additional qualifying event, call 1-800-555-4954. If notice is not provided to the Benefits Choice Center during the 60-day notice period, no extension will be granted.

Status Changes and COBRA

If, during the 18 months (or 29 months, if applicable) of COBRA coverage or the 24 months of USERRA coverage, you experience a qualified status change, you may make any of the changes available to similarly situated active associates. See the Life Events chapter for more information. You must notify the Benefits Choice Center no later than 30 days after the date of the change in status in most cases. Adding family members to COBRA coverage may result in a higher premium.

New Spouse

To enroll your new spouse for coverage during your period of COBRA coverage, you must call the Benefits Choice Center or go to www.livetheorangeflife.com no later than 30 days after the date you are married. Your new spouse will receive coverage, but only as a non-qualified beneficiary. This means he or she does not have independent COBRA rights and may only keep the same coverage as you.

Newborn and Adopted Children

To enroll a newborn or newly adopted child (or child placed for adoption) for coverage during your period of COBRA coverage, you must call the Benefits Choice Center or go to www.livetheorangeflife.com no later than 30 days after the child’s birth, date of adoption or placement for adoption.

If a second qualifying event occurs which would cause the child to lose coverage under the health plan (i.e., divorce, legal separation or death of the parent), the child, as a qualified beneficiary, will have COBRA rights to continue coverage. Your spouse added after your COBRA coverage starts, however, is a non-qualified beneficiary and will not have COBRA rights.

While covered under COBRA, you are also entitled to make other changes consistent with a qualified status change and to make changes during Annual Enrollment periods.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov and mymarketplacesupport.com.

Cost and Paying for COBRA Coverage

Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the Plans (including both employer and associate contributions) for coverage of a similarly situated Plan par-
When COBRA Continuation Coverage Ends

Coverage under COBRA will end on the earliest of the following:

- A qualified beneficiary reaches the end of the 18-month, 29-month, or 36-month maximum coverage period, whichever is applicable
- A qualified beneficiary does not make required COBRA premium payments in full within 30 days of the due date (with the exception of the initial premium which is due within 45 days of the election date)
- A qualified beneficiary becomes covered under another employer’s group health plan after electing COBRA (other than the federal government’s health plan while you are on a Military Leave).
- A qualified beneficiary becomes entitled to Medicare after electing COBRA
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries not just the disabled qualified beneficiary, will end).
- The Company terminates all group health coverage
- COBRA coverage may also be terminated for any reason the Plans would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud)
- When coverage ends for a qualified beneficiary, coverage also ends for non-qualified beneficiaries covered by the qualified beneficiary whose coverage has ended

If your coverage ends before the scheduled coverage period (18, 29, or 36 months), you will receive a written notice indicating:

- The reason the coverage terminated early (such as a failure to pay premiums).
- The date of the termination, and
- Any rights you and other qualified beneficiaries have under the plan and under law to elect other group or individual coverage

If You Have Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov and mymarketplacesupport.com.
Keep Your Plan Informed of Address Changes

To protect your and your family's rights, let the Benefits Choice Center and Plan Administrator know about any changes in the addresses of you or your family members. You should also keep a copy, for your records, of any notices you send to the Benefits Choice Center and Plan Administrator.

For More Information

If you need more information, go to www.livetheorangelife.com or call the Benefits Choice Center toll-free at 1-800-555-4954. Benefits Choice Representatives are available between 9 a.m. and 7 p.m., eastern time, Monday through Friday. The website is available 24 hours a day, Monday through Saturday, and after 1 p.m., eastern time, on Sunday.

The Benefits Choice Center provides COBRA administration services on behalf of the Plan. Please address any written correspondence to:

Benefits Choice Center
4 Overlook Point
P.O. Box 1493
Lincolnshire, IL 60069-1493
### COBRA Qualifying Events (which result in loss of Plan coverage)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of your employment (except for gross misconduct)</td>
<td>You and your covered eligible dependents</td>
<td>18 months from the last day of your final pay period</td>
<td>102%</td>
</tr>
<tr>
<td>Change in your employment status (resulting in a reduction in hours of employment)</td>
<td>You and your covered eligible dependents</td>
<td>18 months from date of qualifying event</td>
<td>102%</td>
</tr>
<tr>
<td>You or a family member covered under COBRA become permanently disabled within required timeframe (60 days of starting COBRA coverage)</td>
<td>You and your covered eligible dependents</td>
<td>29 months from date of original qualifying event within required timeframe (60 days of starting COBRA coverage)</td>
<td>102% (first 18 months), 150% (last 11 months)</td>
</tr>
<tr>
<td>Your Personal Leave</td>
<td>You and your covered eligible dependents</td>
<td>18 months from the 31st day after the date leave began</td>
<td>102%</td>
</tr>
<tr>
<td>Military Leave</td>
<td>You and your covered eligible dependents</td>
<td>24 months from date of qualifying event (18 months under COBRA; six additional months under USERRA)</td>
<td>0% – Associates on Military Leave do not pay for COBRA coverage</td>
</tr>
<tr>
<td>Your death</td>
<td>Your covered eligible dependents</td>
<td>36 months from date of qualifying event</td>
<td>102%</td>
</tr>
<tr>
<td>You divorce or become legally separated from your spouse</td>
<td>Your covered eligible spouse</td>
<td>36 months from date of qualifying event</td>
<td>102%</td>
</tr>
<tr>
<td>End of FMLA period while on Family Leave</td>
<td>You and your covered eligible dependents</td>
<td>18 months from the date of qualifying event</td>
<td>• Active associate rates for the first 24 weeks of Family Leave, 102% after 24th week of Family Leave</td>
</tr>
<tr>
<td>End of FMLA period while on Medical Leave</td>
<td>You and your covered eligible dependents</td>
<td>18 months from the date of qualifying event</td>
<td>• Active associate rates for the first 52 weeks of Medical Leave, 102% after 52nd week of Medical Leave</td>
</tr>
<tr>
<td>Your child is no longer eligible</td>
<td>Your eligible child(ren)</td>
<td>36 months from date of qualifying event</td>
<td>102%</td>
</tr>
<tr>
<td>You enroll in Medicare then later experience termination of employment or reduction of benefits</td>
<td>Your covered eligible dependents</td>
<td>The later of: • 36 months from the entitlement to Medicare, or • 18 months from termination of employment or reduction in hours</td>
<td>102%</td>
</tr>
</tbody>
</table>

1 Eligible dependents include your spouse or child(ren) already covered by the Plan on the day before the qualifying event. Eligible dependents also include a child born to or placed for adoption with you during a period of COBRA coverage. See Who Is Eligible in the Eligibility and Enrollment chapter.

2 If the associate on Military Leave drops coverage, his or her eligible dependents can only continue COBRA for up to 18 months. Eligible dependents can continue for 24 months only if the associate on Military Leave continues for 24 months. If Military Leave ends, associate and/or eligible dependents can continue COBRA for up to 18 months only.

3 Your cost is based on the current total monthly premium times the percentage shown above.
Claiming Benefits
You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under the plans. All forms required to take any action under the plans are available from the claims administrator or plan administrator, as applicable. Please refer to the appropriate section of each benefit chapter of this Benefits Summary for additional information on claiming benefits.

To be eligible for benefits, you must be covered under the applicable plan, properly submit a claim, and follow the plan's claims and appeals procedures. If a claim is denied initially, you must exhaust the appeals procedure before filing a suit and must file suit within the prescribed time limits.

The claim administrator making claim decisions (which for FutureBuilder is the Plan Administrator) has the right and sole discretionary authority to interpret the provisions of the plan under which the claim is made as necessary to determine benefits payable and to make any and all determinations regarding final eligibility for benefits both legal and factual. Its decisions will be conclusive and legally binding on all parties.

Filing Claims for Group Health Plan Benefits
For all group health benefits, questions about claims and appeals of denied claims should be directed to the claims administrator. For phone numbers and addresses, see the Plan Administration chapter. This applies to the following group health benefits:

Self-Insured Plan
- MetLife Dental Plan

Fully-Insured Plans
- Critical Illness Protection Plan (Allstate Benefits)
- EyeMed Vision Plan
- Medical Payment Plan
- Care Solutions for Life EAP
- Life Insurance and Short-term Disability (Aetna Voluntary)

Filing Claims for Plans Other Than Group Health Plans
For information on the process and requirements for filing a claim, see the FutureBuilder chapter for FutureBuilder claims, the Disability chapter for disability claims and the Life Insurance chapter for life insurance claims.

For information regarding appeals, see Aetna Voluntary Life Insurance Appeals Procedure for life insurance claims, Aetna Voluntary Plan Appeals Procedure for disability claims and Appealing a Denied Claim Under FutureBuilder for FutureBuilder appeals, in each case, later in this chapter.

Filing Claims Under the Group Health Plans
If you receive covered health services from an in-network provider, you do not have to file a claim. In-network providers are responsible for filing claims for you. Your group health plan pays in-network providers directly for your covered health services. If an in-network provider bills you for any covered service, contact the claims administrator. However, you are responsible for meeting any annual deductible and for paying copayments and coinsurance to an in-network provider at the time of service, or when you receive a bill from the provider.

If you receive covered health services from an out-of-network provider, you are responsible for filing a claim.
Where to Send Your Claims for Out-of-Network Services

When you receive covered health services from an out-of-network provider, you must submit the claim to the appropriate claims administrator for your group health plan. For addresses and phone numbers, see Claims Administrators in the Plan Administration chapter.

Timely Filing of Claims

You must submit a request for payment of benefits from the health plans within one year after the date of service. If an out-of-network provider submits a claim on your behalf, you will be responsible for the timeliness of the provider’s submitting the claim. If you don’t provide the claim information to the appropriate claims administrator within one year after the date of service, benefits for that service will be denied. This time limit does not apply while you are legally incapacitated. If your claim relates to an inpatient stay, the date of service for the hospital charge is the date your inpatient stay ends.

Information Required for Your Claim

When you request payment of benefits from your health plan, you generally do not have to use a claim form. However, you must provide all of the following information:

• associate’s name and address
• patient’s name, age, and relationship to the associate
• contract number, which is on your ID card (for the Vision Plan, use “Home Depot” in place of a contract number)

• itemized bill from your provider that includes the following:
  — patient diagnosis
  — date(s) of service
  — procedure code(s) and descriptions of service(s) rendered
  — charge for each service rendered
  — provider’s name, address, and tax identification number
• date the injury or sickness began, if applicable
• statement indicating either that you are, or you are not, enrolled for coverage under any other group health insurance plan or program (if you are enrolled for other coverage, you must include the name of any other insurance company)

Benefit Determinations and Claims and Appeals Under the Self-Insured MetLife Dental Plan

Appealing the Initial Determination

If MetLife denies your claim, you may make two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the following address within 180 days of receiving MetLife’s decision:

MetLife, Group Claims Review
P.O. Box 14589
Lexington, KY 40512

Appeals must be in writing and must include at least the following information:

• Name of employee
• Name of the plan
• Reference to the initial decision
• Whether the appeal is the first or second appeal of the initial determination
• An explanation of why you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Reference will not be given to initial denials, and MetLife’s review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will
not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days after MetLife’s receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

**Benefit Determinations and Claims and Appeals Under the Fully-Insured Plans**

The fully-insured plans listed in **Filing Claims for Benefits** earlier in this chapter automatically provide information to participants about the process for appealing denied claims. Such information is adopted by reference as part of the **Claims and Appeals** chapter. In the event of a conflict between the information about the process for appealing denied claims for such plans provided in this chapter and the information provided directly from the plan, the information provided directly from the plan will govern. If you need more information about the process for appealing denied claims for benefits under a fully-insured plan, you should contact the insurance company directly. For phone numbers and addresses, see the **Plan Administration** chapter. Home Depot is not involved in the review of claims or appeals under the fully insured plans.

**Claims Involving the Critical Illness Protection Plan**

**Claim Review**

If a claim is denied, Allstate will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

Allstate will provide you free of charge copies of documents, records and other information relevant to your claim.

**Appeals Procedure**

No action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the plan. No action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Aetna Voluntary Health Coverage Appeals Procedure: Medical Payment Plan**

**Definitions**

**Adverse Benefit Determination:** A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such *adverse benefit determination* may be based on (1) your eligibility for coverage; (2) the results of any Utilization Review activities; (3) a determination that the service or supply is *experimental or investigational*; or (4) a determination that the service or supply is not *medically necessary*.

**Appeal:** A written request to Aetna to reconsider an *adverse benefit determination*.

**Complaint:** Any written expression of dissatisfaction about quality of care or the operation of the Plan.

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

**External Review:** A review of an adverse benefit determination or a final adverse benefit determination made up of physicians or other appropriate health care providers. The IRO must have expertise in the problem or question involved.

**Final Adverse Benefit Determination:** An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.
Claim Determinations

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Note to Arizona residents: If you are resident of Arizona, call Aetna Voluntary at 1-800-508-4014 for more information about appeals rules that apply to you.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for one level of appeal. A final adverse benefit determination notice will also provide an option to request an External Review.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your Appeal. Your appeal may be submitted orally or in writing and must include:

- Your name.
- The Policyholder’s name.
- A copy of Aetna’s notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to the address shown on the notice of adverse benefit determination, or you may call in your appeal using the telephone number listed on the notice. You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to Aetna.

Level One Appeal

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

Post-Service Claims. Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- contact your state’s Department of Insurance to request an investigation of a complaint or appeal; or
- file a complaint or appeal with the your state’s Department of Insurance; or
- establish any:
  — litigation;
  — arbitration; or
  — administrative proceeding.

Regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna’s decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:
• You have received notice of the denial of a claim by Aetna; and
• Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
• The cost of the service or treatment in question for which you are responsible exceeds $500; and
• You have exhausted the applicable internal appeal processes.

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C./FAA
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

EyeMed Vision Care/FAA will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

**Employee Assistance Program: Claim Determinations**

Care Solutions for Life will generally make a determination on your request for EAP services and inform you of its determination in your initial telephone call to request services. If Care Solutions for Life cannot decide while on the initial call, Care Solutions for Life will decide within five calendar days of your request for services or of notice to Care Solutions for Life of a circumstance that affects the availability of further EAP services. Care Solutions for Life will inform you by telephone of its determination within one business day after it decides.

If Care Solutions for Life determines that you need Urgent Care, Care Solutions for Life will provide telephonic crisis counseling and make an appropriate referral through your benefit plan and/or emergency resources in the community. Care Solutions for Life does not make claim determinations relating to Urgent Care.
Because Care Solutions for Life pays all EAP providers directly, you should not make any payment to a provider for EAP services. In the event that you mistakenly pay a provider for EAP services, Care Solutions for Life will make a determination on your request for reimbursement within 15 days after receipt of the claim (if EAP services have not yet been received) or with 30 days after receipt of the claim (if the EAP services have already been received).

### Adverse Determinations of a Claim for EAP Benefits

If a claim for EAP benefits is wholly or partially denied, Care Solutions for Life will provide written notice of the denial to you or your authorized representative. This notice of the decision will:

- give the specific reason or reasons for the denial decision;
- identify Plan provisions on which the decision is based;
- describe any additional material or information necessary for an appeal review and an explanation of why it is necessary; and
- explain the review procedure, including time limits for appealing the decision and to sue in federal court.

### Appeals of Adverse Determinations of Claims for EAP Benefits

If you believe your claim for EAP benefits was denied in error, you may appeal the decision. Your appeal must be submitted in writing to Care Solutions for Life within 180 days following your receipt of a denial notice. Your appeal should state the reasons why you feel your claim for EAP benefits is valid and include any additional documentation that you feel supports your claim for EAP benefits. You can also include any additional questions or comments. You may submit written comments, documents, records and other information relating to your appeal, whether or not the comments, documents, records or information were submitted in connection with the initial claim for EAP benefits. On your request, Care Solutions for Life will make relevant documents available to you.

The review of the initial decision will consider all new information, whether or not it was presented or available for the initial decision. The person who conducts the appeal review will be different from the person(s) who originally denied your claim for EAP benefits and will not report directly to the original decision maker or prior reviewer.

You or your authorized representative will be notified of the appeal decision within the following time frames:

- If the case involves an adverse determination on a request for EAP services or a pre-service adverse determination relating to reimbursement, within thirty days of Care Solutions for Life’s receipt of the request for appeal;
- If the case involves a post-service adverse determination relating to reimbursement, within sixty days of Care Solutions for Life’s receipt of the request for appeal.

### Appeal Decisions

Care Solutions for Life will give you or your authorized representative the decision on the appeal in writing. If the denial is upheld on appeal, the notice will include the following information:

- the specific reason or reasons for the denial decision;
- identification of Plan provisions on which the decision is based;
- notice of your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol or similar criterion relied on in making the decision;
- notice of your right to receive, free of charge, upon your request, reasonable access to, and copies of, all documents, records and other information relevant to the appeal;
- notice of your right to bring a civil lawsuit under ERISA §502(a).

If you do not agree with the final decision of Care Solutions for Life, you may bring a lawsuit in federal district court. You cannot bring legal action unless your claim has been reviewed and denied by Care Solutions for Life.
Aetna Voluntary Life Insurance Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; termination of; or failure to provide or make payment (in whole or in part) for a benefit. Such adverse benefit determination may be based on your eligibility for coverage or your eligibility for benefits.

Appeal: A written request to Aetna to reconsider an adverse benefit determination.

Note: If applicable state law requires the Plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.

Filing Life Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An “authorized representative” means your legal spouse or adult child, or a person you authorize, in writing, to act on your behalf. In addition, the Plan will recognize a court order giving a person authority to submit claims on your behalf.

Claim Determinations – Group Life Coverage

Aetna will make notification of a claim determination as soon as possible but not later than 90 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 90 calendar day claim determination period is required. Such an extension, of not longer than 90 additional calendar days, will be allowed if Aetna notifies you within the first 90 calendar day period. Aetna must notify you, prior to the end of the first 90 calendar day period, of the special circumstances requiring the extension and the date by which a decision can be expected.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. You have 60 calendar days following the receipt of notice of an adverse benefit determination to request your appeal. Your appeal may be submitted in writing and should include:

- Your name;
- Your employer’s name;
- A copy of Aetna’s notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim. Send your appeal to the address shown on the notice of adverse benefit determination. You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Aetna Voluntary Disability Plan Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; termination of; or failure to provide or make payment (in whole or in part) for a benefit. Such adverse benefit determination may be based on your eligibility for coverage.

Appeal: A written request to Aetna to reconsider an adverse benefit determination.

Filing Disability Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

Appeal – Group Life Claims

Aetna shall issue a decision within 60 calendar days of receipt of the request for an appeal. If Aetna determines that due to special circumstances an extension of time for claim processing is required, such an extension, of not longer than 60 additional calendar days, will be allowed if Aetna notifies you within the first 60 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Aetna Voluntary Disability Plan

}
Claim Determinations

Aetna will make notification of a claim determination as soon as possible but not later than 45 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 45 calendar days claim determination period is required. Such an extension, of not longer than 30 additional calendar days, will be allowed if Aetna notifies you within the first 45 calendar days period. If prior to the end of the first 30 calendar days extension period, Aetna again determines that due to matters beyond its control a decision cannot be made within that extension period, the claim determination period may be extended for an additional 30 calendar days. Aetna must notify you, prior to the end of the first extension period, of the circumstance requiring the extension and the date by which a decision can be expected.

The notice of any extension, by Aetna, for any Disability Income Coverage, shall specifically explain: (1) the standards on which entitlement to a benefit is based; (2) the unresolved issues that prevent a decision on the claim; and (3) the additional information needed to resolve those issues.

The claimant will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your appeal. Your appeal may be submitted orally or in writing and should include: (1) your name; (2) your employer’s name; (3) a copy of Aetna’s notice of an adverse benefit determination; (4) your reasons for making the appeal; and (5) any other information you would like to have considered.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Send in your appeal to the address shown on the notice of adverse benefit determination or you may call in your appeal using the toll-free telephone number listed on such notice. You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Appeal

Aetna shall issue a decision within 45 calendar days of receipt of the request for an appeal. If Aetna determines that due to special circumstances an extension of time for claim processing is required, such an extension, of not longer than 45 additional calendar days, will be allowed if Aetna notifies you within the first 45 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Appealing a Denied Claim Under FutureBuilder

If an application for benefits is denied in whole or in part, you or your representative will receive written or electronic notification from the claims administrator or Plan Administrator, within 90 days after your claim is received (45 days for claims based on disability), or 180 days under special circumstances (75 days for claims based on disability) in which case you will be notified in writing before the end of the first 90-day period of the extension (45 days for claims based on disability), the reason why the extension is needed, and the date by which you can expect to receive a decision.

The denial notice will include:

- the reasons for the denial with reference to the specific plan provisions on which the denial was based;
- a description of any additional information needed to perfect the claim;
- a description of the Plan’s review procedures and applicable time limits; and
- a statement of the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If your claim is denied and you would like your claim reconsidered, you or your representative must submit a written request for reconsideration of the claim to the claims administrator or Plan Administrator, as applicable, within 60 days after receiving notice of the denial (180 days for claims based on disability). Any such request should be accompanied by documents, records, or other information in support of the appeal.
You or your representative may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim, free of charge. The review provided will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination. A failure to timely request a review of a denied claim will be treated as full and complete agreement with the denial.

The claims administrator or Plan Administrator will respond within 60 days of the appeal (45 days for claims based on disability), or 120 days under special circumstances (90 days for claims based on disability) in which case you will be notified in writing of the extension, of the reasons for the extension, and the date the review of the appeal is expected to conclude. In its response to the appeal, the claims administrator will explain, in writing:

- the reasons for the decision, again with reference to the specific plan provisions on which that decision is based;
- a description of the Plan’s voluntary appeal procedures (if any); and
- a statement of your right to bring an action under ERISA Section 502(a).

The fiduciary making claim decisions has the right and discretionary authority to interpret the provisions of the Plan under which the claim is made and its decisions will be conclusive and legally binding on all parties.

**Limitation of Actions**

No lawsuit or legal action of any kind with respect to any benefit payable or other matter arising out of or relating to any benefit plan may be brought before exhaustion of the claims and appeal procedures set forth in this chapter. If you fail to exhaust the plan’s claim and appeal procedures, you will be precluded from filing suit in court even if you attempt to file within the time frame provided below.

Other than for FutureBuilder claims (as discussed below) or as otherwise specifically set forth in an insurance contract for a fully-insured plan, any lawsuit or legal action to receive plan benefits must be filed within one (1) year from the date a final adverse determination is made, or is deemed to have been made, in accordance with the plan’s claims and appeal procedures. If the plan fails to respond to any claim or appeal in accordance with the terms of the plan, a final adverse benefit determination is deemed to have been made as of the latest date the plan was otherwise required to make a determination in accordance with the plan’s terms.

For FutureBuilder claims, any lawsuit or legal action must be brought the earlier of one (1) year after denial of appeal by the Plan Administrator or two (2) years following (a) in the case of any payment, the date such payment was made, or (b) the date your claim arose.

In addition, for FutureBuilder, any lawsuit or legal action in connection with FutureBuilder may only be brought or filed in Federal District Court for the Northern District of Georgia, Atlanta Division.

Any lawsuit or legal action against the plans for which the plan has not established a claims and appeal procedure must be filed within one (1) year from the date the claim arose.
CHAPTER CONTENTS

147 Benefit Plan Administration
147 Qualified Domestic Relations Order (QDRO) Under FutureBuilder
147 Qualified Medical Child Support Order
147 Provider Networks
148 Plan Legal Matters
148 Plan Year
148 Plan and Employer Identification Numbers

148 How the Plans Are Funded
148 Authority and Control
149 Your Rights Under the Employee Retirement Income Security Act (ERISA)
149 Receive Information About Your Plan and Benefits
149 Continue Group Health Plan Coverage
149 Prudent Actions by Plan Fiduciaries
149 Enforce Your Rights

150 Assistance With Your Questions
150 Limitation of Actions
150 Plan Termination and Amendment
150 Purpose of this Benefits Summary
151 Claims Administrators
152 Plan Administration Summary
Benefits Plan Administration

Many of the Company benefit plans operate under the guidelines of ERISA (Employee Retirement Income Security Act of 1974, as amended). The Company maintains these Plans for the exclusive benefit of its associates and, when applicable, associates’ legal spouses and eligible domestic partners and/or dependent children and/or beneficiaries. ERISA requires that certain disclosures must be made to Plan participants. The following pages include this information as well as other important details about your benefits coverage.

Qualified Domestic Relations Order (QDRO) Under FutureBuilder

If you are a participant or beneficiary/alternate payee under a QDRO, you are entitled to obtain from the Plan Administrator for FutureBuilder, without charge, a description of the Plan’s procedures governing QDRO determinations. See When Benefits Are Not Paid: Qualified Domestic Relations Order (QDRO) in the FutureBuilder chapter for more information about QDROs, including fees.

Qualified Medical Child Support Order

The group health plans subject to ERISA provide coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCISO) even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. To cover your child, however, you must be covered in the group health plan. If the group health plan receives a QMCSO and you are otherwise eligible, your child will be enrolled (and so will you if you are not enrolled) in accordance with the QMCSO and the Plan’s QMCSO procedures. Additionally, the Company will deduct from your pay any contributions required for such coverage unless payment is made by a state agency.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency that meets the requirements under ERISA §609 or an order or a judgment from a state court or administrative body directing the Company to cover a child under the group health plan to the extent the order meets the requirements of ERISA §609. If you have any questions or you would like to receive a copy of the written procedure, free of charge, for determining whether a QMCSO is valid, please contact the Plan Administrator.

Provider Networks

Certain benefit options under the Vision and Dental Plans have provider networks which vary among the options. Benefits are generally greater when services are provided by a network provider. The same doctors and other health care providers may not be included in your Plan’s provider network from year to year. You should read your enrollment material to ensure that your network isn’t changing in the next Plan Year. Before you call for an appointment, you should confirm the doctor’s or other health care provider’s participation in your Plan’s network by contacting your claims administrator. Lists and/or directories of network providers are available, free of charge by contacting the applicable claims administrator listed in the Plan Administration Summary. Associates may also

Getting the Most Value From Your Plan

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request a copy of the official plan documents for the Plans</td>
<td>Contact the Plan Administrator at: The Administrative Committee Home Depot U.S.A., Inc., Benefits Department, Building C-18 2455 Paces Ferry Road Atlanta, GA 30339-4024</td>
</tr>
<tr>
<td>Receive a copy of the written procedures for determining whether a QMCSO is valid</td>
<td>For FutureBuilder: The Home Depot FutureBuilder Administrative Committee The Home Depot, Inc. Benefits Department, Building C-18 2455 Paces Ferry Road Atlanta, GA 30339-4024</td>
</tr>
<tr>
<td>Find out who the claims administrator is for a specific Plan</td>
<td>See the Plan Administration Summary at the end of this section for claim administrator phone numbers and addresses. The Plan Administrator and the Claims Administrator often are two different entities.</td>
</tr>
<tr>
<td>Get answers to questions about your rights under ERISA or help in obtaining documents</td>
<td>Call the publications hotline of the Employee Benefits Security Administration (EBSA) at 1-866-444-3272; or go to <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a>; or Contact the nearest EBSA office.</td>
</tr>
<tr>
<td>File a claim or appeal</td>
<td>See the Claims and Appeals chapter</td>
</tr>
</tbody>
</table>
access up-to-date provider lists and directories through websites of the individual plans, and through toll-free Member Services numbers. For the Vision Plan, the information is provided in the Vision chapter. For the Dental Plan, the information is provided in the Dental chapter.

**Plan Legal Matters**

Service of process for all legal matters should be made on the Plan Sponsor’s registered agent for service of process, CT Corp., whose address is available from the Secretary of State in each jurisdiction in which the Plans are administered. Service may also be made upon the Plan Administrator or Trustee at:

**Home Depot U.S.A., Inc.**  
Benefits Department C-18  
2455 Paces Ferry Road  
Atlanta, GA 30339-4024  
Attn: Plan Administrator

**The Home Depot FutureBuilder Administrative Committee**  
Benefits Department C-18  
2455 Paces Ferry Road  
Atlanta, GA 30339-4024

Service of process for insured benefit claims should be made on the insurance company or its agent for service of legal process.

**Plan Year**

The Plan Administrator maintains the Plans and all records on a fiscal-year basis—February 1 through January 31 of each year.

For FutureBuilder, the Company maintains the Plan and all records on a calendar year basis—January 1 through December 31 of each year.

**Plan and Employer Identification Numbers**

The IRS has assigned the employer identification number 58-1853319 to the Plan Sponsor of all plans except FutureBuilder. For FutureBuilder, the IRS has assigned the employer identification number 95-3261426 to the Plan Sponsor. For Plan numbers, see Plan Administration Summary. Upon request, the plan administrator can provide you with a list of affiliated employers that have adopted the Plans.

**How the Plans Are Funded**

The Plan is obligated to pay all benefits and administrative expenses of the Plan and all such amounts will be paid first from the Plan’s assets, which include associate contributions and any additional amounts to which the Plan is entitled. The Company may, in its sole discretion, contribute additional amounts as necessary to fund the benefits or administrative expenses if Plan assets are insufficient and the Company will be entitled to reimbursement from the Plan upon request. If a benefit under the Plan is fully insured pursuant to an insurance contract issued by an insurance carrier, the insurance carrier pays all benefits from its general assets (subject to payment of the required premium). The Company may require associates to fund the total cost of the benefits and administrative expenses under the Plan or the Company may choose to share, in whole or part, the cost with the associates. Any contribution required by associates will be communicated by the Company during the applicable enrollment period.

The Company reserves the right to change the contribution requirement at any time for any reason.

The Company provides benefits for The Home Depot Term Life and Disability Plans through a group insurance policy underwritten by Aetna.

The Company provides benefits for The Home Depot Legal Services Plan (MetLaw) through a group insurance policy underwritten by Metropolitan Life Insurance Company.

Medical Payment Plan benefits are provided through a group insurance policy underwritten by the Aetna Life Insurance Company. Vision benefits under the Vision Plan are provided through a group insurance policy underwritten by Fidelity Security Life Insurance Company. Critical Illness Protection Plan benefits are provided through a group insurance policy underwritten by American Heritage Life Insurance Company. The Company provides benefits for the Dental Plan through self-funding.

The Home Depot FutureBuilder is a tax-qualified defined contribution retirement Plan. Both the Company’s and the associates’ contributions to The Home Depot FutureBuilder are held in the Plan’s trust. Associate contributions are made to the trust, as soon as administratively practical after being withheld from the associates’ pay. Benefits under FutureBuilder are not insured under Title IV of ERISA because the Plan is not a defined benefit pension plan.

**Authority and Control**

The Plan Administrator has the exclusive right and discretion to interpret the terms and conditions of the Plan, and to decide all matters arising in its adminis-
Your Rights Under the Employee Retirement Income Security Act (ERISA)

As a participant in The Home Depot Welfare Plan for Part-Time associates, which includes the Medical Payment Plan, Life, Disability, Critical Illness Protection Plan, Legal Services and Care Solutions for Life benefits, the Home Depot Medical and Dental Plan with respect to dental benefits only, The Home Depot Vision Plan and The Home Depot FutureBuilder, 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 the following.

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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue certain coverage options for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. See the COBRA Coverage chapter for more information.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or 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 charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110* a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

* Subject to adjustment for inflation.
In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), 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, DC 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 at 1-866-444-3272;
- logging on to the Internet at www.dol.gov/ebsa; or
- contacting the EBSA field office nearest you.

**Limitation of Actions**

No lawsuit or legal action of any kind with respect to any benefit payable or other matter arising out of or relating to any benefit plan may be brought before exhaustion of the claim and appeal procedures set forth in the Claims and Appeals chapter. If you fail to exhaust the plan’s claim and appeal procedures, you will be precluded from filing suit in court even if you attempt to file within the time frame provided below.

Other than for FutureBuilder claims (as discussed below) or as otherwise specifically set forth in an insurance contract for a fully-insured plan, any lawsuit or legal action to receive plan benefits must be filed within one (1) year from the date a final adverse determination is made or is deemed to have been made in accordance with the plan’s claims and appeal procedures. If the plan fails to respond to any claim or appeal in accordance with the terms of the plan, a final adverse benefit determination is deemed to have been made as of the latest date the plan was otherwise required to make a determination in accordance with the terms of the plan.

For FutureBuilder claims, any lawsuit or legal action must be brought earlier of one (1) year after denial of appeal by the Plan Administrator or two (2) years following (a) in the case of any payment, the date such payment was made, or (b) the date your claim arose.

Any lawsuit or legal action against the plans for which the plan has not established a claims and appeal procedure must be filed within one (1) year from the date the claim arose.

See the Claims and Appeals or FutureBuilder chapter for information regarding where a lawsuit involving FutureBuilder may be brought.

**Plan Termination and Amendment**

The Plan Sponsor expects and intends to continue the Plans but reserves its right to amend or terminate the Plans, in whole or in part, without notice at any time and for any reason.

The Plan Sponsor may also increase or decrease its contributions or the associates’ contributions to the Plans at any time and for any reason.

If the Plans are terminated while you are covered by the Plan, you will not have any further rights under the Plan other than the payment of benefits for covered losses or expenses incurred before the Plans are terminated. For your rights if FutureBuilder is terminated, see Right to Amend or Terminate the Plan in the FutureBuilder chapter.

**Purpose of this Benefits Summary**

This Benefits Summary, also known as a summary plan description ("SPD"), is meant as a convenient, easy-to-read reference guide to the Plans. It does not, however, provide every detail of the full Plans and does not change, expand or modify the terms of the Plans. If there is any conflict between this SPD and the official legal documents of the Plans, the official legal documents will take precedence in all cases. Legal documents include the official Plan document, trust agreements and insurance contracts (as applicable). You may request a copy of these legal documents by writing to the applicable Plan Administrator.
### Claims Administrators

#### Medical Payment Plan

Aetna Voluntary  
Attn: Claim Department  
P.O. Box 14079  
Lexington, KY 40512-4079  
1-800-508-4015

#### Critical Illness Protection Plan

Allstate Benefits  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6687  
1-866-828-8766

<table>
<thead>
<tr>
<th>Vision Plan</th>
<th>Dental Plans</th>
<th>Employee Assistance Plan</th>
</tr>
</thead>
</table>
| EyeMed Vision Care  
Attn: OON Claims  
P.O. Box 8504  
Mason, Ohio 45040-7111  
Fax: 1-866-293-7373  
ononclaims@eyemedvisioncare.com | MetLife Dental Claims  
P.O. Box 981282  
El Paso, TX 79998-1282  
1-800-638-9909  
www.metlife.com/dental | Care Solutions for Life  
Aetna  
EAP Appeals - 1250  
151 Farmington Avenue, R32  
Hartford, CT 06156  
1-800-553-3504 |
# Plan Administration Summary

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Type</th>
<th>Plan Number</th>
<th>Plan Sponsor</th>
<th>Plan Trustee</th>
<th>Plan Administrator*</th>
<th>Claims Administrator, Insurer or Recordkeeper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Depot Welfare Benefits Plan for Part-time Associates</strong></td>
<td>A group welfare plan for payment of medical payment, critical illness, life, disability and pre-paid legal benefits through contracts of insurance</td>
<td>510</td>
<td>Home Depot U.S.A., Inc. Benefits Department, Building C-18 2455 Paces Ferry Rd, Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>Not applicable</td>
<td>The Administrative Committee Home Depot U.S.A., Inc. Benefits Department, Building C-18 2455 Paces Ferry Rd., Atlanta, GA 30339-4024 1-770-433-8211</td>
<td><strong>For Life and Disability:</strong> Aetna Voluntary Attn: Claim Department P.O. Box 14079 Lexington, KY 40512-4079 1-800-508-4015 <strong>For Legal Services Plan:</strong> Hyatt Legal Services 1111 Superior Avenue Cleveland, OH 44114 1-800-423-0300 <strong>For Critical Illness Protection:</strong> Allstate Benefits 1776 American Heritage Life Drive Jacksonville, FL 32224-6687 1-866-828-8766 <strong>MetLife Dental Claims</strong> P.O. Box 981282 El Paso, TX 79998-1282 1-800-638-9909 <a href="http://www.metlife.com/d">www.metlife.com/d</a></td>
</tr>
<tr>
<td><strong>Home Depot Medical and Dental Plan</strong></td>
<td>A group welfare plan for reimbursement of dental care claims through self-funding</td>
<td>501</td>
<td>Home Depot U.S.A., Inc. Benefits Department, Building C-18 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>Not applicable</td>
<td>The Home Depot FutureBuilder Administrative Committee The Home Depot, Inc. Benefits Department, Building C-18 2455 Paces Ferry Rd., Atlanta, GA 30339-4024 1-770-433-8211</td>
<td><strong>For Life and Disability:</strong> Aetna Voluntary Attn: Claim Department P.O. Box 14079 Lexington, KY 40512-4079 1-800-508-4015 <strong>For Legal Services Plan:</strong> Hyatt Legal Services 1111 Superior Avenue Cleveland, OH 44114 1-800-423-0300 <strong>For Critical Illness Protection:</strong> Allstate Benefits 1776 American Heritage Life Drive Jacksonville, FL 32224-6687 1-866-828-8766 <strong>MetLife Dental Claims</strong> P.O. Box 981282 El Paso, TX 79998-1282 1-800-638-9909 <a href="http://www.metlife.com/d">www.metlife.com/d</a></td>
</tr>
<tr>
<td><strong>Home Depot Vision Plan</strong></td>
<td>A welfare plan for reimbursement of vision care claims through a contract of insurance</td>
<td>511</td>
<td>Home Depot U.S.A., Inc. Benefits Department, Building C-18 2455 Paces Ferry Rd., Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>Not applicable</td>
<td>The Home Depot FutureBuilder Administrative Committee The Home Depot, Inc. Benefits Department, Building C-18 2455 Paces Ferry Rd., Atlanta, GA 30339-4024 1-770-433-8211</td>
<td><strong>For Life and Disability:</strong> Aetna Voluntary Attn: Claim Department P.O. Box 14079 Lexington, KY 40512-4079 1-800-508-4015 <strong>For Legal Services Plan:</strong> Hyatt Legal Services 1111 Superior Avenue Cleveland, OH 44114 1-800-423-0300 <strong>For Critical Illness Protection:</strong> Allstate Benefits 1776 American Heritage Life Drive Jacksonville, FL 32224-6687 1-866-828-8766 <strong>MetLife Dental Claims</strong> P.O. Box 981282 El Paso, TX 79998-1282 1-800-638-9909 <a href="http://www.metlife.com/d">www.metlife.com/d</a></td>
</tr>
<tr>
<td><strong>The Home Depot FutureBuilder—a 401(k) and Stock Ownership Plan</strong></td>
<td>A tax-qualified defined contribution retirement plan, with associate and company contributions</td>
<td>001</td>
<td>The Home Depot, Inc. Benefits Department, Building C-18 2455 Paces Ferry Rd., Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>Not applicable</td>
<td>The Northern Trust Co. 50 S. LaSalle St., Chicago, IL 60675</td>
<td><strong>The claims administrator and insurer is:</strong> EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111 Fax: 1-866-293-7373 <a href="mailto:onclaims@eyemedvisioncare.com">onclaims@eyemedvisioncare.com</a></td>
</tr>
</tbody>
</table>
The Home Depot Health Benefits Notice of Privacy Practices

**Your Information. Your Rights. The Plan’s Responsibilities.**

**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.**

En español: Este documento es una actualización del libro de Resumen de Beneficios que usted recibió anteriormente. Si usted tiene dificultad en entender cualquier parte de este documento, llame al 1-800-555-4954. Seleccione la opción que le permita hablar en español; luego seleccione la opción para asociados de Puerto Rico. Su llamada será transferida a un representante que habla español. Los representantes están disponibles de lunes a viernes, 8:00 A.M.–5:00 P.M. (Hora Estándar del Atlántico).

You and your eligible dependents receive group health benefits, that include dental and vision benefits through group health plans (collectively, the “Plan”) offered by Home Depot U.S.A., Inc. and its participating subsidiaries (the “Plan Sponsor”). This Notice of Privacy Practices (“Notice”) describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The Plan is required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as protected health information (“PHI”). Generally, PHI is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan.

Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment or health care operations, or for any other purposes that are permitted or required by law, your privacy rights, your right to file a complaint and whom to contact for additional information. This Notice does not address medical information from your disability, workers’ compensation or life insurance programs, or any other health information not created or received by the Plan. These privacy practices may not be the same as those adopted by your health care providers or insurers. Please check with your providers or insurers if you would like to understand their privacy practices.

**THE PLAN’S OBLIGATIONS**

The Plan is required by law to:

- maintain the privacy of your PHI;
- provide you with certain rights with respect to your PHI;
- provide you with a copy of this Notice of the Plan’s legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that is currently in effect.

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your PHI that the Plan maintains, as allowed or required by law, and to make the new terms applicable to all of the PHI it maintains. The Plan will revise this Notice and post a new Notice promptly at livetheorangefamily.com after making any material change to this Notice or its privacy policies. A paper copy of this Notice is also available upon request.
HIPAA NOTICE

How The Plan May Use and Disclose Your Protected Health Information

Under the law, the Plan may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that the Plan may use and disclose your PHI without your authorization.

Uses and Disclosures for Treatment, Payment and Health Care Operations

The Plan may use and disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining a specific written permission from you, known as an “authorization.”

For Treatment. The Plan may use and disclose PHI as needed for your medical treatment. For example, PHI may be used and disclosed to coordinate and manage the activities of different health care providers who provide you with health care services covered under the Plan.

For Payment. The Plan may use and disclose your PHI as part of activities related to the Plan’s payment for health care services. For example, the Plan may disclose your PHI to a doctor or hospital that calls to find out if you are eligible for coverage under the Plan. The Plan also will disclose your PHI to third parties, including third-party administrators and insurers hired by the Plan to make health benefit coverage determinations, to pay health care providers, to determine subrogation rights and coordinate benefits.

For Health Care Operations. The Plan may use and disclose PHI as part of its general business operations as a group health plan. For example, the Plan may disclose PHI to assess the overall performance of the Plan, to audit claims processing and payment activities, for legal services, for premium rating and for medical reviews. The Plan will use and disclose your PHI for the management and administrative activities of the Plan. However, the Plan will not use genetic information for underwriting purposes.

Other Uses and Disclosures For Which Authorization is Not Required

In addition, the Plan may use and disclose PHI without your written authorization:

As Required by Law. The Plan may use or disclose PHI when required to do so by law.

To Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan’s behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with the Plan.

As Required for Judicial or Law Enforcement Purposes. The Plan may disclose PHI in a judicial or administrative proceeding and in response to a subpoena or other legal process (in certain circumstances), if the Plan is assured that the requesting party has made a good faith attempt to provide written notice of such disclosure to you. The Plan may also disclose your PHI for law enforcement purposes, such as reporting certain types of wounds, identifying or locating a suspect, fugitive, material witness or missing person. Except as otherwise required by law or in the case of an emergency, the Plan will disclose PHI about an individual who may be a victim of a crime only if that individual agrees to the disclosure.

For Public Health Activities and Public Health Risks. The Plan may disclose PHI to a public health authority in charge of collecting information, such as about births and deaths, injury, preventing and controlling disease, reports of child abuse or neglect, reactions to medications or product defects or problems or to notify a person who may be at risk for contracting or spreading a communicable disease. The Plan may disclose PHI about an individual whom the Plan reasonably believes to be a victim of abuse, neglect or domestic violence if required by law to report such information, if the victim agrees to such disclosure, or the Plan believes disclosure is necessary to prevent serious harm and the victim is unable to consent due to incapacity.
For Health Oversight Activities. The Plan may disclose PHI to the government for oversight activities, such as audits, investigations, inspections, licensure or disciplinary actions, and other activities for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye and Tissue Donation. If you are an organ donor, the Plan may release PHI after your death to organ procurement organizations to facilitate organ, eye and tissue donation and transplantation.

Research. The Plan may use and disclose PHI for medical research purposes, subject to protections of your privacy.

To Avoid a Serious Threat to Health or Safety. The Plan may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. The Plan may use and disclose PHI of military personnel and veterans under certain circumstances. The Plan may also disclose PHI to authorized federal officials for intelligence, counterintelligence, other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Workers’ Compensation. The Plan may disclose PHI to comply with workers’ compensation or other similar laws that provide benefits for work-related injuries or illnesses.

Treatment Alternatives or Health-related Benefits and Services. The Plan may use and disclose your PHI to inform you of treatment alternatives or other health-related benefits and services covered under the Plan or available to you; to inform you regarding the health care providers participating in the Plan’s networks; to inform you about replacement of or enhancement to the Plan; and to inform you of other similar matters that may be of interest to you, such as wellness and disease management programs. The Plan may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift of nominal value.

Disclosures to Plan Sponsor. The Plan may disclose your PHI to the Plan Sponsor and Business Associates, and may permit insurance companies that provide benefits under the Plan to disclose your PHI to the Plan Sponsor and Business Associates in accordance with its privacy policies. The Plan Sponsor has put protections in place to assure that the information will only be used for plan administration purposes and never for employment purposes.

Disclosures to You or for HIPAA Compliance Investigations. The Plan may disclose your PHI to you or your authorized representative, and is required to do so in certain circumstances in connection with your rights of access to and an accounting of certain disclosures of your PHI. The Plan also must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the “Secretary”) when requested by the Secretary to investigate Plan’s compliance with privacy regulations issued under HIPAA.

Spouses and Other Family Members. With only limited exceptions, the Plan will send all mail to you, the associate. This includes mail relating to your spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by your spouse and other family members and information on the denial of any Plan benefits to your spouse and other family members. If a person covered under the Plan has requested Confidential Communications (see below), and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Confidential Communications.

Uses and Disclosures to Which You Have an Opportunity to Object

Unless you object, the Plan may disclose your PHI to a family member, other relative, friend or other person you identify as involved in your health care or payment for your health care. The Plan may also notify those people about your location or condition. In some circumstances, the Plan may make the disclosures identified in this paragraph without first giving you an opportunity to agree or object, such as in an emergency.
Other Uses and Disclosures of PHI
For Which Authorization is Required

Except as otherwise provided in this notice, all other types of uses and disclosures of your PHI will be made only with your written authorization. For example, subject to specific conditions, without your written authorization the Plan: (i) will not use or disclose your psychotherapy notes; (ii) will not use or disclose your PHI for marketing; and (iii) will not sell your PHI.

You may revoke your authorization at any time. The revocation must be in writing. Upon receipt of the written revocation of authorization, the Plan will stop using or disclosing your PHI, except to the extent necessary because the Plan has already taken action in reliance on the authorization.

Your Rights

The Plan is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. The Plan reserves the right to change the terms of this Notice and its privacy policies, and to make the new terms applicable to all of the PHI it maintains. The Plan will revise this Notice and post a new Notice promptly after making an important change to its privacy policies. You have the following rights with respect to your PHI:

**Right to Request Restrictions.** You may request that the Plan restrict the use and disclosure of your PHI. The Plan is not required to agree to any restrictions you request, but if the Plan does so it will be bound by the restrictions to which it agrees except in emergency situations.

The Plan will comply with any restriction request if: (i) except as otherwise required by law, the disclosure is to the Plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

**Right to Request Confidential Communications.** You have the right to request that communications of PHI to you from the Plan be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by email rather than regular mail. Your requests must be made in writing. The Plan will accommodate your reasonable requests.

**Right to Inspect and Copy.** Generally, you have the right to inspect and copy your PHI that the Plan maintains in a “designated record set” by making the request in writing. The Plan may deny your request to inspect and copy in certain circumstances. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), the Plan will inform you of the extent to which your request has or has not been granted. In some cases, the Plan may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, the Plan may impose a reasonable fee to cover copying, postage and related costs. If the Plan denies access to your PHI, it will explain the basis for denial and whether or not you have an opportunity to have your request and the denial reviewed.

**Right to an Electronic Copy of Electronic Medical Records.** Generally, you have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your PHI if it is maintained electronically. If the PHI cannot be readily produced in the electronic form and format you request, it will be provided in a readable electronic form and format as agreed to by you and the Plan. If an electronic form and format cannot be agreed upon, you will be provided a paper copy. The Plan may impose a reasonable fee to cover costs.

**Right to Amend.** If you believe that your PHI maintained by the Plan contains an error or needs to be updated, you have the right to request that the Plan correct or supplement your PHI. Your request must explain why you are requesting an amendment to your PHI. Within 60 days of receiving your request (unless extended by an additional 30 days), the Plan will inform you of the extent to which your request has or has not been granted. If your request is denied, the Plan will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the Plan’s denial attached; and (iii) complain about the denial.
Right to an Accounting. You generally have the right to request and receive a list of the disclosures of your PHI that the Plan has made at any time during the 6 years prior to the date of your request (but not before April 14, 2003). The list will not include disclosure for which you have provided a written authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. Within 60 days of receiving your written request (unless extended by an additional 30 days), the Plan will either provide you with the accounting or notice of the denial of your request. The Plan will provide the list to you at no charge, but if you make more than one request in a year there may be a charge for each additional request.

Right to Paper Copy. You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically.

Complaints. If you believe your privacy rights with respect to your PHI have been violated, you may file a complaint with the Plan by contacting the HIPAA Privacy Officer (listed below) and submitting a written complaint. You also have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services for civil rights by:

- Sending a letter to 200 Independence Avenue SW, Washington DC 20201;
- Calling 1-877-696-6755; or
- Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

The Plan will in no manner penalize you or retaliate against you for filing a complaint regarding the Plan’s privacy practices.

Right to be Notified of a Breach. You have the right to be notified in the event that the Plan (or a business associate) discovers a breach of your unsecured PHI.

Contact Information
Complaints, submissions required to be in writing, inquiries and questions with respect to your privacy rights or this Notice of Privacy Practices should be directed to:

HIPAA Privacy Officer
The Home Depot
2455 Paces Ferry Road, NW, C-20
Atlanta, Georgia 30339-4024
privacy@homedepot.com
770-433-8211 ext. 18440

Effective Date: October 1, 2016
| Benefits Choice Center: Benefits questions & enrollment | 1-800-555-4954 | Log on to www.livetheorangelife.com
| HR Services: HR/Pay questions | 1-866-myTHDHR (1-866-696-4347) | www.myTHDHR.com
| Aetna Voluntary | 1-800-508-4015 | Log on to www.livetheorangelife.com for access to your personal account
| Allstate Benefits | 1-866-828-8766 | Log on to www.livetheorangelife.com for access to your personal account
| MetLife | 1-800-638-9909 | Log on to www.livetheorangelife.com for access to your personal account
| EyeMed | 1-888-203-7447 | Log on to www.livetheorangelife.com for access to your personal account
| Adoption Assistance Program | 1-800-555-4954 | www.livetheorangelife.com
| Associate Discounts | | Log on to www.livetheorangelife.com
| Auto Insurance Choice Program | 1-888-667-7648 | Log on to www.livetheorangelife.com
| Back-up Dependent Care Program—Bright Horizons | 1-877-543-2822 | www.careadvantage.com/homedepot
| CareDirect—Bright Horizons | 1-877-543-2822 | www.careadvantage.com/homedepot
| Care Solutions for Life | 1-800-553-3504 | www.livetheorangelife.com
| College Coach Program | 1-866-468-3123 | https://passport.getintocollege.com
| ESPP (Employee Stock Purchase Plan) | 1-800-843-2150 | www-us.computershare.com/employee; To enroll: Log on to www.livetheorangelife.com
| Financial Engines Investment Advice | 1-800-601-5957 | www.livetheorangelife.com
| Foot Orthotics Discount Program | 1-877-442-6437 | http://hanger.com/patientcarecenters
| Health Advocate | 1-800-519-6689 | http://healthadvocate.com/members
<p>| The Home Depot Awareness Line: Report workplace concerns | 1-800-286-4909 | |</p>
<table>
<thead>
<tr>
<th>To Learn About...</th>
<th>Phone Number</th>
<th>Internet Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity Theft Protection (AllClear)</td>
<td>1-877-676-0373</td>
<td><a href="http://www.enroll.allclearid.com">www.enroll.allclearid.com</a></td>
</tr>
<tr>
<td>Matching Gift (A program of The Home Depot Foundation)</td>
<td>1-888-628-2442</td>
<td><a href="http://www.givingprograms.com/homedepot">www.givingprograms.com/homedepot</a></td>
</tr>
<tr>
<td>Purchasing Power</td>
<td>1-800-541-4349</td>
<td><a href="http://www.homedepot.purchasingpower.com">www.homedepot.purchasingpower.com</a></td>
</tr>
<tr>
<td>Quit for Life (Quit Tobacco Program)</td>
<td>1-866-784-8454</td>
<td></td>
</tr>
<tr>
<td>Rethink</td>
<td>1-877-988-8871</td>
<td><a href="http://www.homedepot.rethinkbenefits.com">www.homedepot.rethinkbenefits.com</a></td>
</tr>
<tr>
<td>Schwab PCRA Brokerage Account</td>
<td>1-888-393-7272</td>
<td>Log on to <a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a></td>
</tr>
<tr>
<td>Sleepio</td>
<td></td>
<td><a href="http://www.sleepio.com/homedepot">www.sleepio.com/homedepot</a></td>
</tr>
<tr>
<td>Tuition Reimbursement Program</td>
<td>1-800-555-4954</td>
<td><a href="http://www.livetheorangelife.com">www.livetheorangelife.com</a></td>
</tr>
<tr>
<td>THD Road Companion</td>
<td>1-877-272-4481</td>
<td><a href="http://www.THDRoadCompanion.com">www.THDRoadCompanion.com</a></td>
</tr>
<tr>
<td></td>
<td>1-877-335-7899</td>
<td></td>
</tr>
</tbody>
</table>
2017 BIWEEKLY PAYROLL DEDUCTIONS
Payroll deductions for all other benefits will be available during your enrollment session.

<table>
<thead>
<tr>
<th>MEDICAL PAYMENT PLAN OPTIONS¹</th>
<th>ASSOCIATE ONLY</th>
<th>ASSOCIATE + SPOUSE</th>
<th>ASSOCIATE + CHILD(REN)</th>
<th>ASSOCIATE + FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Only</td>
<td>$6.69</td>
<td>$13.38</td>
<td>$10.94</td>
<td>$19.44</td>
</tr>
<tr>
<td>Hospital Plus I</td>
<td>$19.40</td>
<td>$43.38</td>
<td>$38.59</td>
<td>$62.57</td>
</tr>
<tr>
<td>Hospital Plus II</td>
<td>$34.53</td>
<td>$76.59</td>
<td>$68.17</td>
<td>$110.23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DENTAL &amp; VISION COVERAGE ALL ASSOCIATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>METLIFE DENTAL OPTIONS</td>
</tr>
<tr>
<td>$500 Annual Maximum</td>
</tr>
<tr>
<td>$1,000 Annual Maximum</td>
</tr>
<tr>
<td>$2,000 Annual Maximum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EYEMED VISION OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select $120</td>
</tr>
<tr>
<td>Select $150</td>
</tr>
</tbody>
</table>

¹ The Medical Payment Plan is NOT a traditional medical plan but will provide some limited assistance with hospitalization costs. The Hospital Plus I and Hospital Plus II options are not available to associates in HI, WA, MN and ND.

- For weekly payroll deductions, take the biweekly payroll deductions and divide by 2.
- In some instances your paycheck may not be enough to cover the entire amount of your benefits premiums. In those cases, the amount of the premium above your paycheck is still owed and will be collected from your future paychecks.
Creating your benefits password
The first time you log on to www.livetheorangelife.com or call the Benefits Choice Center, you'll create a password. You'll use this password each time you call or access the website. This is not the password or PIN printed on your paycheck.

Your password
• Can contain numbers, letters or both
• Can be between 4 and 20 characters long
• Can be the same as your paycheck PIN

When creating your password, you will be asked to provide the following identification information for security purposes: last 4 digits of your Social Security number, birth date, home ZIP code and date of hire.

What if you forget your password?
• If you use www.livetheorangelife.com, you can enter a hint when creating the password to help you remember your password later.
• You can speak to a Benefits Choice Center representative and reset your password immediately by providing the identification information above.

You can use www.livetheorangelife.com and the automated telephone system to request a new password. You will receive a temporary password in the mail within 7–10 days.

Your password prevents unauthorized people from accessing or changing your benefits, including your FutureBuilder account contribution elections and investments. In order to ensure your privacy, be sure to keep your password in a safe place, and do not share your password with anyone.

Livetheorangelife.com Website
• Available 24 hours a day, 7 days a week, from any computer with Internet access
• Get information about your benefit plans and check your benefit coverage
• Change your coverage if you marry, divorce, have a baby or adopt a child
• Enroll in benefits during your eligibility period as a new associate or during Annual Enrollment
• Enroll in FutureBuilder and access your account
The purpose of this book, called the Summary Plan Description (SPD), is to describe and explain benefit plans available to salaried and full-time hourly associates working in the United States of America. The SPD is intended only to help you understand the benefit plans available to you and can in no way modify the actual terms and provisions as specified in the legal documents that define the benefit plans. If there are differences between the information contained in the SPD and the provisions of the legal documents, the legal documents always govern. Legal documents include the official Plan document, trust agreements, and insurance contracts. You may request a copy of these legal documents by writing to The Home Depot, Benefits Department C-18, 2455 Paces Ferry Road, Atlanta, GA 30339.

Benefits are provided to associates and their eligible dependents based on information the Company may request over the phone, in writing or online. The Company may ask you to provide original documentation for the purpose of verification before granting benefits. The Company may also ask you to sign a release authorizing the Company to solicit the required documentation and/or information from a designated third party. Providing false information may result in exclusion from (i.e., loss of eligibility for) all Company-sponsored welfare benefit plans and/or disciplinary action against you in accordance with the Company’s Standards of Performance.

© 2017 Home Depot Product Authority, LLC. All rights reserved. Your Benefits Resources is a trademark of Hewitt Management Company LLC.