The purpose of this book, called the Summary Plan Description (SPD), is to describe and explain benefit plans available to full-time hourly and salaried associates working in the United States of America. The SPD is intended only to help you understand those 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 Plan document, the trust agreements, and insurance contracts. You may request a copy of these legal documents by writing to The Home Depot, Benefits Department C-9, 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, online, and through an automated phone response system. 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 (i.e., loss of eligibility from all Company-sponsored welfare benefit plans) and/or disciplinary action against you, in accordance with the Company’s Code of Conduct.
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. 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 St. Thomas, who receive different versions of the 2009 Benefits Summary.

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Remember!

NO Enrollment = No Coverage!!

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. 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 St. Thomas, who receive different versions of the 2009 Benefits Summary.

Your Benefits Resources™ Web site

- 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

Creating your benefits password

The first time you log on to the Your Benefits Resources Web site or call the Benefits Choice Center, you’ll create a password. You’ll use this password each time you call or access the Web site. 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: Social Security number, birth date, home ZIP code and date of hire.

What if you forget your password?

- If you use the Your Benefits Resources Web site, 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 the Your Benefits Resources Web site and the automated telephone system to request a new password. You will receive a temporary password in the mail within 7–10 days.
Life Events

U.S. Salaried & Full-Time Hourly Associates

Chapter Contents

2 Life Events
2 Same-sex Domestic Partner Life Events
3 Marriage
3 Divorce/Legal Separation/Annulment
4 Judgement, Order or Decree, including a Qualified Medical Child Support Order (QMCSO)
4 Birth
5 Adoption, Placement or Termination of Adoption
5 Death of...
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6 Gain or Loss of Other Coverage
7 Gain or Loss of Other Coverage
9 Lifetime Limit Reached
9 Change of Employment Status
10 Military Leave
11 Leaves of Absence
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 within 30 days of your 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 allowed changes in your benefits after qualified status change</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</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 Your Benefits Resources™ and make your changes.

Although, due to IRS regulations, you are generally not permitted to make midyear election changes during the year for benefits paid through a cafeteria plan on a pre-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 book 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 to help guide you through the benefit coverages you may need to change following a particular life event. Absent a qualified status change, no mid-year election changes can be made.

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 medical plan, it would be consistent to elect coverage under the Company's Medical Plan. However, if you did not lose coverage as a result of the divorce, it would not be consistent for you to elect medical coverage.

If you experience a qualified status change during the grace period under the healthcare spending account, changes are only allowed for your election in the current year and not in the year to which the grace period applies.

For purposes of this Life Events chapter, your spouse means your spouse as defined in the Eligibility and Enrollment chapter, and references to your child or children only include your own children, and do not include the child(ren) of your same-sex domestic partner. In addition, references to your dependents do not include your same-sex domestic partner or his or her child(ren) regardless of whether they are considered your dependents under other chapters in this summary.

For information on benefits for your same-sex domestic partner, see the Benefits for Same-sex Domestic Partners chapter. For information on life insurance and/or AD&D coverage for your opposite-sex partner see the Life Insurance and AD&D chapters.

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.

Same-sex Domestic Partner Life Events

For information on making coverage changes for your same-sex domestic partner or children of your partner, see the Benefits for Same-sex Domestic Partners chapter.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You may 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, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, AD&amp;D Insurance, Long-term Care, Legal Services Plan</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marriage</strong></td>
<td>Marital certificate if different last name</td>
<td>Date of marriage</td>
<td>Can add coverage for self, spouse and/or children and change medical option (e.g., from HMO to PPO)</td>
<td>Can start or increase contributions</td>
<td>Can start or increase contributions</td>
<td>Can add or increase coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>You wish to add</strong></td>
<td>Marital certificate</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 stop or decrease contributions if covered under new spouse’s health plan</td>
<td>Can stop or decrease contributions if new spouse is not employed or makes a dependent care election under his or her plan</td>
<td>Can drop or decrease coverage for self, spouse and/or children</td>
<td></td>
</tr>
<tr>
<td><strong>You wish to drop</strong></td>
<td>Marital certificate</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 stop or decrease contributions if covered under new spouse’s health plan</td>
<td>Can stop or decrease contributions if new spouse is not employed or makes a dependent care election under his or her plan</td>
<td>Can drop or decrease coverage for self, spouse and/or children</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>Final divorce decree or legal separation decree with official court signature</th>
<th>Date of decree</th>
<th>Can drop coverage for children with proof of coverage under other parent’s plan</th>
<th>Can start, stop, increase or decrease contributions</th>
<th>Can start, stop, increase or decrease contributions</th>
<th>Can add, increase, drop or decrease coverage for self and/or children</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You must drop coverage for spouse and any stepchildren who cease to be your dependents</strong></td>
<td>Final divorce decree or legal separation decree with official court signature</td>
<td>Date of decree</td>
<td>Can drop coverage for children with proof of coverage under other parent’s plan</td>
<td>Can start, stop, increase or decrease contributions</td>
<td>Can start, stop, increase or decrease contributions</td>
<td>Can add, increase, drop or decrease coverage for self and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>You wish to add self and/or your eligible children under the plan</strong></td>
<td>Final divorce decree or legal separation decree with official court signature</td>
<td>Date of decree</td>
<td>Can add or change coverage option for self and/or children if you or at least one child has lost coverage under spouse’s plan</td>
<td>Can start or increase contributions where coverage is lost under spouse’s health plan</td>
<td>Can start or increase contributions where coverage is lost under spouse’s health plan</td>
<td>Can add or increase coverage for self and/or children</td>
<td></td>
</tr>
</tbody>
</table>

1 SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.

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

3 If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.

4 If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You may 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, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, AD&amp;D Insurance, Long-term Care, Legal Services Plan</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement, Order or Decree, including a Qualified Medical Child Support Order (QMCSCO)*</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</td>
<td>Coverage is automatically added for child(ren) and self, if not enrolled, as specified by the judgement order or decree</td>
<td>Medical Plan option may change to provide required coverage</td>
<td>Can increase or start contributions</td>
<td>No change permitted</td>
</tr>
<tr>
<td>Requires coverage of your child under spouse’s plan</td>
<td>Approved order requiring coverage</td>
<td>Date other employer plan accepts the order</td>
<td>Drop coverage for child(ren) covered by the order</td>
<td>Can drop coverage for self, spouse and/or other dependents if you gain coverage under spouse’s plan following birth</td>
<td>Can stop or decrease contributions</td>
<td>Can add or increase coverage for spouse and/or children</td>
<td>No change permitted</td>
</tr>
<tr>
<td>Birth³</td>
<td>You wish to add self, spouse and/or new child⁴</td>
<td>Birth certificate</td>
<td>Date of birth</td>
<td>Can add coverage for new child, self, other children and spouse and/or change coverage option (e.g., from HMO to PPO)</td>
<td>Can start or increase contributions</td>
<td>Can start or increase contributions</td>
<td>Can add or increase coverage for spouse and/or children</td>
</tr>
<tr>
<td>You wish to drop coverage for self, spouse, or other children and cover under spouse’s plan</td>
<td>Proof of other coverage under spouse’s plan and birth certificate</td>
<td></td>
<td>Can drop coverage for self, spouse and/or other dependents if you gain coverage under spouse’s plan following birth</td>
<td>Can stop or decrease contributions</td>
<td>No change permitted</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information.

A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.

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

3 If you are already covered under the self-insured HMO, PPO or OOA Medical Plan with associate + family or associate + child(ren), and you add your newborn or newly adopted child (or child placed for adoption) within the first 12 months of birth, adoption or placement for adoption, coverage will be effective from date of the qualifying event. If you are already covered under the self-insured HMO, PPO, or OOA Medical Plans with associate only or associate and spouse and add your newborn or newly adopted child after 60 days but within six months of the birth or adoption, coverage will be effective the date the Benefits Choice Center receives your request. For other allowable changes after 30 days, please see the Newborn and Adopted Children section in the Enrollment and Eligibility chapter.

4 If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.

5 If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.

6 A QMCSO may require coverage for your child, but not your spouse or former spouse.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You may 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, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, AD&amp;D Insurance, Long-term Care, Legal Services Plan1,2</th>
<th>Disability1,2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption, Placement or Termination of Adoption2</td>
<td></td>
<td></td>
<td>Can add self, spouse and child(ren) and change coverage option (e.g., HMO to PPO)</td>
<td>Can start or increase contributions</td>
<td>Can start or increase contributions</td>
<td>Can add or increase coverage for self, spouse and/or child</td>
<td>Not applicable</td>
</tr>
<tr>
<td>You wish to add self, spouse and/or new child4</td>
<td>Final adoption decree or legal documentation of placement</td>
<td>Date of adoption or placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You wish to drop coverage and cover child under spouse's plan</td>
<td>Can drop coverage for self, spouse and/or dependents if become covered under spouse's plan</td>
<td></td>
<td>Can stop or decrease contributions if termination number of dependents</td>
<td>Can stop or decrease contributions if termination decreases the number of dependents</td>
<td></td>
<td>No change permitted</td>
<td></td>
</tr>
<tr>
<td>Death of...</td>
<td></td>
<td></td>
<td>Must drop coverage for child who ceases to be an eligible dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your dependent covered under Home Depot plan</td>
<td>Death certificate</td>
<td>Date of death</td>
<td>Must drop coverage for dependent who died</td>
<td>Can decrease or stop contributions</td>
<td>Can decrease or stop contributions</td>
<td>Drop coverage for deceased dependent; can drop or decrease your coverage</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Your spouse, and you and/or your child(ren) lose coverage under your spouse’s plan</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 plan1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.
2 Must be actively at work for coverage to take effect.
3 If you are already covered under the self-insured HMO, PPO or OOA Medical Plan with associate + family or associate + child(ren), and you add your newborn or newly adopted child (or child placed for adoption) within the first 12 months of birth, adoption or placement for adoption, coverage will be effective from date of the qualifying event. If you are already covered under the self-insured HMO, PPO, or OOA Medical Plans with associate only or associate and spouse and add your newborn or newly adopted child after 60 days but within six months of the birth or adoption, coverage will be effective the date the Benefits Choice Center receives your request. For other allowable changes after 30 days, please see the Newborn and Adopted Children section in the Enrollment and Eligibility chapter.
4 If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.
5 If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You may be asked to provide the Benefits Choice Center with...</th>
<th>You must notify the Benefits Choice Center within 30 days after...²</th>
<th>Medical, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, AD&amp;D Insurance, Long-term Care, Legal Services Plan¹²</th>
<th>Disability¹²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Coverage Due to Moving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You, your spouse and/or your dependent changes place of residence, causing a loss of coverage in this plan or a spouse’s plan</td>
<td>Address must be updated in payroll system</td>
<td>Your move to new ZIP code</td>
<td>Can add or drop coverage for you, your spouse or child(ren) and/or change coverage options³</td>
<td>No change permitted</td>
<td>Can start, stop, increase or decrease contributions</td>
<td>No change permitted</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Gain or Loss of Other Coverage¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain of coverage due to spouse’s employer’s period of coverage differing from Home Depot’s period of coverage</td>
<td>Proof of gain of coverage</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>No change permitted</td>
<td>Can stop or decrease contributions</td>
<td>Can stop or decrease 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>Proof of loss of coverage</td>
<td>Effective date of coverage lost</td>
<td>Can add or increase coverage for self, spouse and/or children if covered under the spouse’s plan¹⁴</td>
<td>Can start or increase contributions</td>
<td>Can add or increase coverage for self, spouse and/or children</td>
<td>Can start or increase contributions</td>
<td></td>
</tr>
<tr>
<td>Gain coverage due to change in spouse’s or dependent’s employment</td>
<td>Proof of other coverage</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>No change permitted</td>
<td>Can drop or decrease coverage for self, spouse and/or children</td>
<td>Can drop or decrease coverage for self, spouse and/or children</td>
<td></td>
</tr>
</tbody>
</table>

¹ SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.
² Must be actively at work for coverage to take effect.
³ 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.
⁴ If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.
⁵ If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.
### LIFE EVENTS

You can change your benefits as follows:

| If you have the following change in status... | You may be asked to provide the Benefits Choice Center with... | You must notify the Benefits Choice Center within 30 days after... | Medical, Dental & Vision | Health Care Spending Account | Dependent Day Care Spending Account | Voluntary Term Life, Dependent Term Life, AD&D Insurance, Long-term Care, Legal Services Plan | Disability
---|---|---|---|---|---|---|---|
| Loss of coverage due to child’s loss of eligibility under the Home Depot plans | | | | | | | Not applicable
| Proof of loss of coverage | Effective date of coverage lost | You must drop coverage for dependent child | No change permitted | Can stop or decrease contributions | Can stop or decrease coverage for self, spouse and/or children | | 
| You, your child or dependent lose coverage under another health plan because it no longer offers benefits to similarly situated individuals | | | Can add coverage and/or change coverage for you, your spouse or your children\(^1\) | | | Can add or increase coverage for self, spouse and/or children | 
| Date coverage ends | Can add or increase coverage for self, spouse and/or children or change coverage option if you added dependent\(^1\) | Can increase or start contributions | No change permitted | Can add or increase coverage for self, spouse, and/or children | You are automatically enrolled in coverage when first eligible | See the Disability chapter for more information on coverage changes once enrolled
| Loss of coverage due to you, your spouse’s or your dependent’s loss of eligibility under another health plan\(^2\) | | | | | | | 
| Date other coverage involuntarily ends | Can add or increase coverage for self, spouse and/or children or change coverage option if covered under spouse’s plan\(^2\) | No change permitted | Can increase or start contributions | Can add or increase coverage for self, spouse, and/or children | |

---

**Gain or Loss of Other Coverage\(^1\)** (continued)

1. SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the [Life Insurance](#) chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.

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

3. 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.

4. If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.

5. If you were hired as a full-time employee before January 1, 2001, see the [Disability](#) chapter for more information on your enrollment options.

6. 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).
### You can change your benefits as follows:

<table>
<thead>
<tr>
<th>Gain or Loss of Other Coverage</th>
<th>Benefits Choice Center</th>
<th>Benefits Choice Center within 30 days after...</th>
<th>Medical, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, AD&amp;D Insurance, Long-term Care, Legal Services Plan</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Loss of coverage due to the exhaustion of COBRA coverage</strong></td>
<td>Proof of loss of COBRA coverage</td>
<td>Date COBRA coverage ends with other employer</td>
<td>Can add or increase coverage for self, spouse and/or children or change coverage option if covered under spouse’s plan</td>
<td>Can increase or start contributions</td>
<td>No change permitted</td>
<td>No change permitted</td>
<td>You are automatically enrolled in coverage when first eligible</td>
</tr>
<tr>
<td><strong>Spouse’s employer eliminates or adds a benefit option (e.g., HMO, PPO, POS or Indemnity)</strong></td>
<td>Proof of elimination or addition of benefit option and proof that no similar option is offered</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>No change permitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>You, your spouse or your dependent lose coverage under Medicare or Medicaid, and you wish to add coverage</strong></td>
<td>Proof of loss of Medicare or Medicaid coverage</td>
<td>Date when coverage ends</td>
<td>Can add or increase coverage for self, spouse and/or children who lost coverage under Medicare or Medicaid (medical only)</td>
<td>Can increase or start contributions</td>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>You or your spouse gain coverage by Medicare or Medicaid, and you wish to drop coverage</strong></td>
<td>Proof of Medicare or Medicaid coverage</td>
<td>Date when Medicare or Medicaid coverage begins</td>
<td>Can drop or decrease coverage for self, spouse and/or children covered by Medicare or Medicaid (medical only)</td>
<td>Can decrease or stop contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1. SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.
2. Must be actively at work for coverage to take effect.
3. You may notify the Benefits Choice Center after the loss of coverage has occurred but before the 30 days have passed since that loss of coverage.
4. If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.
5. If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.
6. Participation in the Long-term Care and Legal Services Plan will continue.
7. Exhaustion of COBRA means that an individual’s COBRA continuation coverage ceases for any reason other than either the failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim for an intentional misrepresentation of a material fact in connection with the plan).
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>Lifetime Limit Reached</th>
<th>Medical, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, A&amp;D Insurance, Long-term Care, Legal Services Plan</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>You, your spouse or your dependent have a claim for benefits denied due to reaching a lifetime limit on all benefits under another health plan¹</td>
<td>Proof that lifetime limit has been reached</td>
<td>Date lifetime limit reached</td>
<td>Can add coverage and/or change coverage option for you, your spouse or your child(ren)²</td>
<td>Can increase or start contributions</td>
<td>No change permitted</td>
</tr>
<tr>
<td>You, your spouse or your dependent have a claim for benefits denied due to reaching a lifetime limit on all benefits under a Home Depot medical coverage option</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Change of Employment Status**

<table>
<thead>
<tr>
<th>Salaried to Full-Time Hourly</th>
<th>No change allowed</th>
<th>No change allowed</th>
<th>No change allowed</th>
<th>No change allowed</th>
<th>Can add, increase, decrease or drop coverage</th>
<th>You are automatically enrolled in coverage when first eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Time Hourly to Salaried</td>
<td>Date of employment status change or eligibility date</td>
<td>Can add coverage for self, spouse, and/or children³</td>
<td>Can start contributions</td>
<td>Can start contributions</td>
<td>Can add coverage for self, spouse and/or children</td>
<td>See the appropriate Disability chapter for more information on coverage changes once enrolled</td>
</tr>
<tr>
<td>Part-Time Hourly to Full-Time Hourly</td>
<td>Coverage, except Vision, cancelled for self, spouse and/or children. See the Part-time Benefits Summary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information.

² A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.

³ Must be actively at work for coverage to take effect.

⁴ If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.

⁵ If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.

⁶ Participation in the Long-term Care and Legal Services Plan will continue.

⁷ Associate must notify the BCC within 30 days of the date he/she receives notice that a claim was denied due to the application of the lifetime limit.
You can change your benefits as follows:

<table>
<thead>
<tr>
<th>Military Leave</th>
<th>Proof of military leave</th>
<th>Date leave begins or date leave ends</th>
<th>Coverage before leave will automatically be reinstated. OR can add, change or stop coverage for you, your spouse or your children*</th>
<th>Coverage before leave will automatically be reinstated OR can add, increase or stop contributions</th>
<th>Coverage before leave will automatically be reinstated OR can add, increase or stop contributions</th>
<th>Coverage before leave will automatically be reinstated OR can add, except coverage requiring a statement of health OR can add, increase or stop coverage for self, spouse and/or children</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaving for and returning from a military leave of absence within the same calendar year</td>
<td>Proof of military leave</td>
<td>Date leave begins or date leave ends</td>
<td>Coverage before leave will automatically be reinstated. OR can add, change or stop coverage for you, your spouse or your children*</td>
<td>Coverage before leave will automatically be reinstated OR can add, increase or stop contributions</td>
<td>Coverage before leave will automatically be reinstated OR can add, increase or stop contributions</td>
<td>Coverage before leave will automatically be reinstated OR can add, except coverage requiring a statement of health OR can add, increase or stop coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Leaving for and returning from a military leave of absence in a subsequent year</td>
<td>Proof of military leave</td>
<td>Date leave begins or date leave ends</td>
<td>Coverage before leave will automatically be reinstated. OR can add, change or stop coverage for you, your spouse or your children*</td>
<td>Coverage before leave will automatically be reinstated OR can add, increase or stop contributions</td>
<td>Coverage before leave will automatically be reinstated OR can add, increase or stop contributions</td>
<td>Coverage before leave will automatically be reinstated OR can add, except coverage requiring a statement of health OR can add, increase or stop coverage for self, spouse and/or children</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

1 SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.
2 Must be actively at work for coverage to take effect.
3 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.
4 If you enroll your spouse in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you. If you enroll yourself (the associate) in medical coverage, you must indicate and complete the Simple Steps Health Assessment to receive the health assessment credit in each of your paychecks.
5 If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.
6 Participation in the Long-term Care and Legal Services Plan will continue.
## LIFE EVENTS

You can change your benefits as follows:

<table>
<thead>
<tr>
<th>If you have the following change in status...</th>
<th>You may 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, Dental &amp; Vision</th>
<th>Health Care Spending Account</th>
<th>Dependent Day Care Spending Account</th>
<th>Voluntary Term Life, Dependent Term Life, AD&amp;D Insurance, Long-term Care, Legal Services Plan¹²³</th>
<th>Disability¹²³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leaves of Absence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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 children</td>
<td>Can stop contributions or continue under COBRA⁴</td>
<td>Contributions stop⁴</td>
<td>Can drop coverage for you, your spouse or children</td>
<td>Coverage ends⁴</td>
<td></td>
</tr>
<tr>
<td>Returning from a leave of absence within the same calendar year</td>
<td>Date leave ends.</td>
<td>Coverage before leave will automatically be reinstated.</td>
<td>Contribution amount before leave will automatically be reinstated. You can increase contribution amount to make up for contributions missed during leave.</td>
<td>Coverage before leave will automatically be reinstated</td>
<td>Coverage before leave will automatically be reinstated. If you want to add/stop or increase/decrease coverage, see the applicable chapter for requirements (Life Insurance chapter, AD&amp;D chapter or the Full-time Hourly Disability or Salaried Disability chapter). For information on Long-term Care or the Legal Services Plan, call the Benefits Choice Center.</td>
<td></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)</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>If you return from leave in a subsequent year, the Health Care spending account coverage you enrolled in during Annual Enrollment will start and you can enroll in the Dependent Day Care spending account within 30 days of your return from leave. You will need to adjust your contribution amount depending on the number of pay periods remaining in the calendar year.</td>
<td>Coverage before leave will automatically be reinstated. If you want to add/stop or increase/decrease coverage, see the applicable chapter for requirements (Life Insurance chapter, AD&amp;D chapter or the Full-time Hourly Disability or Salaried Disability chapter). For information on Long-term Care or the Legal Services Plan, call the Benefits Choice Center.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your spouse. See the Life Insurance chapter for more information.
2 Must be actively at work for coverage to take effect.
3 If you were hired as a full-time employee before January 1, 2001, see the Disability chapter for more information on your enrollment options.
4 If your contributions stopped during your leave, you cannot submit expenses you have during the leave even if you elect to increase your biweekly contributions to make up contributions missed during your leave.
5 Disability benefits will continue if your disability began before the start of your leave.
Eligibility & Enrollment

U.S. Salaried & Full-Time Hourly Associates

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13 Salaried Associate Eligibility
13 Temporary Associates, Leased Employees and Independent Contractors
14 When Coverage Begins
14 Dependent Eligibility: Medical, Dental and Vision Plans
15 Over Age 19 Unmarried Dependent Children Who Are Full-Time Students
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25 If You’re Rehired
25 Full-Time Hourly Associates
26 Salaried Associates
26 Service Requirements For MetLife Group Benefits If You Are Rehired
Get the Most Value from Your Home Depot Benefits

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll for benefits</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call the Benefits Choice Center at 1-800-555-4954.</td>
</tr>
<tr>
<td>Change your benefit elections if you have a qualified status change</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call the Benefits Choice Center at 1-800-555-4954.</td>
</tr>
</tbody>
</table>

Full-Time Hourly Associate Eligibility

As a full-time hourly associate, you are eligible to participate in the Company’s health and welfare benefit Plans, including Group Benefits, as described in this book if you are classified by the Company as full-time hourly and have completed your waiting period as follows:

- U.S., except Hawaii—90 days of active service
- Hawaii—28 days of active service

Group Benefits include the Legal Services Plan, Long-term Care Insurance, Auto and Home Insurance and Veterinary Pet Insurance. For more information on these plans, call the Benefits Choice Center and say “Additional Programs” at the main menu.

Your coverage begins on the first day after you complete your waiting period, as follows:

<table>
<thead>
<tr>
<th>Where You Work</th>
<th>Your Waiting Period</th>
<th>When Coverage Begins</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S., except Hawaii</td>
<td>90 days</td>
<td>on the 91st day</td>
</tr>
<tr>
<td>Hawaii</td>
<td>28 days</td>
<td>on the 29th day</td>
</tr>
</tbody>
</table>

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.

Salaried Associate Eligibility

If you are classified by the Company as a salaried associate, you are eligible to participate immediately in the Company’s health and welfare benefit plans, including Group Benefits, as described in this book.

Group Benefits include the Legal Services Plan, Long-term Care Insurance, Auto and Home Insurance and Veterinary Pet Insurance. For more information on these plans, call the Benefits Choice Center and say “Additional Programs” at the main menu.

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

Medical coverage for salaried associates begins on your date of hire if you enroll during your initial eligibility period. However, if you enroll in one of the Aetna medical plans or the Aetna HMO, CIGNA HMO or UHC HMO, you will have different coverage from the plan you enrolled in during your first 90 days of employment. See Medical and Prescription Drug Coverage for Salaried Associates During the First 90 Days of Employment in the Medical chapter for more information. This does not apply to associates in California or Hawaii.

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 FutureBuilder. See the eligibility rules for additional information. Leased employees and independent contractors are also ineligible for these benefits.¹

If you are working for the Company as a temporary associate, 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 temporary associate, leased employee or independent contractor.

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 date of determination, even if the determination becomes effective on an earlier date.
When Coverage Begins
Coverage may be postponed for all Plans, except Medical, 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 and complete your waiting period.
- 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 are not working due to a work-related injury, coverage for you and your family will not be delayed. Coverage will start the day after you complete your waiting period.

Dependent Eligibility: Medical, Dental and Vision Plans
The following dependents can participate in the Medical, Dental and Vision Plans as described in this book:

- Your legal spouse, unless you are legally separated. Your legal spouse is a person of the opposite sex to whom you are married under state law.
- Common-law spouses are not eligible for medical coverage except a fully insured HMO in states where it is required.1
- For medical coverage only in California, domestic partners are eligible if ALL of the following requirements are met:
  - Both persons file a declaration of Domestic Partnership with the Secretary of State;
  - Both persons have a common residence. It is not necessary that the legal right to possess the residence be in both of their names;
  - Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved or annulled;
  - The two persons are not related by blood in a way that would prevent them from being married to each other in California; and
  - Both persons are at least 18 years of age and are capable of consenting to the domestic partnership; and either of the following is true:
    - Both persons are of the same sex; or
    - The domestic partner is of the opposite sex and one or both persons are over age 62 and also meet the eligibility criteria for Medicare benefits.

You may cover a same-sex domestic partner and his or her eligible dependents if you do not have a legal spouse. Your same-sex domestic partner may not be eligible for certain fully insured plans (the following HMOs: BCBS of Western NY, BCBS of Illinois and Kaiser of Georgia).

Your same-sex domestic partner must meet all of the following requirements:

- Is an adult who is of the same-sex as you;
- Is at least age 18 or older;
- He or she has not registered as a member of another domestic partnership within the past six months;
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage;
- Is in an exclusive, mutually committed relationship with you and intends to continue the relationship indefinitely;
- Has lived with you for at least six consecutive months and intends to do so indefinitely;
- Is not related to you in a manner that would bar a legal marriage in the state in which you live;
- Is not married or in a civil union or similarly recognized relationship with any one but you; and
- Shares with you the responsibility for common welfare and basic financial obligations on a continuing basis.

1 The Company recognizes common-law spouses as dependents for fully insured HMOs in the following states where this is mandatory: District of Columbia and Rhode Island.
Under Age 19 Unmarried Dependent Children

This includes the following:

- Natural and adopted children, and children placed with you for adoption.
- Stepchildren and children for whom you have custody or are a legal guardian who meet ALL of the following requirements:
  - Do not have health coverage available through a natural parent’s benefits program;
  - Are in the custody or legal guardianship of you or your spouse; and
  - Whom you or your spouse claims on your federal income tax return.
- Children of your same-sex domestic partner who meet ALL of the following requirements:
  - Do not have health coverage available through a natural parent’s benefits program;
  - Are in the custody or legal guardianship of you or your same-sex domestic partner;
  - Whom you or your same-sex domestic partner claim on your federal income tax return; and
  - Will be enrolled in a plan(s) that covers same-sex domestic partners.
- Dependent grandchildren are not eligible unless the associate is enrolled in a fully insured HMO that is filed in a state that requires coverage for dependent grandchildren (District of Columbia, Maryland, Massachusetts, New Hampshire, and Oregon). The HMO that is required to cover dependent grandchildren are:
  - Kaiser—Portland: Kaiser—Portland covers dependents of dependents (grandchildren) as long as the parent of the grandchild is a dependent of the subscriber and the grandchild has been covered since birth by any health plan.
- Unmarried 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.

Over Age 19 Unmarried Dependent Children Who Are Full-Time Students

This includes the following:

- Unmarried dependent children, as defined in Under Age 19 Unmarried Dependent Children, up to age 25 if the child is a full-time student in high school or at an accredited college, university or approved vocational trade school and you provide over 50% of the child’s financial support.
- A dependent is determined to be a full-time student if he or she meets the institution’s definition of a full-time student for at least five months during the calendar year. Schools may include any accredited institution that is eligible for federal grants or student loans, including two- and four-year programs. The dependent does not have to be continuously enrolled as a full-time student to be eligible.
- Coverage for full-time students will end on the day the dependent child reaches age 25.
- If your dependent meets the five-month requirement for full-time student status, you must drop that dependent before the end of the year if you stop providing at least 50% of the child’s financial support.

Disabled Dependent Children

You may cover your dependent children who are unmarried dependent children, as defined in Under Age 19 Unmarried Dependent Children, and are incapable of self-support upon reaching age 19 because of mental or physical disability, as long as they are covered under the Plan before age 19 or, if later, when first eligible. You can continue coverage for your disabled child as long as the mental or physical disability continues. Proof of disability must be received by the Benefits Choice Center for review and approval within 30 days after coverage would otherwise end.

If you first become eligible for the Medical, Vision and Dental Plans when your disabled child is over age 19, you can cover that child if:

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

A dependent is considered to be disabled if that child is incapable of self-support because of mental retardation or physical disability and such disability existed prior to that child turning age 19.

The Company’s Medical, Vision and Dental Plans reserve the right to have your child examined by a physician of their choice to determine the existence of your child’s disability.
Newborn and Adopted Children
If you are not covered under a Company Medical Plan option, to enroll a newborn or newly adopted child (or child placed for adoption) for coverage, you must call the Benefits Choice Center or access the Your Benefits Resources Web site no later than 30 days after the child’s birth, date of adoption or placement for adoption.

However, if you are already covered under the Company's self-insured Medical Plan, and you add your newborn, or newly adopted child (or child placed for adoption) within 60 days, coverage is effective from the date of the qualifying event. If you are already covered under the Medical Plan either as Associate Only or Associate + Spouse, and you add your new child after 60 days but within six months of the child’s birth, adoption or placement for adoption, coverage is effective the date the Benefits Choice Center receives your request.

If you are already covered under the self-insured Medical Plans with Associate + Family or Associate + Child(ren), and you add your newborn or newly adopted child (or child placed for adoption) within the first 12 months after birth, adoption or placement for adoption, coverage will be effective from date of the birth, adoption or placement for adoption.

If you wish to change your coverage option due to the birth of a child, you must call the Benefits Choice Center or go to the Your Benefits Resources Web site to add the child within 30 days if you are not covered under the Medical or Dental Plan or within 60 days if you are covered.

Family Members Who Can’t Participate
The following family members cannot participate in the Company’s benefit Plans as described in this book:
- your spouse, if you are legally separated
- your ex-husband or ex-wife, if divorced from you
- your common-law spouse (except as described in Dependent Eligibility: Medical, Dental and Vision Plans)
- your opposite-sex domestic partner, except where participation is specifically provided for in this Benefits Summary (e.g., medical coverage in California under certain circumstances, long-term care, legal services, voluntary dependent life and voluntary AD&D).
- your same-sex domestic partner and his or her children if the same-sex domestic partner does not or ceases to satisfy the requirements as outlined in Dependent Eligibility: Medical, Dental and Vision Plans
- 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—see Military Leave of Absence, in the Leaves of Absences chapter for more information)
- children over age 19, unless they are full-time students or they meet the requirements for disabled children or they have fully insured coverage and the state’s insurance laws require that coverage is extended past age 19
- foster children

Dependent Eligibility: Voluntary Dependent Term Life Insurance (Spouse and Child) and Family Protection Plus AD&D Plans
The following dependents can participate in the Company’s Voluntary Dependent Term Life Insurance and Family Protection Plus AD&D Plans as described in the Life Insurance and AD&D chapters:
- Your legal spouse, unless you are legally separated. Your legal spouse is a person of the opposite sex to whom you are married under state law.
- Your same- or opposite-sex domestic partner, who must meet all of the following requirements:
  — Has an exclusive mutual commitment to you to share responsibility for each other's welfare and financial obligations which has existed for at least six months prior to his or her enrollment in life insurance and/or AD&D coverage(s) and which is expected to last indefinitely;
  — Has shared the same residence with you for at least six months prior to his or her enrollment in life insurance and/or AD&D coverage(s);
  — Is 18 years of age or older;
  — Is not married; and
  — Is not related to you by blood in a manner that would bar marriage in the state in which you reside (does not apply to Maine residents)

You may not cover a same- or opposite-sex domestic partner and/or his or her child(ren) if you have a legal spouse.
Under Age 19 Unmarried Dependent Children
The following dependents are eligible to participate:

- A child who is supported solely by you and permanently living in the home of which you are the head;
- A child who is legally adopted or placed with you for adoption;
- A child, stepchild or child of your same- or opposite-sex domestic partner who lives in your home and is dependent on you for more than one-half of his or her support, as defined by the Internal Revenue Code of the United States, and has been reported as a dependent on your most recent Federal income tax return; and
- A child for whom benefits must be provided by court order, that the Company has been notified of (as set forth in a divorce decree).

Over Age 19 Unmarried Dependent Children Who Are Full-Time Students
This includes the following:

- Unmarried dependent children, as defined in Under Age 19 Unmarried Dependent Children, up to age 26 if the child is a full-time student at a high school or an accredited college, university or approved vocational trade school and primarily dependent on the associate for support.
- A dependent is determined to be a full-time student if he or she meets the institution’s definition of a full-time student for at least five months during the calendar year. Schools may include any accredited institution that is eligible for federal grants or student loans, including two- and four-year programs. The dependent does not have to be continuously enrolled as a full-time student to be eligible.
- Coverage for full-time students will end at the end of the year the dependent child reaches age 26.
- If your dependent meets the five-month requirement for full-time student status, you must drop that dependent before the end of the year if he or she ceases to be dependent on you for financial support.

Disabled Dependent Children
If your dependent child (as defined in Under Age 19 Unmarried Dependent Children) is covered under the Voluntary Dependent Term Life Insurance and/or Family Protection Plus Voluntary AD&D Plan on the day before he or she reaches age 19 (or, if later, when first eligible), he or she will continue to be an eligible dependent after reaching age 19 as long as the child remains unable to work in self-sustaining employment because of a physical handicap or developmental disability and:

- The child is and remains chiefly dependent on you for support;
- The child is and remains a dependent as defined in Under Age 19 Unmarried Dependent Children except for the age limit;
- You provide proof, when requested, that the child is and remains unable to work and is dependent on you since the age limit. Proof will not be requested more than once a year, and the proof must be acceptable to the insurance company; and
- You make any payment for the coverage as required by the Company.
Newborn and Adopted Children
To enroll a newborn or newly adopted child (or child placed with you for adoption) in Voluntary Dependent Term Life coverage for children, you must call the Benefits Choice Center or access the Your Benefits Resources Web site no later than 30 days after the child’s birth, date of adoption or placement with you for adoption. Even if you have children enrolled in Voluntary Dependent Term Life Insurance coverage for children when you have a newborn or newly adopted child, you must call the Benefits Choice Center or access Your Benefits Resources to enroll your new child.

Family Members Who Can’t Participate
The following family members cannot participate in the Voluntary Dependent Term Life and Family Protection Plus Voluntary AD&D Plans as described in this book:

- Your spouse, if you are legally separated
- Your ex-husband or ex-wife, if divorced from you
- Your same- or opposite-sex domestic partner and his or her children if the same- or opposite-sex domestic partner does not or ceases to satisfy the requirements as outlined in Dependent Eligibility: Voluntary Dependent Term Life Insurance (Spouse and Child) and Family Protection Plus Voluntary AD&D Plans
- 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—see Military Leave of Absence, in the Leaves of Absences chapter for more information)

- Children over age 19, unless they are full-time students or they meet the requirements for disabled children
- Foster children
- Children for whom the associate is only a legal guardian except eligible stepchildren and eligible children of your same-sex domestic partner
- A child less than 14 days old (for Family Protection Plus Voluntary AD&D only)
- Children over age 26, even if a full-time student, unless they are disabled
- Your spouse (or same- or opposite-sex domestic partner) age 70 or over (for Family Protection Plus Voluntary AD&D only)

Enrolling for Coverage

Enrolling as a New Associate
You will receive benefits enrollment information after you join the Company. You must access the Your Benefits Resources Web site or call the Benefits Choice Center to enroll:

- Full-time hourly associates: within 90 days of your date of hire
- Salaried associates: within 30 days of your date of hire

Paper enrollments will not be accepted. If the enrollment mailer was mailed to the address on the Company records, no exception will be made. You are responsible for updating your postal address in the Company records. Please call the Human Resources Service Center at 1-866-698-4347 to update your information.

If you do not enroll when you are first eligible as a new hire, you will not be able to enroll in Medical, Vision, Dental benefits or the Spending Accounts until the next Annual Enrollment unless you have a qualified status change during the year. You may enroll in Voluntary Term Life (subject to an approved Statement of Health form), Voluntary Dependent Term Life for your spouse (an approved Statement of Health may be required), Voluntary Dependent Term Life for your child, Voluntary AD&D or Short- and Long-Term Disability (subject to an approved Statement of Health form) during any rolling 12-month period.

Note: Some of the Company benefit Plans have pre-existing condition limitations.

Enrolling or Making Changes After Initial Enrollment
By enrolling or making changes to your benefits (including such actions as, but not limited to, adding a dependent or verifying a child’s full-time student status), you are responsible for providing truthful and accurate information. Providing false information may result in exclusion from (i.e., loss of eligibility for) all Company-sponsored welfare benefit plans and/or disciplinary action as outlined in the Company’s code of conduct.
### Enrolling in Benefits as a New Associate

<table>
<thead>
<tr>
<th>Plan</th>
<th>Is Enrollment Necessary?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>U.S.: Yes. Associates, but not their dependents, are enrolled automatically in the PPO Medical Plan. If you do not want coverage, you must complete an HC-5 form <strong>within 30 days of your date of hire. You must enroll your dependents if you want them to have coverage.</strong></td>
</tr>
<tr>
<td>Hawaii: No. Associates, but not their dependents, are enrolled automatically in the PPO Medical Plan. If you do not want coverage, you must complete an HC-5 form <strong>within 30 days of your date of hire. You must enroll your dependents if you want them to have coverage.</strong></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Yes.</td>
</tr>
<tr>
<td>Basic Term Life Insurance</td>
<td>No. Automatic with Medical enrollment. Not available otherwise. This is a Company-paid benefit.</td>
</tr>
<tr>
<td>Basic Dependent Term Life Insurance</td>
<td>No. Automatic when you enroll dependents in Medical. Not available otherwise. This is a Company-paid benefit.</td>
</tr>
<tr>
<td>Dental</td>
<td>Yes.</td>
</tr>
<tr>
<td>Full-time Hourly Associate Disability Insurance: U.S.—Short- and/or Long-term Hawaii—Long-term</td>
<td>No. Enrollment is automatic for newly eligible associates during their initial eligibility period. If you do not want disability insurance, you must opt out during your enrollment period. If you opt out of STD/LTD coverage, you must complete and submit a Statement of Health form, which must be approved by MetLife, to later enroll for coverage.</td>
</tr>
<tr>
<td>Salaried Associate Disability Insurance (Short-term and Long-term)</td>
<td>No. Enrollment is automatic. This is a Company-paid benefit.</td>
</tr>
<tr>
<td>Salaried Associate Supplemental Disability Insurance</td>
<td>Yes.</td>
</tr>
<tr>
<td>Voluntary Term Life Insurance</td>
<td>Yes. If you do not enroll when first eligible, you must complete and submit a Statement of Health form which must be approved by MetLife.</td>
</tr>
<tr>
<td>Voluntary Dependent Term Life Insurance for Spouse/SSDP</td>
<td>Yes. You must complete and submit a statement of Health for all coverage over $20,000, which must be approved by MetLife. To cover a domestic partner, you must complete an affidavit and return to MetLife, if applicable.</td>
</tr>
<tr>
<td>Voluntary Dependent Term Life Insurance for Children</td>
<td>Yes.</td>
</tr>
<tr>
<td>Basic Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
<td>No. Coverage is automatic. This is a Company-paid benefit.</td>
</tr>
<tr>
<td>Voluntary AD&amp;D Insurance</td>
<td>Yes.</td>
</tr>
<tr>
<td>Spending Accounts (health care and dependent day care)</td>
<td>Yes.</td>
</tr>
<tr>
<td>Long-term Care Insurance</td>
<td>Yes. If you do not enroll when first eligible, you must complete and submit a Statement of Health form, which must be approved by MetLife. You must also complete and submit a Statement of Health form, which must be approved by MetLife, for any dependents that you enroll.</td>
</tr>
<tr>
<td>Legal Services Plan</td>
<td>Yes.</td>
</tr>
<tr>
<td>FutureBuilder</td>
<td>Yes.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan</td>
<td>Yes.</td>
</tr>
</tbody>
</table>

For help, go to [http://resources.hewitt.com/homedepot](http://resources.hewitt.com/homedepot) or call 1-800-555-4954
If you and your spouse or same-sex domestic partner both work for the Company, you have enrollment options that include the following:

### If You and Your Spouse or Same-sex Domestic Partner Both Work for the Company

<table>
<thead>
<tr>
<th>Plan</th>
<th>Choice</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Each of you can enroll in associate-only coverage</td>
<td>With this choice, both you and your spouse are automatically covered for the Company-paid Basic Term Life Insurance. See the Life Insurance chapter for more information.</td>
</tr>
<tr>
<td></td>
<td>One of you can enroll in associate + spouse (or same-sex domestic partner) coverage</td>
<td>Your spouse or same-sex domestic partner will be covered by Basic Dependent Term Life Insurance. See the Life Insurance chapter for more information.</td>
</tr>
</tbody>
</table>
|                             | One of you can enroll in associate + family (children and spouse or same-sex domestic partner) coverage | With this choice,  
  - Your spouse and children are covered as dependents.  
  - Your spouse must be enrolled in the same Medical Plan Option, such as PPO, that you elect.  
  Your spouse and each child are covered by Basic Dependent Term Life Insurance for $2,000. See the Life Insurance chapter for more information. |
| Prescription Drugs          | See next column                                                      | Your Prescription Drug coverage level will be the same as your Medical coverage. For example, if you enroll in the PPO with associate + family, your coverage level in the Prescription Drug Plan will also be associate + family. If you enroll in an HMO for Medical coverage, prescription drug benefits are provided through your HMO Plan provider. |
| Dental                      | Each of you can enroll in associate-only coverage                    |                                                                                                                                                                                                             |
|                             | One of you can enroll in associate + spouse (or same-sex domestic partner) coverage | With this choice,  
  - Your spouse and children are covered as dependents.  
  - Your spouse must be enrolled in the same Dental Plan Option that you elect.                                                                                                                                 |
| Vision                      | Each of you can enroll in associate-only coverage                    |                                                                                                                                                                                                             |
|                             | One of you can enroll in associate + spouse (or same-sex domestic partner) coverage |                                                                                                                                                                                                             |
|                             | One of you can enroll in associate + family (children and spouse or same-sex domestic partner) coverage | With this choice,  
  - Your spouse and children are covered as dependents.  
  - Your spouse must be enrolled in the same Dental Plan Option that you elect.                                                                                                                                 |
| Voluntary Term Life         | Each of you can enroll in Voluntary Term Life                        |                                                                                                                                                                                                             |
|                             | Each of you can enroll each other in Voluntary Dependent Term Spouse Life | You and your spouse can be covered as a dependent spouse under each other’s plans.                                                                                                                                 |
|                             | Each of you can enroll your children in Voluntary Dependent Term Child Life | Both you and your spouse can cover your children under this plan.                                                                                                                                                                                                 |
| Voluntary AD&D              | Each of you can enroll in associate-only Voluntary AD&D Option       |                                                                                                                                                                                                             |
|                             | One of you can enroll in the Voluntary Family Protection Plus AD&D Option | With this choice, your spouse and children are covered as dependents.                                                                                                                                                                                                 |
|                             | Each of you can enroll in Voluntary Family Protection Plus AD&D       | Both you and your spouse can cover each other and your children under this plan.                                                                                                                                                                                          |
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.

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

- once a year during Annual Enrollment; and
- when you experience a qualified change in status.

Any change made during a subsequent Annual Enrollment period for Medical, Dental, Vision, Group Legal Plans and/or Spending Account coverage will start on January 1 of the new Plan year.

For more information on qualified status changes, see the Life Events chapter. For information on making coverage changes for your same-sex domestic partner or children of your partner, see the Benefits for Same-sex Domestic Partners chapter.

You may change your benefit elections for Voluntary Term Life Insurance, Voluntary Dependent Term Life Insurance, Voluntary AD&D Insurance, and Long-term Care Plan:

- once every rolling 12 months from the date of the election; and
- when you experience a qualified change in status.

You will be required to provide a Statement of Health form for some of these Plans. A Statement of Health form is required if you didn’t enroll when first eligible for Voluntary Term Life and for Long-term Care Insurance. A Statement of Health form may be required for Voluntary Dependent Term Life Insurance for your spouse.

A Statement of Health form is also required, when:

- increasing Voluntary Term Life Insurance coverage for yourself more than one times pay during any subsequent 12-month period or if your request for coverage exceeds three times your pay or $500,000 at any time.
- enrolling in life insurance coverage for your spouse or same- or opposite-sex domestic partner that is above $20,000 or increasing the coverage amount during any subsequent 12-month period.

The insurance company, Metropolitan Life Insurance (MetLife), has the authority to approve or decline your request for coverage depending upon whether you are determined to be in good health. Your coverage will start on the date MetLife approves your request.

A Statement of Health form is not required for Voluntary AD&D.

For more information, see the Life Insurance and AD&D chapters.

Annual Enrollment

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

Enrolling in Medical, Dental and Vision Coverage and the Spending Accounts

There may be times when the Company requires you to actively enroll in the medical, dental and vision plans during Annual Enrollment by going to the Your Benefits Resources Web site or calling the Benefits Choice Center. To have coverage in the medical, dental, and vision plans in 2009, you must have actively enrolled in that coverage during your annual enrollment period in 2008. The spending accounts always require you to re-enroll each year during Annual Enrollment.

Enrolling in Life and AD&D Insurance and Disability

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

More About Annual Enrollment

In years that the Company does not require you to actively enroll in medical, dental and vision coverage during Annual Enrollment and you do not access the Your Benefits Resources Web site 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.
The spending accounts always require you to re-enroll each year during Annual Enrollment.

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, subject to any statement of health approval.

Each year during Annual Enrollment, regardless of whether the Company requires you to re-enroll or not, you must:

- If you are enrolled in a Company medical plan and want to receive the health assessment credit:
  — Indicate whether you want to receive the credit during your Annual Enrollment session; and
  — Complete the Simple Steps Health Assessment. Associates who reside in Hawaii are not eligible for this credit.

- Provide information about your spouse’s or same-sex domestic partner’s employment if you enroll your spouse or same-sex domestic partner in a Company Medical Plan. You may be eligible for the spouse medical credit.

- Verify the full-time student status of any unmarried dependents over age 19.

The Health Assessment Credit

If you are enrolled in a Home Depot medical plan, you are eligible for a health assessment credit if you complete the Simple Steps Health Assessment. The health assessment credit applies to associates only and does not apply to associates who live in Hawaii.

During your enrollment session, you will indicate whether you want to receive the per paycheck credit by completing the Simple Steps Health Assessment. Participation in the Simple Steps Health Assessment is voluntary and your responses to the assessment are completely confidential. However, you must complete the assessment in order to receive the credit.

Once you complete your annual enrollment session and your enrollment has been confirmed, you’ll see a link to the Simple Steps Health Assessment on the Aetna Web site. Simply click the link, provide your name, date of birth, ZIP code and Social Security number, and complete the assessment. If you can’t complete the assessment immediately following your enrollment session, you’ll find the link in the Action Needed section of Your Benefits Resources. It’s important to go through all of the questions in the assessment even if you don’t know the answers to all of the questions. When you are finished, click “complete” to receive the Health Assessment Credit.

To receive your credit, you must complete the Health Assessment when you enroll in medical coverage as a new hire or when you have a qualified status change and during Annual Enrollment. If you take the Health Assessment during Annual Enrollment, you’ll begin receiving your credit in your first paycheck in the following year. If you take it at any time other than during Annual Enrollment, you will begin receiving your credit as soon as administratively possible.

The Spouse Medical Credit

You will receive $50 per biweekly pay period if you qualify for the Spouse Medical Credit. To qualify for this credit, your spouse or same-sex domestic partner must be enrolled in Company medical coverage and:

- work for a company with 100 or fewer employees
- work part-time, be unemployed or self-employed
- work for the Company or a Company subsidiary

If you elect medical coverage for your spouse or same-sex domestic partner and your spouse or same-sex domestic partner works full-time for another company with more than 100 employees that offers medical benefits, you do not qualify for this credit.

To receive your credit you must certify your spouse’s (or same-sex domestic partner’s) employment when you enroll as a new hire, when you have a qualified status change, and during an Annual Enrollment.
Full-Time Student Status Verification
The full-time student status of any unmarried dependents over age 19 must be verified each year during Annual Enrollment or the student will lose coverage January 1 of the following year, unless they live in a state where coverage is extended as required by state law.

The Company may ask you to provide written verification of your child’s full-time student status. If the required documentation is not provided within 30 days of the request, medical and/or dental coverage for your child will be terminated. Providing false information may result in exclusion from (i.e., loss of eligibility for) all Company-sponsored welfare benefit plans and/or disciplinary action as outlined in the Company’s code of conduct.

Qualified Change in Status/Life Events
You cannot change or cancel your Medical, Dental, Vision or Spending Accounts elections mid-year except as shown in the Life Events chapter (or the Benefits for Same-sex Domestic Partners chapter).

When Changes to Coverage Take Effect
For your election to become effective, you must call the Benefits Choice Center, and speak to a representative within 30 days after the date the qualified change in status occurs.

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 coverages will be effective on the date of the change in status.

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 and LTD and Hawaii medical Associate-Only category), you do not have to do anything.

Full-Time Hourly Associates:
Opting Out of Automatic Enrollment
All newly eligible associates are automatically enrolled in the following Plans:

- **U.S.**
  - Short-term Disability (STD), except in CA, NJ and RI
  - Long-term Disability (LTD)

- **Hawaii**
  - Medical (Associate-Only category)
  - Long-term Disability (LTD)

If you experience a change in status due to marriage, divorce, birth, adoption, or placement for adoption, you may also access the Your Benefits Resources Web site to make your election changes within 30 days after the date 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 from (i.e., loss of eligibility for) all Company-sponsored welfare benefit plans and/or disciplinary action as outlined in the Company’s code of conduct.

If you do not want the coverage, you must opt out by accessing the Your Benefits Resources Web site or calling the Benefits Choice Center before your 91st day (29th day in Hawaii) of employment or before the end of Annual Enrollment.

If you opt out of the plans, you may enroll in STD (SSTD in New York) and LTD during any rolling 12-month period, and a Statement of Health form is required. You also may elect these coverages 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 for Full-Time Hourly Associates chapter for more information.

Hawaii associates are automatically enrolled in the Hawaii Medical Plan PPO. Hawaii associates who do not want medical coverage must complete an HC-5 form and return the signed form to the Benefits Choice Center before your 28th day of employment or before the end of Annual Enrollment. This form verifies that you are exempt from enrolling in the Medical Plan. Associates who drop the coverage may re-enroll during Annual Enrollment or within 30 days of the occurrence of a qualified status change.
**Cost for Coverage**

You are automatically covered and make no contributions for the cost of your Basic Term Life (if enrolled in the Medical Plan), Basic Dependent Term Life (if dependents are enrolled in a Medical Plan) and Basic Accidental Death and Dismemberment insurance. If you are a salaried associate, you are automatically covered and make no contributions to Short-term Disability and Long-term Disability.

The other benefit Plans, including the Medical, Vision, Dental, Spending Accounts, Disability Insurance (for full-time hourly associates), Voluntary Term Life Insurance, Voluntary Dependent Term Life Insurance, Voluntary Accidental Death and Dismemberment Insurance, Supplemental Long-term Disability Insurance (for salaried associates), Long-term Care Insurance and Legal Services 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.

If you are not on The Home Depot payroll system, your contributions will be deducted from your paycheck, except contributions for the following MetLife Group Benefits plans:

- Long-term Care
- Legal Services Plan
- Auto and Home Insurance
- Veterinary Pet Insurance

**About Pre-Tax Contributions**

By enrolling in Medical, Vision and/or Dental Plans, you authorize the Company to reduce your gross pay with pre-tax dollars for the required premiums. By enrolling in the Spending Accounts, you authorize the Company to reduce your gross pay with pre-tax dollars for the amounts you elect. 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, Vision, Dental and Spending Accounts. While you pay less in current taxes, the amount of your pay used to determine Social Security benefits at retirement may be reduced slightly.

For more information about tax advantages of the Spending Accounts, see the Spending Accounts chapter in this book. If you have additional questions, please seek the advice of your tax or financial advisor.

**When Your Coverage Ends**

Medical, Vision, Dental, Spending Accounts, Disability, Basic Term Life, Voluntary Term Life, Basic Dependent Term Life, Voluntary Dependent Term Life, Basic AD&D, Voluntary AD&D Insurance, Long-term Care and Legal Services Plans will end as follows, unless otherwise required by law:

- at midnight on the date you or any member of your family (dependents) no longer meet the eligibility requirements for participation in the Plans. (Exception: May be the last day of the calendar year for a full-time student between ages 19 and 24 who has been covered for at least five months out of the year. Upon reaching age 25, coverage for the full-time student will end at midnight of his or her birthday, unless they live in a state where coverage is extended as required by state law.)
- if you are on a leave of absence, the Leaves of Absence chapter explains when coverage ends for your specific type of leave.
- when you experience an employment status change (from full-time to part-time), your coverage ends on the last day of the pay period that includes 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.
- if you are on a leave of absence, your eligibility to file a new disability claim ends on the day your leave begins.
Continuing Coverage
In some cases, you may continue Medical, Vision and Dental coverage as well as your Health Care Spending Account for you and your eligible family members after your coverage would typically end. See the COBRA Coverage chapter for more information.

Employment Status Changes
Full-Time Hourly Associates
If your employment status changes to part-time, your enrollment in the Health and Welfare plans will be handled as follows:

• If you have not completed the waiting period (U.S., except Hawaii—90 days; Hawaii—28 days), 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 waiting period (U.S., except Hawaii—on the 91st day; Hawaii—on the 29th 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 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 are not enrolled in the Health and Welfare plans on your employment status change date, you must enroll within 30 days of your change date.

If You’re Rehired
Full-Time Hourly Associates
If you stop working for the Company and are rehired on a regular full-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 must 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 waiting period (U.S., except Hawaii—90 days; Hawaii—28 days) 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 (U.S., except Hawaii—on the 91st day; Hawaii—on the 29th 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 waiting period (U.S., except Hawaii—90 days; Hawaii—28 days) to be eligible for benefits.

In all cases, if 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 of and in same calendar year, the coverage you had before your termination will be reinstated with no lapse. You must contact the Benefits Choice Center to have your coverage reinstated.
Salaried Associates
If you stop working for the Company, and you are rehired as a full-time salaried associate, your enrollment in the Plans will be handled as follows:

- **Within 30 days.** You are automatically reinstated in the same coverage unless a qualified status change occurred and you elect to change your coverage.
- If you have a status change, you may be able to add, drop, decrease or increase certain coverages. See the Life Events chapter for more information.
- **After 30 days.** If you are rehired after 31 days or within 30 days but in a different tax year from when you terminated, you will receive an enrollment kit and you must re-enroll to receive coverage.

If you decline coverage or fail to enroll within the 30 day deadline, you may not enroll until the next Annual Enrollment, unless you have a qualified status change during the year.

If you are rehired as a full-time hourly associate, the rules listed in If You’re Rehired—Full-Time Hourly Associates apply.

Service Requirements For MetLife Group Benefits If You Are Rehired
If you leave the Company and are later rehired, the following rules apply to service for your MetLife Group Benefits (Long-Term Care, Legal Services Plan, Auto and Home Insurance and Veterinary Pet Insurance):

- **For full-time hourly associates:**
  - If you are rehired six calendar months or less from termination, all previous service is counted toward benefit eligibility.
  - If you are rehired more than six calendar months after termination, previous service is not counted toward benefit eligibility.

- **For salaried associates:**
  - If you are rehired within 30 days, your coverage through the Company will continue through payroll deductions. If you pay your premiums through payroll deduction, you will continue to pay in this way.
  - If you transfer from Puerto Rico or St. Thomas to the United States, you will become eligible for U.S. benefits as of the later of your eligibility date or move date.
  - If you are eligible for benefits and transfer from a salaried to an hourly status, the 90-day service requirement is waived (i.e., once eligible for benefits, eligibility is not taken away).
Benefits For Same-Sex Domestic Partners

U.S. Salaried & Full-Time Hourly Associates

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28  Same-sex Domestic Partner Eligibility
28  Certifying Your Relationship
29  Enrolling Your Partner and/or Your Partner’s Children
29  Benefits Available to Same-sex Domestic Partners
29  Medical Benefits
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29  Life and AD&D Insurance Benefits
29  Long-Term Care Insurance
29  Legal Services
30  Tax Considerations
30  Determining Your Premiums and Calculating Your Taxable Income
32  Making Coverage Changes
To participate in The Home Depot’s medical, dental, vision, life, voluntary group benefits and AD&D benefits, your same-sex domestic partner must:

- be an adult who is of the same sex as you and be at least age 18 or older;
- he or she has not registered as a member of another domestic partnership within the past six months;
- he or she is not in the relationship solely for the purpose of obtaining the benefits of coverage;
- be in an exclusive, mutually committed relationship with you and intend to continue the relationship indefinitely;
- have lived with you for at least six consecutive months and intend to do so indefinitely;
- not be related to you in a manner that would bar a legal marriage in the state in which you live;
- not be married or in a civil union or similarly recognized relationship with anyone but you; and
- share with you the responsibility for common welfare and basic financial obligations on a continuing basis.

Your same-sex domestic partner’s eligible dependents may be covered under the same plans that you enroll in, provided:

- they do not have health coverage available through a natural parent’s benefit program;
- they are in the legal custody or guardianship of you or your same-sex domestic partner;
- you or your same-sex domestic partner claims them on your federal income tax return; and
- that enrollment in your current medical plan is permitted for the same-sex domestic partner.

Your domestic partner has to meet the eligibility requirements for your partner’s dependents to be eligible; however, you do not have to cover your domestic partner in order to cover his or her eligible dependent children. If you have legally adopted your domestic partner’s children, then the children qualify as eligible dependents without regard to your domestic partner’s eligibility.

Certifying Your Relationship

Before you can enroll your partner and/or your partner’s eligible dependents in benefits, you must certify that your relationship qualifies for same-sex domestic partner benefit coverage. To certify your same-sex domestic partner’s eligibility, you’ll need to answer a series of questions. To certify your relationship, go to Your Benefits Resources or contact the Benefits Choice Center.
Enrolling Your Partner and/or Your Partner’s Children

You may enroll your same-sex domestic partner and/or their partner’s eligible dependents in the Company’s medical, dental, vision, life and AD&D plans in most states. After you have reviewed this chapter along with other applicable benefit chapters in this Benefits Summary and made the choices that are right for you and your family, add your same-sex domestic partner as a dependent and enroll him or her in benefits by accessing the Your Benefits Resources Web site or calling the Benefits Choice Center. To add your partner as a dependent, you will need to answer a series of questions to certify your same-sex domestic partner’s eligibility. Then you can make benefits elections for your partner and/or your partner’s eligible dependents.

You may enroll your partner in benefits when you first become eligible, when you first experience a life event described in Making Coverage Changes, or within 30 days of meeting both of the following eligibility requirements: you and your partner reach age 18 and you complete the sixth consecutive month of living together. You may also enroll your eligible partner and/or your partner’s eligible dependent during annual benefits enrollment. You may enroll your partner in a medical plan in certain coverages in certain states.

Important! If enrolling in or making changes to your benefits (including such actions, but not limited to, adding eligible dependents or verifying a child’s full-time student status), you are responsible for providing truthful and accurate information. Providing false information may result in exclusion from (i.e., loss of eligibility for) all Company-sponsored welfare benefit plans and/or disciplinary action as outlined in the Company’s code of conduct.

Benefits Available to Same-sex Domestic Partners

Medical Benefits

You can enroll your same-sex domestic partner and his or her eligible dependents in most medical plans the Company offers. You must be enrolled in a medical plan that is available to same-sex domestic partners in order to enroll your partner in coverage. If you aren’t, you will have to wait until the next Annual Enrollment to enroll in a medical plan that is available to same-sex domestic partners. Same-sex domestic partners are not eligible to enroll in the following HMOs: BCBS of Western NY, BCBS of Illinois or Kaiser of Georgia.

Dental and Vision Benefits

You can enroll your same-sex domestic partner and his or her eligible dependents as eligible dependents under your dental or vision plans.

Life and AD&D Insurance Benefits

You will be required to complete a Domestic Partner Declaration attesting to your domestic partnership before you receive coverage for Voluntary Dependent Term Life and Voluntary AD&D Family Protection Plus. If you do not return this form, accurately completed and signed after you have enrolled for Voluntary Dependent Term Life and/or voluntary AD&D Family Protection Plus, you will not have this coverage. This form is available at http://resources.hewitt.com/homedepot or by calling 1-800-555-4954. If there is a pending Statement of Health, the Statement of Health must be approved before coverage will be extended. However, you must enroll in coverage through the Benefits Choice Center before sending your Domestic Partner Declaration form.

You can enroll, cancel or change your coverage once during a rolling 12-month period, or when you have a status change. Coverage is subject to receipt of an accurately completed and signed declaration.

Your same-sex domestic partner and/or his or her eligible dependents will be automatically enrolled in Basic Dependent Term Life Insurance if you elect medical coverage for him or her.

For your life insurance or accidental death & dismemberment coverage, you can name your same-sex domestic partner as your beneficiary.

Long-Term Care Insurance

If you enroll your same-sex domestic partner in Long-Term Care Insurance, you will need to complete the application that is included with your Long-Term Care enrollment guide, and you will need to select “Domestic Partner” on the application. If your application is approved, you will receive an affidavit that you must complete and return. If you do not return this affidavit, or if it is not approved, you will not have this coverage.

Legal Services

If you enroll in the Legal Services Plan, coverage under this Plan is also available to your same-sex domestic partner.
**Tax Considerations**
If you enroll your same-sex domestic partner and his or her children in coverage, you will pay the same premium as associates who enroll their spouse and/or eligible dependent children in the medical, dental and vision plans. However, the portion of the premium that you and the Company pay to cover your same-sex domestic partner and/or his or her eligible dependent children will be reported as taxable income on your paycheck. You may also be subject to income tax on the value of Basic Dependent Term Life Insurance provided by the Company. This is because the Internal Revenue Code may not recognize domestic partners as qualifying for tax-free benefits. The portion of the premium that you and the Company pay for your coverage will not be taxable.

In California, if you have registered your partner with the state’s Domestic Partner registry, you may be exempt from state income tax on this amount. Contact your tax advisor.

**Determining Your Premiums and Calculating Your Taxable Income**
The premiums that you pay for medical, dental or vision coverage are the same as those published for covering a spouse and/or child(ren). To determine your taxable income, you must determine the portion of the premium that applies to your same-sex domestic partner’s coverage. Call the Benefits Choice Center to obtain the total premiums for your specific plans.

**How Taxable Income for SSDP Coverage is Calculated**

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<th>Premium Calculation</th>
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<tr>
<td>You + Spouse</td>
<td>Associate + Spouse total premium minus Associate-only premium</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>Associate + Child(ren) total premium minus Associate-only premium</td>
</tr>
<tr>
<td>You + Family</td>
<td>Associate + Family total premium minus Associate-only premium</td>
</tr>
</tbody>
</table>

**2009 Total Premiums**

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<tr>
<th>Coverage</th>
<th>2009 Biweekly Total Premium (associate premium + Company subsidy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>$160.70</td>
</tr>
<tr>
<td>Associate + Spouse</td>
<td>$321.41</td>
</tr>
<tr>
<td>Associate + Child(ren)</td>
<td>$305.34</td>
</tr>
<tr>
<td>Associate + Family</td>
<td>$449.47</td>
</tr>
</tbody>
</table>

1 Weekly payroll deductions for premiums will be half of this amount.
2 This amount does not include prescription drug coverage premiums.
Taxable Income Calculation Examples

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<tr>
<th>Coverage Scenario</th>
<th>Medical Taxable Income Calculation</th>
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<td>Associate + Spouse coverage in the $550 Deductible plan (associate is covering his or her SSDP)</td>
<td>$321.41 - $160.70 = $160.71 of taxable income biweekly</td>
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<tr>
<td>Associate + Child(ren) coverage in the $550 Deductible plan (associate is covering his or her SSDP’s children)</td>
<td>$305.34 - $160.70 = $144.64 of taxable income biweekly</td>
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<tr>
<td>Associate + Family coverage in the $550 Deductible plan (associate is covering his or her SSDP and the SSDP’s children)</td>
<td>$449.47 - $160.70 = $288.77 of taxable income biweekly</td>
</tr>
<tr>
<td>Associate + Child(ren) coverage in the $550 Deductible plan (associate is covering one of his or her own children and his or her SSDP’s children)</td>
<td>No additional taxation</td>
</tr>
<tr>
<td>Associate + Family coverage in the $550 Deductible plan (associate is covering the associate’s children and his or her SSDP)</td>
<td>$449.47 - $305.34 = $144.13 of taxable income biweekly</td>
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Because of certain rules under the Internal Revenue Code, you cannot make pre-tax contributions or receive tax-free employer contributions for your SSDP or your SSDP’s dependent’s health coverage. Accordingly, the company must report these amounts to the IRS as taxable income.
Making Coverage Changes

You may access the Your Benefits Resources Web site or call the Benefits Choice Center to change coverage for your same-sex domestic partner (SSDP) or your partner’s dependent children, only during annual enrollment or when one of the following occurs:

Plan coverage changes

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<th>Change Type</th>
<th>Notification Rules</th>
<th>Full-time &amp; Salaried Medical/Dental/Vision</th>
<th>Full-Time &amp; Salaried Voluntary Term Life, Dependent Term Life, and AD&amp;D Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate &amp; SSDP meeting the following 2 requirements:</td>
<td>Within 30 days of meeting both requirements (from 18th birthday or end of 6th month of residing together)</td>
<td>Can add SSDP and/or eligible dependents of SSDP to the associate’s current coverage*</td>
<td>Can add or increase coverage for self, SSDP and/or eligible dependents of SSDP*</td>
</tr>
<tr>
<td>• Reaching age 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reaching the 6th consecutive month of living together</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSDP’s dependent meeting dependent eligibility requirements</td>
<td>Within 30 days of meeting the dependent eligibility requirements</td>
<td>Can add newly qualified dependent(s) of SSDP to the associate’s current coverage*</td>
<td>Can add or increase coverage for self and/or eligible dependents of SSDP*</td>
</tr>
<tr>
<td>Ceasing to satisfy the SSDP requirements</td>
<td>Within 30 days of ceasing to satisfy the SSDP requirements</td>
<td>Drop SSDP and any covered dependents of SSDP (no changes allowed for the associate’s coverage)</td>
<td>Drop SSDP and dependents of SSDP</td>
</tr>
<tr>
<td>Ending dependent eligibility of SSDP’s dependent</td>
<td>Within 30 days of ceasing to be an eligible dependent of SSDP</td>
<td>Drop dependent(s) of SSDP (no changes allowed for the associate’s coverage)</td>
<td>Drop dependents of SSDP</td>
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<tr>
<td>Death of SSDP (dependents of SSDP will not be able to continue coverage)</td>
<td>As soon as possible following death</td>
<td>Drop deceased SSDP &amp; any covered dependents of the SSDP</td>
<td>Drop deceased SSDP and/or dependent(s) of SSDP</td>
</tr>
<tr>
<td>Death of covered dependent of SSDP</td>
<td>As soon as possible following death</td>
<td>Drop deceased dependent(s) of SSDP</td>
<td>Drop deceased dependent(s) of SSDP</td>
</tr>
<tr>
<td>Birth (of associate’s child)</td>
<td>See the Life Events chapter</td>
<td>Since this is the associate’s child, the rules in the Life Events chapter would be followed</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth (of SSDP’s child)</td>
<td>Within 30 days of birth</td>
<td>Can add new eligible dependent(s) of SSDP to the associate’s current coverage*</td>
<td>Can add or increase coverage for self and/or new eligible dependent(s) of SSDP*</td>
</tr>
<tr>
<td>Adoption/Legal guardianship (associate adopting)</td>
<td>See the Life Events chapter</td>
<td>Since this is the associate’s child, the rules in the Life Events chapter would be followed</td>
<td>N/A</td>
</tr>
<tr>
<td>Adoption/Legal guardianship (SSDP adopting)</td>
<td>Within 30 days of adoption</td>
<td>Can add newly adopted eligible dependent(s) of SSDP to the associate’s current coverage*</td>
<td>Can add or increase coverage for self and/or new eligible dependent(s) of SSDP*</td>
</tr>
</tbody>
</table>

1 If you are in a plan where an SSDP cannot be covered, you cannot change your option. If you have no coverage, you cannot add coverage for yourself or your SSDP or eligible dependents of an SSDP at that time. You will have to wait until the next annual enrollment.

2 If you enroll your same-sex domestic partner in medical coverage, you must certify that the $50 biweekly credit for spouse medical coverage applies to you.

3 SOH (Statement of Health) form may be required for adding or increasing voluntary term life and voluntary dependent term life coverage for you or your same-sex domestic partner. See the Life Insurance chapter for more information. A Statement of Health is also required for all associates who do not enroll when first eligible, and for all dependents under the Long-term Care Plan.
### Plan coverage changes

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<td>QMCSO on Child of SSDP</td>
<td>See the Plan Administration chapter</td>
<td>Can add child as required by valid QMCSO</td>
<td>N/A</td>
</tr>
<tr>
<td>Gain of coverage due to SSDP's annual enrollment differing from Home Depot's</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
<tr>
<td>Loss of coverage due to SSDP's annual enrollment differing from Home Depot's</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
<tr>
<td>Gain of coverage due to SSDP's or eligible dependent of SSDP's change in employment</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
<tr>
<td>Loss of coverage due to SSDP's or eligible dependent of SSDP's change in employment</td>
<td>Within 30 days of loss of coverage</td>
<td>Can add SSDP and/or eligible dependents of SSDP (if each had been covered under the SSDP's plan) to the associate's current coverage</td>
<td>Can add or increase coverage for self, SSDP and/or eligible dependents of SSDP³</td>
</tr>
<tr>
<td>Loss of coverage due to action of SSDP's employer by termination of all plans of the same type or by ceasing all employer contributions</td>
<td>Within 30 days of loss of coverage</td>
<td>Can add SSDP and/or eligible dependents of SSDP (if each had been covered under the SSDP's plan) to the associate's current coverage</td>
<td>Can add or increase coverage for self, SSDP and/or eligible dependents of SSDP³</td>
</tr>
<tr>
<td>Loss of coverage due to an expiration of SSDP's COBRA coverage</td>
<td>Within 30 days of loss of coverage</td>
<td>Can add SSDP and/or eligible dependents of SSDP (if each had been covered under the SSDP's plan) to the associate's current coverage</td>
<td>Can add or increase coverage for self, SSDP and/or eligible dependents of SSDP³</td>
</tr>
<tr>
<td>SSDP's employer eliminates benefit option (i.e. HMO, PPO, POS...)</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
<tr>
<td>SSDP's employer adds a benefit option (i.e. HMO, PPO, POS...)</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
<tr>
<td>You or your SSDP loses coverage under Medicare or Medicaid and you wish to add coverage</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
<tr>
<td>You or your SSDP gains coverage under Medicare of Medicaid and you wish to add coverage</td>
<td>N/A</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
<td>No changes allowed, will have to wait until annual enrollment</td>
</tr>
</tbody>
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1. If you are in a plan where an SSDP cannot be covered, you cannot change your option. If you have no coverage, you cannot add coverage for yourself or your SSDP or eligible dependents of an SSDP at that time. You will have to wait until the next annual enrollment.

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For help, go to http://resources.hewitt.com/homedepot or call 1-800-555-4954
# U.S. Medical

## U.S. Salaried & Full-Time Hourly Associates

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</tr>
<tr>
<td>112</td>
<td>If You Enroll in an Aetna Medical Option</td>
</tr>
<tr>
<td>112</td>
<td>If You Enroll in an HMO</td>
</tr>
<tr>
<td>113</td>
<td>You’ll Receive a 90-Day ID Card From Aetna</td>
</tr>
<tr>
<td>113</td>
<td>Eligibility Rules During Your First 90 Days</td>
</tr>
</tbody>
</table>
The information below is provided so that you can get in touch easily with your Medical Plan. You may also contact the Benefits Choice Center at 1-800-555-4954.

**Contacting Your Medical Plan**

<table>
<thead>
<tr>
<th>Medical Plan Provider</th>
<th>Toll-Free Number</th>
<th>Internet Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Choice POS II</td>
<td>1-800-695-9744</td>
<td><a href="http://www.livethehealthyorangelifecom">www.livethehealthyorangelifecom</a></td>
</tr>
<tr>
<td>Aetna HMO*</td>
<td>1-800-594-9372</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>BCBS—HMO Illinois, Blue Advantage HMO*</td>
<td>1-800-892-2803</td>
<td><a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>Blue Cross Blue Shield of Western New York*</td>
<td>1-800-544-2583</td>
<td><a href="http://www.bcbswny.com">www.bcbswny.com</a></td>
</tr>
<tr>
<td>CIGNA HMO*</td>
<td>1-800-794-4952</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>ConnectiCare—Connecticut*</td>
<td>1-800-251-7722</td>
<td><a href="http://www.connecticare.com">www.connecticare.com</a></td>
</tr>
<tr>
<td>Group Health Cooperative (GHC)—Seattle*</td>
<td>1-888-901-4636</td>
<td>www GHC.org</td>
</tr>
<tr>
<td>HMOA—Hawaii HMO</td>
<td>1-808-948-4672</td>
<td><a href="http://www.hmsa.com">www.hmsa.com</a></td>
</tr>
<tr>
<td>HMOA—Hawaii PPO</td>
<td>1-808-948-6111</td>
<td><a href="http://www.hmsa.com">www.hmsa.com</a></td>
</tr>
<tr>
<td>Health Alliance Plan (HAP) —Detroit*</td>
<td>1-313-872-8100 or</td>
<td><a href="http://www.hap.org">www.hap.org</a></td>
</tr>
<tr>
<td></td>
<td>1-800-422-4641</td>
<td></td>
</tr>
<tr>
<td>Health Net—California</td>
<td>1-800-847-3991</td>
<td><a href="http://www.healthnet.com">www.healthnet.com</a></td>
</tr>
<tr>
<td>Kaiser Permanente—Atlanta*</td>
<td>1-888-866-5813</td>
<td><a href="http://www.kp.org">www.kp.org</a></td>
</tr>
<tr>
<td>Pacificare—Las Vegas*</td>
<td>1-800-347-8600</td>
<td><a href="http://www.pacificare.com">www.pacificare.com</a></td>
</tr>
<tr>
<td>UHC HMO—Massachusetts*</td>
<td>1-866-936-6005</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
</tr>
</tbody>
</table>

* This plan is closed for new enrollment effective 01/01/2009. If you were not enrolled in this plan as of 12/31/08, you will not be eligible to enroll effective 01/01/2009 and going forward.

---

**The Spouse Medical Credit**

You will receive $50 per biweekly pay period if you qualify for the Spouse Medical Credit. To qualify for this credit, your spouse or same-sex domestic partner must be enrolled in Company medical coverage and:

- work for a company with 100 or fewer employees;
- work part-time, be unemployed or self-employed; or
- work for the Company or a Company subsidiary.

If you elect medical coverage for your spouse or same-sex domestic partner and your spouse or same-sex domestic partner works full-time for another company with more than 100 employees that offers medical benefits, you do not qualify for this credit.

To receive your credit you must certify your spouse’s (or same-sex domestic partner’s) employment when you enroll as a new hire, when you have a qualified status change and during every Annual Enrollment.

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**The Health Assessment Credit**

If you are enrolled in a Home Depot medical plan, you are eligible for a health assessment credit if you complete the Simple Steps Health Assessment. The health assessment credit applies to associates only and does not apply to associates who live in Hawaii.

During your enrollment session, you will indicate whether you want to receive the per paycheck credit by completing the Simple Steps Health Assessment. Participation in the Simple Steps Health Assessment is voluntary and your responses to the assessment are completely confidential. However, you must complete the assessment in order to receive the credit.

Once you complete your annual enrollment session and your enrollment has been confirmed, you’ll see a link to the Simple Steps Health Assessment on the Aetna Web site. Simply click the link, provide your name, date of birth, ZIP code and Social Security number, and complete the assessment. If you can’t complete the assessment immediately following your enrollment session, you’ll find the link in the Action Needed section of Your Benefits Resources. It’s important to go through all of the questions in the assessment even if you don’t know the answers to all of the questions. When you are finished, click “complete” to receive the Health Assessment Credit.

To receive your credit, you must complete the Health Assessment when you enroll in medical coverage as a new hire or when you have a qualified status change and during Annual Enrollment. If you take the Health Assessment during Annual Enrollment, you’ll begin receiving your credit in your first paycheck in the following year. If you take it at any time other than during Annual Enrollment, you will begin receiving your credit as soon as administratively possible.
Get the Most Value from Your Plan

What do you need? | Find it here...
---|---
Find an Aetna Choice POS II network provider (doctor, hospital) | Go to [www.livethehealthyorangelife.com](http://www.livethehealthyorangelife.com) and click DocFind® Provider Directory or call Aetna at 1-800-695-9744
Precertify planned hospital stays, inpatient surgery and other services that require precertification | Call Aetna at 1-800-223-6857
• Register in the Beginning Right Maternity Care Program
• Call the Informed Health Line available 24/7
• Contact the Disease Management Program | Call Aetna at 1-800-695-9744
Get detailed information about your HMO’s coverage | Call your Plan’s Member Services department or go to your Plan’s Web site. See Contacting Your Medical Plan. This book does not contain detailed information about HMO coverage.
Change your HMO Primary Care Physician (PCP) | Call your HMO’s Member Services department. See Contacting Your Medical Plan. You must use your HMO’s providers—services provided by non-HMO providers are not covered except in an emergency.

The Medical Plans
The Company offers you a choice of Medical Plans designed to help you and your family maintain good health and also to offer protection from the financial burden of a serious illness or injury.

All Plans offer access to a selection of doctors, specialists, hospitals and other health care providers who are committed to providing you with quality health care services at affordable prices. All Plans pay benefits only for covered services that are considered by the claims administrator to be medically necessary or as indicated within the Plan’s guidelines for care.

Types of Plans Available
The Company offers several basic types of coverage: Aetna Choice POS (Point-of-Service) II Plans, Out-of-Area (OOA) Plans, HMO (Health Maintenance Organization) Plans and, in California only, a POS (Point of Service) Plan.

The types of Plans available to you are based on your home ZIP code.

Detailed information about the Aetna Choice POS II and Out-of-Area Plans is included in this Benefits Summary.

For detailed information about HMO plans, the Health Net and Kaiser Permanente plans in California and the HMSA plans in Hawaii, see the California Medical chapter and Hawaii Medical chapter and the information mailed to your home. You can also contact the Plan directly. See Contacting Your Medical Plan. The detailed information you receive should be considered part of this Benefits Summary.
Coverage Categories
You may select one of four coverage categories for the Medical Plans:

- associate only
- associate + spouse (or same-sex domestic partner)
- associate + child(ren)
- associate + family (children and spouse or same-sex domestic partner)

ID Cards
Once you become covered under a Home Depot Medical Plan, 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. Depending on the Medical Plan you choose, you may have one card for medical services and another one for prescription drug benefits.

Please note that the possession of an ID card does not entitle you to benefits. Your enrollment in a medical plan must be effective when medical services are received for you to be entitled to benefits.

Comparison of the Medical Plans
Because the Company understands that each associate’s situation is unique, a variety of Medical Plans are available. Associates who select an Aetna Choice POS II or Out-of-Area medical option also select a prescription drug plan that best suits their family’s needs.

How the Plans Are Alike
All the Medical Plans cover a wide range of services. Here is a general list of what’s covered:

- office visits
- wellness exams
- routine pediatric care
- inpatient and outpatient hospital services
- physicians’ services
- emergency and urgent care
- mental health and substance abuse treatment
- prescription drugs (separate enrollment election required; for information for Aetna Choice POS II and OOA Plans, see Prescription Drugs later in this chapter)
- prenatal programs
- vision discounts
- wellness programs
- health and fitness discounts
- programs such as special disease management programs for diabetes, asthma and heart conditions

If you are in an HMO, check with your plan to see which of the above services are offered.

How the Plans Are Different
There are three main differences in the Aetna Choice POS II plans:

- how much you pay for the coverage through payroll deductions
- how much you pay out-of-pocket for deductibles, copayments or coinsurance
- whether or not you can go to out-of-network providers and receive benefits

Aetna Choice POS II Plans
The Company offers three Aetna Choice POS II options. Your benefits depend on whether you use your Plan’s in-network providers or you use out-of-network providers. Using in-network providers lowers the cost of health care services for you and for the Company.

Aetna Choice POS II $550 Deductible Plan. You pay more in payroll deductions so that you can have lower deductibles and out-of-pocket maximums.

Aetna Choice POS II $750 Deductible Plan. The $750 Deductible option has a lower payroll deduction than the $550 Deductible with a higher deductible and out-of-pocket maximum.

Aetna Choice POS II $1,000 Deductible Plan. Offers the lowest payroll deduction among the Aetna Choice POS II Plans. Your out-of-pocket maximum, deductible, coinsurance for out-of-network care and copayments are higher than with other choices, but you still have comprehensive coverage.

For more information, see How the Aetna Choice POS II and OOA Plans Work.

Covered services, limitations and exclusions for the Aetna Choice POS II Plans are listed in What’s Covered by the Aetna Choice POS II and OOA Plans and What the Aetna Choice POS II and OOA Do Not Cover.
How the Aetna Choice POS II and OOA Plans Work

Annual Deductible

For most medical services, the Aetna Choice POS II and OOA Plans begin to pay in-network benefits and out-of-network benefits only after you and your family pay an initial amount of covered medical expenses. This is called your annual deductible. Keep in mind, there is a separate deductible for the Prescription Drug Plan noted later in this chapter. The annual deductibles by Plan are:

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>In-Network Individual/Family</th>
<th>Out-of-Network Individual/Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Choice POS II $550</td>
<td>$550/$1,650</td>
<td>$1,100/$3,300</td>
</tr>
<tr>
<td>Aetna Choice POS II $750</td>
<td>$750/$2,250</td>
<td>$1,500/$4,500</td>
</tr>
<tr>
<td>Aetna Choice POS II $1,000</td>
<td>$1,000/$3,000</td>
<td>$2,000/$6,000</td>
</tr>
<tr>
<td>$550 Out-of-Area Plan</td>
<td>$550/$1,650</td>
<td>n/a</td>
</tr>
<tr>
<td>$750 Out-of-Area Plan</td>
<td>$750/$2,250</td>
<td>n/a</td>
</tr>
<tr>
<td>$1,000 Out-of-Area Plan</td>
<td>$1,000/$3,000</td>
<td>n/a</td>
</tr>
</tbody>
</table>

If you have three or fewer family members (including yourself) covered by the Medical Plan, you and each of your family members must satisfy the individual deductible. This means that you pay for your covered expenses up to the deductible before the Plan begins paying benefits for that individual (except for services for which the deductible doesn’t apply). Medical services received at in-network providers count only toward the in-network deductible. Medical claims incurred at out-of-network providers count only toward the out-of-network deductible.

If you have more than three covered family members (including yourself), once the total amount applied toward your family deductible reaches the maximum amount, no other family member has to pay toward the deductible for the remainder of that Plan year. No individual family member, however, can be credited with more than the amount of the individual deductible toward the annual family deductible.

For example, if you are enrolled in the Aetna Choice POS II $550 Plan, use only Aetna Choice POS II providers and have four members in your family with each member incurring covered medical expenses of $450 toward his or her individual deductible within the same year of coverage, your family deductible has been met for in-network coverage when the fourth family member reaches $300 in medical expenses ($450 x 3 + $300 = $1,650).

Hospital Copay

Depending on the Medical Plan you select, you or a covered family member may be required to pay a hospital admission copay in addition to your annual deductible.

<table>
<thead>
<tr>
<th>Per Admission Copay</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Choice POS II $550</td>
<td>$150</td>
<td>$600</td>
</tr>
<tr>
<td>Aetna Choice POS II $750</td>
<td>$200</td>
<td>$600</td>
</tr>
<tr>
<td>Aetna Choice POS II $1,000</td>
<td>$250</td>
<td>$600</td>
</tr>
</tbody>
</table>
Out-of-Pocket Maximums

After your annual deductible is satisfied, the Plan pays a portion of your eligible costs. The amount depends on the type of Plan you choose and whether or not you use in-network or out-of-network providers. The annual deductible and the portion you pay for covered expenses are your out-of-pocket expenses. However, the Plan limits the amount you have to pay out of your own pocket for in-network and out-of-network services.

The Plan pays 100% of most covered in-network and out-of-network medical expenses incurred during the remainder of the calendar year when:

- you or a covered family member has reached the individual out-of-pocket expense limit; or
- your family’s out-of-pocket expenses total the family limit.

Your annual deductible counts toward your out-of-pocket maximum. Please keep in mind there is a separate out-of-pocket maximum for the Prescription Drug Plan.

The Plan does not count the following expenses toward your annual out-of-pocket maximum:

- copayments for in-network office visits
- penalties imposed by the Plan for out-of-network services when you or a covered family member fails to use the precertification program as required (see Precertification Program in this chapter for information)
- any expenses not covered by the Plan
- the hospital per admission copay
- cost for mail service prescription drugs and the pharmacy management program. See Prescription Drugs later in this chapter for more information.
- amounts over the recognized charge. Does not apply to Out-of-Area Plans.

When using an in-network provider for services, copayments (such as the copayment for in-network office visits) are not applied toward the annual deductible or the out-of-pocket maximum. Also, when you or your covered family members meet the out-of-pocket maximum, only those services with an annual deductible and coinsurance will be paid at 100% for the rest of that year. Your option’s annual deductible applies toward your annual out-of-pocket maximum. You will always pay the copayments for in-network services, as well as any other expenses not covered by the Plan. For the Out-of-Area plans, out-of-pocket maximums are combined for in-network and out-of-network services.

Lifetime Maximum Benefits

The Plan provides medical benefits (in-network and out-of-network services combined) with an unlimited lifetime maximum for you and each covered family member. The Aetna Choice POS II Plan has other limitations on specific types of services as listed in the Aetna Choice POS II Plans Summary of Benefits charts.

---

### Out-of-Pocket Maximums

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Choice POS II $550</td>
<td>$3,000/$6,000</td>
<td>$6,000/$12,000</td>
</tr>
<tr>
<td>Aetna Choice POS II $750</td>
<td>$4,000/$8,000</td>
<td>$8,000/$16,000</td>
</tr>
<tr>
<td>Aetna Choice POS II $1,000</td>
<td>$5,000/$10,000</td>
<td>$10,000/$20,000</td>
</tr>
<tr>
<td>$550 Out-of-Area Plan</td>
<td>$3,000/$6,000</td>
<td>n/a</td>
</tr>
<tr>
<td>$750 Out-of-Area Plan</td>
<td>$4,000/$8,000</td>
<td>n/a</td>
</tr>
<tr>
<td>$1,000 Out-of-Area Plan</td>
<td>$5,000/$10,000</td>
<td>n/a</td>
</tr>
</tbody>
</table>

1 Includes annual deductible.

Out-of-pocket expenses for in-network and out-of-network services are not combined when determining if deductibles or maximums have been met. If you and your covered family members use in-network and out-of-network providers during the same plan year, out-of-pocket expenses will accumulate separately toward the deductibles and out-of-pocket amounts.
Office Visit Copayments
The amount of your office visit copayment (and how much you pay through payroll deductions for office visit coverage) depends on which medical option you select and whether you visit a PCP or a specialist.

Primary Care Physician (PCP) This is the network provider who: Is selected from the list of primary care physicians in the Aetna Choice POS II directory; supervises, coordinates and provides initial care and basic medical services as a general or family care practitioner, or in some cases, as an internist or a pediatrician; initiates referrals for specialist care and maintains continuity of patient care.

Specialist A physician who practices in any generally accepted medical or surgical sub-specialty.

Using Aetna Choice POS II Network Providers

Using In-Network Providers
When you use in-network providers (doctors, specialists, hospitals and other health care providers who participate in the Aetna Choice POS II network), the Medical Plan begins to work for you immediately. Here’s how:

- **Doctor office visits**—You pay a copayment (the amount depends on which medical option you choose) with no deductible for most charges related to the treatment of covered illnesses and injuries.
- **Emergency care**—Always try to locate an in-network provider when you require emergency care away from home. However, in a life-threatening emergency if you receive emergency services from an out-of-network provider, your emergency services will be covered at the in-network level.
- **Hospitals and other services**—For most other covered medical services (such as inpatient and outpatient surgeries, home health care, inpatient mental health and substance abuse treatment, alternative treatment centers, etc.), you pay a portion of pre-negotiated charges after you meet the Plan’s individual annual deductible. You also are required to pay a hospital copay if admitted for an inpatient hospital stay. For deductibles related to the Aetna Choice POS II Plans, see Annual Deductible and Hospital Copay in How the Aetna Choice POS II and OOA Plans Work.
- **Fees for services**—In general, the pre-negotiated fees charged by in-network providers are lower than those you might otherwise pay out-of-network providers for the same service.
- **Medical claim forms**—You do not file medical claim forms when you receive in-network services. Your doctor will file claims for you and will receive payment from your plan directly for the covered services.

For more information on Aexcel, see Finding an Aexcel Specialist in this chapter.

<table>
<thead>
<tr>
<th>Office Visit Options</th>
<th>PCP Office Visits</th>
<th>Specialist Office Visits</th>
<th>Aexcel Specialist Office Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Choice POS II $550</td>
<td>$25 copayment</td>
<td>$35 copayment</td>
<td>$25 copayment</td>
</tr>
<tr>
<td>Aetna Choice POS II $750</td>
<td>$30 copayment</td>
<td>$45 copayment</td>
<td>$30 copayment</td>
</tr>
<tr>
<td>Aetna Choice POS II $1,000</td>
<td>$30 copayment</td>
<td>$45 copayment</td>
<td>$30 copayment</td>
</tr>
</tbody>
</table>

For help, go to http://resources.hewitt.com/homedepot or call 1-800-555-4954
Using Out-of-Network Providers

When you use out-of-network providers (doctors, specialists, hospitals and other health care providers not participating in the network), you pay a portion of most covered services after you meet your plan’s individual annual deductible. Refer to the Aetna Choice POS II Plans Summary of Benefits for a detailed list of out-of-network benefits.

Since out-of-network providers can charge any amount for their services, the Plan will pay benefits only on charges considered reasonable and customary (R&C). R&C is the amount charged by the majority of doctors for the same medical services and procedures within the same geographical area. This amount is determined by insurance companies and is used as the maximum allowable amount for calculating the benefit they will pay for medical services.

Generally, claims for a particular procedure are eligible for full benefits; however, some medical claims submitted to the plan will be above the R&C level. If your out-of-network doctor charges more than the R&C level, you will be responsible for paying your share of the covered charges plus 100% of any charges over the R&C level. Always discuss fees with your out-of-network doctor in advance, and ask your doctor whether he or she will agree to waive charges over the R&C level. Choice/PPO Plan fees are pre-negotiated and do not exceed R&C levels. R&C levels do not apply to the Out-of-Area plans.

How to Receive Out-of-Network Benefits

To receive out-of-network benefits, you must submit a claim form along with original itemized bills for services covered under your Plan. When you use out-of-network providers, the Plan begins to pay benefits after you and/or your family meets the Plan’s annual deductible (see Annual Deductible for more information).

After the annual deductible is met, the Plan pays a percentage of most covered medical expenses incurred during the same year by you and your covered family members. Expenses that you pay in excess of the recognized charge do not count toward your deductible or your out-of-pocket maximum.

You will be responsible for paying the difference between what the Plan pays and what your doctor charges. This includes any amounts over the recognized charge.
### Aetna Choice POS II $550 Option

<table>
<thead>
<tr>
<th>Medical Lifetime Maximum</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible—Per calendar year</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family Deductible Limit—once met, all family members will be considered as having met their deductible for the remainder of that calendar year.</td>
<td>$550</td>
<td>$1,100</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum—Includes the maximum amount which a family must meet before all family members receive reimbursement at 100%.</td>
<td>$1,650</td>
<td>$3,300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance</th>
<th>20% after deductible</th>
<th>40% after deductible</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum—Identifies the maximum amount of out-of-pocket expenses that a member will have to pay in a calendar year for most services. Once the limit is met, most expenses will be paid at 100% for the remainder of that calendar year.</th>
<th>$3,000 includes deductible</th>
<th>$6,000 includes deductible</th>
</tr>
</thead>
</table>

| Preventive Care |
|----------------|---------------------|---------------------|
| Preventive Care | 100% Covered, no copay, no deductible | 40%, no deductible |

<table>
<thead>
<tr>
<th>Preventive Care Frequency Limits</th>
<th>Includes routine immunizations, travel immunizations &amp; flu shots.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Child Care Frequency Limits</td>
<td>7 exams in 1st 12 months of life, 2 exams in 13th-24th months; 1 exam per calendar year thereafter to age 18</td>
</tr>
<tr>
<td>Adult Routine Physical Exam</td>
<td>100% Covered, no copay, no deductible</td>
</tr>
<tr>
<td>Adult Routine Physical Exam Frequency Limits</td>
<td>Includes routine immunizations, travel immunizations &amp; flu shots.</td>
</tr>
<tr>
<td>Routine GYN</td>
<td>1 exam per calendar year</td>
</tr>
<tr>
<td>Routine GYN Exam &amp; Pap Smear Frequency Limits</td>
<td>1 routine GYN exam per calendar year with 1 pap smear &amp; related lab fees</td>
</tr>
<tr>
<td>Routine Mammogram</td>
<td>100% Covered, no copay, no deductible</td>
</tr>
<tr>
<td>Routine Mammogram Age/Frequency Limits</td>
<td>1 baseline at age 35, 1 every 2 calendar years after age 35, and 1 every calendar year after age 40</td>
</tr>
<tr>
<td>Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exams (DRE)</td>
<td>100% Covered, no copay, no deductible</td>
</tr>
</tbody>
</table>
### Aetna Choice POS II $550 Option

#### Preventive Care—continued

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exam (DRE) Age/Frequency Limits</strong></td>
<td>1 routine DRE &amp; PSA per calendar year for males age 40 &amp; over</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screenings—For all members age 50+:</strong> Fecal occult blood test every year, Sigmoidoscopy (1 every 5 years), Double contrast barium enema (1 every 5 years), Colonoscopy (1 every 10 years).</td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Routine Eye Exam</strong></td>
<td>Not Covered; discounts available</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Hearing Exam</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Routine Hearing Exams Frequency Limits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Not Covered; discounts available</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Copay/Deductible—Per admission</td>
<td>$150 copay</td>
<td>$600 copay</td>
</tr>
<tr>
<td>Inpatient Hospital Coinsurance—Includes inpatient surgery expenses, room &amp; board &amp; misc fees, physician expenses, routine nursery care, prescription drugs and all other inpatient care.</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Expenses—Hospitals and other facilities (i.e., ambulatory surgery center, hospital outpatient dept.). Includes short-term rehabilitation in a hospital outpatient setting.</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Other Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture—Covered in lieu of anesthesia only</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Allergy Testing &amp; Treatment—Office Visit</td>
<td>Covered at applicable PCP or Specialist Office Visit cost sharing</td>
<td></td>
</tr>
<tr>
<td>Allergy Injections—Not given by the physician, or not in conjunction with an office visit</td>
<td>100% Covered, no copay, no deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Maternity/OBSTRICS—Delivery charges are covered under the Hospital benefit, subject to the per confinement copay, if any.</td>
<td>98 visits - Specialist office visit copay applies to 1st prenatal visit only</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
<td></td>
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### Aetna Choice POS II $550 Option

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<tr>
<th>Service Description</th>
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<tr>
<td><strong>Other Physician Services</strong></td>
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<tr>
<td><strong>Outpatient Surgery</strong>—Surgeon’s charges performed in an office setting.</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
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</tr>
<tr>
<td><strong>Outpatient Surgery</strong>—Surgeon’s charges performed in other settings (outpatient department of hospital or ambulatory surgery center)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic X-ray and Lab</strong>—Performed as part of a physician office visit and billed by physician, covered same as physician office visit cost sharing</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray and Lab</strong>—Performed in an outpatient hospital or other outpatient facility setting including independent lab</td>
<td>10%, no deductible</td>
<td>40% after deductible</td>
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<tr>
<td><strong>Complex Imaging Services</strong>—MRA/MRS, MRI, CT Scan, PET Scan</td>
<td>10%, no deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Medical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$35 UCF copay</td>
<td>40% after deductible</td>
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<tr>
<td><strong>Emergency Room</strong>—Any copay applies only to E.R. Facility expenses. Related expenses—radiology, pathology, anesthesia, surgeon, etc. covered at E.R. coinsurance, no copay.</td>
<td>20% after deductible and if not admitted $50 E.R. Copay</td>
<td>20% after deductible and if not admitted $50 E.R. Copay</td>
</tr>
<tr>
<td><strong>Non-Emergency Use of Emergency Room</strong></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong>—Covers medically necessary travel. Ground ambulance for member convenience or for non-clinical reasons is not covered.</td>
<td>20% after deductible</td>
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<td>Contraceptive Devices, Implants &amp; Injectables—Medical plan covers associated office visit for injection of Depo-Provera and Lunell, Diaphragm fitting, and Cervical Cap, IUD &amp; Norplant devices; see Pharmacy benefit for additional contraceptive coverages</td>
<td>Member cost sharing based on type of service performed and place of service where rendered</td>
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<td><strong>Voluntary Abortion</strong></td>
<td>Member cost sharing based on type of service performed and place of service where rendered</td>
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<tr>
<td><strong>Voluntary Sterilization</strong>—Covers tubal ligation &amp; vasectomy. Excludes reversals.</td>
<td>Member cost sharing based on type of service performed and place of service where rendered</td>
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<tr>
<td><strong>Infertility</strong>—Covers diagnosis and treatment of underlying cause</td>
<td>Member cost sharing based on type of service performed and place of service where rendered</td>
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</tr>
<tr>
<td><strong>Advanced Reproductive Technology (ART)</strong></td>
<td>Not Covered</td>
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<tr>
<td><strong>Other Services</strong></td>
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<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility—90 days per calendar year</td>
<td>20% after deductible 40% after deductible</td>
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</tr>
<tr>
<td>Home Health Care—150 visits per calendar year</td>
<td>20% after deductible 40% after deductible</td>
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<td>Private Duty Nursing—70 8-hr shifts per calendar year</td>
<td>20% after deductible 40% after deductible</td>
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<tr>
<td>Outpatient Short-Term Rehabilitation—Physician's services and services of physical, speech or occupational therapists for diagnosis of developmental delays or for treatment of acute conditions if such services will result in significant improvement in member's condition</td>
<td>20% after deductible applies to physical, occupational and speech therapy</td>
<td>40% after deductible applies to physical, occupational and speech therapy</td>
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<tr>
<td>Spinal Disorders—Spinal Manipulations performed by an MD, DO, chiropractor or therapist, 25 visits per calendar year</td>
<td>100% Covered after $35 specialist copay 40% after deductible</td>
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</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>20% after deductible; foot orthotics excluded 40% after deductible; foot orthotics excluded</td>
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<td>Prosthetics Devices—e.g., artificial limb; breast prosthesis</td>
<td>20% after deductible 40% after deductible</td>
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<tr>
<td>Infusion Therapy—e.g., chemotherapy, hydration therapy, etc. performed in the home, office or outpatient facility.</td>
<td>Member cost sharing based on type of service performed and place of service where rendered</td>
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<th>Mental Health Services</th>
<th>In-Network (You Pay)</th>
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<tbody>
<tr>
<td>Inpatient Mental Disorders Coinsurance</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Inpatient Copay/Deductible—Applies to inpatient Mental Health &amp; Substance Abuse.</td>
<td>20% after deductible and $150 admission copay</td>
<td>40% after deductible and $600 admission copay</td>
</tr>
<tr>
<td>Maximum Inpatient Days Per Year</td>
<td>30 days per year combined with substance abuse</td>
<td></td>
</tr>
<tr>
<td>Outpatient Behavioral Health Visit—Applies to outpatient therapy visits in an office or other outpatient setting</td>
<td>$35</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Maximum Outpatient Visits Per Year</td>
<td>30 visits per year combined with substance abuse</td>
<td></td>
</tr>
<tr>
<td>Residential Treatment Facility—Subject to Inpatient Pre-certification requirements</td>
<td>20% after deductible and $150 admission copay</td>
<td>40% after deductible and $600 admission copay</td>
</tr>
<tr>
<td>Intensive Outpatient—Typically 3-5 hours/day, several days per week (subject to Inpatient Pre-cert requirements)</td>
<td>$35 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Partial Hospitalization—Typically 5-8 hours/day, several days per week (subject to Inpatient Pre-cert requirements)</td>
<td>$35 copay</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

- Partial hospitalization benefits reduce the outpatient benefits one visit for every one visit in the partial hospital setting and are combined with outpatient maximum benefits.

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<tr>
<th>Alcohol and Drug Abuse Services</th>
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</tr>
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<tbody>
<tr>
<td>Inpatient Rehabilitation &amp; Detoxification Coinsurance—In a hospital or treatment facility</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Maximum Inpatient Days Per Year</td>
<td>30 days per year combined with mental disorders</td>
<td></td>
</tr>
<tr>
<td>Outpatient Chemical Dependency Visit—Applies to outpatient visits in an office or other outpatient setting</td>
<td>$35</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Maximum Outpatient Visits Per Year</td>
<td>30 visits per year combined with mental disorders</td>
<td></td>
</tr>
</tbody>
</table>
### Aetna Choice POS II $750 Option

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<tr>
<th></th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Deductible</strong>—Per calendar year</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Family Deductible Limit</strong>—Once met, all family members will be considered as having met their deductible for the remainder of that calendar year.</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong>—Identifies the maximum amount of out-of-pocket expenses that a member will have to pay in a calendar year for most services. Once the limit is met, most expenses will be paid at 100% for the remainder of that calendar year.</td>
<td>$4,000 includes deductible</td>
<td>$8,000 includes deductible</td>
</tr>
<tr>
<td><strong>Family Out-of-Pocket Maximum</strong>—Specifies the amount which a family must meet before all family members receive reimbursement at 100%.</td>
<td>$8,000 includes deductible</td>
<td>$16,000 includes deductible</td>
</tr>
<tr>
<td><strong>Primary Care Physician’s Office Visit</strong>—Applies to internist, general physician, family practitioner or pediatrician.</td>
<td>$30 PCP copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$45 Specialist copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Aexcel Specialist Office Visit</strong></td>
<td>$30 Specialist copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Walk-In Clinic</strong></td>
<td>$30 PCP copay</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th></th>
<th>100% Covered, no copay, no deductible</th>
<th>40%, no deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well Child Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well Child Care Frequency Limits</strong>—Includes routine immunizations, travel immunizations &amp; flu shots.</td>
<td>7 exams in 1st 12 months of life, 2 exams in 13th-24th months; 1 exam per calendar year thereafter to age 18</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Routine Physical Exam</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Adult Routine Physical Exam Frequency Limits</strong>—Includes routine immunizations, travel immunizations &amp; flu shots.</td>
<td>1 exam per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Routine GYN</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Routine GYN Exam &amp; Pap Smear Frequency Limits</strong></td>
<td>1 routine GYN exam per calendar year with 1 pap smear &amp; related lab fees</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Mammogram</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Routine Mammogram Age/Frequency Limits</strong></td>
<td>1 baseline at age 35, 1 every 2 calendar years after age 35, and 1 every calendar year after age 40</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exams (DRE)</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
</tbody>
</table>
### Preventive Care—continued

<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exam (DRE) Age/Frequency Limits</strong></td>
<td>1 routine DRE &amp; PSA per calendar year for males age 40 &amp; over</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screenings</strong></td>
<td>For all members age 50+: Fecal occult blood test every year, Sigmoidoscopy (1 every 5 years), Double contrast barium enema (1 every 5 years), Colonoscopy (1 every 10 years).</td>
<td>100% Covered, no copay, no deductible</td>
</tr>
<tr>
<td><strong>Routine Eye Exam</strong></td>
<td>Not Covered; discounts available</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Hearing Exam</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40%, no deductible</td>
</tr>
<tr>
<td><strong>Routine Hearing Exams Frequency Limits</strong></td>
<td>1 exam per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Not Covered; discounts available</td>
<td></td>
</tr>
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</table>

### Hospital Care

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<tr>
<th>Service</th>
<th>In-Patient (You Pay)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Copay/Deductible</strong></td>
<td>$200 copay</td>
<td>$600 copay</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Coinsurance</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Expenses</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
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### Other Physician Services

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<th>Service</th>
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<tr>
<td><strong>Acupuncture</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Allergy Testing &amp; Treatment</strong></td>
<td>Covered at applicable PCP or Specialist Office Visit cost sharing</td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Injections</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Maternity /Obstetrics</strong></td>
<td>OB Visits - Specialist office visit copay applies to 1st prenatal visit only</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
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<tr>
<td><strong>Outpatient Surgery</strong>—Surgeon’s charges performed in an office setting.</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
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</tr>
<tr>
<td><strong>Outpatient Surgery</strong>—Surgeon’s charges performed in other settings (outpatient department of hospital or ambulatory surgery center)</td>
<td>20% after deductible</td>
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</tr>
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### Diagnostic Procedures

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<td><strong>Diagnostic X-ray and Lab</strong>—Performed as part of a physician office visit and billed by physician, covered same as physician office visit cost sharing</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
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<td><strong>Diagnostic X-ray and Lab</strong>—Performed in an outpatient hospital or other outpatient facility setting including independent lab</td>
<td>10%, no deductible</td>
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<td><strong>Complex Imaging Services</strong>—MRA/MRS, MRI, CT Scan, PET Scan</td>
<td>10%, no deductible</td>
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### Emergency Medical Care

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<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$45 UCF copay</td>
<td>40% after deductible</td>
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<tr>
<td><strong>Emergency Room</strong>—Any Copay applies only to E.R. Facility expenses. Related expenses - radiology, pathology, anesthesia, surgeon, etc. covered at E.R. coinsurance, no copay.</td>
<td>20% after deductible and if not admitted $75 E.R. Copay</td>
<td>20% after deductible and if not admitted $75 E.R. Copay; in-network deductible applies</td>
</tr>
<tr>
<td><strong>Non-Emergency Use of Emergency Room</strong></td>
<td>Not covered</td>
<td></td>
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<tr>
<td><strong>Ambulance</strong>—Covers medically necessary travel. Ground ambulance for member convenience or for non-clinical reasons is not covered.</td>
<td>20% after deductible</td>
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<tr>
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<td>Home Health Care—150 visits per calendar year</td>
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<td>Outpatient Short-Term Rehabilitation—Physician's services and services of physical, speech or occupational therapists for diagnosis of developmental delays or for treatment of acute conditions if such services will result in significant improvement in member's condition</td>
<td>20% after deductible applies to physical, occupational and speech therapy</td>
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<td>Spinal Disorders—Spinal Manipulations performed by an MD, DO, chiropractor or therapist, 25 visits per calendar year</td>
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</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Disorders Coinsurance</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Copay/Deductible</strong></td>
<td>20% after deductible and $200 admission copay</td>
<td>40% after deductible and $600 admission copay</td>
</tr>
<tr>
<td><strong>Maximum Inpatient Days Per Year</strong></td>
<td>30 days per year combined with substance abuse</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Behavioral Health Visit</strong></td>
<td>$45</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Maximum Outpatient Visits Per Year</strong></td>
<td>30 visits per year combined with substance abuse</td>
<td></td>
</tr>
<tr>
<td><strong>Residential Treatment Facility</strong></td>
<td>20% after deductible and $200 admission copay</td>
<td>40% after deductible and $600 admission copay</td>
</tr>
<tr>
<td><strong>Intensive Outpatient</strong></td>
<td>$45 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Partial Hospitalization</strong></td>
<td>$45 copay</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

### Alcohol and Drug Abuse Services

<table>
<thead>
<tr>
<th>Alcohol and Drug Abuse Services</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Rehabilitation &amp; Detoxification Coinsurance</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Maximum Inpatient Days Per Year</strong></td>
<td>30 days per year combined with mental disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Chemical Dependency Visit</strong></td>
<td>$45</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Maximum Outpatient Visits Per Year</strong></td>
<td>30 visits per year combined with mental disorders</td>
<td></td>
</tr>
</tbody>
</table>
### Aetna Choice POS II $1,000 Option

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Deductible</strong>—Per calendar year</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Family Deductible Limit</strong>—Once met, all family members will be considered as having met their deductible for the remainder of that calendar year.</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong>—Identifies the maximum amount of out-of-pocket expenses that a member will have to pay in a calendar year for most services. Once the limit is met, most expenses will be paid at 100% for the remainder of that calendar year.</td>
<td>$5,000 includes deductible</td>
<td>$10,000 includes deductible</td>
</tr>
<tr>
<td><strong>Family Out-of-Pocket Maximum</strong>—Specifies the amount which a family must meet before all family members receive reimbursement at 100%.</td>
<td>$10,000 includes deductible</td>
<td>$20,000 includes deductible</td>
</tr>
<tr>
<td><strong>Primary Care Physician’s Office Visit</strong>—Applies to internist, general physician, family practitioner or pediatrician.</td>
<td>$30 PCP copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$45 Specialist copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Aexcel Specialist Office Visit</strong></td>
<td>$30 Specialist copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Walk-In Clinic</strong></td>
<td>$30 PCP copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td><strong>Well Child Care Frequency Limits</strong>—Includes routine immunizations, travel immunizations &amp; flu shots.</td>
<td>7 exams in 1st 12 months of life, 2 exams in 13th-24th month, 1 exam per calendar year thereafter to age 18</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Routine Physical Exam</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td><strong>Adult Routine Physical Exam Frequency Limits</strong>—Includes routine immunizations, travel immunizations &amp; flu shots.</td>
<td>1 exam per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Routine GYN</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td><strong>Routine GYN Exam &amp; Pap Smear Frequency Limits</strong></td>
<td>1 routine GYN exam per calendar year with 1 pap smear &amp; related lab fees</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Mammogram</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td><strong>Routine Mammogram Age/Frequency Limits</strong></td>
<td>1 baseline at age 35, 1 every 2 calendar years after age 35, and 1 every calendar year after age 40</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exams (DRE)</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
</tbody>
</table>
### Aetna Choice POS II $1,000 Option

#### Preventive Care—continued

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exam</strong>&lt;br/&gt;<strong>DRE Age/Frequency Limits</strong></td>
<td>1 routine DRE &amp; PSA per calendar year for males age 40 &amp; over</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screenings</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td>For all members age 50+: Fecal occult blood test every year, Sigmoidoscopy (1 every 5 years), Double contrast barium enema (1 every 5 years), Colonoscopy (1 every 10 years).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Eye Exam</strong></td>
<td>Not Covered; discounts available</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Hearing Exam</strong></td>
<td>100% Covered, no copay, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td><strong>Routine Hearing Exams Frequency Limits</strong></td>
<td>1 exam per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Not Covered; discounts available</td>
<td></td>
</tr>
</tbody>
</table>

#### Hospital Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Copay/Deductible</strong>&lt;br/&gt;Per admission</td>
<td>$250 copay</td>
<td>$600 copay</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Coinsurance</strong>&lt;br/&gt;Includes inpatient surgery expenses, room &amp; board &amp; misc fees, physician expenses, routine nursery care, prescription drugs and all other inpatient care.</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Expenses</strong>&lt;br/&gt;Hospitals and other facilities (i.e., ambulatory surgery center, hospital outpatient dept.). Includes short-term rehabilitation in a hospital outpatient setting.</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

#### Other Physician Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture</strong>&lt;br/&gt;Covered in lieu of anesthesia only</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Allergy Testing &amp; Treatment</strong>&lt;br/&gt;Office visit</td>
<td>Covered at applicable PCP or Specialist Office Visit cost sharing</td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Injections</strong>&lt;br/&gt;Not given by the physician, or not in conjunction with an office visit</td>
<td>100% Covered, no copay, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Maternity / Obstetrics</strong>&lt;br/&gt;Delivery charges are covered under the Hospital benefit, subject to the per confinement copay, if any.</td>
<td>OB Visits—Specialist office visit copay applies to 1st prenatal visit only</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
<td></td>
</tr>
</tbody>
</table>
### Aetna Choice POS II $1,000 Option

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery—Surgeon’s charges performed in an office setting.</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery—Surgeon’s charges performed in other settings (outpatient department of hospital or ambulatory surgery center)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab—Performed as part of a physician office visit and billed by physician, covered same as physician office visit cost sharing</td>
<td>Covered at applicable PCP or Specialist office visit cost sharing</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab—Performed in an outpatient hospital or other outpatient facility setting including independent lab</td>
<td>10%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Complex Imaging Services—MRA/MRS, MRI, CT Scan, PET Scan</td>
<td>10%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Medical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$45 UCF copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Emergency Room—Any copay applies only to E.R. Facility expenses. Related expenses - radiology, pathology, anesthesia, surgeon, etc. covered at E.R. coinsurance, no copay.</td>
<td>20% after deductible and if not admitted $100 E.R. Copay</td>
<td>20% after deductible and if not admitted $100 E.R. Copay; in-network deductible applies</td>
</tr>
<tr>
<td>Non-Emergency Use of Emergency Room</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Ambulance—Covers medically necessary travel. Ground ambulance for member convenience or for non-clinical reasons is not covered.</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
## Aetna Choice POS II $1,000 Option

### Family Planning

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive Devices, Implants &amp; Injectables</strong>—Medical plan covers associated</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
</tr>
<tr>
<td>office visit for injection of Depo-Provera and Lunell, Diaphragm fitting, and</td>
<td>rendered</td>
<td>rendered</td>
</tr>
<tr>
<td>Cervical Cap, IUD &amp; Norplant devices; see Pharmacy benefit for additional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>contraceptive coverages</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Voluntary Abortion</strong></td>
<td>Member cost sharing based on type of service performed and place of service where</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
</tr>
<tr>
<td></td>
<td>rendered</td>
<td>rendered</td>
</tr>
<tr>
<td><strong>Voluntary Sterilization</strong>—Covers tubal ligation &amp; vasectomy. Excludes reversals.</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
</tr>
<tr>
<td></td>
<td>rendered</td>
<td>rendered</td>
</tr>
<tr>
<td><strong>Infertility</strong>—Covers diagnosis and treatment of underlying conditions</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
</tr>
<tr>
<td></td>
<td>rendered</td>
<td>rendered</td>
</tr>
<tr>
<td><strong>Advanced Reproductive Technology (ART)</strong></td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

### Other Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility</strong>—90 days per calendar year</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Home Health Care</strong>—150 visits per calendar year</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong>—70 8-hr shifts per calendar year</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Short-Term Rehabilitation</strong>—Physician’s services and services of</td>
<td>20% after deductible applies to physical, occupational and speech therapy</td>
<td>50% after deductible applies to physical, occupational and speech therapy</td>
</tr>
<tr>
<td>physical, speech or occupational therapists for diagnosis of developmental delays or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or for treatment of acute conditions if such services will result in significant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>improvement in member’s condition within a 60-day period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spinal Disorders</strong>—Spinal Manipulations performed by an MD, DO, chiropractor or</td>
<td>100% Covered after $45 specialist copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>therapist, 25 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>20% after deductible; foot orthotics excluded</td>
<td>50% after deductible; foot orthotics excluded</td>
</tr>
<tr>
<td><strong>Prosthetics Devices</strong>—e.g., artificial limb; breast prosthesis</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong>—e.g., chemotherapy, hydration therapy, etc. performed in the</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
<td>Member cost sharing based on type of service performed and place of service where</td>
</tr>
<tr>
<td>home, office or outpatient facility.</td>
<td>rendered</td>
<td>rendered</td>
</tr>
</tbody>
</table>

For help, go to http://resources.hewitt.com/homedepot or call 1-800-555-4954
Aetna Choice POS II $1,000 Option

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th>In-Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Disorders Coinsurance</strong></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Copay/Deductible</strong>—Applies to inpatient Mental Health &amp; Substance Abuse.</td>
<td>20% after deductible and $250 admission copay</td>
<td>50% after deductible and $600 admission copay</td>
</tr>
<tr>
<td><strong>Maximum Inpatient Days Per Year</strong></td>
<td>30 days per year combined with substance abuse</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Behavioral Health Visit</strong>—Applies to outpatient therapy visits in an office or other outpatient setting</td>
<td>$45</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Maximum Outpatient Visits Per Year</strong></td>
<td>30 visits per year combined with substance abuse</td>
<td></td>
</tr>
<tr>
<td><strong>Residential Treatment Facility</strong>—Subject to Inpatient Pre-certification requirements</td>
<td>20% after deductible and $250 admission copay</td>
<td>50% after deductible and $600 admission copay</td>
</tr>
<tr>
<td><strong>Intensive Outpatient</strong>—Typically 3-5 hours/day, several days per week (subject to Inpatient Pre-cert requirements)</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Partial Hospitalization</strong>—Typically 5-8 hours/day, several days per week (subject to Inpatient Pre-cert requirements). Partial hospitalization benefits reduce the outpatient benefits one visit for every one visit in the partial hospital setting and are combined with outpatient maximum benefits.</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

| Alcohol and Drug Abuse Services | |
|---------------------------------|---------------------|-------------------------|
| **Inpatient Rehabilitation & Detoxification Coinsurance**—In a hospital or treatment facility. | 20% after deductible | 50% after deductible |
| **Maximum Inpatient Days Per Year** | 30 days per year combined with mental disorders | |
| **Outpatient Chemical Dependency Visit**—Applies to outpatient visits in an office or other outpatient setting | $45 copay | 50% after deductible |
| **Maximum Outpatient Visits Per Year** | 30 visits per year combined with mental disorders | |
Maternity Care Programs

If you enroll in an Aetna Choice POS II or Aetna Out-of-Area option, you are eligible to participate in the Beginning RightSM Maternity Program. As soon as your doctor confirms your pregnancy, you should immediately call Aetna to register in the Beginning Right program. The program provides comprehensive educational materials about prenatal care, labor and delivery, and newborn care. And, if you have issues or risk factors that need special attention, the program nurses can give you personal case management to find ways to lower your risks.

Pregnant mothers can join the Smoke-Free Moms-to-Be® program to help to stop smoking during pregnancy. Stopping smoking can lower your baby's risk for preterm delivery, low birth weight, sudden infant death syndrome (SIDS).

If you enrolled in an Aetna Choice POS II option and are pregnant or thinking of becoming pregnant, call 1-800-695-9744.

Go Online for even more health information on women's health: www.womenshealth.aetna.com. You’ll find information on pregnancy and baby care, as well as:

- reproductive health
- menopause
- breast health
- heart health
- migraines
- depression

Precertification Program

The Aetna Plan precertification program is designed to help ensure that the treatment or surgery recommended for you and your covered family members is the most appropriate. Specifically, the program:

- coordinates with your doctor to obtain information required for precertification
- may recommend that you or your family member get a second surgical opinion
- may recommend an alternative treatment, which may be considered more appropriate (the choice of which treatment to receive, however, is always yours)
- advises your doctor or hospital if the recommended treatment is a covered health service or has been otherwise approved (the choice of which treatment to receive, however, is always yours)
- monitors hospital stays until you or your covered family member is discharged

When You Need Precertification

You or your provider should call Aetna to precertify medical treatment at least 14 days before any planned hospital admission or inpatient surgery. To receive full benefits under the Plan, you (or your provider) must precertify services and treatments. The list of services for which you must obtain precertification includes, but is not limited to, the following:

- Inpatient confinements
  - surgical and non-surgical, excluding vaginal or Caesarian deliveries
  - skilled nursing facility
  - rehabilitation facility
  - inpatient hospice (except Medicare)
  - Observation stays greater than 23 hours
- Reconstructive procedures that may be considered cosmetic
  - blepharoplasty/canthopexy/canthoplasty
  - excision of excessive skin due to weight loss
  - rhinoplasty/rhytidectomy
  - gastroplasty/gastric bypass
  - pectus excavatum repair
  - breast reconstruction/breast enlargement
  - breast reduction/mammoplasty
  - surgical treatment of gynecomastia
  - lpectomy or excess fat removal
  - sclerotherapy or surgery for varicose veins
- Artificial intervertebral disc surgery
• Lumbar spinal fusion surgery
• Uvulopalatopharyngoplasty, including laser-assisted procedures
• Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
• Dental implants and oral appliances
• Elective (non-emergent) transportation by ambulance or medical van, and all transfers via air ambulance
• The following conditionally eligible services (all services deemed “never effective” by Aetna are excluded from coverage)
  — stereotactic radiosurgery
  — somatosensory evoked potential studies
  — cognitive skills development
  — hyperbaric oxygen therapy
  — osteochondral allograft/knee
  — cochlear device and/or implantation
  — osseointegrated implant
  — percutaneous implant of neuroelectrode array, epidural
  — GI tract imaging through capsule endoscopy
  — Botox injections—botulinum toxin type A
  — Alpha 1-proteinase inhibitor—human
  — negative pressure wound therapy pump
  — high-frequency chest wall oscillation generator system
• Medical injectables
  — Synagis
  — erythropoiesis stimulating agents (ESA), such as darbepoetin alpha (Aranesp), and epoetin alpha (Epogen and Procrit), and epoetin beta (Micera)
  — intravenous immunoglobulin (IVIG)
  — growth hormone
  — blood-clotting factors
  — interferons, when used for hepatitis C: Pegasys®, Peg Intron®, Rebetron®, Roferon A®, Intron A®, Infergen®

NOTE: Some medical injectibles will only be offered through the Prescription Drug Program. Please check with Caremark; pre-certification may be required.

• All home health care services, including home uterine monitoring
• Selected durable medical equipment
  — electric or motorized wheelchairs and scooters
  — clinitron and electric beds
  — limb prosthetics
  — customized braces
• In-network level of benefits for nonparticipating physicians and providers for non-emergent services only when there is an identified network deficiency
• Special programs
  — to precertify mental health or substance abuse services, see your Aetna ID card
  — Beginning Right Maternity Program, including genetic testing, antenatal testing, perinatal consultations and counseling
  — BRCA genetic testing
  — pre-implantation genetic testing
• Transplant Services for all major organ transplant evaluations and transplants including, but not limited to, kidney, liver, heart, lung and pancreas, and bone marrow replacement or stem cell transfer after high-dose chemotherapy
• (Where applicable) Outpatient imaging precertification for CTs, coronary computed tomographic angiography, MRI/MRA, nuclear cardiology, PET scans through regional-specific managed service organizations (MedSolutions, Care Core National and National Imaging Solutions)
• Bariatric surgery: see Bariatric Surgery later in this chapter

Additional Precertification Information
For inquiries regarding pre-certification please call 1-800-223-6857.

• Precertification approvals are valid for six months in all states.

The Plan does not require precertification for lengths of stay 48 hours or less for normal childbirth nor for lengths of stay 96 hours or less for cesarean section deliveries. If the maternity stay exceeds these lengths of stay, however, precertification is required.
In an Emergency
In an emergency, you or your family must notify Aetna within 48 hours of any hospital admission. Precertification is not necessary in emergency situations if you are not admitted to the hospital.

Penalty for Not Precertifying
If you are using out-of-network providers and you do not call Aetna to precertify a required medical treatment, the Plan will reduce your benefits by $500 per occurrence. Penalty amounts do not count toward your out-of-pocket maximum or your deductible.

Precertification for Skilled Facility and In-Patient Hospice Care
• If precertification has been requested and denied:
  —no benefits will be paid for room and board
  —benefits for all other skilled facility or hospice care facility expenses will be paid at the percentage specified under your medical plan option
• If precertification has not been requested and the confinement (or any day of such confinement) is necessary:
  —no benefits will be paid for room and board
  —benefits for all other skilled facility or hospice care facility expenses will be paid at the percentage specified under your medical plan option
• If precertification has not been requested and the confinement (or any day of such confinement) is not necessary:
  —no benefits will be paid for room and board
  —no benefits for will be paid for all other expenses

Precertification for Home Health Care, Outpatient Hospice Care, and Skilled Nursing Care
• If precertification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not necessary, no benefits will be paid for the denied or unnecessary service or supply.
• If certification has not been requested for a service or supply and the service or supply is necessary, benefits for the necessary service or supply will be paid as follows:
  —expenses incurred for the service or supply, up to the excluded amount, will not be covered
  —benefits for all other covered medical expenses incurred for the service or supply will be paid at percentage specified under your medical plan option

Whether or not a day of confinement or a service or supply has been precertified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan.

To get precertification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred. If a person's physician believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies. Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If services and supplies for hospice care have been certified and the person later requires confinement in a hospital for pain control or acute symptom management, any other precertification requirement in this Plan will be waived for confinement in a hospital.

Precertification for Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders
If, in connection with the treatment of alcoholism, drug abuse, or a mental disorder, a person incurs covered medical expenses while confined in a hospital or treatment facility; and
• it has not been precertified that such confinement (or any day of such confinement) is necessary; and
• the confinement has not been ordered and prescribed by the BHCC or an Aetna network provider upon referral by the BHCC

Covered medical expenses incurred on any day not certified during the confinement will be paid only as follows:
• With respect to expenses for hospital and treatment facility board and room:
  —If precertification has been requested and denied, or if precertification has not been requested and the confinement is not necessary, no benefits will be paid.
  —If precertification has not been requested and the confinement is necessary, such expenses, up to the excluded amount, will not be covered medical expenses.
• With respect to all other hospital and treatment facility expenses:
  — if certification has been requested and denied, or if precertification has not been requested and the confinement is necessary, such expenses, up to the excluded amount, will not be covered medical expenses.
  — if precertification has not been requested and the confinement is not necessary, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for covered medical expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not necessary will not be applied to hospital and treatment facility board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an emergency admission, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person’s physician believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Health Care Assessment Program

Aetna’s Simple Steps to a Healthier Life is an online health and wellness program to help you discover ways to achieve a healthier, more balance life. It gives you guidance and support to help you eat better, lose weight, get in shape, and relieve stress. If you are enrolled in an Aetna medical option and take the Aetna Simple Steps to a Healthier Life® Health Assessment, you receive a credit* in each biweekly paycheck and personalized information on how to improve your health. Based on your results, Aetna may recommend an online Healthy Living Program, such as Get-in-Shape, Cancer-Fighting, Diabetes-Fighting, Healthy Heart, Stress Relief and Weight Loss.

For more information on the Aetna Simple Steps to a Healthier Life® Health Assessment, go to www.livethehealthyorangeflife.com.

Disease Management Program

Aetna’s Health Connections Disease Management program provides support and resources on managing more than 30 chronic health conditions. Aetna Health Connections health support is provided by more than 2,000 clinical professionals, including doctors, nurses, pharmacists, social workers, wellness counselors, nutritionists, and weight loss therapists among others. They will work with you to coordinate your health care needs, help ensure that you understand your doctor’s prescribed treatment plan in order to manage a chronic medical condition, and help you learn how to embrace a healthier lifestyle. Aetna Health Connections also offers you a high-quality suite of user-friendly, web-based tools and health information resources. For more information, go to www.livethehealthyorangeflife.com or call 1-800-695-9744.

Case Management Program

We base our Aetna Health Connections case management program on the Case Management Society of America’s definition of case management. Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality health outcomes.

* This credit is not available to associates in Hawaii.
Case managers review and coordinate services for members with multiple and complex needs with identified gaps in their care and for members who are at risk for high cost or high utilization. Case managers collaborate with the member, family, caregiver, member authorized representative, treating practitioner, health care provider community and our other programs to coordinate care, with a focus on member education and maximizing quality outcomes.

Case managers provide the member with information about alternative coverage or continuing care opportunities, as appropriate, and inform the member of ways to obtain that coverage or care in the vent the member’s benefits end and the member requires additional care. Alternative options for coverage or care may include local, state, or federally funded agencies or non-profit organizations.

When in case management, case managers, in coordination with the attending physician, member or member designee, develop a case management plan. The case manager’s plan may reflect short and long-term goals targeted to facilitate the achievement of individual member’s health goal.

Aetna Discount Programs and Services

If you enroll in one of the Aetna medical options, you may have access to these discount programs and services at no extra cost:

- **preferred rates for fitness club memberships** in the GlobalFit™ network (with over 2,000 locations). Go to www.globalfit/fitness for a list of participating clubs. Then enroll online or call 1-800-298-7800.

- **discounts on complementary health services and natural products.** The Aetna Natural Products and ServicesSM program provides savings through American Specialty Health Networks, Inc. This includes massage therapy, acupuncture, chiropractic care, dietetic counseling, and natural products (such as over-the-counter vitamins, yoga equipment, aromatherapy, and nutritional and health supplements).

- **discounts on hearing services and products.** Aetna HearingSM provides discounts on hearing aids, hearing exams, and hearing aid services. Go to www.hearpo.com/aetna for more information.

- **weight management program discounts.** You and your eligible family members can save on weight loss programs and products from Jenny Craig®. A 30-day membership is free, then you get 30% off an OnTrack 6-month (Gold) or 12-month (Platinum) membership. Or you can get 15% off a Jenny Rewards 12-month membership. Get a personalized registration coupon through your Aetna member Web site.

- **other savings programs!** Aetna offers other savings programs such as discounts on Sonicare® toothbrushes, discounts on Zagat.com subscriptions, discounts on eDiets® memberships, and more. Go to www.livethehealthyorangeflife.com to find out about other healthy savings programs.

Finding an Aexcel® Specialist in Aetna’s Network

Depending on your location, you may have access to Aetna’s Performance Network that provides Aexcel-designated doctors in 12 specialty areas. These Aexcel doctors are some of the best performers, in terms of clinical performance and efficiency, in their specialty areas. When you visit an Aexcel doctor, you can eliminate referrals and you also may lower your out-of-pocket costs.

**The 12 medical specialties are:**

- Cardiology
- Obstetrics and Gynecology
- Cardiotoracic Surgery
- Orthopedics
- Gastroenterology
- Otolaryngology/ENT
- General Surgery
- Plastic Surgery
- Neurology
- Urology
- Neurosurgery
- Vascular Surgery

Aetna analyzes specialists’ performance using nationally recognized standards from many groups, including the American Heart Association, American College of Obstetricians and Gynecologists, Agency for Health Research and Quality, Society of Thoracic Surgeons, and Centers for Medicare & Medicaid Services.

To find out more about Aexcel or to find an Aexcel-designated specialty, go to the DocFind® online directory at www.livethehealthyorangeflife.com. When you see the blue star symbol and/or dates next to some names, this lets you know if those doctors are Aexcel-designated (and when their designation begins or ends).
Informed Health® Line
Aetna plan participants can use the Informed Health Line 24 hours a day, seven days a week to talk with a registered nurse about your health questions. The nurse counselors can help you better understand symptoms, discuss self-care options, and decide if you should see a doctor. They also can help you better understand a diagnosis and your treatment options. Call the Informed Health Line at 1-800-895-9744.

Go Online for Even More Health Information
Use the Healthwise® Knowledgebase to find out more about a health condition or medications you take. Healthwise Knowledgebase is easy-to-use and has powerful search functions to help you find information about more than 3,400 topics—health conditions, medical tests and procedures, medications and everyday health and wellness issues. Content is written and reviewed by an expert team of physicians, nurses, medical writers and researchers, and updated as new research is reported.

Go to www.livethehealthyorangelifecom to access Healthwise Knowledgebase.

Create Your Personal Health Record with Make HistorySM
Aetna’s Make HistorySM is a secure, online tool that lets you create, view, access, and manage your personal health information and share it with your doctors. By creating your Personal Health History, you can:
• **Keep our health information in one place.** It’s always available for you to access in an emergency.
• **Share your history with your doctor.** You can print your detailed health summary and take it with you to give your doctors a more detailed view of your health.
• **Maintain or even improve your health.** Based on your health profile provided by insurance claims and information you enter yourself, the Personal Health Record generates personalized health-related alerts that can help you address your health needs in a timely manner.

To access Make HistorySM and create a Personal Health Record for yourself and/or covered family members, go to www.aetna.com and access the Aetna Navigator™ member Web site.

Out-of-Area Plans
If your ZIP code is outside the standard Aetna network areas, you may choose the $550, $750 or $1,000 Out-of-Area Plan. You may go to any doctor and receive the same benefits as you would in-network for the Aetna Choice POS II $550, $750 or $1,000 Plans.

The Out-of-Area Plan is administered by Aetna. If you receive services from a provider in the Aetna network, you will be able to pay your copay and the provider will submit the claim for you. If you receive services from a provider that is not in the network, you will need to pay out of your pocket at the time of service and submit a claim for reimbursement. For more information on finding an in-network provider, see Finding In-Network Providers earlier in this chapter.

For more information on how the OOA Plans work, see How the Aetna Choice POS II and OOA Plans Work earlier in this chapter. If you live in California, see the California Medical chapter.

Covered services, limitations and exclusions for the Out-of-Area Plans are listed in the What’s Covered by the Aetna Choice POS II and OOA Plans and What the Aetna Choice POS II and OOA Plans Do Not Cover sections.
What’s Covered by the Aetna Choice POS II and OOA Plans

The Aetna Choice POS II and OOA Plans cover most medical bills for illness or injury, as long as the treatment, service or supply is considered medically necessary or is a covered service. The Plan considers a service or supply medically necessary if it is a generally accepted health care practice and is required to treat the condition of the patient, as determined by the claims administrator. The fact that a doctor or other provider of medical services prescribes, recommends or approves a treatment, service or supply does not automatically make it a covered expense under the Medical Plan. The Well-Care benefits cover in- and out-of-network preventive prostate cancer screenings, mammograms, Pap smears, colorectal screenings, in-network well-child care services and some additional in-network well-adult care services.

For percentages of coinsurance and deductible amounts for the Aetna Choice POS II and OOA Plans, see the Aetna Choice POS II and OOA Plans Summary of Benefits charts.

Alcoholism or Drug Abuse

Certain expenses for the treatment shown below are covered medical expenses, subject to the plan’s maximum inpatient days per year limit.

Inpatient Treatment
If a person is a full-time inpatient either in a hospital or in a treatment facility, then coverage is as shown below:

- **hospital**: treatment of medical complications of alcoholism or drug abuse, such as cirrhosis of the liver, delirium tremens, or hepatitis; and effective treatment of alcoholism or drug abuse
- **treatment facility**: room and board, up to the private room limit; other necessary services and supplies

Outpatient Treatment
Expenses incurred for the effective treatment of alcoholism or drug abuse while the person is not confined as a full-time inpatient in a hospital or treatment facility will be considered covered medical expenses and subject to the Plan’s maximum outpatient visits per year limit.

Bariatric Surgery

Coverage for bariatric surgery requires you to satisfy the following eligibility criteria in order to seek approval for the bariatric surgery benefit. To review these eligibility requirements, precertify, find a designated Institute of Excellence (IOE) or get other information regarding your bariatric surgery benefit, please call: **1-800-695-9744**.

You must meet these initial eligibility requirements. Other rules may apply:

- Meet the following Obesity Guidelines:*  
  —BMI of equal to or greater than 40, irrespective of co-morbidities as defined by National Institute of Health (NIH), or
  —BMI of equal to or greater than 35, with at least one significant co-morbid condition as defined by National Institute of Health (NIH). AND
- Complete a six-month physician supervised weight loss program that includes nutritionist/dietician involvement prior to surgery; AND
- Complete a pre-surgery psychological evaluation; AND
- Have the surgery performed at a facility that has been designated a Bariatric Surgery Institute of Excellence as defined by Aetna AND
- Seek prior approval before obtaining any Bariatric Services through pre-certification/prior notification to activate bariatric surgery benefit.

If you live more than 100 miles from a designated Institute of Excellence, you may be eligible for Travel and Lodging reimbursement of up to $50 per night per person (up to $100 total). There is a $10,000 Travel & Lodging maximum per procedure. All Travel and Lodging reimbursement must be pre-approved.

Exclusions Related to Bariatric Surgery

- Cosmetic Surgery to correct such skin conditions as excess skin after successful weight loss, unless medically necessary
- Breast Reduction and Abdominoplasty, unless medically necessary
- Revisions, unless medically necessary
- Any member under the age of 18

* Obesity Guidelines are based on National Institute of Health (NIH) guidelines. Eligibility design will be updated automatically for BMI as NIH guidelines are updated.
Skilled Nursing Facility
The Plan covers charges made by a skilled nursing facility for the following services and supplies, provided that they are furnished to a covered person while he or she is confined while convalescing from a disease or injury:

- room and board, including charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily room and board in a private room that exceeds the private room limit
- use of special treatment rooms
- x-ray and lab work
- physical, occupational or speech therapy
- oxygen and other gas therapy
- other medical services usually given by a skilled facility. This does not include private or special nursing, or physician's services
- medical supplies

Benefits will be paid for no longer than 90 days during any one calendar year.

Skilled Nursing Facility Limitations
Charges for these skilled facility expenses are not covered:

- drug addiction
- chronic brain syndrome
- alcoholism
- senility
- mental retardation
- any other mental disorder

Emergency Room
It is important that all visits to a hospital emergency room occur in the context of a “true emergency,” such as a life-threatening illness or injury. These include severe breathing problems, major burns, head injuries, acute heart attack symptoms, uncontrollable bleeding, unconsciousness or other extreme circumstances.

- emergency care. Covered medical expense for charges made by the hospital will be covered if treatment is received in the emergency room of a hospital while a person is not a full-time inpatient. You must meet the required individual deductible and verify the treatment is a true emergency.
- non-emergency care. No benefits are payable if treatment is received in the emergency room of a hospital while a person is not a full-time inpatient and the treatment is not for emergency care.

Family Planning
The charges made by a physician or hospital services even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are covered medical expenses.

Benefits will be payable for:

- a vasectomy for voluntary sterilization
- a tubal ligation for voluntary sterilization
- voluntary abortions

Charges for the reversal of a sterilization procedure are not covered.

Home Health Care
Home health care expenses are covered if:

- the charge is made by a home health care agency; and
- the care is given under a home health care plan; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available
- part-time or intermittent home health aide services for patient care.
- physical, occupational, and speech therapy.
- the following expenses to the extent they would have been covered under this Plan if the person had been confined in a hospital or skilled facility:
  - medical supplies;
  - drugs and medicines prescribed by a physician; and
  - lab services provided by or for a home health care agency.

The plan covers up to 150 visits in a calendar year. Each visit by a nurse or therapist is considered one visit. Each visit of up to four hours by a home health aide is considered one visit.
Limitations to Home Health Care Expenses
The Plan does not cover these home health care expenses:

- services or supplies that are not a part of the home health care plan
- services of a person who usually lives with you or who is a member of your or your spouse/same sex partner’s family
- services of a social worker
- transportation
- services that are custodial care

Hospice Care
This is care given to a terminally ill person by or under arrangements with a hospice care program.

Hospice Facility Expenses
Charges made by a hospice facility, hospital or skilled facility for:

- Inpatient Care: room and board and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management. Charges that exceed the private room limit for daily room and board are not covered.

- Outpatient Care: services and supplies furnished to a person while not confined as a full-time patient.

Hospice Outpatient Care
Charges made by a hospice care agency for:

- part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day
- medical social services under the direction of a physician, including:
  - assessment of the person’s social, emotional, and medical needs, and home and family situation;
  - identification of the community resources that are available to the person; and
  - assisting the person to obtain those resources as needed.
- psychological and dietary counseling
- consultation or case management services by a physician
- physical and occupational therapy
- part-time or intermittent home health aide services (mainly for caring for the person) for up to eight hours in any one day
- medical supplies
- drugs and medicines prescribed by a physician
- psychological and dietary counseling

The plan covers outpatient care charges made by these providers, as long as the provider is not an employee of a hospice care agency and the hospice care agency is responsible for the care of the person:

- physician for consultant or case management services
- physical or occupational therapist

- home health care agency for:
  - physical and occupational therapy
  - part-time or intermittent home health aide services (mainly for caring for the person) for up to eight hours in any one day
  - medical supplies
  - drugs and medicines prescribed by a physician
  - psychological and dietary counseling

Not included are charges for:

- bereavement counseling
- funeral arrangements
- pastoral counseling
- financial or legal counseling, including estate planning and the drafting of a will
- homemaker or caretaker services that are not solely related to care of the person, including sitter or companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house
- respite care furnished during a period of time when the person’s family or usual caretaker cannot, or will not, attend to the person’s needs
Hospitals

Inpatient Hospital Expenses
Charges made by a hospital for semi-private room and board and other hospital services and supplies while a covered person is confined as a full-time inpatient.

For In-Network Care
If a private room is used, the daily board and room charge will be covered if your network provider requests a private room and Aetna approves this request. If these procedures are not followed, any part of the daily board and room charge that is more than the private room limit is not covered.

For Out-of-Network Care
You are responsible for any charge for daily room and board that in a private room that exceeds the Plan’s semi-private room limit.

Outpatient Hospital Expenses
Charges made by a hospital for hospital services and supplies that are provided to a covered person who is not a full-time inpatient.

Mental Disorders
Charges incurred for the treatment of a mental disorder on an inpatient or an outpatient basis are covered medical expenses to the same extent as charges incurred for the treatment of any other disease.

Maternity Benefits
As required by federal law, maternity benefits are not restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan does not require that a provider obtain authorization from or notify the plan for prescribing the length of stay not in excess of 48 hours (or 96 hours).

In-network maternity benefits include the following:
- Initial visit to confirm pregnancy—covered at 100% after specialist copayment
- Medically necessary ultrasounds, sonograms and other diagnostic tests—covered at the applicable cost sharing based on the place in which the service was rendered.
- Global delivery fee—includes subsequent prenatal visit, routine urinalysis, delivery and postnatal visits—covered at coinsurance after deductible.

Hospital copay applies.

Mastectomies
Federal law requires group health plans offering mastectomy coverage also to cover reconstructive surgery and prostheses following mastectomies.

Therefore, if you or a covered family member receives benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, coverage will also be provided for the following:
- all stages of reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- breast prosthesis (artificial replacements)
- treatment of physical complications with respect to all stages of a mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes)

This coverage will be provided in consultation with the attending physician and the patient, and it will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable.
Surgery
• pre-admission tests performed in the hospital or other location, such as a laboratory or doctor’s office
• surgeon’s fees related to a surgical procedure covered by the Plan
• assistant surgeon’s fees during a covered surgical procedure, if it is determined that the condition of the patient and the type of surgery performed requires the use of a second doctor
• doctors’ fees for administering anesthesia during a covered surgical procedure. To qualify for benefits, the anesthesia must be administered by a doctor other than the surgeon or the assistant surgeon, except if the attending doctor is performing outpatient oral surgery

Transplant Services
Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue. For example:

• Heart
• Lung
• Heart/ Lung
• Simultaneous Pancreas Kidney (SPK)
• Pancreas
• Kidney
• Liver
• Intestine
• Bone Marrow/Stem Cell

Multiple organs replaced during one transplant surgery
• Tandem transplants (Stem Cell)
• Sequential transplants
• Re-transplant of same organ type within 180 days of the first transplant
• Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be more than one Transplant Occurrence:
• Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
• Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
• Re-transplant after 180 days of the first transplant
• Pancreas transplant following a kidney transplant
• A transplant necessitated by an additional organ failure during the original transplant surgery/process
• More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

Benefits will be paid at 100% for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The plan covers:
• Charges made by a physician or transplant team.
• Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
• Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
• Charges for activating the donor search process with national registries.
• Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
• Inpatient and outpatient expenses directly related to a transplant.
Covered transplant expenses are typically incurred during the four phases of transplant care described below.

Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence. A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;

2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

**Important Reminders**

To ensure coverage, all transplant procedures need to be precertified by Aetna. Refer precertification Section of this booklet.

**Limitations**

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

If a person is a transplant patient, this Plan will pay a benefit for travel expenses and lodging expenses but only to the extent described below and only if charges incurred for the transplant procedures and treatment types are covered medical expenses.

Any charges made by the transplant facility for services and supplies that are:

- furnished in connection with any of the procedures or treatment listed below; and
- are included under this Plan as covered medical expenses will be considered to be expenses incurred for in-network care and paid at 100%.

**Transplant Procedure and Treatment Types Transplant Travel Expenses**

These are expenses incurred by a transplant patient and approved in advance by Aetna for transportation between his or her home and the transplant facility to receive services in connection with any listed procedure or treatment. Also included are expenses incurred by a companion, and approved in advance by Aetna, for transportation when traveling with a transplant patient between the transplant patient’s home and the IOE facility to receive such services.
IOE Lodging Expenses
These are expenses incurred by an transplant patient, and approved in advance by Aetna, for lodging away from home:

- while traveling between his or her home and the facility to receive services in connection with any listed procedure or treatment; or
- to receive outpatient services from the facility in connection with any listed procedure or treatment.

The maximum benefit payable for these expenses is $50 per night.

Also included are expenses incurred by a companion, and approved in advance by Aetna, for lodging away from home:

- while traveling with an IOE patient between the transplant patient's home and the facility to receive services in connection with any listed procedure or treatment; or
- when the companion's presence is required to enable a transplant patient to receive such services on an inpatient or outpatient basis. The maximum benefit payable for these expenses is $50 per night.

Oral Surgery
Expenses for the treatment of the mouth, jaws, and teeth are covered medical expenses, but only those for:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "physician" includes a dentist.

The Plan covers surgery needed to:

- treat a fracture, dislocation, or wound
- cut out:
  - teeth partly or completely impacted in the bone of the jaw
  - teeth that will not erupt through the gum
  - other teeth that cannot be removed without cutting into bone
  - the roots of a tooth without removing the entire tooth
  - cysts, tumors, or other diseased tissues
- cut into gums and tissues of the mouth when not done in connection with the removal, replacement or repair of teeth
- alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- non-surgical treatment of infections or diseases, excluding those of or related to the teeth

Dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut out due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury

The treatment must be done in the calendar year of the accident or the next one.

If crowns (caps), dentures (false teeth), bridgework or in-mouth appliances are installed due to such injury, covered medical expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain
• for root canal therapy
• for routine tooth removal (not needing cutting of bone)

The plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

The plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

Not included are charges:
• to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing
• to repair, replace, or restore fillings, crowns, dentures or bridgework
• for non-surgical periodontal treatment
• for dental cleaning, in-mouth scaling, planing or scraping
• for myofunctional therapy; this is muscle training therapy or training to correct or control harmful habits

Routine Physical Exams
Charges made by your primary care physician or a network provider for a routine physical exam given to you, your spouse/same sex partner, or your dependent child may be covered medical expenses. If charges for a dependent child’s routine physical exam are covered under any other benefit section, charges in connection with that physical exam are not considered covered medical expenses under this section. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are immunizations for infectious disease, testing for tuberculosis, x-rays, lab, and other tests given in connection with the exam.

For more information, see the Summary of Benefits chart in this chapter.

These routine physical exam charges are not covered:
• services that are covered under any other group plan provided by the Company
• services for diagnosis or treatment of a suspected or identified injury or disease
• exams given while the person is confined in a hospital or other facility for medical care
• services that are not provided by a physician or under his/her direct supervision
• medicines, drugs, appliances, equipment, or supplies
• psychiatric, psychological, personality or emotional testing or exams
• exams in any way related to employment
• premarital exams
• vision or dental exams

Routine Cancer Screenings
For information, see the Summary of Benefits chart in this chapter.

Short-Term Rehabilitation Expenses
Therapy
Cognitive Therapy. Cognitive therapy is treatment to restore memory, perception, and normal thought processes following an injury to the brain.

Coverage is limited to treatment to restore memory, perception and normal thought processes following an injury to the brain. Therapy is expected to result in significant improvement in body function lost or impaired by disease (e.g., stroke) or accidental injury; or, it’s aimed at slowing or preventing further deterioration of body function impaired by a neurological disease such as multiple sclerosis, cerebral palsy, polio, spina bifida and amyotrophic lateral sclerosis (Lou Gehrig’s disease). Covered therapy does not include therapy to develop cognitive skills that did not exist before the injury or therapy from which no further improvement can be expected. A licensed medical doctor or psychologist, other than a person who is related to the patient by blood or marriage, must provide therapy within the scope of his or her profession.

Occupational Therapy. Occupational therapy is the therapeutic use of work and self-care activities to restore independent function and prevent disability.

Coverage is limited to treatment to restore the loss of independent function and prevent disability of the therapeutic use of work and self-care activities caused by an injury or illness. Therapy is expected to result in significant improvement in body function lost or impaired by disease (e.g., stroke) or accidental injury; or, it’s aimed at slowing or preventing further deterioration of body function impaired by a neurological disease such as multiple sclerosis, cerebral palsy, polio, spina bifida and...
amyotrophic lateral sclerosis (Lou Gehrig’s disease). Covered therapy does not include therapy for transportation activities or therapy from which no further improvement can be expected. A registered or licensed occupational therapist, other than a person who is related to the patient by blood or marriage, must provide therapy within the scope of his or her profession.

**Physical Therapy.** Physical therapy is the use of physical means, such as massage, manipulation, heat, hydrotherapy, ultrasound or exercises to treat a disability of the body due to illness or injury.

Coverage is limited to charges for manipulation, heat, hydrotherapy, ultrasound or exercises/interventions to treat a disability of the body due to illness or injury. Therapy is expected to result in significant improvement in body function lost or impaired by disease (e.g., stroke) or accidental injury; or, it’s aimed at slowing or preventing further deterioration of body function impaired by a neurological disease such as multiple sclerosis or polio. Covered therapy does not include visual therapy or therapy from which no further improvement can be expected. A licensed medical physician, chiropractor or physical therapist, other than a person who is related to the patient by blood or marriage, must provide the physical therapy within the scope of his or her profession.

**Speech Therapy.** Speech therapy is treatment to restore the skills necessary for intelligible speech. The loss of such skills must be due to illness or injury.

Coverage is limited to charges necessary to restore an existing speech function (the ability to express thoughts, speak words and form sentences) that has been lost or impaired as a result of a disease or an injury. Significant functional improvement must be expected within a reasonable time frame. Significant improvement means the speech therapy is expected to restore the level of speech that the individual had obtained prior to the illness or injury. Covered therapy does not include therapy from which no further improvement can be expected. A registered or licensed speech therapist, other than a person who is related to the patient by blood or marriage, must provide therapy within the scope of his or her profession.

**Exception.** Coverage for cognitive, physical, occupational and speech therapy will be available as stated above for situations where children have failed to acquire the necessary skills as a result of cerebral palsy, autism, Down syndrome or a severe neurological or genetic disorder. Therapy must be expected to result in significant improvement or be aimed at slowing or preventing further deterioration.

All covered therapy must be diagnosed and prescribed by a licensed physician. Specific evaluation with standard test scores and measurable goals and objectives to determine progress and improved functional ability must be provided. Due to the review requirements of the Plan, authorization of benefits may be done on a retroactive basis. Therefore, it is possible that if services are rendered prior to approval, some or all of these services may not be covered.

If approved, these services will be covered, based on the coinsurance level of the Plan you elected, after the appropriate individual annual deductible has been met. Some coverages may have limitations. The appropriate out-of-pocket maximum applies.

The Plan does not provide coverage for sensory (auditory) integration therapy. This procedure has been proposed as a treatment approach to the management of children with various communication, behavioral, emotional and learning disorders.

The effectiveness of this therapy is unproven. A meta-analysis of multiple research on sensory integration treatment was published in April 1999, which concluded that more recent studies do not show overall positive effects from sensory (auditory) integration therapy. In addition, the Plan does not cover charges for speech, cognitive, occupational and/or physical therapy services related to developmental delay for children or adults.
Other Medical Expenses

The Plan covers charges for:

- oxygen and/or rental of equipment required for its administration
- x-ray, radium, radioactive isotope therapy, outpatient radiation therapy, chemotherapy, dialysis and respiratory therapy blood (if not replaced), or other fluids actually injected into the circulatory system
- insulin syringes and test tapes if used by a provider during an office visit
- a selected group of injectable prescription drugs that are typically considered self-administered drugs
- first pair of contact lenses or eyeglasses following cataract surgery
- anesthetics
- rental of durable medical and surgical equipment.

In lieu of rental, the following may be covered:

- the initial purchase of such equipment if Aetna is shown that: long term care is planned, and that such equipment either cannot be rented or is likely to cost less to purchase than to rent
- repair of purchased equipment
- replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition, or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent similar equipment. Precertification is required for durable medical equipment.

- Artificial limbs and eyes. The plan does not cover charges for:
  - eyeglasses
  - vision aids
  - hearing aids
  - communication aids
  - orthopedic shoes, foot orthotics, or other devices to support the feet, unless necessary to prevent complications of diabetes
- coverage for services related to the treatment of varicose veins if medically necessary. Precertification is required.
- Prescription drugs—See Prescription Drugs later in this chapter.

Private Duty Care

The charges made by a R.N. or L.P.N. or a nursing agency for "skilled nursing services" are included as covered medical expenses. No other charges made by a R.N. or L.P.N. or a nursing agency are covered. As used here, private duty care means services for:

- visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than eight hours for the purpose of performing specific skilled nursing tasks.
- private duty nursing by a R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Private duty services that are not covered include:

- nursing care that does not require the education, training and technical skills of a R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs and companionship activities.
- private duty nursing care given while the person is an inpatient in a hospital or other health care facility.
- care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- care provided solely for skilled observation except for no more than one four-hour period per day for a period of no more than ten consecutive days following the occurrence of:
  - change in patient medication;
  - need for treatment of an emergency condition by a physician, or the onset of symptoms indicating the likely need for such services;
  - surgery;
  - release from inpatient confinement; or
  - any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by a R.N. or L.P.N.
What the Aetna Choice POS II and OOA Plans Do Not Cover

Coverage is not provided for:

- services and supplies not necessary for the diagnosis, care, or treatment of the disease or injury involved, as determined by Aetna. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.
- services not medically necessary for diagnosis or treatment of an illness or injury, unless specifically covered by the Plan
- services or expenses incurred by you or your family before coverage started or after coverage has terminated under the plan (see the COBRA Coverage chapter for more information)
- any services or supplies covered by a state workers' compensation act or similar program or legislation
- wigs, unless medically necessary
- any services for which a charge would not have been made in the absence of coverage
- charges for services or supplies submitted more than 12 months from the date services were provided
- charges made by a non-participating physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time. The maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one-half the amount otherwise payable for all other allowed surgical procedures
- charges for the removal of organs or tissues to be donated to another, other than to a person covered by the Plan
- charges made by any covered provider who is a member of your or your dependent's family
- care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist.
- services, treatment, education testing, or training related to learning disabilities or developmental delays if therapy is not expected to result in significant improvement or be aimed at slowing or preventing further deterioration. For more information, see the Therapy section.
- care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury
- treatment such as primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon dioxide therapy
- treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field
- services of a resident physician or intern rendered in that capacity.
- charges that are made only because there is health coverage.
- charges that a covered person is not legally obliged to pay.
- charges for custodial care, as determined by Aetna
- charges, to the extent allowed by the law of the jurisdiction where the group contract is delivered, for services and supplies:
  - furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government
  - furnished, paid for, or for which benefits are provided or required under any law of a government. This exclusion will not apply to "no fault" auto insurance if it is:
    - required by law
    - provided on other than a group basis
- charges for hearing aids, eyeglasses, contacts, eye examinations, eye exercises, correction to vision (including but not limited to LASIK Radial Keratotomy) or fitting of glasses, unless specifically covered by the Plan.
- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- sex change surgery or any treatment of gender identity disorders
- charges for services or treatment related to impotency and/or infertility, unless such services or treatment are to diagnose and/or treat a specific medical condition (other than previous voluntary sterilization) causing the impotency and/or infertility, and such charges are not directly related to giving birth and/or the birth process.
• charges for in vitro fertilization and other artificial insemination

• routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided under the Plan

• marriage, family, child, career, social adjustment, pastoral, or financial counseling

• acupuncture therapy (except when acupuncture is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan)

• 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 and is malformed as a result of a severe birth defect (including harelip, webbed fingers or toes) as a direct result of disease or surgery performed to treat disease or injury incurred in the accident which causes the injury; or in the next calendar year.

• charges that are not reasonable, as determined by Aetna

• reversal of a sterilization procedure

• services or supplies furnished by a network provider in excess of the provider’s negotiated charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid

• Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

• Any non-emergency charges incurred outside of the United States

• Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

• Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider’s license.

• Contraception, except as specifically described in the What the Plan Covers Section: over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

• Costs for services resulting from the commission of, or attempt to commit a felony by the covered person.

• Dental Services except as covered as Oral Surgery under the plan.

• Orthodontic services or treatment (including appliances) related to temporomandibular joint (TMJ) syndrome unless all other nonsurgical options are deemed unsuccessful

• Disposable take-home supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neckbraces, compresses, and other devices not intended for reuse by another patient.

• Facility charges for care services or supplies provided in:
  — rest homes;
  — assisted living facilities;
  — similar institutions serving as an individuals primary residence or providing primarily custodial or rest care;
  — health resorts;
  — spas, sanitariums; or infirmaries at schools, colleges, or camps

• charges for orthopedic shoes and other supportive appliances for the feet other than for expenses which are specified in the What’s Covered by the Aetna Choice POS II and OOA Plans section

• Home and mobility: Any addition or alternation to a home, workplace or other environment, or vehicle and any related equipment or device, including:
  — Bathroom equipment such as bathtub seats, benches, rails, and lifts;
  — Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
  — Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
—Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;

—Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;

—Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;

—Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;

—Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and

—Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alternations to any vehicle or transportation device.

• Miscellaneous charges for services or supplies including:

—Annual or other charges to be in a physician’s practice;

—Charges to have preferred access to a physician’s services such as boutique or concierge physician practices;

—Cancelled or missed appointment charges or charges to complete claim forms;

• Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

• Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

• Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. These excluded charges will not be used when determining benefits. The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Experimental or Investigational Treatment

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures, provided all of the following conditions are met:

• You have been diagnosed with cancer or a condition likely to cause death within one year or less;

• Standard therapies have not been effective or are inappropriate;

• Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;

• You are enrolled in a clinical trial that meets these criteria;

• The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;

• The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;

• The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;

• The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI designated cancer center; and

• You are treated in accordance with protocol.
HMO Plans

HMO means Health Maintenance Organization. With an HMO, you and your dependents receive care from a Primary Care Physician (PCP).

When you are in an HMO, your PCP coordinates all your medical care and refers you to specialists if necessary. If you or your dependents seek care outside the HMO network, you will be responsible for the entire cost. Out-of-network care is not covered in the HMO. The only exception is for emergency care.

If you need coverage for dependents who may be out of the HMO service area (e.g., college students away from home or children for whom you are required to provide insurance through a court order), be sure to check with the HMO about coverage limitations.

The following plans are closed for new enrollment effective 01/01/2009. If you were not enrolled in this plan as of 12/31/08, you will not be eligible to enroll effective 01/01/2009 and going forward.

- Aetna HMO
- BCBS—Illinois
- CIGNA HMO
- ConnectiCare—Connecticut
- GHC/Puget Sound—Seattle
- HAP—Detroit
- Kaiser—Georgia
- Kaiser—Northwest (Portland)
- UHC Massachusetts HMO
- PacifiCare
- BCBS—Western NY POS

HMO Standard and Basic Options

If you live in the following service areas, you have a choice of two HMOs, a Standard Option HMO and a Basic Option HMO:

- BCBS—Illinois*
- ConnectiCare—Connecticut*
- GHC/Puget Sound—Seattle*
- HAP—Detroit*
- Kaiser—Georgia*
- Kaiser—Northwest (Portland)*

If you live in other service areas and an HMO is available to you, you have only one HMO option.

The standard and basic options are different in the level of coverage they provide and in your share of the cost of the coverage. In most cases, if you choose the Standard Option HMO, your cost for coverage will be greater because you have higher benefits and lower out-of-pocket costs as shown in the following chart.

<table>
<thead>
<tr>
<th></th>
<th>Standard Option</th>
<th>Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of HMO coverage</td>
<td>Higher</td>
<td>Lower</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td>Lower</td>
<td>Higher</td>
</tr>
<tr>
<td>Office visit copayments</td>
<td>Lower</td>
<td>Higher</td>
</tr>
</tbody>
</table>

For all the HMOs offered, the provider network is the same for the standard and basic options except for BCBS—Illinois; in this HMO, the standard option uses the Blue Advantage Network and the basic option uses the HMOI Network. Refer to the HMO Summary of Benefits charts for details on how the standard and basic options in each service area differ.

* This plan is closed for new enrollment effective 01/01/2009. If you were not enrolled in this plan as of 12/31/08, you will not be eligible to enroll effective 01/01/2009 and going forward.
HMO Benefits
The following benefits are available when you use HMO providers:

- **Doctor office visits, well-child care and well-adult care**—You pay a copayment with no deductible for most charges related to the treatment of covered illnesses or injuries and preventive services.

- **Emergency care**—Always try to locate an HMO provider when you require emergency care away from home. However, if an HMO provider is unavailable and you receive emergency services from a non-HMO hospital, your emergency services will be covered at the HMO in-network level for life-threatening situations only.

- **Prescription drugs**—Each HMO offers its own prescription drug plan. In most cases, you pay a fixed copayment for generic and brand-name prescription drugs.

This is true for the retail and mail-order prescription drug programs offered through the HMOs. For details, please refer to information provided to you by your specific HMO Plan.

- **Hospitals and other services**—For most medical services (such as inpatient and outpatient surgeries, home health care, inpatient mental health and substance abuse treatment, alternative treatment centers, etc.), you pay a hospital copayment then services are covered according to your HMO’s benefits schedule. Please refer to your specific HMO Plan for the hospital copayment amount.

**How to Receive HMO Benefits**
To receive benefits, you must visit an HMO provider. Services you receive from providers outside the HMO are not covered, except in life-threatening emergencies. For up-to-date information on HMO providers, call your Plan’s Member Services department or visit its Web site.

**How the HMO Plans Work**

**Annual Deductible**
Most HMOs available through the company require an annual deductible before benefits are paid for some services. The deductible varies according to the HMO. The services to which the deductible applies vary by plan. The exact amount is included in the information provided by your HMO.

**Out-of-Pocket Maximums**
The out-of-pocket maximum limits the amount of money you have to pay before benefits are covered at 100%. This feature protects you from financial hardship in the case of a catastrophic illness. Out-of-pocket maximums vary according to local HMOs. The exact amount is included in the information provided by your HMO. You also may contact the HMO’s Member Services department by calling the toll-free number listed on your ID card.

For information on other provisions of your HMO Plan, see the information mailed to you by the HMO or call its Member Services department at the toll-free number listed on your ID card.

**Lifetime Maximum Benefits**
Most of the HMO Plans provide benefits with an unlimited lifetime maximum for you and each covered family member. The charts on the following pages provide some detail about HMOs you may be eligible for if you live in their service area. Complete HMO details regarding covered services, limitations and exclusions—as well as information about filing and appealing claims for the HMOs—are not described in detail in this Benefits Summary. Refer to **Contacting Your Medical Plan** for how to receive complete details on HMO coverage. The detailed information you receive should be considered part of this Benefits Summary.
<table>
<thead>
<tr>
<th>Background Information</th>
<th>Aetna HMO; UHC HMO (MA)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen?</td>
<td>No</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$250 Individual; $500 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,500 Individual; $5,000 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Limit does not apply</td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
</tr>
<tr>
<td>Routine Office Visit</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Annual Physical Exam</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>$25 copay PCP; $35 copay specialist</td>
</tr>
<tr>
<td>Mammography</td>
<td>$35 copay; age limits apply</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>$25 copay; not covered if solely for the purpose of travel or employment</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td></td>
</tr>
<tr>
<td>Hospital copay/Coinsurance</td>
<td>90% covered after $500 copay per admission</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$250 copay</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$35 copay; limited to 20 visits per year</td>
</tr>
<tr>
<td>Infertility Benefits</td>
<td></td>
</tr>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>Not covered</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* This plan is closed for new enrollment effective 01/01/2009. If you were not enrolled in this plan as of 12/31/08, you will not be eligible to enroll effective 01/01/2009 and going forward.
<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>Aetna HMO; UHC HMO (MA)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>$500 copay; ER copay waived if admitted</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% covered; when medically necessary; medical transportation is covered during a medical emergency; routine transportation is not covered</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>Retail: Generic</td>
<td>$5 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$20 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$50 copay; 30-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$10 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$40 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$75 copay; 90-day supply</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$35 copay; limited to 20 visits per year</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>$500 copay per admission then covered at 90% after deductible; limited to 30 days per year</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td></td>
</tr>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$35 copay; limited to 20 visits per year</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>$500 copay per admission then covered at 90% after deductible; limited to 30 days per year</td>
</tr>
</tbody>
</table>

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### Background Information

<table>
<thead>
<tr>
<th></th>
<th>BCBS IL—Standard Option* (Blue Advantage)</th>
<th>BCBS IL—Basic Option** (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$0 Individual; $0 Family</td>
<td>$0 Individual; $0 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$3,000 Individual; $6,000 Family</td>
<td>$3,000 Individual; $6,000 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Limit does not apply</td>
<td>Limit does not apply</td>
</tr>
</tbody>
</table>

### Primary Care

<table>
<thead>
<tr>
<th></th>
<th>BCBS IL—Standard Option* (Blue Advantage)</th>
<th>BCBS IL—Basic Option** (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Office Visit</td>
<td>$25 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th></th>
<th>BCBS IL—Standard Option* (Blue Advantage)</th>
<th>BCBS IL—Basic Option** (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>$10 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>$10 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>100% covered after office visit copay</td>
<td>100% covered after office visit copay</td>
</tr>
<tr>
<td>Mammography</td>
<td>100% covered after office visit copay</td>
<td>100% covered after office visit copay</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>100% covered after office visit copay</td>
<td>100% covered after office visit copay</td>
</tr>
</tbody>
</table>

### Inpatient Care

<table>
<thead>
<tr>
<th></th>
<th>BCBS IL—Standard Option* (Blue Advantage)</th>
<th>BCBS IL—Basic Option** (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital copay</td>
<td>$250 per day for first 3 days</td>
<td>$500 copay per admission</td>
</tr>
</tbody>
</table>

### Outpatient Care

<table>
<thead>
<tr>
<th></th>
<th>BCBS IL—Standard Option* (Blue Advantage)</th>
<th>BCBS IL—Basic Option** (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>$200 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$40 copay; discounts available through BlueExtras</td>
<td>$40 copay; discounts available through BlueExtras</td>
</tr>
</tbody>
</table>

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2 PCP referral required. Chiropractic services available through alternative medical group.

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### Infertility Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>BCBS IL—Standard Option</th>
<th>BCBS IL—Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>100% covered; copays apply; limitations apply; PCP referral required</td>
<td>100% covered; copays apply; limitations apply; PCP referral required</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>100% covered; copays apply; limitations apply</td>
<td>100% covered; copays apply; limitations apply</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Rx copay applies</td>
<td>Rx copay applies</td>
</tr>
</tbody>
</table>

### Emergency Care

<table>
<thead>
<tr>
<th>Service</th>
<th>BCBS IL—Standard Option</th>
<th>BCBS IL—Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>100% covered after inpatient copay</td>
<td>100% covered after inpatient copay</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$200 copay</td>
<td>$200 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$25 copay; if affiliated with medical group</td>
<td>$30 copay; if affiliated with medical group</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% covered; ground only</td>
<td>100% covered; ground only</td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th>Service</th>
<th>BCBS IL—Standard Option</th>
<th>BCBS IL—Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$5 copay; 34-day supply</td>
<td>$10 copay; 34-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$25 copay; 34-day supply</td>
<td>$30 copay; 34-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$50 copay; 34-day supply</td>
<td>$50 copay; 34-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$10 copay; 90-day supply</td>
<td>$20 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$50 copay; 90-day supply</td>
<td>$60 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$100 copay; 90-day supply</td>
<td>$100 copay; 90-day supply</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>BCBS IL—Standard Option</th>
<th>BCBS IL—Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$40 copay; limited to 20 visits per year; serious mental illness allows an additional 60 outpatient visits at $40 copay</td>
<td>$40 copay; limited to 20 visits per year; serious mental illness allows an additional 60 outpatient visits at $40 copay</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>$250 copay per day for first 3 days; limited to 20 days per year; serious mental illness allows an additional 45 inpatient days</td>
<td>$500 copay per admission; limited to 20 days per year; serious mental illness allows an additional 45 inpatient days</td>
</tr>
</tbody>
</table>

### Substance Abuse Services

<table>
<thead>
<tr>
<th>Service</th>
<th>BCBS IL—Standard Option</th>
<th>BCBS IL—Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$40 copay; limited to 20 visits per year</td>
<td>$40 copay; limited to 20 visits per year</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>$250 copay per day for first 3 days; limited to 20 days per year</td>
<td>$500 copay per admission; limited to 20 days per year</td>
</tr>
</tbody>
</table>

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### BCBS Western NY—Standard Option Only*  

<table>
<thead>
<tr>
<th>Background Information</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Referral to OB-GYN</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Self-Referral to Specialist</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Default PCP Assigned if None Chosen?</strong></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$0 Individual; $0 Family</td>
<td>$500 Individual; $1,000 Family</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$1,500 Individual; $3,000 Family</td>
<td>$10,000 Individual; $20,000 Family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>80% covered</td>
<td>60% covered</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Limit does not apply</td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

### Primary Care

| Routine Office Visit                                        | $20 copay                                      | 60% covered after deductible is met |
| Specialty Care                                              | $20 copay                                      | 60% covered after deductible is met |

### Preventive Care

| Annual Physical Exam                                        | $20 copay                                      | Not covered                               |
| Pediatric Exams                                             | 100% covered                                   | 60% covered after deductible is met |
| Pap Smears (annually)                                       | $20 copay                                      | 60% covered after deductible is met |
| Mammography                                                 | 100% covered                                   | 60% covered after deductible is met |
| Child Immunizations                                         | 100% covered; for immunizations and inoculations for dependents up to age 19 | 60% covered after deductible is met |

### Inpatient Care

| Hospital coinsurance                                        | 80% covered (maternity admissions 100% covered) | 60% covered |

### Outpatient Care

| Outpatient Surgery                                          | 80% covered                                    | 60% covered after deductible is met |
| Chiropractic Services                                       | $20 copay; when medically necessary            | 60% covered after deductible is met, when medically necessary |

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### Infertility Benefits

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>80% covered</td>
<td>60% covered after deductible is met</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Subject to medical review; Rx copay applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Emergency Care

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>80% covered</td>
<td>60% covered after deductible is met</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$20 copay</td>
<td>$100 covered after deductible is met</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$100 copay; must be medically necessary</td>
<td>$100 copay; must be medically necessary</td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$7 copay; 30-day supply when obtained from a participating pharmacy</td>
<td>Not covered</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$30 copay; 30-day supply when obtained from a participating pharmacy</td>
<td>Not covered</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$50 copay; 30-day supply when obtained from a participating pharmacy</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$21 copay; 90-day supply</td>
<td>$21 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$90 copay; 90-day supply</td>
<td>$90 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$150 copay; 90-day supply</td>
<td>$150 copay; 90-day supply</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$20 copay; limited to 20 visits per year, combined with out-of-network</td>
<td>20% covered after deductible is met, limited to 20 visits per year, combined with in-network</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>80% covered; limited to 30 days per year, combined with out-of-network</td>
<td>60% covered after deductible is met, limited to 30 days per year, combined with in-network</td>
</tr>
</tbody>
</table>

### Substance Abuse Services

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$20 copay; limited to 60 visits per year; 20 visits may be used for family therapy, combined with out-of-network</td>
<td>60% covered after deductible is met, limited to 60 visits per year; 20 visits may be used for family therapy, combined with in-network</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Background Information

**CIGNA HMO**

<table>
<thead>
<tr>
<th><strong>Self-Referral to OB-GYN</strong></th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Referral to Specialist</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Default PCP Assigned if None Chosen?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$250 Individual; $500 Family</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$2,500 Individual; $5,000 Family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90% covered</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Limit does not apply</td>
</tr>
</tbody>
</table>

### Primary Care

**Routine Office Visit** $25 copay

**Specialty Care** $35 copay

### Preventive Care

**Annual Physical Exam** $25 copay

**Pediatric Exams** $25 copay

**Pap Smears (annually)** $25 copay PCP; $35 copay specialist

**Mammography** $35 copay

**Child Immunizations** $25 copay; not covered if solely for the purpose of travel or employment

### Inpatient Care

**Hospital copay/coinsurance** $500 copay per admission; Covered at 90% after deductible

### Outpatient Care

**Outpatient Surgery** $250 copay

**Chiropractic Services** $35 copay; limited to 60 visits per year

### Infertility Benefits

**In Vitro Fertilization** Not covered

**Artificial Insemination** Not covered

**Infertility Testing** Yes

**Fertility Drugs** Not covered

---

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<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>CIGNA HMO**</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>$500 copay; ER copay waived if admitted</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% covered; when medically necessary; medical transportation is covered during a medical emergency; routine transportation is not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$5 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$20 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$50 copay; 30-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$10 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$40 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$75 copay; 90-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$35 copay; limited to 24 visits per year</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>$500 copay per admission then covered at 90% after deductible; limited to 30 days per calendar year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$25 copay for first 2 visits. After 2 visits, $35 copay per visit, limited to 20 visits per calendar year.</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>$500 copay per admission then covered at 90% after deductible; limited to 30 days per calendar year</td>
</tr>
</tbody>
</table>

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### Background Information

<table>
<thead>
<tr>
<th></th>
<th>ConnectiCare-Statewide—Standard Option**</th>
<th>ConnectiCare-Statewide—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$0 Individual; $0 Family¹</td>
<td>$0 Individual; $0 Family¹</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$0 Individual; $0 Family</td>
<td>$0 Individual; $0 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Limit does not apply</td>
<td>Limit does not apply</td>
</tr>
</tbody>
</table>

### Primary Care

<table>
<thead>
<tr>
<th>Service</th>
<th>ConnectiCare-Statewide—Standard Option**</th>
<th>ConnectiCare-Statewide—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Office Visit</td>
<td>$20 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$30 copay</td>
<td>$45 copay</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>ConnectiCare-Statewide—Standard Option**</th>
<th>ConnectiCare-Statewide—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>$20 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>$20 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>$30 copay, as part of routine OB/GYN visit</td>
<td>$45 copay, as part of routine OB/GYN visit</td>
</tr>
<tr>
<td>Mammography</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>$20 copay; applies to the associated PCP office visit</td>
<td>$30 copay; no copay if visit is for immunizations only</td>
</tr>
</tbody>
</table>

### Inpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>ConnectiCare-Statewide—Standard Option**</th>
<th>ConnectiCare-Statewide—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital copay</td>
<td>$300 copay per day; limited to $1,500 annual maximum</td>
<td>$500 copay per day; limited to $2,000 annual maximum</td>
</tr>
</tbody>
</table>

### Outpatient Care¹

<table>
<thead>
<tr>
<th>Service</th>
<th>ConnectiCare-Statewide—Standard Option**</th>
<th>ConnectiCare-Statewide—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>$300 copay</td>
<td>$500 copay</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$30 copay; limited to 20 visits per year</td>
<td>$45 copay; limited to 10 visits per year</td>
</tr>
</tbody>
</table>

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2 Some benefits are subject to a $100 calendar year deductible per member, then 80% covered thereafter, up to benefit maximum. These benefits include Disposable Medical Supplies (up to $300 max), Durable Medical Equipment (up to $1,500 max) and Ostomy supplies and equipment (up to $1,000 max). Check with ConnectiCare for details.

3 $75 copay applies to Advanced Imaging Services including Angiography/Interventional, Computerized Tomography/ Dx Nuclear Medicine, Magnetic Resonance Imaging, Nuclear Cardiology and PET scans. $10 copay applies to all other radiology services except mammography and bone density testing.

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<table>
<thead>
<tr>
<th>Infertility Benefits</th>
<th>ConnectiCare-Statewide—Standard Option*</th>
<th>ConnectiCare-Statewide—Basic Option*</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>Contact plan for state-mandated benefit details</td>
<td>Contact plan for state-mandated benefit details</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>Contact plan for state-mandated benefit details</td>
<td>Contact plan for state-mandated benefit details</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Contact plan for state-mandated benefit details</td>
<td>Contact plan for state-mandated benefit details</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Care</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>100% covered; after applicable hospital copay</td>
<td>100% covered; after applicable hospital copay</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$100 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$50 copay</td>
<td>$75 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$15 copay; 30-day supply</td>
<td>$20 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$30 copay; 30-day supply; generics dispensed unless member pays difference in price and generic copay</td>
<td>$20 copay; 30-day supply; generics dispensed unless member pays difference in price and generic copay</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$40 copay; 30-day supply; generics dispensed unless member pays difference in price and generic copay</td>
<td>$40 copay; 30-day supply; generics dispensed unless member pays difference in price and generic copay</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$30 copay; 90-day supply</td>
<td>$40 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$60 copay; 90-day supply; generics dispensed unless member pays difference in price and generic copay</td>
<td>$40 copay; 90-day supply; generics dispensed unless member pays difference in price and generic copay</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$80 copay; 90-day supply; generics dispensed unless member pays difference in price and generic copay</td>
<td>$80 copay; 90-day supply; generics dispensed unless member pays difference in price and generic copay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$30 copay; contact plan for visit limitations</td>
<td>$45 copay; contact plan for visit limitations</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>$300 copay per day; limited to $1,500 annual maximum; combined with substance abuse; contact plan for visit limitations</td>
<td>$500 copay per day; limited to $2,000 annual maximum, combined with substance abuse; contact plan for visit limitations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$30 copay</td>
<td>$45 copay</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>$300 copay per day; limited to $1,500 annual maximum; combined with mental health</td>
<td>$500 copay per day; limited to $2,000 annual maximum, combined with mental health</td>
</tr>
</tbody>
</table>

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# U.S. Medical

## BENEFITS SUMMARY

### GHC/Puget Sound-Seattle—Standard Option**

<table>
<thead>
<tr>
<th>Background Information</th>
<th>GHC/Puget Sound-Seattle—Standard Option**</th>
<th>GHC/Puget Sound-Seattle—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned If None Chosen?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$250 Individual; $750 Family</td>
<td>$500 Individual; $1,500 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,000 Individual; $6,000 Family</td>
<td>$2,000 Individual; $6,000 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% covered</td>
<td>80% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$2,000,000</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

### Primary Care

- **Routine Office Visit**: $15 copay after deductible
- **Specialty Care**: $15 copay after deductible

### Preventive Care

- **Annual Physical Exam**: $15 copay
- **Pediatric Exams**: $15 copay
- **Pap Smears (annually)**: $15 copay
- **Mammography**: $15 copay
- **Child Immunizations**: 90% covered

### Inpatient Care

- **Hospital coinsurance**: 90% covered after deductible

### Outpatient Care

- **Outpatient Surgery**: $15 copay, then 90% covered after deductible
- **Chiropractic Services**: $15 copay, after deductible; limited to 10 visits per year

### Infertility Benefits

- **In Vitro Fertilization**: Not covered
- **Artificial Insemination**: Not covered
- **Infertility Testing**: Not covered
- **Fertility Drugs**: Not covered

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For help, go to http://resources.hewitt.com/homedepot or call 1-800-555-4954
<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>GHC/Puget Sound-Seattle—Standard Option*</th>
<th>GHC/Puget Sound-Seattle—Basic Option*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When Followed by Admission</strong></td>
<td>90% covered after deductible</td>
<td>80% covered after plan deductible</td>
</tr>
<tr>
<td><strong>When Not Followed by Admission</strong></td>
<td>$100 copay for a network facility; $150 copay for a non-network facility; deductible and coinsurance apply</td>
<td>$100 copay after Plan deductible for a network facility; $150 copay for a non-network facility; deductible and coinsurance apply</td>
</tr>
<tr>
<td><strong>Urgent Care Clinic Visit</strong></td>
<td>$15 copay after deductible</td>
<td>$25 copay after deductible</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>80% covered</td>
<td>80% covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail: Generic</strong></td>
<td>$15 copay; 30-day supply; formulary applies</td>
<td>$15 copay; 30-day supply; formulary applies</td>
</tr>
<tr>
<td><strong>Retail: Formulary Brand</strong></td>
<td>$30 copay; 30-day supply; formulary applies</td>
<td>$30 copay; 30-day supply; formulary applies</td>
</tr>
<tr>
<td><strong>Retail: Non-Formulary Brand</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Mail Order: Generic</strong></td>
<td>$30 copay; 90-day supply; formulary applies</td>
<td>$30 copay; 90-day supply</td>
</tr>
<tr>
<td><strong>Mail Order: Formulary Brand</strong></td>
<td>$60 copay; 90-day supply; formulary applies</td>
<td>$60 copay; 90-day supply</td>
</tr>
<tr>
<td><strong>Mail Order: Non-Formulary Brand</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient—Coverage Level/Visits</strong></td>
<td>$15 copay; limited to 20 visits per year; after deductible</td>
<td>$25 copay after deductible is met; limited to 20 visits per year</td>
</tr>
<tr>
<td><strong>Inpatient—Coverage Level/Days</strong></td>
<td>90% covered after deductible; limited to 30 days per year</td>
<td>80% covered after deductible is met to 12 days per year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehab Outpatient—Coverage Level/Visits</strong></td>
<td>$15 copay after deductible; limited to a combined maximum for inpatient and outpatient of $14,500 per 24-month period</td>
<td>$25 copay after deductible is met; limited to a combined maximum for inpatient and outpatient of $14,500 per 24-month period</td>
</tr>
<tr>
<td><strong>Rehab Inpatient—Coverage Level/Days</strong></td>
<td>90% covered after deductible; limited to a combined maximum for inpatient and outpatient of $14,500 per 24-month period</td>
<td>80% covered after deductible is met; limited to a combined maximum for inpatient and outpatient of $14,500 per 24-month period</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Background Information</th>
<th>HAP-Detroit—Standard Option*</th>
<th>HAP-Detroit—Basic Option*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$250 Individual; $500 Family</td>
<td>$300 Individual; $600 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,000 Individual; $4,000 Family</td>
<td>$2,500 Individual; $5,000 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% covered</td>
<td>80% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Limit does not apply</td>
<td>Limit does not apply</td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Office Visit</td>
<td>$15 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$25 copay; with referral</td>
<td>$35 copay; with referral</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Physical Exam</td>
<td>$15 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>$15 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Mammography</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital coinsurance</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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### Infertility Benefits

<table>
<thead>
<tr>
<th></th>
<th>HAP-Detroit—Standard Option**</th>
<th>HAP-Detroit—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>90% covered; limitations apply</td>
<td>80% covered; limitations apply</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Covered; limitations apply contact plan for details</td>
<td>Covered; limitations apply contact plan for details</td>
</tr>
</tbody>
</table>

### Emergency Care

<table>
<thead>
<tr>
<th></th>
<th>HAP-Detroit—Standard Option**</th>
<th>HAP-Detroit—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>90% covered; after deductible</td>
<td>80% covered; after deductible</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$15 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>90% covered; after deductible; for emergency services only</td>
<td>80% covered; after deductible; for emergency services only</td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th></th>
<th>HAP-Detroit—Standard Option**</th>
<th>HAP-Detroit—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$5 copay; 30-day supply</td>
<td>$10 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$30 copay; 30-day supply</td>
<td>$30 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$45 copay; 30-day supply</td>
<td>$50 copay; 30-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$10 copay; 90-day supply</td>
<td>$20 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$60 copay; 90-day supply</td>
<td>$60 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$90 copay; 90-day supply</td>
<td>$100 copay; 90-day supply</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th></th>
<th>HAP-Detroit—Standard Option**</th>
<th>HAP-Detroit—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$25 copay; 35 visits per member per calendar year</td>
<td>$35 copay; 20 visits per member per calendar year</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>90% covered; after deductible; limited to 45 days, renewable after 60 days</td>
<td>80% covered; after deductible; limited to 45 days, renewable after 60 days</td>
</tr>
</tbody>
</table>

### Substance Abuse Services

<table>
<thead>
<tr>
<th></th>
<th>HAP-Detroit—Standard Option**</th>
<th>HAP-Detroit—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$25 copay; limited to 35 visits per member per calendar year or state-mandated annual aggregate dollar amount, whichever is greater</td>
<td>$35 copay; limited to 35 visits per member per calendar year or state-mandated annual aggregate dollar amount, whichever is greater</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>90% covered; limited to 45 days, renewable after 60 days or state-mandated annual aggregate dollar amount, whichever is greater</td>
<td>80% covered; limited to 45 days, renewable after 60 days or state-mandated annual aggregate dollar amount, whichever is greater</td>
</tr>
</tbody>
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<tr>
<th>Background Information</th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
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<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$250 Individual; $500 Family</td>
<td>$500 Individual; $1,000 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$1,000 Individual; $2,000 Family</td>
<td>$2,000 Individual; $4,000 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% covered</td>
<td>80% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Limit does not apply</td>
<td>Limit does not apply</td>
</tr>
</tbody>
</table>

**Primary Care**

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Office Visit</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$35 copay</td>
<td>$35 copay</td>
</tr>
</tbody>
</table>

**Preventive Care**

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>$25 copay; limited to one exam per year</td>
<td>$25 copay; limited to one exam per year</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>100% covered to 24 months of age; $25 thereafter</td>
<td>100% covered to 24 months; otherwise $25 copay per visit</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>100% covered; after applicable office visit copay</td>
<td>100% covered; after applicable office visit copay</td>
</tr>
<tr>
<td>Mammography</td>
<td>100% covered; within plan guidelines</td>
<td>100% covered; within plan guidelines</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>100% covered; no copay up to 24 months for well-child visits; subject to applicable office visit copay thereafter</td>
<td>100% covered; no copay up to 24 months for well-child visits; subject to applicable office visit copay thereafter</td>
</tr>
</tbody>
</table>

**Inpatient Care**

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital coinsurance</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
</tbody>
</table>

**Outpatient Care**

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$35 copay; limited to 30 visits per year</td>
<td>$35 copay; limited to 30 visits per year</td>
</tr>
</tbody>
</table>

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## Infertility Benefits

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Emergency Care

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$50 copay; at designated Kaiser Permanente Medical Centers and after hours/urgent care facilities</td>
<td>$50 copay; at designated Kaiser Permanente Medical Centers and after hours/urgent care facilities</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$100 copay per trip</td>
<td>$100 copay per trip</td>
</tr>
</tbody>
</table>

## Prescription Drugs

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$10 copay; 30-day supply; at Kaiser Permanente pharmacies; $16 copay at network pharmacies</td>
<td>$15 copay; 30-day supply; at Kaiser Permanente pharmacies; $21 copay at network pharmacies</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$30 copay; 30-day supply; at Kaiser Permanente pharmacies; $36 copay at network pharmacies</td>
<td>$30 copay; 30-day supply; at Kaiser Permanente pharmacies; $36 copay at network pharmacies</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$20 copay; 90-day supply; through Kaiser Permanente pharmacies</td>
<td>$30 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$60 copay; 90-day supply; through Kaiser Permanente pharmacies</td>
<td>$60 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Mental Health Services

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$35 copay; unlimited visits</td>
<td>$35 copay; unlimited visits</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>90% covered after deductible; unlimited days</td>
<td>80% covered; unlimited days</td>
</tr>
</tbody>
</table>

## Substance Abuse Services

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Georgia—Standard Option**</th>
<th>Kaiser-Georgia—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$35 copay; limited to 40 visits per year</td>
<td>$35 copay; limited to 40 visits per year</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>90% covered after deductible; limited to 30 days per year</td>
<td>90% covered after deductible; limited to 30 days per year</td>
</tr>
</tbody>
</table>

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### Kaiser-Portland—Standard Option**

<table>
<thead>
<tr>
<th>Background Information</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen?</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$250 Individual; $750 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$1,500 Individual; $3,000 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

#### Primary Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Office Visit</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$25 copay</td>
</tr>
</tbody>
</table>

#### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>$15 copay; diagnostic x-ray and lab, 90% covered</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>100% covered birth through age 2; $15 copay thereafter</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>$15 copay; diagnostic x-ray and lab 90% covered</td>
</tr>
<tr>
<td>Mammography</td>
<td>90% covered</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>100% covered after office visit copay</td>
</tr>
</tbody>
</table>

#### Inpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital coinsurance</td>
<td>90% covered after deductible</td>
</tr>
</tbody>
</table>

#### Outpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>90% covered after deductible</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$15 copay; limited to 30 visits per year</td>
</tr>
</tbody>
</table>

### Kaiser-Portland—Basic Option**

<table>
<thead>
<tr>
<th>Background Information</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$500 Individual; $1,500 Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,500 Individual; $7,500 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

#### Primary Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Office Visit</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>80% covered after deductible</td>
</tr>
</tbody>
</table>

#### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>$20 copay; diagnostic x-ray and lab, 90% covered</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>100% covered birth through age 2; $20 copay thereafter</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>$20 copay; diagnostic x-ray and lab 80% covered</td>
</tr>
<tr>
<td>Mammography</td>
<td>80% covered</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>100% covered after office visit copay</td>
</tr>
</tbody>
</table>

#### Inpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital coinsurance</td>
<td>80% covered after deductible</td>
</tr>
</tbody>
</table>

#### Outpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>80% covered after deductible is met</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$20 copay; limited to 30 visits per year</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Benefits</th>
<th>Kaiser-Portland—Standard Option**</th>
<th>Kaiser-Portland—Basic Option**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infertility Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>50% covered after deductible for diagnosis and treatment; donor services excluded</td>
<td>50% covered after deductible for diagnosis and treatment; donor services excluded</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When Followed by Admission</td>
<td>90% covered after deductible is met</td>
<td>80% covered after deductible is met</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>90% covered after deductible is met</td>
<td>80% covered after deductible is met</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$15 copay after deductible is met</td>
<td>$20 copay after deductible is met</td>
</tr>
<tr>
<td>Ambulance</td>
<td>90% covered after deductible is met</td>
<td>80% covered after deductible is met</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail: Generic</td>
<td>$15 copay; 30 day supply; formulary applies</td>
<td>$15 copay; 30 day supply; formulary applies</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$30 copay; 30 day supply; formulary applies</td>
<td>$30 copay; 30 day supply; formulary applies</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$30 copay; 90 day supply; maintenance formulary drugs only</td>
<td>$30 copay; 90 day supply; maintenance formulary drugs only</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$60 copay; 90 day supply; maintenance formulary drugs only</td>
<td>$60 copay; 90 day supply; maintenance formulary drugs only</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$15 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$15 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>90% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
</tbody>
</table>

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## Background Information

<table>
<thead>
<tr>
<th>Pacificare-Las Vegas—Standard Option Only**</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Referral to OB-GYN</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Self-Referral to Specialist</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Default PCP Assigned if None Chosen?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$0 Individual; $0 Family</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$1,500 Individual; $3,000 Family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Limit does not apply</td>
</tr>
</tbody>
</table>

### Primary Care

- **Routine Office Visit** $15 copay
- **Specialty Care** $25 copay

### Preventive Care

- **Annual Physical Exam** $15 copay PCP; $25 copay specialist
- **Pediatric Exams** $15 copay PCP; $25 copay specialist
- **Pap Smears (annually)** $15 copay PCP; $25 copay specialist
- **Mammography** 100% covered; included with office visit copay
- **Child Immunizations** $15 copay PCP; $25 copay specialist

### Inpatient Care

- **Hospital copay** $500 copay per admission, then 100% covered

### Outpatient Care

- **Outpatient Surgery** $250 copay
- **Chiropractic Services** $15 copay

---

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2. PCP authorization for services required.

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### Infertility Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>Not covered</td>
</tr>
<tr>
<td>Infertility Testing</td>
<td>No</td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Emergency Care

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>100% covered; inpatient copay applies to admission</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% covered</td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th>Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic</td>
<td>$5 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand</td>
<td>$25 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary Brand</td>
<td>$50 copay; 30-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic</td>
<td>$10 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand</td>
<td>$50 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand</td>
<td>$100 copay; 90-day supply</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th>Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$25 copay limited to 45 visits per year</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>$500 copay per admission limited to 45 days per year</td>
</tr>
</tbody>
</table>

### Substance Abuse Services

<table>
<thead>
<tr>
<th>Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Outpatient—Coverage Level/Visits</td>
<td>$25 copay limited to 45 visits per year</td>
</tr>
<tr>
<td>Rehab Inpatient—Coverage Level/Days</td>
<td>$500 copay per admission limited to 45 days per year</td>
</tr>
</tbody>
</table>

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General Information About the Medical Plans

Claiming Benefits Under the Aetna Plans

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under the Plan. All forms required to take any action under the Plans are available from Aetna. Please refer to the descriptions of each benefit for additional information on claiming benefits.

To be eligible for benefits, you must be covered under the 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. Suits must be brought no later than one year following the date on which the appeals process under the Plan is exhausted.

Filing Claims Under the Aetna Plans

If you receive covered health (medical) services from an in-network provider, you do not have to file a claim. In-network providers are responsible for filing claims for you. Aetna pays in-network providers directly for your covered health services. If an in-network provider bills you directly for any covered service, contact the claims administrator. However, you are responsible for meeting any annual deductible and for paying copayments 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 as a result of an emergency, or if you receive services from an out-of-network provider, you must submit the claim to Aetna.

Timely Filing of a Claim

You must submit a request for payment of benefits 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 claims submission. If you don’t provide the claim information to Aetna within one year after the date of service, benefits for that service will be denied or reduced, according to the claims administrator’s discretion. This time limit does not apply while you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to the associate. Aetna will not reimburse third parties that have purchased or been assigned benefits by any health care provider.

Information Required for Your Claim

When you request payment of benefits from Aetna, you 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
- 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)
Payment of Benefits
Aetna will make a benefit determination as described below. Benefits will be paid directly to you unless either of the following is true:

- The provider notifies Aetna that your signature is on file, assigning benefits directly to that provider, or
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Appealing a Claim
Please refer to the Claims and Appeals chapter for more information on appealing a claim.

Right to Recover Payment
If your Medical Plan makes a payment by mistake, the plan has the right to recover the amount of overpayment from any person, insurance company or other organization to which the payment was made.

Subrogation and Reimbursement
If you or your covered family members (“covered persons”) are injured or become ill because of an act or omission of a third party, the Medical Plan is not obligated to pay any benefits relating to the injury or illness. However, the Medical Plan may advance payment of benefits relating to the injury or illness to the extent of the amounts receivable or received by the covered person from the third party, an insurer or any other person by way of settlement, judgment or other payment.

To this end, the Medical Plan assumes and shall be subrogated to all rights of recovery the covered person may have against the responsible third party, any liability or other insurance covering such third party and any person or entity who is or may be obligated to provide benefits or payments to a covered person, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, other insurance carriers or third party administrators or any person or entity who is liable for payment to a covered person on any equitable or legal liability theory. These third parties and persons or entities are collectively referred to as “third parties.”

The Medical Plan also shall have first right of reimbursement out of the proceeds of any settlement, judgment or other payment by any such third parties to or on behalf of a covered person in an amount equal to the benefits the Medical Plan paid.

The Medical Plan shall also have a lien against the proceeds of any recovery from any such third parties (whether by settlement, judgment or other payment) for that portion of the total recovery which is due the Medical Plan for benefits paid. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any covered person that could be subject to the Medical Plan’s right of recovery if and when received by the covered person.

To aid the Medical Plan in the enforcement of its right of reimbursement and subrogation, the covered persons agree as follows:

- That a covered person will cooperate with the Plan in a timely manner in protecting its rights to subrogation, reimbursement and liens, including, but not limited to:
  - providing any relevant information requested by the Medical Plan,
  - signing and/or delivering such documents as the Medical Plan or its agents reasonably request to secure the subrogation and reimbursement claim and lien rights,
  - responding to requests for information about any accident or injuries,
  - appearing at depositions and in court, and
  - obtaining the consent of the Medical Plan or its agents before releasing any third party from liability for payment of medical expenses.
• That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a covered person. A covered person’s failure or refusal to sign any such document shall not impair or modify in any way the Medical Plan’s rights to subrogation, reimbursement and liens.

• That the Plan Administrator of the Medical Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

• That covered persons must notify the Medical Plan Administrator within five business days of any proceeding relating to a claim against a third party and within two business days of any recovery or settlement.

• That no court costs or attorneys’ fees may be deducted from the Medical Plan’s recovery without the Medical Plan’s express written consent; any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall be inapplicable to the Medical Plan; and thus, shall not defeat this right; and the Medical Plan is not required to participate in or pay court costs or attorneys’ fees to the attorney hired by a covered person to pursue his or her damage/personal injury claim. Provided, however, that the Medical Plan Administrator may allow a proportional reduction for attorneys’ fees of the covered persons if their attorneys cooperate fully in enforcement of the Medical Plan’s rights.

• That the “Make Whole Doctrine” is inapplicable and, regardless of whether a covered person has been fully compensated or made whole, the Medical Plan may collect from covered persons the proceeds of any full or partial recovery that a covered person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability), judgment or other payment, irrespective of how such recovery is construed, designed or designated. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

• That benefits paid by the Medical Plan may also be considered to be benefits advanced.

• That covered persons agree that if they receive any payment from any third party as a result of an injury or illness, whether by settlement (either before or after any determination of liability) or judgment, the covered person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the covered person’s duties hereunder.

• That covered persons or an authorized agent, such as the covered person’s attorney, must hold any funds received from any third party that are due and owed to the Medical Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the covered person.

• That the Medical Plan shall be entitled to recover reasonable attorneys’ fees from covered persons incurred in collecting from the covered person any funds held by the covered person that he or she recovered from any third party.

• That the Medical Plan may set off any future benefits otherwise allowed by the Medical Plan the value of benefits paid or advanced under this section to the extent not recovered by the Medical Plan.

• That covered persons will neither accept any settlement that does not fully compensate or reimburse the Medical Plan without the Medical Plan’s written approval, nor will the covered person do anything to prejudice the Medical Plan’s rights under this section.

• That covered persons will assign to the Medical Plan all rights of recovery against third parties, to the extent of the benefits the Medical Plan provided, plus reasonable costs of collection.

• That the Medical Plan’s right of reimbursement is first in priority, and must be paid regardless of whether the covered person is made whole and regardless of the designation of the recovery.

• That the Medical Plan’s rights will not be reduced due to the covered person’s own negligence.
• That the Medical Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including filing suit in the covered person’s name, which does not obligate the Medical Plan in any way to pay the covered person part of any recovery the Medical Plan might obtain for the amounts due the Medical Plan for benefits paid and attorneys’ fees incurred. The Medical Plan shall not be obligated in any way to pursue this right independently or on behalf of the covered person.

• That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

• That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Medical Plan beneficiary, this section applies to the personal representative of the deceased Medical Plan beneficiary.

• If a covered person files a petition for bankruptcy after any injury or condition giving rise to subrogation or reimbursement, the covered person agrees that the Medical Plan’s right of subrogation, reimbursement, and lien existed in time prior to the creation of the bankruptcy estate.

• The Medical Plan’s right of subrogation and reimbursement will be based on the Medical Plan’s language in effect at the time of judgement, payment, or settlement.

Refund of Overpayments

If benefits are paid by the 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 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 Plan. If the refund is due from another person or organization, the covered person agrees to help the 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 Plan may be reduced. The reductions will equal the amount of the required refund. The Plan also retains all other rights in addition to the right to reduce future benefits that may be legally available.

Coordinating With Other Plans

If you or a covered family member is insured under another employer’s group health Plan, the Medical Plan will coordinate coverage with the other plan. The benefits payable under the Medical Plan, after reduction for benefits paid from all other primary plans, will not exceed the amount the Medical Plan would have paid if you had no other coverage.

To determine which plan is primary (the primary plan pays benefits first), the following rules apply:

• a plan without a coordination provision is always the primary plan

• if all plans have a coordination provision, then the rules below apply:
  — the plan covering the participant for whom the claim is made, other than as the dependent, pays first, and the other plan pays second
  — the plan of the parent whose birthday (excluding the year of birth) occurs earlier in the calendar year is primary (for example, if the father’s birthday is June 1 and the mother’s birthday is May 1, the mother’s plan would be primary for covered dependent children)
  — when birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time will be primary
  — when the parents of a covered dependent child are divorced or separated and the parent with custody has not remarried, that parent’s plan pays first for the child; the plan of the parent without custody pays second
—when the parent with custody of a covered dependent child has remarried, that parent’s plan pays first, the stepparent’s plan pays second and the plan of the parent without custody pays last
—when there is a court decree that would otherwise establish financial responsibility for the health care expenses of a covered dependent child, the plan covering the parent with financial responsibility is primary
—when none of the above establish an order of benefits determination, the plan that has covered the participant for the longest period of time will pay first

If the Medical Plan is secondary, the Plan may pay benefits after the other plan has paid—but only if there are payable expenses that exceed the primary plan’s payment. Payment works as follows:

• The Medical Plan determines the amount it would have paid if it were the primary plan.
• If the amount actually paid by the primary plan is less than the amount that the Medical Plan would have paid as the primary plan, the Medical Plan will pay the difference between the amount it would have paid and the actual amount paid by the primary plan.

Certificates of Health Plan Creditable Coverage

After your coverage (or your dependent’s coverage) ends, a Certificate of Health Plan Creditable Coverage will be sent to your current address listed with the Plan Administrator. This certificate provides evidence of your health care coverage. You may need this certificate if you become covered by another group health plan or insurance policy with a pre-existing medical condition clause. A group health plan is required by law to reduce the duration of its pre-existing condition exclusion, day-for-day, by any period of prior coverage—provided you do not have a 63-day or longer break in health care coverage (not counting waiting periods for coverage). You and your dependents also have the right to request a Certificate of Health Plan Coverage at any time during the 24 months following loss of coverage. You may request this certification from the Benefits Choice Center at 1-800-555-4954.

If You’re Age 65 or Older

If you are an active associate age 65 or older (or an active associate’s spouse age 65 or older) who is eligible for Medicare, you may choose to end your coverage under the Company Medical Plan and elect Medicare coverage instead. Or, you may choose to continue coverage under this plan, which will be considered your primary plan and will pay benefits first.

Medicare will be the primary payer to the full extent permitted by law, including for those individuals not in current employment, and as legally permitted for individuals with end-stage renal disease or who were totally disabled.

If you are an active associate (or an active associate’s spouse) age 65 or older and have elected coverage under this plan, you should submit your claims to the Plan first. After the Company Plan pays, send a copy of the original bill along with a copy of the Company’s Plan’s explanation of benefits to Medicare for reimbursement.
Access to Medical Coverage After Retirement

As an associate, you and your dependents may be eligible for medical coverage after you retire. To qualify for this benefit:

• you must be at least age 55 when you retire and
• have worked for the Company for a minimum of five years,
• you and your dependents must be covered under the Medical Plan at the time you retire, and
• you must continue medical coverage for you and your dependents under COBRA after your retirement, for the maximum period allowed.

Prior to the end of your COBRA continuation period, you will receive information about converting medical coverage for you and your dependents to an individual policy issued by your Medical Plan. Pre-existing conditions will not apply and evidence of good health will not be required as long as you apply within the required time frame. Benefit levels and monthly premiums will be determined by your Medical Plan at the time of application.

If you are age 65 or over at the time you retire, you are not eligible for a conversion policy.

For conversion information specific to the HMO Plans, you should contact your HMO’s Member Services department. The number is located on your medical ID card.

Under the Health Net plans, conversion is not limited by age, years of service, or COBRA enrollment. Contact the Member Services department for specific information. The number is located on your medical ID card. Home Depot does not provide these benefits; they are individual policies.

Important Terms

Custodial Care

An institution providing room and board and other institutional or nursing services provided for a person due to his or her age or mental or physical condition, mainly to aid the person in daily living. Or, medical services given merely as care to maintain the person’s present state of health that cannot reasonably be expected to significantly improve a medical condition.

Doctor or Physician Providers

For purposes of the Medical Plan, doctor means a licensed, practicing doctor or dentist who is not related to the participant’s family by blood or by marriage. The definition includes the following:

• Doctor of Medicine (M.D.)
• Doctor of Osteopathy (D.O.)
• Doctor of Dental Surgery (D.D.S.)
• Doctor of Podiatry (D.P.M.)
• Doctor of Chiropractic (D.C.)
• Psychologist (Ph.D.)

The definition does not include a resident physician, intern, person in training or those not licensed to practice medicine independently.

Explanation of Benefits (EOB)

An EOB is a statement sent to you by the claims administrator after you have filed a claim. It will include benefits paid on your claim by the Medical Plan and charges payable by you.

Extended Care Facility

An institution providing room, board and skilled nursing services for medical care. To be covered under the Medical Plan, the facility must:

• be a legally operated institution or part of such an institution and maintain a daily clinical record for each patient
• make available the services of a doctor at all times
• offer 24-hour nursing services under the supervision of a graduate registered nurse
• not be primarily a place for the aged or substance abusers; or a rest home, educational institution, custodial facility or similar institution

Home Health Care Agency

A public or private agency or organization or part of one that provides skilled nursing and other therapeutic services in the home. To be covered under the Medical Plan, a home health care agency must:

• be licensed as a home health care agency and maintain a daily clinical record for each patient
• be staffed by professionals, including at least one legally qualified doctor and one registered nurse
• provide full-time supervision of caregivers by a legally licensed doctor or by a registered nurse
• not be an agency used mainly for the care and treatment of mental health disorders or substance abuse

Hospice Care
A coordinated plan of home and inpatient care that treats the terminally ill patient and family as a unit. Care is provided by a team made up of trained medical personnel and counselors. The team acts under an independent hospice administration and helps the family unit cope with physical, psychological, spiritual, social and economic stresses. The hospice must have obtained any required state or other governmental licenses and be approved by the claims administrator.

Hospital
A hospital must be legally operated and must:
• provide 24-hour room, board and nursing services for all patients and have a staff of one or more doctors available at all times
• provide on-premise facilities for diagnosis, therapy, and major surgery
• not be a health care facility that is primarily a nursing home, rest home, convalescent home or a residential treatment center for the treatment of substance abuse or mental health problems

Mental Health Providers
The licensing of mental health care providers varies from state to state. To make sure that all mental health claims are processed consistently, our Medical Plan covers care from the following, as long as they are not related to the participant’s family by blood or by marriage:
• LMFT—Licensed Marriage and Family Therapist
• LMHC—Licensed Mental Health Counselor
• LPC—Licensed Professional Counselor
• LCPC—Licensed Clinical Professional Counselor
• LPCC—Licensed Professional Clinical Counselor
• LMHP—Licensed Mental Health Provider
• LPCMH—Licensed Professional Counselor of Mental Health
• LCSW—Licensed Clinical Social Worker
• CSW—Clinical Social Worker
• LFMCC—Licensed Family Marriage Clinical Counselor
• Psychologist—Ph.D.
If you have questions or need to locate a mental health care provider, call your Plan’s Member Services department.

Residential Treatment Center
Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of mental health or substance abuse conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a Residential Treatment Center.

A person is considered Confined in a Residential Treatment Center when she/he is a registered bed patient in a Residential Treatment Center upon the recommendation of a Physician.

Coverage for Associates Working in a Foreign Country
The Medical Plan provides fully insured medical and dental coverage to you if you are an expatriate associate working on assignment in a foreign country and if you are enrolled in medical and dental coverage immediately before beginning your expatriate assignment. The Company provides this coverage at no charge to you. You will be covered under the expatriate medical and dental coverage while in your assigned country, but will use the standard Home Depot medical plan that you are enrolled in, if any, while you are in the United States. If your family remains in the U.S. while you are on assignment, they will be covered under the standard Home Depot medical or dental plan in which you have enrolled, if any.
Enrolling in the Prescription Drug Plan

By enrolling in the Aetna Choice POS II or Out-of-Area Medical Plan, you are agreeing to enroll and make the required contributions for a Prescription Drug Plan. You may not enroll in one plan without also enrolling in the other.

If you elect an Aetna Choice POS II or Out-of-Area Medical Plan and do not elect one of the prescription drug options during your enrollment period, you will be enrolled automatically in the $50 Deductible/Mail Copay Option. See the CVS Caremark Prescription Drug Coverage chart below for more information.

If you are an HMO participant, a California or Hawaii associate during your first 90 days of employment, prescription drug benefits are provided through your medical plans.

This is also true for salaried associates during their first 90 days of employment. For more information, see Medical and Prescription Drug Coverage for Salaried Associates During the First 90 Days of Employment.

Coverage Categories

When you select your prescription drug option, you will be assigned automatically to the same coverage category you elect for the Medical Plan:

- associate only
- associate + spouse (or same-sex domestic partner)
- associate + child(ren)
- associate + family (children and spouse or same-sex domestic partner)

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CVS Caremark Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Coverage Categories</th>
<th>Caremark $50 Deductible/Mail Copay</th>
<th>Caremark $50 Deductible/Coinsurance</th>
<th>Caremark $100 Deductible/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (individual/family)</td>
<td>$50/$150</td>
<td>$50/$150</td>
<td>$100/$300</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (individual/family)</td>
<td>$750/$1,500</td>
<td>$750/$1,500</td>
<td>$1,500/$3,000</td>
</tr>
<tr>
<td>Mandatory Generic—If you receive a brand when a generic is available</td>
<td>The generic coinsurance or copay plus the difference in cost between the brand and generic drug</td>
<td>The generic coinsurance plus the difference in cost between the brand and generic drug</td>
<td>The generic coinsurance plus the difference in cost between the brand and generic drug</td>
</tr>
</tbody>
</table>

Retail (30-day supply)

| Generic (no deductible) | You pay 20% | You pay 20% | You pay 20% |
| Preferred Brand (deductible applies) | You pay 25% | You pay 30% | You pay 35% |
| Non-Preferred Brand (deductible applies) | You pay 45% | You pay 50% | You pay 55% |

Mail Order (90-day supply with no deductible)

| Generic | You pay $7 | You pay 20% | You pay 20% |
| Preferred Brand-name | You pay $50 | You pay 25% | You pay 30% |
| Non-preferred Brand-name | You pay $80 | You pay 45% | You pay 50% |
The Prescription Drug Options

You have three prescription drug options:

- **Caremark $50 Deductible/Mail Copay**—$50 deductible for preferred and non-preferred brand drugs with a copay for mail order prescriptions;
- **Caremark $50 Deductible/Coinsurance**—$50 deductible for preferred and non-preferred brand drugs with coinsurance for mail order prescriptions; or
- **Caremark $100 Deductible/Coinsurance**—$100 deductible for preferred and non-preferred brand drugs with coinsurance for mail order prescriptions.

All of the options feature:

- **No deductible for generic drugs.** You won’t have to meet your prescription drug plan deductible to begin receiving benefits for generic drugs. There are over 11,000 generic drugs approved by the FDA.
- **No deductible and lower costs when you use the mail order service.** You’ll save time and money when you use the mail order service to purchase your maintenance drugs (up to a 90-day supply) and you pay no deductible on generic, preferred and non-preferred drugs you get through the mail. Maintenance drugs are drugs you take on an ongoing basis to treat chronic or long-term conditions, including, but not limited to, diabetes, heart disease, arthritis, high cholesterol, asthma, high blood pressure and allergies.
- **No deductible and lower cost when you get your maintenance drugs at a CVS pharmacy.** You can purchase an 84-90 day supply of your maintenance drugs at a CVS pharmacy. When you get your maintenance drugs at a CVS pharmacy, there is no deductible for generic, preferred and non-preferred drugs, and you pay the mail order price. Maintenance drugs are drugs you take on an ongoing basis to treat chronic or long-term conditions, including, but not limited to, diabetes, heart disease, arthritis, high cholesterol, asthma, high blood pressure and allergies.
- **Coverage for oral contraceptives.** Oral contraceptives are only covered by the Mail Service prescription drug program or 84-90 day supplies at CVS pharmacies. You will not be reimbursed for the cost of oral contraceptives purchased from a retail pharmacy.

Generics are preferred. All of the options also have an extra charge for brand drugs if a generic equivalent is available. If you or your doctor requests that a brand drug be dispensed when a generic equivalent is available, you will pay the deductible, if not already met, (for a retail prescription) plus the generic copay or coinsurance (depending on your option and mail or retail choice) plus the difference between the gross cost of the generic and the brand drug. This amount is not applied to your deductible or out-of-pocket maximum.

Here is an example of how this extra charge works for the $50 Deductible/Coinsurance option. This example assumes that the deductible has been met.

<table>
<thead>
<tr>
<th>Cost of Brand Drug</th>
<th>Cost of Generic</th>
<th>Coinsurance for Generic (20% of $5.33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$42.02</td>
<td>$5.33</td>
<td>$1.07</td>
</tr>
</tbody>
</table>

Cost of brand - cost of generic + coinsurance for generic

The example amounts to $37.76

Prior Authorization Drugs

If you or a covered family member is prescribed a drug that requires prior authorization from CVS Caremark, your physician or his or her representative should call CVS Caremark at 1-800-626-3046 or fax the request to 1-866-502-2296. If you call CVS Caremark to request prior authorization, you will be instructed to have your physician contact CVS Caremark to make the request.

When CVS Caremark receives the call or fax from your physician, the request for prior authorization will be evaluated and the request will be approved or denied within 24 to 48 hours. If more information is needed, your doctor's office will be notified. If the prior authorization is approved, CVS Caremark will notify your physician. If prior authorization is denied, you and your physician will receive a letter which will include directions on how to appeal the denial. For more information, see the Claims and Appeals chapter.
The chart below identifies some of the drugs that require prior authorization. Contact CVS Caremark at www.caremark.com or call 1-866-490-3376 (1-866-490-DEPO) for more information.

**Drugs that will Require Prior Authorization or are Subject to Quantity Limitations**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
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<tbody>
<tr>
<td>Actiq</td>
<td>Epipen</td>
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<tr>
<td>Amerge</td>
<td>Immitrex</td>
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<tr>
<td>Ana-Kit</td>
<td>Maxalt</td>
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<tr>
<td>Anzemet</td>
<td>Migranal</td>
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<tr>
<td>Axert</td>
<td>Retin-A</td>
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<tr>
<td>Botox</td>
<td>Stadol NS</td>
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<tr>
<td>Celebrex</td>
<td>Tamiflu</td>
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<tr>
<td>Diffucan</td>
<td>Toradol</td>
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<td></td>
<td>Zomig</td>
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<tr>
<td></td>
<td>Specialty or Biotech Drugs</td>
</tr>
</tbody>
</table>

**Clinical Management Programs**

Through a series of safety checks, the CustomCare Program helps ensure that your prescription drug treatment is appropriate for your health situation. If these safety checks reveal a potential problem, a CVS Caremark pharmacy professional will directly contact your physician to review your treatment, and sometimes suggest a change to the current therapy. Under no circumstances will CVS Caremark change your medication without your doctor’s consent. If a suggested change is authorized, you will be notified via phone and/or letter which will contain the authorized change.

For medication to work properly, you must take it correctly. That’s why CVS Caremark also reviews medications that require you to take multiple doses (based on frequency per day or number of tablets/capsules per dose) and, if appropriate, suggests ways to make it easier for you to take your medication properly. For example, it may be possible to reduce the number of times you must take your medication each day without changing the total daily dosage. This not only helps you take your medication as instructed but also can reduce your out-of-pocket cost.

**Specialty Pharmacy**

The Home Depot Prescription Drug Plan through CVS Caremark includes a Specialty Pharmacy Program. This program offers you convenient access and delivery of your specialty medicine, along with personalized service and educational support for your specific therapy. Examples of drugs that fall into this program include injectibles used to treat multiple sclerosis and rheumatoid arthritis, and growth hormone.

Using CVS Caremark Specialty Pharmacy Services is easy and convenient. When you call CVS Caremark at 1-800-237-2767, a Specialty Pharmacy Specialist will promptly assist you with ongoing delivery needs, questions and support. In addition, a CVS Caremark pharmacist is available for emergency consultations 24 hours a day, seven days a week. Keep in mind, prior authorization is required for specialty pharmacy drugs.

**Using the Prescription Drug Plan**

The Prescription Drug Plan is designed to encourage you to use generic drugs and preferred brand-name drugs. You may still obtain non-preferred brand-name prescriptions, but you will pay a higher percentage of the cost. The definitions below explain the drug categories.

**Generic**

These are prescription drugs labeled by their basic chemical name. They have the same chemical composition, potency and form as brand-name equivalents, but are less expensive.

**Brand Name**

**Preferred Brand**—These are brand-name prescription drugs with no generic equivalent and are published on Caremark’s Primary Preferred Drug list which is revised quarterly. Copies are available at www.caremark.com or by calling 1-866-490-3376.

**Non-Preferred Brand**—These are brand-name prescription drugs with equally effective generic equivalents or preferred brand alternatives that do not appear on Caremark’s Primary Preferred Drug List.
How the Retail Program Works
There are over 62,000 participating retail pharmacies in the national network. To locate a CVS Caremark participating retail pharmacy in your area, go to www.caremark.com and use the “Find a Local Pharmacy” search or call CVS Caremark Customer Care toll-free at 1-866-490-3376 (866-490-DEPO).

After you meet the applicable annual deductible, you pay a percentage of the discounted price for preferred brand drugs, and a higher percentage of the discounted price for non-preferred brand drugs.

Under each of the options, you only pay a deductible for brand name drugs at retail. There is no deductible for generic drugs.

If you or your doctor requests that a brand drug be dispensed when a generic equivalent is available, you will pay the generic copay or coinsurance (depending on your option) plus the difference between the gross cost of the generic and the brand drug. This amount is not applied to your deductible or out-of-pocket maximum.

If there is no generic drug for your prescription, you may choose the preferred or the non-preferred brand-name drug. However, you will pay more for the non-preferred brand.

If a non-preferred brand does not have a preferred brand alternative, it will be covered at the preferred brand benefit level.

How the Mail Service Program Works
The most cost-effective way to fill prescriptions for maintenance medications is through the Mail Service drug program, administered by CVS Caremark. When you and your covered family members enroll in any of the prescription drug options, you may participate in the Mail Service prescription drug program.

New in 2009, you can pick up your 90-day mail-order prescription at a CVS Caremark retail location and still pay the mail service copays or coinsurance (depending on your option).

Advantages of the Mail Service Program
Savings—You can get up to a 90-day supply of medication when you get a prescription filled through the CVS Caremark Mail Service Program. Ask your doctor to write a prescription for up to a 90-day supply plus refills, when clinically appropriate.

Convenience—You can expect your medication to arrive 10 to 14 calendar days after CVS Caremark receives your prescription. Your package will include a new mail service order form and an invoice, if applicable. You also will receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Quality—CVS Caremark operates seven mail service pharmacies across the United States to provide quick service to plan participants wherever they live. To ensure your safety, CVS Caremark’s mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, CVS Caremark’s pharmacists check each prescription to make sure it’s filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medicines you may be prescribed.

Requesting a New Mail Service Prescription
To use the CVS Caremark Mail Service Program, ask your doctor to write a prescription for up to a 90-day supply plus refills, when clinically appropriate. Then, complete a mail service order form and send it to CVS Caremark along with your original prescription and the appropriate payment to:

CVS Caremark
P.O. Box 659541
San Antonio, TX 78238

Requesting a Mail Service Prescription (Three Ways)
Online—You can order your mail service refills using www.caremark.com. Register online to receive refill reminders, informative newsletters and other email alerts. Have your benefit ID number handy to register.

By Phone—Call CVS Caremark Customer Care toll-free at 1-866-490-3376 (866-490-DEPO) for fully automated refill service. Have your benefit ID number ready.

By Mail—Once you receive your medication, keep your refill labels to use on your next order form. Attach the refill label provided to the mail service order form and enclose payment with your order.
Program Limitations

Although most types of medicines are covered, there are some medicines, supplies and expenses that are not covered or have limited coverage. They include, but are not limited to:

- Smoking cessation medicines or aides (Prescription and OTC)
- Cosmetic drugs
- Fluoride products
- Fertility drugs, unless approved for non-fertility purposes
- Allergy serums
- Experimental drugs
- Over-the-counter (OTC) items
- Immunization agents
- Any prescription drug more than one year old or not permitted by law in the state the medication is being dispensed.
- Vitamins, except single entity products for vitamins D, B, K, B12, folic acid and iron replacement.
- Medicines otherwise covered under the Medical Program.
- Medicines intended solely for cosmetic purposes, such as Rogaine®/Minoxidil®.
- Diet medications/Anti obesity agents, such as Bontril.
- “Self-care” medicines and products (such as hand lotion).
- Any medicine that is not identified in the American Hospital Formulary Service Drug

- Medicines determined to be experimental or still under clinical investigation by health professionals.
- Over-the-counter medicines, even if the medicine also is available by prescription (e.g., Tagament®, Zyrtec, Claritin®, Zantac® or Monistat®).
- Nutritional and diet supplements (such as Multi Vitamins), including any supplements for newborn infants.
- Prescription devices such as elastic bandages and supports, GI-GU ostomy and irrigation supplies and needles/syringes other than insulin. However, respiratory prescription devices are covered, with the exception of Peak Flow Meters.
- Vaccines and toxoids are not covered under the Caremark Mail Service Program. Eligible vaccines and toxoids are covered when the prescriptions are filled at retail pharmacies.
- Any medicine provided while the person is an inpatient or outpatient in any healthcare facility.
- Any drug or medicine considered illegal under the Federal Food, Drug and Cosmetic Act, including, but not limited to, prescription drugs purchased in foreign countries for reimportation into the United States and prescription drugs purchased on the Internet from foreign countries. However, medicines purchased while on vacation in a foreign country due to a medical emergency may be covered. Call Caremark at 800-772-2301 if you have questions about coverage under these circumstances.
- Any supply with a National Drug Code (NDC) that is classified as a device, not a medicine. Any medicine determined not medically necessary.
- Emergency contraceptive kits.
- Alcohol wipes.
- Lancet devices.
- The expenses of administration or injection of any medicine.
- Any prescription, which exceeds the day supply limit per prescription or refill.
- Any refill of a medicine exceeding the number of refills specified by the provider.
- Any refill of a medicine more than one year after the latest prescription for the medicine or other than as permitted by the law of the jurisdiction in which the medicine is dispensed.
- Medicines that do not meet prior authorization requirements.
- Any erectile dysfunction (ED) medications

Please Note: You may purchase some of these medications through CVS Caremark at a discount. For more information, go to www.caremark.com or call 1-800-241-2784.
Coverage at Non-Participating Pharmacies

Both brand-name (preferred and non-preferred) and generic prescriptions filled at non-participating pharmacies will be covered at 50% after meeting a $300 prescription drug deductible. There is a $3,000 individual annual out-of-pocket maximum.

Disadvantages of using non-participating pharmacies are:

- Prescriptions are not discounted.
- You must pay in full for your prescriptions at the time of purchase.
- You have a higher annual deductible to satisfy and a higher out-of-pocket maximum.
- You must file a CVS Caremark prescription drug claim form in order to be reimbursed.

Filing Claims for Benefits

Prescription Drugs Purchased at Non-participating Pharmacies

When you use a participating pharmacy, you will not need to file a prescription drug claim. However, if you use a non-participating pharmacy, you must file a claim for benefits. Each claim should include the following information:

- associate’s name and Alternative ID number located on the ID card
- patient’s name
- pharmacy’s name, address and telephone number
- name of the prescribing doctor
- prescription number
- name of prescription drug
- date prescription was filled
- charge
- National Drug Control (NDC) number

You can obtain prescription drug claim forms by logging on to www.caremark.com. Click on My Coverage, and then click on My Prescription Plan. From there, click on Print Forms, and then click on Prescription Drug Claim Form. Mail the completed claim form along with the prescription detail receipt(s) to the following address:

CVS Caremark
Attn: Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

CVS Caremark Mail Service Program

When you use the CVS Caremark Mail Service Program, you do not have to file a claim. Simply mail your original prescription along with the mail service order form and your copayment or coinsurance (depending on your option) to CVS Caremark.
Medical Coverage During Your First 90 Days

As a salaried associate, under any plan you choose, your medical coverage begins on your date of hire if you enroll during your initial eligibility period. In order to provide you with coverage for yourself and your dependents from your hire date, depending on the medical plan you choose, you may be required to have different coverage from the plan you enrolled in during your first 90 days of employment.

To find out if you will have different medical coverage during your first 90 days, review the Medical Coverage During Your First 90 Days chart.

If you are required to have different coverage during your first 90 days of employment:

- The coverage category you selected when you enrolled (associate only, associate + spouse or same-sex domestic partner, associate + children or associate + family) will automatically apply for your first 90 days and after.
- The cost of your medical plan coverage during your first 90 days will be the same as the cost of the medical plan and coverage category that you chose for coverage after 90 days.

Prescription Drug Coverage During Your First 90 Days

Regardless of the plan you enrolled in, you will have different prescription drug coverage through Aetna during your first 90 days. Oral contraceptives can be obtained through a retail pharmacy during your first 90 days; beginning on your 91st day, oral contraceptives are available only through the mail-service program. See Prescription Drugs in this chapter for more information.

### Medical Coverage During Your First 90 Days

<table>
<thead>
<tr>
<th>You enrolled in:</th>
<th>Your medical coverage for the first 90 days is:</th>
<th>On your 91st day of coverage, your medical coverage will be with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna $550 Deductible</td>
<td>Aetna $550 Deductible/Open Choice PPO network</td>
<td>Aetna $550 Deductible/Choice POS II network</td>
</tr>
<tr>
<td>Aetna $750 Deductible</td>
<td>Aetna $750 Deductible/Open Choice PPO network</td>
<td>Aetna $750 Deductible/Choice POS II network</td>
</tr>
<tr>
<td>Aetna $1,000 Deductible</td>
<td>Aetna $1,000 Deductible/Open Choice PPO network</td>
<td>Aetna $1,000 Deductible/Choice POS II network</td>
</tr>
<tr>
<td>Aetna HMO</td>
<td>Aetna $550 Deductible/Open Choice PPO network</td>
<td>Aetna HMO/Aetna’s HMO network</td>
</tr>
<tr>
<td>CIGNA HMO</td>
<td>Aetna $550 Deductible/Open Choice PPO network</td>
<td>CIGNA HMO/CIGNA’s HMO network</td>
</tr>
<tr>
<td>UHC HMO</td>
<td>Aetna $550 Deductible/Open Choice PPO network</td>
<td>UHC HMO/UHC’s HMO network</td>
</tr>
</tbody>
</table>

1 For information on the Aetna $550 Deductible option, see the Medical chapter.
If You Enroll in an Aetna Medical Option

Your Aetna coverage is described in this Medical chapter. However, the Aetna 90-day coverage uses the Aetna Open Choice PPO network. This network is very similar to Aetna’s Choice POS II network, which will be your network on your 91st day. To find a network provider, go to www.livethehealthyorangelife.com, click Doc Find, then click Salaried First 90 Days.

During your first 90 days, your coverage is slightly different for the following services: spinal manipulations, mental health and substance abuse and E-visits. Coordination of benefit rules also are slightly different during your first 90 days.

For more information, call Aetna at 1-800-695-9744.

Any part or all of the deductible and out-of-pocket maximum that you satisfy under the Aetna 90-day medical plan will automatically be carried over into the Aetna plan that you enrolled in. Call CVS/Caremark to have any out-of-pocket maximum you have satisfied in the 90-day prescription drug plan carried over into the CVS/Caremark prescription drug plan in which you enrolled.

If You Enroll in an HMO

If you enroll in the Aetna HMO, CIGNA HMO or UHC HMO, you will have coverage under the Aetna $500 Deductible Plan and prescription drug coverage with Aetna during your first 90 days. You do not have to do anything—you will be automatically enrolled in medical and prescription drug coverage with Aetna. While you have coverage with Aetna during your first 90 days:

- You must use the Aetna Open Choice PPO network of physicians, hospitals and pharmacies for medical care and prescription drugs during your first 90 days of employment. To find an Open Choice PPO network provider, go to www.livethehealthyorangelife.com, click Doc Find, then click Salaried First 90 Days.
- Your benefits will be different from the plan you chose for the rest of the year.
- On your 91st day of employment, you will begin medical and prescription drug coverage under the HMO you enrolled in and you will have to change your provider to one in your HMO’s network.

Tell your doctor’s office and other providers that your coverage will be changing and provide them with your new ID card. This will allow them to submit claims for care you’ve received after your 90th day to the correct plan administrator.

### Aetna Prescription Drug Coverage During Your First 90 Days

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Deductible (individual/family)</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Maximum (individual/family)</td>
<td>$750/$1,500</td>
<td></td>
</tr>
<tr>
<td>Mandatory Generic—If you receive a brand drug when a generic equivalent is available</td>
<td>The generic coinsurance plus the difference in the cost of the brand and the generic drug</td>
<td></td>
</tr>
</tbody>
</table>

### Retail

<table>
<thead>
<tr>
<th>Retail Coverage</th>
<th>Generic</th>
<th>You pay 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Brand</td>
<td>You pay 25%</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>You pay 45%</td>
<td></td>
</tr>
</tbody>
</table>

### Mail Order

<table>
<thead>
<tr>
<th>Mail Order Coverage</th>
<th>Generic</th>
<th>You pay 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Brand</td>
<td>You pay 25%</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>You pay 45%</td>
<td></td>
</tr>
</tbody>
</table>

### Prescription Drug Administrator on Your 91st Day

<table>
<thead>
<tr>
<th>Administrator</th>
<th>Aetna Choice POS II options</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS/Caremark</td>
<td></td>
</tr>
<tr>
<td>Aetna HMO</td>
<td>Aetna (as part of the HMO)</td>
</tr>
<tr>
<td>CIGNA HMO</td>
<td>CIGNA (as part of the HMO)</td>
</tr>
<tr>
<td>UHC HMO</td>
<td>UHC (as part of the HMO)</td>
</tr>
</tbody>
</table>
For certain conditions, such as chemotherapy or third trimester of pregnancy, you may be able to continue using your current care providers for the duration of your specific treatment plan—even if they don't participate in your HMO's network—through certain transition of care rules. Call your HMO's member services number for more information—numbers are listed in the Medical chapter.

Any part or all of the deductible and out-of-pocket maximum that you satisfy under the Aetna 90-day medical plan will carry over into the HMO that you enrolled in. Call your HMO to have any deductible and out of pocket maximum you satisfied in the 90-day medical and prescription drug plan carried over into the HMO in which you enrolled.

You'll Receive a 90-Day ID Card From Aetna
You'll receive an ID card from Aetna for your 90-day coverage. You also will receive written confirmation of your coverage during your first 90 days in the mail soon after you enroll.

Eligibility Rules During Your First 90 Days
If you are enrolled in a medical plan that requires 90-day coverage, the eligibility rules are the same as those described in the Eligibility and Enrollment chapter except for the following:

- You can enroll your spouse if you are legally separated. Keep in mind that on your 91st day, your spouse is not eligible for coverage if you are legally separated.
- The rules for dependent children during your first 90 days are:
  — Natural and adopted children and children placed with you for adoption;
  — Stepchildren and children for whom you have custody or are a legal guardian; and
  — Children of your same-sex domestic partner.
Keep in mind that additional eligibility requirements for dependent children apply on your 91st day. See the Eligibility and Enrollment chapter for these additional requirements.

- In addition to the same-sex domestic partner requirements in the Eligibility and Enrollment chapter, the following requirements apply during your first 90 days:
  — Your same-sex domestic partner must be of the age of consent in your state of residence (keep in mind that you cannot cover a same-sex domestic partner under the age of 18 as of your 91st day)

—You may be asked to demonstrate your same-sex domestic partner’s interdependence with you by submitting proof of at least three of the following:
- Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
- Common ownership of a motor vehicle;
- Driver’s license listing a common address;
- Proof of joint bank accounts or credit accounts;
- Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
- Assignment of a durable property power of attorney or health care power of attorney.

If you cover a dependent who meets the 90-day eligibility requirements but does not meet the eligibility requirements as of the 91st day (see the Eligibility and Enrollment chapter) you must call the Benefits Choice Center to remove that dependent from your coverage as of the 91st day.
California Medical

U.S. Salaried & Full-Time Hourly Associates

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116  Precertification
116  The Health Net Out-of-Area Plans (California)
123  Health Net and Kaiser Permanente HMOs
126  Health Net Salud HMO y más California-Mexico Cross-Border Coverage
129  Health Net Salud HMO y más Prescription Drug Coverage
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 Kaiser Permanente medical office and get information about your medical plan</td>
<td>Go to <a href="http://my.kp.org/homedepot">http://my.kp.org/homedepot</a> or call 1-800-464-4000</td>
</tr>
<tr>
<td>Find a Health Net network provider and get information about your medical plan</td>
<td>Go to <a href="http://www.healthnet.com/homedepot">www.healthnet.com/homedepot</a> or call 1-800-847-3991</td>
</tr>
<tr>
<td>Find Health Net Salud HMO y más network providers and participating pharmacies in California</td>
<td>Call (011-52-664) 683-29-02 or (011-52-664) 683-30-05</td>
</tr>
<tr>
<td>Find SIMNSA network providers and participating pharmacies in Mexico</td>
<td></td>
</tr>
</tbody>
</table>

California Medical Options
As a California associate, depending on where you live, you have the following medical plan options:

- Health Net Select POS
- Health Net Basic HMO
- Health Net Standard HMO
- Kaiser Permanente Basic HMO
- Kaiser Permanente Standard HMO

The Kaiser Permanente Basic and Standard HMOs and the Health Net Basic and Standard HMOs offer the same coverage and have the same payroll deduction. The difference is Kaiser Permanente offers integration of Kaiser Permanente services. At most locations members can see their personal physician, receive x-ray, lab and pharmacy services all under one roof during extended office hours. There are also no claim forms required with Kaiser Permanente.

See Get the Most Value from Your Plan in this chapter to find out how to find a Kaiser Permanente medical facility or a Health Net network provider.

If you live in Los Angeles, Orange, Riverside or San Bernardino counties, you may be eligible to participate in the Salud HMO y más Plan, described later on in this chapter.

If you live outside an HMO network area, you will have two out-of-area options:

- Health Net OOA $450
- Health Net OOA $1,200

You will see the options available to you when you enroll on the Your Benefits Resources Web site as a new hire, during Annual Enrollment, or if you move to a new location with a different plan.

ID Cards
Once you become covered under a Health Net or Kaiser Permanente medical plan, you will receive an identification (ID) card. 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 to verify your benefits. Please note that the possession of an ID card alone does not entitle you to benefits. You must be enrolled in a medical plan to receive benefits.

Health Net Select POS and the Health Net and Kaiser Permanente HMO Medical Plans
The charts provide information about services covered by the Health Net and Kaiser Permanente Medical Plans. For complete information on covered services, limitations, exclusions, and filing claims, see the Health Net Summary of Benefits booklet and the Evidence of Coverage booklet or the Kaiser Permanente’s Summary of Benefits. These booklets are considered part of this Benefits Summary. Also, see Contacting Your Medical Plan for Health Net’s and Kaiser Permanente’s toll-free Member Services number and Web site address.
Precertification
For information about precertification requirements, you should refer to the Health Net Summary of Benefits or Evidence of Coverage booklet available online at www.healthnet.com/homedepot and mailed to you after enrollment. You also may call Health Net Member Services. The number is listed in Get the Most Value from Your Plan and is also printed on your ID card.

The Health Net Select POS Plan (California)
The Select POS (point-of-service) Plan is available only in California. This Plan, available through Health Net, offers you flexibility in how to receive health care services. Services are covered at three levels.

Associates and each covered family member can use any level at any time. Out-of-pocket expenses vary depending on the level of service chosen.

The Select POS Plan requires you to select a PCP, whom you use for the Select I level of benefits described below.

Select I—HMO. Offers comprehensive health care that must be coordinated by a PCP. See Health Net HMOs for more information.

Select II—PPO. Allows you to self-refer to any physician in the Health Net PPO physician network at a higher copayment than Select I.

Select III—Out-of-Network. Allows you to see any licensed provider for covered services. You will have higher out-of-pocket costs when you use this level of care.

The Health Net Out-of-Area Plans (California)
If your ZIP code is outside a Health Net network area, you may choose a $450 Out-of-Area Plan or a $1,200 Out-of-Area Plan. For covered services information, see Out-of-Area Plans Summary of Benefits section in this California Medical chapter.

Quick Comparison of California’s Medical Plans

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll Deduction</td>
<td>Highest</td>
<td>Highest</td>
<td>Highest</td>
<td>Lowest</td>
<td>Middle</td>
</tr>
<tr>
<td>Out-of-Pocket Costs</td>
<td>Lowest</td>
<td>Middle</td>
<td>Highest</td>
<td>Middle</td>
<td>Lowest</td>
</tr>
<tr>
<td>Claim Filing</td>
<td>No claim forms</td>
<td>Claim forms may be required</td>
<td>You pay for the service, then submit a claim for reimbursement</td>
<td>No claim forms</td>
<td>No claim forms</td>
</tr>
<tr>
<td>Physician Access</td>
<td>Your Health Net PCP coordinates all your care</td>
<td>You may go to any physician in Health Net’s PPO provider network</td>
<td>You may go to any physician you choose</td>
<td>Your Health Net PCP coordinates all your care</td>
<td>Your Health Net PCP coordinates all your care</td>
</tr>
</tbody>
</table>

1 This is a fully insured plan which is governed by the information provided directly to you by your health care plan insurer. If there are differences between the information in this book and the information in your plan’s coverage booklets, the coverage booklets will govern. For detailed information about any fully insured plan, contact the Plan Administrator directly. Plan phone numbers and Web site addresses are listed in Get the Most Value from Your Plan. You may also call the Member Services number listed on your ID card.
The Select II (PPO) and Select III (Out-of-Network) in- and out-of-network deductibles and out-of-pocket maximums are not combined.

Health Net Select I, II and III Plans—POS Network

<table>
<thead>
<tr>
<th>Background Information</th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$0/Individual; $0/Family</td>
<td>$450/Individual; $1,350/Family</td>
<td>$1,000/Individual; $3,000/Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,000/Individual; $4,000/Family</td>
<td>$2,500/Individual; $5,000/Family</td>
<td>$6,000/Individual; $12,000/Family</td>
</tr>
</tbody>
</table>

**Dependent Exceptions**

- **Common-Law Spouses**: No
- **Dependent Grandchildren**: No

**Office Visits**

- **Primary Care**: $20 copay
- **Specialty Care**: $30 copay
  
  **Covered at 50% of R&C after annual deductible**

**Preventive Care**

- **Annual Well-Care Exam**: 100% covered, according to the Plan's periodic health evaluation schedule. No coverage for third-party requests such as physicals for schools that are outside the periodic health evaluation schedule.
- **Well-Child Exams and Immunizations**: 100% covered, according to the Plan's periodic health evaluation schedule; deductible waived. No coverage for third-party requests such as physicals for schools that are outside the periodic health evaluation schedule.
- **Pap Smears (annually)**: 100% covered
- **Mammography**: 100% covered
- **Prostate-Specific Antigen (PSA)**: 100% covered
- **Pathology charges only covered at 50% of R&C after annual deductible**

**Inpatient Care**

- **Hospital copay/Deductible**: Covered at 80%
  
  **$300 per admission; covered at 80% after annual deductible**

**Outpatient Care**

- **Outpatient Surgery**: Covered at 80%
  
  **Covered at 80% after annual deductible**

  **50% of R&C after annual deductible**

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1 This is a fully insured plan which is governed by the information provided directly to you by your health care plan insurer. If there are differences between the information in this book and the information in your plan’s coverage booklets, the coverage booklets will govern. For detailed information about any fully insured plan, contact the Plan Administrator directly. Plan phone numbers and Web site addresses are listed in Get the Most Value from Your Plan. You may also call the Member Services number listed on your ID card.
The Select II (PPO) and Select III (Out-of-Network) in- and out-of-network deductibles and out-of-pocket maximums are not combined.

### Health Net Select I, II and III Plans—POS Network

#### Emergency Care

<table>
<thead>
<tr>
<th></th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>Covered at 80%</td>
<td>$300 per admission; covered at 80% after annual deductible</td>
<td>$500 per admission; covered at 50% of R&amp;C after annual deductible</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$150 copay</td>
<td>Covered at 80% after annual deductible</td>
<td>Covered at 50% of R&amp;C charges after annual deductible</td>
</tr>
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</table>

#### Urgent Care

<table>
<thead>
<tr>
<th></th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$150 copay</td>
<td>Covered at 80% after annual deductible</td>
<td>Covered at 50% of R&amp;C charges after annual deductible</td>
</tr>
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</table>

#### Background Information

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<th></th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Benefits</td>
<td>$15 copay; 30-visit maximum</td>
<td>Covered at 50% of R&amp;C charges after annual deductible (25 visit maximum combined Select III)</td>
<td>Covered at 50% of R&amp;C after annual deductible (25 visit maximum combined Select I)</td>
</tr>
</tbody>
</table>

#### Infertility Benefits

<table>
<thead>
<tr>
<th></th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility—Diagnosis and Treatment of Underlying Cause</td>
<td>Member cost share based on location of service</td>
<td>Member cost share based on location of service</td>
<td>Member cost share based on location of service</td>
</tr>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Mental Health/Substance Abuse Services

<table>
<thead>
<tr>
<th></th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient—Coverage Level/Visits</td>
<td>$30 copay (30-visit annual maximum); $20 for severe(^3) (unlimited)</td>
<td>$35 copay (30-visit annual maximum on Select II and Select III combined) $50 maximum payable per visit</td>
<td>Covered at 50% of R&amp;C charges after annual deductible (30-visit annual maximum on Select II and Select III combined); $50 maximum payable per visit</td>
</tr>
<tr>
<td>Inpatient—Coverage Level/Days</td>
<td>Covered at 80% (30-day annual maximum); no day-limit for severe(^3)</td>
<td>A $300 per admission copay then covered at 80% after annual deductible (30-day annual maximum on Select II and Select III combined)</td>
<td>A $500 per admission copay then covered at 50% of R&amp;C charges after annual deductible (30-day annual maximum on Select II and Select III combined)</td>
</tr>
</tbody>
</table>

---

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2. Maximums do not apply to severe mental illness in adults or children or to serious emotional disturbances of a child on Select 1 (HMO).

3. The following conditions are considered severe mental illness—Anorexia nervosa, bulimia nervosa, bipolar disorder, major depressive disorders, obsessive-compulsive disorder, panic disorders, schizophrenia, schizo-affective disorder, serious emotional disturbances of children.
The Select II (PPO) and Select III (Out-of-Network) in- and out-of-network deductibles and out-of-pocket maximums are not combined.

**Health Net Select I, II and III Plans—POS Network**—continued

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Select I (HMO)</th>
<th>Select II (PPO)</th>
<th>Select III (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic—On Recommended Drug List</td>
<td>$5 copay per prescription; 30-day supply</td>
<td>$5 copay per prescription; 30-day supply</td>
<td>$5 copay per prescription; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand—On Recommended Drug List</td>
<td>$30 copay per prescription; 30-day supply</td>
<td>$30 copay per prescription; 30-day supply</td>
<td>$30 copay per prescription; 30-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary—Not On Recommended Drug List</td>
<td>$60 copay per prescription; 30-day supply</td>
<td>$60 copay per prescription; 30-day supply</td>
<td>$60 copay per prescription; 30-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic—On Recommended Drug List</td>
<td>$10 copay per prescription; 90-day supply</td>
<td>$10 copay per prescription; 90-day supply</td>
<td>$10 copay per prescription; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand—On Recommended Drug List</td>
<td>$50 copay per prescription; 90-day supply</td>
<td>$50 copay per prescription; 90-day supply</td>
<td>$50 copay per prescription; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand—Not On Recommended Drug List</td>
<td>$90 copay per prescription; 90-day supply</td>
<td>$90 copay per prescription; 90-day supply</td>
<td>$90 copay per prescription; 90-day supply</td>
</tr>
</tbody>
</table>

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2 Sexual dysfunction drugs are covered at 50%

3 No coverage through non-participating pharmacies.
### Health Net Out-of-Area Plans

<table>
<thead>
<tr>
<th></th>
<th>$450 Health Net Out-of-Area Plan</th>
<th>$1,200 Health Net Out-of-Area Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$450/Individual; $1,350/Family</td>
<td>$1,200/Individual; $3,600/Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,500/Individual; $5,000/Family</td>
<td>$4,000/Individual; $8,000/Family</td>
</tr>
<tr>
<td><strong>Dependent Exceptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common-Law Spouses</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Dependent Grandchildren</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$35 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Well-Care Exam</td>
<td>100% covered, according to the Plan's periodic health evaluation schedule. No coverage for third-party requests such as physicals for schools that are outside the periodic health evaluation schedule.</td>
<td>100% covered, according to the Plan's periodic health evaluation schedule; deductible waived. No coverage for third-party requests such as physicals for schools that are outside the periodic health evaluation schedule.</td>
</tr>
<tr>
<td>Well-Child Exams and Immunizations</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Mammography</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Prostate-Specific Antigen (PSA)</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital copay/Deductible</td>
<td>$300 per admission; covered at 80% after annual deductible</td>
<td>$300 per admission; covered at 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Covered at 80% after annual deductible</td>
<td>Covered at 80% after annual deductible</td>
</tr>
</tbody>
</table>

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### Health Net Out-of-Area Plans

<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>$450 Health Net Out-of-Area Plan</th>
<th>$1,200 Health Net Out-of-Area Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Followed by Admission</td>
<td>$300 then covered at 80% after annual deductible</td>
<td>$300 then covered at 80% after annual deductible</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>Covered at 80% after annual deductible</td>
<td>Covered at 80% after annual deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$35 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Covered at 80% after annual deductible</td>
<td>Covered at 80% after annual deductible</td>
</tr>
</tbody>
</table>

### Background Information

| Chiropractic Benefits                  | $35 copay; 25 visits per year | $35 copay; 25 visits per year |

### Infertility Benefits

<table>
<thead>
<tr>
<th>Infertility—Diagnosis and Treatment of Underlying Cause</th>
<th>Member cost share based on location of service</th>
<th>Member cost share based on location of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Mental Health/Substance Abuse Services

<table>
<thead>
<tr>
<th>Outpatient—Coverage Level/Visits(^2)</th>
<th>$35 copay (30-visit annual maximum); $25 for severe(^2), unlimited</th>
<th>$35 copay (30-visit annual maximum); $25 for severe, unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient—Coverage Level/Days(^3)</td>
<td>$300 per admission; Covered at 80% (30-day annual maximum) No day limit for severe(^2)</td>
<td>$300 per admission; Covered at 80% (30-day annual maximum) No day limit for severe</td>
</tr>
</tbody>
</table>

---

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3. The following conditions are considered severe mental illness—Anorexia nervosa, bulimia nervosa, bipolar disorder, major depressive disorders, obsessive-compulsive disorder, panic disorders, schizophrenia, schizo affective disorder, serious emotional disturbances of children.
### Health Net Out-of-Area Plans

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>$450 Health Net Out-of-Area Plan</th>
<th>$1,200 Health Net Out-of-Area Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail: Generic—</strong>&lt;br&gt;On Recommended Drug List</td>
<td>$5 copay per prescription; 30-day supply</td>
<td>$5 copay per prescription; 30-day supply</td>
</tr>
<tr>
<td><strong>Retail: Formulary Brand—</strong>&lt;br&gt;On Recommended Drug List</td>
<td>$30 copay per prescription; 30-day supply</td>
<td>$30 copay per prescription; 30-day supply</td>
</tr>
<tr>
<td><strong>Retail: Non-Formulary—Not On</strong>&lt;br&gt;Recommended Drug List</td>
<td>$60 copay per prescription; 30-day supply</td>
<td>$60 copay per prescription; 30-day supply</td>
</tr>
<tr>
<td><strong>Mail Order: Generic—</strong>&lt;br&gt;On Recommended Drug List</td>
<td>$10 copay per prescription; 90-day supply</td>
<td>$10 copay per prescription; up to 90-day supply</td>
</tr>
<tr>
<td><strong>Mail Order: Formulary Brand—</strong>&lt;br&gt;On Recommended Drug List</td>
<td>$50 copay per prescription; 90-day supply</td>
<td>$50 copay per prescription; 90-day supply</td>
</tr>
<tr>
<td><strong>Mail Order: Non-Formulary Brand —</strong>&lt;br&gt;Not On Recommended Drug List</td>
<td>$90 copay per prescription; 90-day supply</td>
<td>$90 copay per prescription; 90-day supply</td>
</tr>
</tbody>
</table>

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2. Sexual dysfunction drugs are covered at 50%.

3. No coverage through non-participating pharmacies.
Health Net and Kaiser Permanente HMOs

The following charts provide some detail about the Health Net and Kaiser Permanente Basic and Standard HMOs in California in which you may be eligible to participate. You will see the medical options available to you when you enroll on the Your Benefits Resources Website. Complete HMO detail regarding covered services, limitations and exclusions, as well as information about filing and appealing claims for the HMOs are not described in detail in this Benefits Summary.

Please see the information mailed to your home by the HMO you enrolled in or call the HMO’s toll-free Member Services number on your medical ID card. See Get the Most Value from Your Plan in this chapter.

<table>
<thead>
<tr>
<th>Background Information</th>
<th>Health Net and Kaiser Permanente—Basic’ (You Pay)</th>
<th>Health Net and Kaiser Permanente—Standard’ (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referral to OB-GYN—OB-GYN must be part of the same participating physician group as your PCP</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-Referral to Specialist</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Default PCP Assigned if None Chosen</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$0/Individual; $0/Family</td>
<td>$0/Individual; $0/Family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,500/Individual; $5,000/Family</td>
<td>$2,000/Individual; $4,000/Family</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Limit does not apply</td>
<td>Limit does not apply</td>
</tr>
</tbody>
</table>

Primary Care

| Routine Office Visit                                | $25 copay                                         | $20 copay                                          |
| Specialty Care                                      | $35 copay                                         | $30 copay                                          |

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### Health Net and Kaiser Permanente HMOs

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Health Net and Kaiser Permanente—Basic1 (You Pay)</th>
<th>Health Net and Kaiser Permanente—Standard1 (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>100% covered; according to plan’s periodic health evaluation schedule. No coverage for third-party requests such as physicals for schools that are outside the periodic health evaluation schedule.</td>
<td>100% covered; according to plan’s periodic exam schedule. No coverage for third-party requests such as physicals for schools that are outside the periodic health evaluation schedule.</td>
</tr>
<tr>
<td>Pediatric Exams</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Pap Smears (annually)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Copay</td>
<td>$500 per admission plus 10% coinsurance</td>
<td>$250 copay per day; up to 4 days per admission; maximum per admission $1,000</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$350 copay in a hospital or ambulatory surgery center. If performed in a PCP office: $25; specialist office: $35</td>
<td>$250 copay in a hospital or ambulatory surgery center. If performed in a PCP office: $20; specialist office: $30</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$15 copay; limited to 30 visits per year</td>
<td>$15 copay; limited to 30 visits per year</td>
</tr>
<tr>
<td>Infertility Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility—Diagnosis and Treatment of Underlying Cause</td>
<td>Member cost share based on location of service</td>
<td>Member cost share based on location of service</td>
</tr>
<tr>
<td>In Vitro Fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fertility Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When Followed by Admission</td>
<td>hospital copay and coinsurance applies</td>
<td>100% covered; hospital copay applies</td>
</tr>
<tr>
<td>When Not Followed by Admission</td>
<td>$200 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
</tbody>
</table>

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### Health Net and Kaiser Permanente HMOs—continued

#### Prescription Drugs

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Net and Kaiser Permanente—Basic (You Pay)</th>
<th>Health Net and Kaiser Permanente—Standard (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail: Generic—On Recommended Drug List</td>
<td>$5 copay; 30-day supply</td>
<td>$5 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Formulary Brand—On Recommended Drug List</td>
<td>$30 copay; 30-day supply</td>
<td>$30 copay; 30-day supply</td>
</tr>
<tr>
<td>Retail: Non-Formulary—Not On Recommended Drug List</td>
<td>Health Net: $60 copay; 30-day supply; Kaiser: $30 copay; 30-day supply</td>
<td>Health Net: $60 copay; 30-day supply; Kaiser: $30 copay; 30-day supply</td>
</tr>
<tr>
<td>Mail Order: Generic—On Recommended Drug List</td>
<td>$10 copay; 90-day supply</td>
<td>$10 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Formulary Brand—On Recommended Drug List</td>
<td>$50 copay; 90-day supply</td>
<td>$50 copay; 90-day supply</td>
</tr>
<tr>
<td>Mail Order: Non-Formulary Brand—Not On Recommended Drug List</td>
<td>Health Net: $90 copay; Kaiser: $50 copay; 90-day supply</td>
<td>Health Net: $90 copay; Kaiser: $50 copay; 90-day supply</td>
</tr>
</tbody>
</table>

#### Mental Health/Substance Abuse Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Health Net</th>
<th>Kaiser</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Mental Illness—Outpatient therapy</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Severe Mental Illness—Inpatient Care</td>
<td>Health Net: $500 per admit + 10% coinsurance; Kaiser: $500 per admit + 10% coinsurance</td>
<td>Health Net: $250 per day; 4 day copay ($1,000) max per admission; Kaiser: $250 per day; 4 day copay ($1,000) max per admission</td>
</tr>
<tr>
<td>Other Mental Illness—Outpatient therapy</td>
<td>Health Net: $35 copay; up to 30 visits per calendar year; Kaiser: $25 copay; up to 20 visits per calendar year; $12 group visit</td>
<td>Health Net: $30 copay; up to 30 visits per calendar year; Kaiser: $25 copay; up to 20 visits per calendar year; $10 group visit</td>
</tr>
<tr>
<td>Other Mental Illness—Inpatient Care</td>
<td>Health Net: $500 per admit + 10% coinsurance; up to 30 days per calendar year; Kaiser: $500 per admit + 10% coinsurance; up to 30 days per calendar year</td>
<td>Health Net: $250 per day; 4 day copay ($1,000) max per admission; up to 30 days per calendar year; Kaiser: $250 per day; 4 day copay ($1,000) max per admission; up to 30 days per calendar year</td>
</tr>
<tr>
<td>Chemical Dependency Rehabilitation—Outpatient therapy</td>
<td>Health Net: $35 copay; up to 30 visits per calendar year; Kaiser: $25 copay; $5 copay group visit; unlimited</td>
<td>Health Net: $30 copay; up to 30 visits per calendar year; Kaiser: $25 copay; $5 copay group visit; unlimited</td>
</tr>
<tr>
<td>Chemical Dependency Rehabilitation—Detoxification</td>
<td>Health Net: $500 per admit + 10% coinsurance; Kaiser: $500 per admit + 10% coinsurance</td>
<td>Health Net: $250 per day; 4 day copay ($1,000) max per admission; Kaiser: $250 per day; 4 day copay ($1,000) max per admission</td>
</tr>
<tr>
<td>Chemical Dependency Rehabilitation—Inpatient Care</td>
<td>Health Net: $500 per admit + 10% coinsurance; up to 30 days per calendar year; Kaiser: $100 per admit Transitional Residential Recovery Services up to 120 days every 5 years</td>
<td>Health Net: $250 per day; 4 day copay ($1,000) max per admission; up to 30 days per calendar year; Kaiser: $100 per admit Transitional Residential Recovery Services up to 120 days every 5 years</td>
</tr>
</tbody>
</table>

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4. Must use participating pharmacies.

5. Outpatient visits and inpatient day maximums are combined for non-severe mental illnesses and for chemical dependency.

For help, go to [http://resources.hewitt.com/homedepot](http://resources.hewitt.com/homedepot) or call 1-800-555-4954

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**Prescription Drugs**

- **Retail: Generic—On Recommended Drug List**
  - Health Net: $5 copay; 30-day supply
  - Kaiser: $5 copay; 30-day supply

- **Retail: Formulary Brand—On Recommended Drug List**
  - Health Net: $30 copay; 30-day supply
  - Kaiser: $30 copay; 30-day supply

- **Retail: Non-Formulary—Not On Recommended Drug List**
  - Health Net: $60 copay; 30-day supply
  - Kaiser: $30 copay; 30-day supply

- **Mail Order: Generic—On Recommended Drug List**
  - Health Net: $10 copay; 90-day supply
  - Kaiser: $10 copay; 90-day supply

- **Mail Order: Formulary Brand—On Recommended Drug List**
  - Health Net: $50 copay; 90-day supply
  - Kaiser: $50 copay; 90-day supply

- **Mail Order: Non-Formulary Brand—Not On Recommended Drug List**
  - Health Net: $90 copay; Kaiser: $50 copay; 90-day supply

---

**Mental Health/Substance Abuse Services**

- **Severe Mental Illness—Outpatient therapy**
  - Health Net: $25 copay
  - Kaiser: $25 copay

- **Severe Mental Illness—Inpatient Care**
  - Health Net: $500 per admit + 10% coinsurance
  - Kaiser: $500 per admit + 10% coinsurance

- **Other Mental Illness—Outpatient therapy**
  - Health Net: $35 copay; up to 30 visits per calendar year
  - Kaiser: $25 copay; up to 20 visits per calendar year; $12 group visit

- **Other Mental Illness—Inpatient Care**
  - Health Net: $500 per admit + 10% coinsurance; up to 30 days per calendar year
  - Kaiser: $500 per admit + 10% coinsurance; up to 30 days per calendar year

- **Chemical Dependency Rehabilitation—Outpatient therapy**
  - Health Net: $35 copay; up to 30 visits per calendar year
  - Kaiser: $25 copay; $5 copay group visit; unlimited

- **Chemical Dependency Rehabilitation—Detoxification**
  - Health Net: $500 per admit + 10% coinsurance
  - Kaiser: $500 per admit + 10% coinsurance

- **Chemical Dependency Rehabilitation—Inpatient Care**
  - Health Net: $500 per admit + 10% coinsurance; up to 30 days per calendar year
  - Kaiser: $100 per admit Transitional Residential Recovery Services up to 120 days every 5 years

---

1. This is a fully insured plan which is governed by the information provided directly to you by your health care plan insurer. If there are differences between the information in this book and the information in your plan’s coverage booklets, the coverage booklets will govern. For detailed information about any fully insured plan, contact the Plan Administrator directly. Plan phone numbers and Web site addresses are listed in Get the Most Value from Your Plan. You may also call the Member Services number listed on your ID card.

2. Sexual dysfunction drugs are covered at 50%.

3. Maximums do not apply to severe mental illness in adults or children or to serious emotional disturbances of a child. The following conditions are considered severe mental illness—Anorexia nervosa, bulimia nervosa, bipolar disorder, major depressive disorders, obsessive-compulsive disorder, panic disorders, schizophrenia, schizo affective disorder, serious emotional disturbances of children.

4. Must use participating pharmacies.

5. Outpatient visits and inpatient day maximums are combined for non-severe mental illnesses and for chemical dependency.
Health Net Salud HMO y más California-Mexico Cross-Border Coverage

The Salud HMO y más Plan is available only in California for eligible associates. You are eligible to participate in Salud HMO y más if you reside in Los Angeles, Orange, and parts of San Bernardino or Riverside counties.

When you enroll, you can receive care through a select provider network in your local area—Los Angeles, Orange, San Bernardino or Riverside counties. You also have the flexibility to receive care in northern Mexico—Tijuana, Mexicali, Rosarito or Tecate—from participating SIMNSA (Sistemas Médicos Nacionales, S.A. de C.V.) providers, often at a reduced cost.

Salud HMO y más members in California have two options for medical care:

<table>
<thead>
<tr>
<th>Your Health Care in California</th>
<th>Your Health Care in Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit your PCP (Primary Care Physician) or other providers if your PCP refers you.</td>
<td>Visit participating SIMNSA providers in Mexico without referrals and pay lower copays.</td>
</tr>
</tbody>
</table>

You can enroll your eligible dependents in Mexico who live within 50 miles of the California-Mexico border in Salud HMO y más and receive benefits when they visit SIMNSA providers. When in California, your eligible dependents may visit California providers for emergency and urgent care only. The chart below provides basic information about the plan. For complete information on covered services, limitations, exclusions and filing claims, see the Salud HMO y más Summary of Benefits and Evidence of Coverage booklet available at www.healthnet.com/homedepot.

### Health Net Salud HMO y más Network

<table>
<thead>
<tr>
<th>Background Information</th>
<th>SIMNSA Network (Mexico members) (You Pay)</th>
<th>Health Net Salud Network (California members) (You Pay)</th>
<th>SIMNSA Network (Self-referral for California members) (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum (for each member)</td>
<td>N/A</td>
<td>$1,500/for each member; $3,000/for two members; $4,500/for each family</td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$5 copay</td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Primary Care</td>
<td>$5 copay</td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Routine Physician Office Visit (within your medical group)</td>
<td>$5 copay</td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$5 copay</td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Periodic Health Evaluations</td>
<td>$5 copay</td>
<td>$15 copay, hearing 100% covered</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Vision and Hearing Examinations</td>
<td>100% covered</td>
<td>20%</td>
<td>100% covered</td>
</tr>
<tr>
<td>Immunizations for foreign travel/occupational purposes</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Immunizations except foreign travel/occupational purposes</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Dental Services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed)</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
</tbody>
</table>
## Health Net Salud HMO y más Network—continued

<table>
<thead>
<tr>
<th>Hospital and Skilled Nursing Facility Services</th>
<th>SIMNSA Network (Mexico members) (You pay)</th>
<th>Health Net Salud Network (California members) (You pay)</th>
<th>SIMNSA Network (Self-referral for California members) (You pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited days of hospital care with ancillary services in a private room in Mexico. In the US, unlimited days of hospital care in a semi-private room or ICU with ancillary services (excludes care for chemical dependency/mental disorders)</td>
<td>100% covered</td>
<td>$250 deductible&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% covered</td>
</tr>
<tr>
<td>Confinement for infertility services</td>
<td>50%</td>
<td>Not covered</td>
<td>50%</td>
</tr>
<tr>
<td>Confinement in a skilled nursing facility (limited to 100 days a calendar year)</td>
<td>100% covered</td>
<td>$250 deductible&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% covered</td>
</tr>
<tr>
<td>Maternity care includes routine nursery charges</td>
<td>100% covered</td>
<td>$250 deductible&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% covered</td>
</tr>
<tr>
<td>Outpatient services other than surgery</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Outpatient surgery at hospital or ambulatory surgical center</td>
<td>100% covered</td>
<td>$250</td>
<td>100% covered</td>
</tr>
</tbody>
</table>

## Emergency and Urgent Care

| Use of emergency room (facility and professional services) | $10 copay; waived if admitted | $100 copay; waived if admitted | $10 copay; waived if admitted |
| Use of urgent care center (facility and professional services) | $10 copay | $50 copay | $10 copay |

## Other Services

| Chiropractic Benefits | N/A | $15 copay | N/A |

## Pregnancy Care

| Prenatal and postnatal office visit | 100% covered | 100% covered | 100% covered |
| Normal delivery, Cesarean section. Includes newborn inpatient care provided by a member physician | 100% covered | $250 deductible<sup>1</sup> | 100% covered |

## Family Planning (professional services only)

| Contraceptive devices | 100% covered | 100% covered | 100% covered |

## Care for Mental Disorders

| Outpatient mental visit for severe mental illness<sup>4</sup> | $5 copay<sup>1</sup> | $15 copay<sup>1</sup> | $5 copay<sup>1</sup> |
| Inpatient care in a hospital or skilled nursing facility for severe mental illness<sup>4</sup> | 100% covered<sup>1</sup> | $250 deductible<sup>1, 3</sup> | 100% covered<sup>1</sup> |
| Physician visit to hospital or skilled nursing facility for severe mental illness<sup>4</sup> | 100% covered<sup>1</sup> | 100% covered<sup>1</sup> | 100% covered<sup>1</sup> |

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1. Mental health and substance abuse services must be provided by a SIMNSA provider.
2. Inpatient: A $250 deductible is required for each inpatient hospital admission. After the deductible is satisfied, the balance is payable at 100%.
3. Administered by Managed Health Network (MHN). Authorizations provided by MHN. Contact MHN at 1-800-363-9371.
4. Severe mental illnesses include the following conditions: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (autism), anorexia nervosa, bulimia nervosa, and serious emotional disturbances in children (under age 18).
### Health Net Salud HMO y más Network—continued

<table>
<thead>
<tr>
<th>Other Mental Illnesses (Non-severe mental illnesses)</th>
<th>SIMNSA Network (Mexico members) (You pay)</th>
<th>Health Net Salud Network (California members) (You pay)</th>
<th>SIMNSA Network (Self-referral for California members) (You pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient mental visit for non-severe mental illness</strong></td>
<td>$5 copay$^{1,2}</td>
<td>$15 copay up to a maximum of 30 visits per calendar year$^{3,4}</td>
<td>$5 copay$^{1,2}</td>
</tr>
<tr>
<td><strong>Inpatient care in a hospital or skilled nursing facility for non-severe mental illness</strong></td>
<td>100% covered/up to a maximum of 20 days per calendar year$^{1}$</td>
<td>$250 copay per day up to a maximum of $1,000 per calendar year; 20 day maximum$^{3,4}</td>
<td>100% covered/up to a maximum of 20 days per calendar year$^{1}$</td>
</tr>
<tr>
<td><strong>Physician visit to hospital or skilled nursing facility for non-severe mental illness</strong></td>
<td>100% covered$^{1}$</td>
<td>100% covered</td>
<td>100% covered$^{1}$</td>
</tr>
</tbody>
</table>

### Chemical Dependency Rehabilitation

| Outpatient consultation (therapy, counseling or psychological testing) in an outpatient facility | $5 copay$^{1,2} | $15 copay; up to a maximum of 30 visits per calendar year$^{3,4} | $5 copay$^{1,2} |
| Detoxification (acute care for substance abuse) | 20%$^{1}$ | $250 copay per day; up to a maximum of $1,000 per calendar year; 30 day maximum$^{4} | 20%$^{1}$ |
| Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility | 100% covered/up to a maximum of 30 days per calendar year$^{1}$ | $250 copay per day; up to a maximum of $1,000 per calendar year; 30 day maximum$^{3,4}$ | 100% covered/up to a maximum of 30 days per calendar year$^{1}$ |

---

1. Mental health and substance abuse services must be provided by a SIMNSA provider.
2. Outpatient (non-severe) services: Outpatient mental health care and outpatient chemical dependency rehabilitation are limited to a combined limit of 20 visits for each member in a calendar year through SIMNSA HMO Network.
3. Outpatient visit and inpatient day maximums are combined for non-severe mental illnesses and chemical dependency.
4. Administered by Managed Health Network (MHN). Authorizations provided by MHN. Contact MHN at 1-800-363-9371.
Health Net Salud HMO y más Prescription Drug Coverage

The Salud HMO y más covers prescription drugs when purchased in a SIMNSA or Health Net participating pharmacy:

- To find a Health Net participating pharmacy in California or to get a copy of the Health Net Recommended Drug List, go to www.healthnet.com or call the Health Net Customer Contact Center at 1-800-847-3991.

- To find a SIMNSA participating pharmacy in Mexico and for information on SIMNSA's Recommended Drug List, call SIMNSA at (011-52-664) 683-29-02 or (011-52-664) 683-30-05.

For complete information on covered services, limitations and exclusions, see the Salud HMO y más Summary of Benefits and Evidence of Coverage booklet mailed to your home after enrollment or available online at www.healthnet.com/homedepot.com.

Generic drugs will be dispensed when a generic equivalent is available. If you request a brand-name drug when a generic equivalent is available, you must pay the difference between the generic equivalent and the brand-name drug plus the Level 2 drug copayment.

Mail Order Drug Program

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through the Prescription By Mail Drug Program. Through this program, you can receive up to a 90-day supply of maintenance medication for a lower cost. Mail order drug coverage is limited to participants residing or working in the U.S. For more information on the mail order drug program, go to www.healthnet.com or call the Customer Contact Center at 1-800-847-3991.

### Outpatient Prescription Medication

<table>
<thead>
<tr>
<th>Drugs dispensed by SIMNSA</th>
<th>SIMNSA Participating Pharmacy</th>
<th>Health Net Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I drugs listed on the Health Net Recommended Drug List (primarily generic)</td>
<td>$5 copay</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin)</td>
<td>Not applicable</td>
<td>$5 copay; 30 day supply</td>
</tr>
<tr>
<td>Level III (drugs not listed on the Health Net Recommended Drug List)</td>
<td>Not applicable</td>
<td>$30 copay; 30 day supply</td>
</tr>
</tbody>
</table>

### Mail Order

| Level I drugs listed on the Health Net Recommended Drug List (primarily generic) | Not applicable | $10 copay; 90 day supply |
| Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) | Not applicable | $50 copay; 90 day supply |
| Level III (drugs not listed on the Health Net Recommended Drug List) | Not applicable | $90 copay; 90 day supply |
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   131 Using PPO Providers
   131 How to Receive PPO Benefits
   132 Using Non-PPO Providers
   132 How to Receive Non-PPO Benefits
   132 Annual Deductible
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133 HMSA's Health Plan Hawaii Plus (HMO)
   133 Using HMO Providers
   133 How to Receive HMO Benefits
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137 Chiropractic Benefits
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138 Vision Care
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138 Retail Prescription Drug Program
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139 Claiming Benefits Under the Group Health Plans
140 Certificates of Health Plan Coverage
140 If You’re Age 65 or Older
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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 an HMSA provider or hospital</td>
<td>Go to <a href="http://www.hmsa.com">www.hmsa.com</a> or call 1-808-948-6372</td>
</tr>
</tbody>
</table>

Choosing a Medical Plan

HMSA’s Preferred Provider Plan allows you the option of seeking medical care using both in-network and out-of-network doctors. HMSA’s Health Plan Hawaii Plus allows you to seek medical care using only in-network doctors, except in the case of an emergency.

ID Cards

Once you become covered under an HMSA medical plan, you will receive an identification (ID) card. 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 to verify your benefits. Please note that the possession of an ID card alone does not entitle you to benefits. Your enrollment in a medical plan must be effective when medical services are received to be entitled to benefits.

HMSA’s Preferred Provider Plan (PPO)

The Preferred Provider Plan lets you choose any doctor. Your benefits depend on whether you use your Plan’s Preferred Provider Organization (PPO) providers or non-PPO providers. Using PPO providers lowers the cost for health care services for you.

Using PPO Providers

When you use in-network providers (doctors, specialists, hospitals and other health care providers who participate in the network), the Medical Plan begins to work for you immediately. Here’s how:

- **Doctor office visits, well-child care and well-adult care**—You pay a copayment with no deductible for most charges related to the treatment of covered illnesses, injuries and preventive services.
- **Emergency care**—Always try to locate an in-network provider when you require emergency care away from home. However, in a life-threatening emergency, if you receive emergency services from an out-of-network provider, your emergency services will be covered at the in-network level. However, you will be responsible for any charges above the eligible charge. See Using Non-network Providers later in this chapter for more information on eligible charges.
- **Hospitals and other services**—For most other covered major-medical services (such as inpatient and outpatient surgeries, home health care, inpatient mental health and substance abuse treatment, alternative treatment centers, etc.), you pay a portion of pre-negotiated charges.
- **Fees for services**—In general, the pre-negotiated fees charged by in-network providers are lower than those you might otherwise pay out-of-network providers for the same service.
- **Medical claim forms**—You do not file medical claim forms when you receive in-network services. Your doctor will file claims for you and will receive payment from your Plan directly.

Refer to the Summary of Covered Services charts for a detailed list of PPO benefits.

How to Receive PPO Benefits

To receive PPO benefits, you must visit a PPO provider. For current information and to obtain a directory of providers and hospitals free of charge, call HMSA at 1-808-948-6372. You may also find this information on their Web site at www.hmsa.com.

Once you have identified a doctor, call the doctor’s office to verify that new patients are being accepted. Let the doctor know that you are a member of the HMSA Preferred Provider Plan.

When you call for an appointment, you should always confirm your doctor’s participation in the HMSA Preferred Provider Plan.
Using Non-PPO Providers

When you use non-PPO providers (doctors, specialists, hospitals, and other health care providers not participating in the network), you pay 30% and the Plan pays 70% for most covered services, after you meet your Plan’s individual annual deductible. Refer to the Summary of Covered Services for a detailed list of non-PPO benefits.

Since non-PPO providers can charge any amount for their services, the Plan will pay benefits only on charges considered an eligible charge (EC). EC is the lower of either the provider’s actual charge or the amount established as the maximum allowable fee. This amount is determined by HMSA and is used as the maximum allowable amount for calculating the benefit they will pay for medical services.

If your non-PPO doctor charges more than the EC, you will be responsible for paying your share of the covered charges plus 100% of any charges over the EC. Always discuss fees with your non-PPO doctor in advance, and ask your doctor whether he or she will agree to waive charges over the EC.

How to Receive Non-PPO Benefits

To receive non-PPO benefits, you must submit the original itemized bills for services covered under your Plan. When you use non-PPO providers, the Plan begins to pay benefits after you and/or your family pay an initial amount of covered expenses. This is called your annual deductible.

After the annual deductible is met, the Plan pays 70% of most covered medical expenses incurred during the same year by you and your covered family members. Expenses that you pay in excess of EC do not count toward your deductible.

Remember, you will be responsible for paying the difference between what the Plan pays and what your doctor charges. This includes any amounts over the EC.

Annual Deductible

The Plan begins to pay PPO and non-PPO benefits not eligible for a copayment only after you and your family pay an annual deductible, as follows:

<table>
<thead>
<tr>
<th>Deductible Type</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$100 (only for major medical services)</td>
<td>$100</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$300 (only for major medical services)</td>
<td>$300</td>
</tr>
</tbody>
</table>

For additional information, refer to HMSA’s Guide to Benefits.

Out-of-Pocket Maximums

The Plan limits the amount you have to pay out of your own pocket for PPO and non-PPO services. Covered medical expenses for PPO and non-PPO services are limited to the following out-of-pocket annual maximums:

<table>
<thead>
<tr>
<th>Deductible Type</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Maximum</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$7,500</td>
<td>$7,500</td>
</tr>
</tbody>
</table>

For additional information, refer to HMSA’s Guide to Benefits.

If your PPO doctor charges more than the eligible charge (EC), the amount over the eligible charge will not count toward your annual out-of-pocket maximum.

Lifetime Maximum Benefits

The Plan provides Medical Plan benefits (PPO and non-PPO services combined) with a $1,000,000 lifetime maximum for you and each covered family member. The lifetime maximum accumulates from all benefits received under this coverage and any other HMSA coverage you have or had as a member or dependent, regardless of any interruptions in coverage. Amounts over the eligible charge (EC) do not count toward the lifetime maximum. If you reach your lifetime maximum, HMSA will renew your lifetime maximum up to $10,000 per calendar year.

This lifetime maximum renewal will begin on January 1 of the calendar year following the year in which you reach your lifetime maximum.

The Plan has other limitations on specific types of services as described separately in this book.
HMSA’s Health Plan Hawaii Plus (HMO)

The HMSA Health Plan Hawaii Plus Plan offers quality medical coverage with lower out-of-pocket costs to you. When you choose this HMO Plan, you agree to use only your Plan’s HMO providers. Services provided by non-HMO providers are not covered except in an emergency.

Using HMO Providers

The following benefits are available when you use HMO providers:

- **Doctor’s office visits** — You pay a copayment with no deductible for most charges related to the treatment of covered illnesses or injuries.
- **Well-child care** — Services, including immunizations, for children through age five.
- **Well-woman care** — Includes routine annual Pap smears and routine mammograms.
- **Well-man care** — Prostate cancer screening tests (PSAs) as directed by your PCP.
- **Well-adult care** — Routine annual physical examinations.
- **Emergency care** — Always try to locate an HMO provider when you require emergency care away from home. Depending upon where you receive emergency care will determine how the Plan pays.
- **Hospitals and other services** — For most other covered medical services (such as inpatient and outpatient surgeries, home health care, inpatient mental health and substance abuse treatment), refer to HMSA’s Guide to Benefits.

You do not file medical claim forms when you receive services. Your doctor will file claims for you and will receive payment from the Plan directly. Refer to the Summary of Covered Services for a detailed list of benefits.

How to Receive HMO Benefits

To receive benefits, you must select a Primary Care Physician (PCP) at the time of enrollment. If you do not, HMSA will select one for you. Once you have selected a PCP, call for an appointment before going to see your doctor. You must contact your physician for a referral before seeing another physician or obtaining services other than those provided by your PCP. If, for any reason, you would like to select a new PCP, call an HMSA Member Services representative to make the change. Additional reasons you may need to change your PCP:

- when you move
- when your PCP was originally chosen by HMSA

**Remember:** If you visit another provider or receive special services without a referral from your PCP and approval from HMSA Health Plan Hawaii Plus, your claim for these services will be denied.

Annual Deductible

There is no annual deductible for the HMO Plan.

Out-of-Pocket Maximums

The Plan limits the amount you have to pay out of your own pocket. Covered medical expenses are limited to the following out-of-pocket annual maximums:

- Individual maximum: $1,500
- Family maximum: $4,500

For additional information, refer to HMSA’s Guide to Benefits.

Lifetime Maximum Benefits

The Plan provides Medical Plan benefits with an unlimited lifetime maximum for you and each covered family member.

The Plan has other limitations on specific types of services as described separately in this book.
## Summary of Covered Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>HMSA—Health Plan Hawaii Plus (HMO)</th>
<th>HMSA—Preferred Provider Plan (PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When You Use HMO Providers</td>
<td>When You Use Non-HMO Providers</td>
</tr>
<tr>
<td></td>
<td>Individual</td>
<td>Family</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>None</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>$300 (for certain services)</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>Individual $1,500</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Family $4,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>All benefits Unlimited</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office Visits</td>
<td>Office Visits You pay $14</td>
<td>Not covered</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>X-rays covered at 90%; laboratory tests covered at 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well-Child Care Through Age 6 (including immunizations)</td>
<td>Children through 12 months (6 office visits) Covered at 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children age 13 months through 24 months (2 office visits per year) Not covered</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td></td>
<td>Children age 2 through 6 years (1 office visit per year) Not covered</td>
<td></td>
</tr>
<tr>
<td>Preventive Visits</td>
<td>Pap smears Covered at 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive mammograms 1 baseline at ages 35–39 1 every year after age 40 Not covered</td>
<td>Covered at 80%</td>
</tr>
<tr>
<td></td>
<td>Prostate-Specific Antigen (PSA) test; 1 every year at or after age 50 Covered at 80%, age 50 and over</td>
<td></td>
</tr>
</tbody>
</table>

1 This is a fully insured plan which is governed by the information provided directly to you by your health care plan insurer. If there are differences between the information in this book and the information in your plan’s coverage booklets, the coverage booklets will govern. For detailed information about any fully insured plan, contact the Plan Administrator directly. Plan phone numbers and Web site addresses are listed in Contacting Your Medical Plan. You may also call the Member Services number listed on your ID card.
2 Combined in- and out-of-network.
### Summary of Covered Services—continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>HMSA—Health Plan Hawaii Plus (HMO)¹</th>
<th>HMSA—Preferred Provider Plan (PPO)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs—Drug Plan 357/358</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Individual Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Generic drugs</strong></td>
<td>$5 copay; 30-day supply</td>
<td>$5 copay; 30-day supply</td>
</tr>
<tr>
<td><strong>Preferred brand drugs</strong></td>
<td>$10 copay; 30-day supply</td>
<td>$10 copay; 30-day supply</td>
</tr>
<tr>
<td><strong>Other brand-name drugs</strong></td>
<td>100% of remaining eligible charge</td>
<td>100% of remaining eligible charge</td>
</tr>
<tr>
<td>plus $35 other brand-name drug cost share; 30-day supply</td>
<td>after $10 member copayment + $35 other brand-name drug cost share</td>
<td>after $10 member copayment + $35 other brand-name drug cost share</td>
</tr>
<tr>
<td><strong>Mail-Order Prescription Drug Program (administered by PrecisionRx) (up to 90-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10 copay; 90-day supply</td>
<td>$10 copay; 90-day supply</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$20 copay; 90-day supply</td>
<td>$20 copay; 90-day supply</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible per admission</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Room &amp; board (semi-private)</td>
<td>Covered at 100%</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td>Covered at 100%</td>
<td>Covered at 90%</td>
<td>Covered at 70% of EC after annual deductible</td>
</tr>
<tr>
<td>Doctors’ services</td>
<td>Covered at 100%</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td>Surgeons’ services</td>
<td>Cutting covered at 90%; non-cutting covered at 80%</td>
<td>Cutting covered at 90%; non-cutting covered at 80%</td>
</tr>
<tr>
<td>Anesthesiologists’ services</td>
<td>Covered at 90%</td>
<td>Covered at 90% for inpatient and 80% for outpatient</td>
</tr>
<tr>
<td>Diagnostic services (x-rays and laboratory tests)</td>
<td>Covered at 90% for inpatient and 80% for outpatient</td>
<td>Covered at 90% for a cutting procedure and 80% for a non-cutting procedure</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn nursery charges/doctors’ visits</td>
<td>Covered at 100%</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Covered at 90%</td>
<td>Covered at 90% for a cutting procedure and 80% for a non-cutting procedure</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¹ This is a fully insured plan which is governed by the information provided directly to you by your health care plan insurer. If there are differences between the information in this book and the information in your plan’s coverage booklets, the coverage booklets will govern. For detailed information about any fully insured plan, contact the Plan Administrator directly. Plan phone numbers and Web site addresses are listed in Contacting Your Medical Plan. You may also call the Member Services number listed on your ID card.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>² Combined in- and out-of-network.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For help, go to http://resources.hewitt.com/homedepot or call 1-800-555-4954
### Summary of Covered Services—continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>HMSA—Health Plan Hawaii Plus (HMO)&lt;sup&gt;1&lt;/sup&gt;</th>
<th>HMSA—Preferred Provider Plan (PPO)&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When You Use HMO Providers</td>
<td>When You Use PPO Providers</td>
</tr>
<tr>
<td></td>
<td>When You Use Non-HMO Providers</td>
<td>When You Use Non-PPO Providers</td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room treatment</td>
<td>$25 copay</td>
<td>Covered worldwide at 80%</td>
</tr>
<tr>
<td></td>
<td>Covered worldwide at 80%</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered at 90% of Emergency Care</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Covered at 100% semi-private room rate (up to 100 days per calendar year)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered at 90% of Emergency Care</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered at 100% (up to 365 visits per illness or injury)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered at 100% of Emergency Care</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered at 50%</td>
<td>Covered at 80% of Emergency Care</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If medically necessary, to the nearest emergency hospital</td>
<td>Covered at 80%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse Treatment&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Covered at 100% (up to 30 days per calendar year) for hospital and facility; 80% covered for psychiatrist and psychologist services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office visits</td>
<td>For mental health, $14 copay (up to 24 visits per calendar year). For substance abuse, $14 copay (No visit limit)</td>
<td>Covered at 90% (up to 24 visits per calendar year)</td>
</tr>
</tbody>
</table>

1 This is a fully insured plan which is governed by the information provided directly to you by your health care plan insurer. If there are differences between the information in this book and the information in your plan’s coverage booklets, the coverage booklets will govern. For detailed information about any fully insured plan, contact the Plan Administrator directly. Plan phone numbers and Web site addresses are listed in Contacting Your Medical Plan. You may also call the Member Services number listed on your ID card.

2 Plan maximums apply only to mental health. There are no plan maximum for substance abuse.

### Chiropractic Benefits

Administered by American Specialty Health Insurance (ASHI). For more information, call the number on the back of your ASHI ID card, which will be mailed to your home.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic benefit (per calendar year)</td>
<td>You pay $20 copay per visit; 24 visit maximum</td>
<td>You pay 50% coinsurance up to $30 per visit, 12 visit maximum (combined with in-network)</td>
</tr>
</tbody>
</table>
What’s Covered Under the HMO and PPO

Maternity Benefits
As required by federal law, maternity benefits are not restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan does not require that a provider obtain authorization from the Plan for prescribing the length of stay not in excess of 48 hours (or 96 hours).

Mastectomies
Federal law requires group health plans offering mastectomy coverage to also cover reconstructive surgery and prostheses following mastectomies. Therefore, if you or a covered family member receive benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, coverage will also be provided for:
- reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses (artificial replacements), and
- treatment of physical complications with respect to all stages of a mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes).

This coverage will be provided in consultation with the attending physician and the patient, and it will be subject to the same annual deductible, co-insurance and/or copayment provisions otherwise applicable.

Chiropractic Benefits
Chiropractic benefits are administered by American Specialty Health Insurance (ASHI). The ASHI chiropractic benefits plan is a fully insured plan that is governed by the information provided directly to you by ASHI. If there are any discrepancies between the information in this book and the information provided by ASHI, the information provided by ASHI will govern. For detailed information about chiropractic benefits, contact ASHI directly. ASHI contact information can be found on the back of your ASHI ID card.

What’s Not Covered Under the HMO and the PPO
Limitations and exclusions for the HMO and PPO Plans are not described in detail in this Benefits Summary. Please refer to HMSA’s Guide to Benefits for detailed information. This Guide is considered part of this Benefits Summary.
## HMSA Vision Coverage

<table>
<thead>
<tr>
<th>Vision Services</th>
<th>HMO</th>
<th>PPO</th>
<th>Non-Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>$14 copay; limited to one exam per year</td>
<td>100% after $10 deductible</td>
<td>Up to $40(^1)</td>
</tr>
<tr>
<td>Single Lenses</td>
<td>$10 copay</td>
<td>100% after $10 deductible</td>
<td>Up to $16(^2)</td>
</tr>
<tr>
<td>Multifocal Lenses</td>
<td>$10 copay</td>
<td>100% after $10 deductible</td>
<td>Up to $25(^3)</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$25 copay; $130 maximum</td>
<td>Plan pays up to $130 after $25 annual deductible</td>
<td>Up to $50(^4)</td>
</tr>
<tr>
<td>Contact Lens Fitting(^5)</td>
<td>Plan pays up to $45</td>
<td>Plan pays up to $45</td>
<td>Up to $20</td>
</tr>
<tr>
<td>Frames</td>
<td>$15 copay; must be from a designated category</td>
<td>100% after $15 annual deductible(^6)</td>
<td>Up to $12</td>
</tr>
</tbody>
</table>

1 Payment of entire claim is due at appointment and sent in for reimbursement.
2 Benefit is limited to one contact lens fitting per calendar year.
3 Frames must be chosen from a group selected by the provider. Other restrictions apply.

### Vision Care

By participating in one of the Hawaii Medical Plans, you are automatically enrolled in a vision care program through the Plan you choose. You may also participate in the Vision Plan available to all associates. See the Vision chapter for more information.

### HMSA Vision

Show your HMSA Health Plan ID card to participating providers to obtain vision care services and receive discounts under the Plan.

To find a vision center that participates in HMSA, Preferred Provider Plan, or Health Plan Hawaii Plus, call an HMSA Member Services representative at 1-808-948-6372.

### Prescription Drug Benefits

All HMSA Medical Plan participants can purchase their prescription drugs through HMSA (retail) and PrecisionRx (mail order). HMSA and PrecisionRx encourage use of generic drugs and preferred brand-name drugs. You may still obtain other brand-name prescriptions, but you will pay more.

Refer to HMSA’s Guide to Benefits for definitions and explanations of these drug categories.

### Mail-Order Prescription Drug Program (Administered by PrecisionRx)

The most cost-effective way to fill prescriptions for maintenance medications is through mail order. When you and your covered family members enroll in the Medical Plan, you are automatically enrolled in the mail-order prescription drug program.

#### Requesting a Mail-Order Prescription

To use the mail-order prescription drug program, ask your doctor to prescribe ongoing medication for up to a 90-day supply, plus refills. Then, complete and mail a patient profile questionnaire along with your original prescription(s) and the appropriate payment to:

**HMSA Prescription Delivery Program**

PrecisionRx
P.O. Box 961025
Fort Worth, TX 76161
General Information About the Hawaii Medical Plans

Claiming Benefits Under the Group Health Plans

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under the Plan. All forms required to take any action under the Plans are available from the claims administrator. Please refer to the descriptions of each benefit for additional information on claiming benefits.

To be eligible for benefits, you must be covered under the 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. Suits must be brought no later than one year following the date on which the appeals process under the Plan is exhausted.

Filing Claims Under the Group Health Plan

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 directly for any covered service, contact the claims administrator. However, you are responsible for meeting any annual deductible and for paying copayments 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 timely filing of your claim.

Where to Send Your Claims for Out-of-Network Services

When you receive covered health services as a result of an emergency, or if you receive services from an out-of-network provider, you must submit the claim to the appropriate group health plan.

Timely Filing of a Claim

You must submit a request for payment of benefits 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 claim submission. If you don’t provide the claim information to your health Plan within one year after the date of service, benefits for that service will be denied or reduced, according to the claims administrator’s discretion. This time limit does not apply while you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to the associate. The group health Plan will not reimburse third parties that have purchased or been assigned benefits by any healthcare provider.
Information Required for Your Claim

When you request payment of benefits from your health Plan, you 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
- 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)

Payment of Benefits

The claims administrator of your group health Plan will make a benefit determination as described below. Benefits will be paid directly to you unless either of the following is true:

- The provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider, or
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Certificates of Health Plan Coverage

After your coverage (or your dependent’s coverage) ends, a Certificate of Health Plan Coverage will be sent to the current address listed with the Plan Administrator. This certificate provides evidence of your health care coverage with the Company. You may need this certificate should you become covered by another group health plan or insurance policy with a pre-existing medical condition clause. A group health Plan is required by law to reduce the duration of its pre-existing condition exclusion, day-for-day, by any period of prior coverage—provided you do not have a 63-day or longer break in health care coverage (not counting waiting periods for coverage). You and your dependents also have the right to request a Certificate of Health Plan Coverage at any time during the 24 months following loss of coverage. You may request a copy from the Benefits Choice Center at 1-800-555-4954.

If You’re Age 65 or Older

If you are an active associate age 65 or older (or an active associate’s spouse age 65 or older) who is eligible for Medicare, you may choose to end your coverage under the Company Medical Plan and elect Medicare coverage instead. Or, you may choose to continue coverage under this Plan, which will be considered your primary Plan and will pay benefits first.

Medicare will be the primary payor to the full extent permitted by law, including for those individuals not in current employment, and as legally permitted for individuals with end-stage renal disease or who are totally disabled.

Right to Recover Payment

For detailed information on HMSA’s third-party liability rules, please refer to HMSA’s Guide to Benefits.
Dental

U.S. Salaried & Full-Time Hourly Associates

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144 Orthodontia Benefits from Previous Plans Transfer to MetLife Plans
144 Maximum Lifetime Orthodontia Benefit When Treatment Begins Applies Throughout Orthodontia Treatment
144 Selecting a MetLife Dentist
144 Scheduling Appointments with Your PDP Dentist
144 Pretreatment Estimate of Benefits
145 The Alternate Benefit Provision Allows for Suitable Dental Treatment
145 Filing Claims for Out-of-Network Services
145 Limitations
145 Changing Your Dental Plan

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148 Preventive and Diagnostic
148 Basic Restorative
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152 Subrogation
152 COBRA (Continuing Coverage After Termination)
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>Go to <a href="http://www.resources.hewitt.com/homedepot">www.resources.hewitt.com/homedepot</a>, click the Health, Insurance tab, then Dental 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

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.
- **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 network dentist because PDP network negotiated fees typically range from 10% to 35% less than average fees for the same or similar services charged by dentists in your area.
- **Access to large network of providers**. The MetLife PDP network has nearly 110,000 dentists. To find a MetLife network dentist near you, go to www.metlife/dental.com. If your dentist is not part of the network, he or she can apply to become a MetLife PDP dentist by going to www.metdental.com, a Web site 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 or non-network dentist. However, when you use a MetLife PDP network dentist, you’ll pay the negotiated fee, which is typically 10% to 35% 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 plan 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 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 restorative dental services are subject to the deductible and coinsurance. This plan has an annual maximum benefit of $500 per covered individual.

The MetLife $1,000 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 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. This plan has an annual maximum benefit of $2,000 per covered individual and a separate lifetime orthodontia maximum benefit of $1,500.

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

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.

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

- associate only
- associate + spouse (or same-sex domestic partner)
- associate + child(ren)
- associate + family (children and spouse or same-sex domestic partner)
Special Rules for Orthodontia

Orthodontia Benefits from Previous Plans Transfer to MetLife Plans

Any orthodontia benefits you received in prior Home Depot dental plans will be transferred to the MetLife plan and subtracted from the lifetime maximum orthodontia benefit in the MetLife $1,000 Max or the MetLife $2,000 Max option, if you enroll in either of those options.

For example, if you were in the Traditional Plus dental plan and received an orthodontia benefit of $500, from that plan, that $500 benefit would be subtracted from the lifetime maximum orthodontia benefit in the MetLife plan. If you enroll in the MetLife $1,000 Max option, which has a $750 lifetime maximum orthodontia benefit, you would have a $250 orthodontia benefit ($750 - $500 already used benefit) available to you in the MetLife $1,000 Max option.

If you were in the Gold Plus dental plan and received an orthodontia benefit of $1,500 from that plan, you would not be eligible for an orthodontia benefit from either of the MetLife plans because the highest orthodontia lifetime maximum in the MetLife options is $1,500 in the $2,000 Max option.

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 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 plan 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 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 10-35% below the average fees charged in a dentist’s community for the same or substantially similar services.

There are nearly 110,000 participating MetLife PDP dentist locations nationwide, including 25,000 specialist locations. To get a list of these participating PDP dentists:

- Go to www.metlife/dental.com, 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 PDP and you’d like to encourage him or her to apply, tell your dentist to go to www.medental.com, or call 1-877-638-3379 for an application. The Web site and phone number are designed for use by dental professionals only.

Scheduling Appointments with Your PDP Dentist

To set up an appointment with your network 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 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 must file all claims within 12 months of the date services are provided. The 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 are not 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 Plan

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. For information on making coverage changes for your same-sex domestic partner, see the Benefits for Same-sex Domestic Partners chapter.
## 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></th>
<th>MetLife $500 Max</th>
<th>MetLife $1,000 Max</th>
<th>MetLife $2,000 Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$25/$75</td>
<td>$50/$150</td>
<td>$50/$150</td>
</tr>
<tr>
<td>(individual/family)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$500</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>(per covered individual)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive and</td>
<td>Covered at 100%</td>
<td>Covered at 100%*</td>
<td>Covered at 100%*</td>
</tr>
<tr>
<td>Diagnostic Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(deductible does not apply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Restorative Care</td>
<td>You pay 30%</td>
<td>You pay 25%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>(fillings, root canals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Restorative Care</td>
<td>No coverage</td>
<td>You pay 60%</td>
<td>You pay 50%</td>
</tr>
<tr>
<td>(bridges, dentures, crowns)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>No coverage</td>
<td>50% up to $750</td>
<td>50%* up to $1,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lifetime maximum</td>
<td>lifetime maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>per covered child</td>
<td>per covered child</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Plan pays this percentage of the reasonable and customary (R&C) charge if you use a non-MetLife dentist.
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 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 options. 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 plan and go to your dentist for a filling (a basic restorative service):
- the in-network PDP negotiated fee is $245
- the out-of-network R&C cost is $400
- the dentist’s usual fee is $475

Example B: You are enrolled in MetLife $2,000 maximum plan and go to your dentist for a crown (a major restorative service):
- the in-network 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>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>

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>$475.00</td>
</tr>
<tr>
<td>$1,000 MetLife Max dental option pays: 75% x $400 R&amp;C fee</td>
<td>$250.00</td>
</tr>
<tr>
<td>Your out-of-pocket cost</td>
<td>$225.00</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 such 12-month period
- gingivectomy, gingivoplasty and gingival curettage
- pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- 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
  —adjustments of dentures, if at least six months have passed since the installation of the denture
What’s Not Covered

The Dental Plan options 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
- 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
• pulp therapy and apexification/recalcification
• 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

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 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 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.
### Which Plan is the Primary Plan When Coordination of Benefits Applies?

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you (the [The Home Depot associate]) are the patient…</td>
<td>The [The Home Depot Dental Plan] is the primary plan.</td>
</tr>
<tr>
<td>When your spouse (or same sex partner) 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>
</tbody>
</table>
| If you are legally separated or divorced (or were never married)…         | 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:  
  - The plan of the parent with custody of the child.  
  - The plan of the spouse of the parent with custody of the child.  
  - The plan of the parent not having custody of the child.  
  - The plan of the spouse of the parent not having custody of the child. |
| If the above rules do not establish the order…                           | The plan covering the claimant for the longest period of time will be primary except:  
  - 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.  
  - 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. |
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 over-payment from any person, insurance company or other organization to whom the payment was made.

Subrogation
There is no subrogation provision within this 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, other organization to whom the payment was made.

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.
Vision

U.S. Salaried & Full-Time Hourly Associates

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156 Contact Lenses
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160 Vision Care Discount Program Through Aetna

LIVE the Orange LIFE!
## Get the Most Value from Your Plan

### Vision Plan Options

The EyeMed Vision Plan offers you two options:

- **EyeMed Select $120 option.**
- **EyeMed Select $150 option; and**

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.

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Find an EyeMed Select network provider</td>
<td>Go to <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>; or call EyeMed's Home Depot Member Services Department at 1-888-203-7447 from 8 a.m. to 11 p.m. Eastern time Monday through Saturday and 11 a.m. to 8 p.m. Eastern time on Sunday.</td>
</tr>
<tr>
<td>• Get a claim form for an out-of-network provider</td>
<td>Get an EyeMed Provider Nomination Form at <a href="http://www.livethehealthyorangefile.com">www.livethehealthyorangefile.com</a> and give it to your provider OR Call EyeMed’s Customer Care Center at 1-888-203-7447 to request that a form be sent to your vision care provider or give your vision care provider’s information to the Customer Care Representative during your call.</td>
</tr>
<tr>
<td>• Get a new EyeMed Select ID card</td>
<td></td>
</tr>
<tr>
<td>• Get information on eye health</td>
<td></td>
</tr>
<tr>
<td><strong>Nominate your vision care provider to the EyeMed vision network</strong></td>
<td></td>
</tr>
<tr>
<td><strong>File a claim for an out-of-network provider</strong></td>
<td>Mail, fax or e-mail your claim form and itemized receipts to: EyeMed Vision Care, Attn: OON Claims, P.O. Box 8504, Mason, Ohio 45040-7111 <a href="mailto:oonclaims@eyemedvisioncare.com">oonclaims@eyemedvisioncare.com</a> Fax: 1-866-293-7373</td>
</tr>
<tr>
<td><strong>Find out more about discounted laser vision correction surgery</strong></td>
<td>Go to <a href="http://www.eyemedlasik.com">www.eyemedlasik.com</a>; or call 1-877-552-7376 (1-877-5LASER6)</td>
</tr>
<tr>
<td><strong>Get information on the EyeMed discount program (available to all Home Depot associates who are not enrolled in an EyeMed vision option)</strong></td>
<td>Go to <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>; or call EyeMed’s Home Depot Member Services Department at 1-888-203-7447 from 8 a.m. to 11 p.m. Eastern time Monday through Saturday and 11 a.m. to 8 p.m. Eastern time on Sunday.</td>
</tr>
<tr>
<td><strong>Get information on the Aetna Vision Discount program (only for those enrolled in Aetna Medical Plan)</strong></td>
<td>Call Aetna at 1-800-793-8616 from 8 a.m. to 11 p.m. Eastern time Monday through Saturday or 11 a.m. to 8 p.m. Eastern time on Sunday. For information on discounts on LASIK, call 1-800-422-6600</td>
</tr>
</tbody>
</table>

- **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 over 33,000 providers including thousands of independent optometrists, ophthalmologists and opticians.
- **Large network of leading optical retailers.** LensCrafters, Pearle Vision, Sears Optical, Target Optical and JC Penny Optical 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 (or same-sex domestic partner)
- associate + child(ren)
- associate + family (children and spouse or same-sex domestic partner)

Using EyeMed Select Network Providers
To find an EyeMed Select network provider, go to www.eyemedvisioncare.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 also can go to www.eyemedvisioncare.com to request a new ID card.

When you receive services at an EyeMed Select location, 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 provider arranges eyewear fabrication and delivery.

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 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.eyemedvisioncare.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.

- 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 us for processing. Out-of-network reimbursements are sent directly to you. Payment will include an Explanation of Benefits (EOB).

What’s Covered Under the Vision Plan

Eyeglasses
The EyeMed Select $120 option provides benefits for frames once every 24 months and the EyeMed Select $150 option provides benefits for frames once every 12 months. If you use an EyeMed Select 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 calendar year 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 eyeglasses 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 if one of the following exists:

- To correct extreme vision problems (as determined by EyeMed) that cannot be corrected with spectacle lenses
- Certain conditions of keratoconus
- Certain conditions of anisometropia
- Certain conditions of high ametropia

EyeMed recommends that your provider verify that contact lenses are medically necessary before submitting the claim. If proper verification is not obtained, you will 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 providers only.

After initial purchase, replacement contact lenses may be obtained by going to www.eyemedcontact.com at substantial savings and mailed directly to the member. The contact lens benefit allowance is not applicable to this service.

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.

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.
### The EyeMed Select Vision Options

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<th>Item</th>
<th>EyeMed Select $120</th>
<th>EyeMed Select $150</th>
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<td><strong>EyeMed Select Providers:</strong></td>
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<td></td>
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<tr>
<td>You Pay</td>
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<td></td>
</tr>
<tr>
<td><strong>Non-EyeMed Select Providers:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Reimbursement After You Submit Claim</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Eyeglasses (frames and lenses)

- **Exam (once every 12 months)**
  - $0 copay
  - Up to $40
  - $0 copay
  - Up to $40

#### Standard Plastic Lenses

- **Standard plastic lenses**
  - **Single vision**
    - $15 copay
    - Up to $35
    - $0 copay
    - Up to $35
  - **Bifocal**
    - Up to $55
    - Up to $55
  - **Trifocal**
    - Up to $75
    - Up to $75
  - **Lenticular**
    - Up to $75
    - Up to $75
  - **Standard progressive (once every 12 months)**
    - $80
    - Up to $55
    - Up to $84
  - **Premium progressive (once every 12 months)**
    - fixed pricing list
    - Up to $55
    - Up to $140

#### Specialty Lens Options

- **UV Coating**
  - $0
  - Up to $11
  - $0 copay for all, covered in full
  - Up to $11
- **Tint (Solid and Gradient)**
  - $0
  - Up to $11
  - $0 copay for all, covered in full
  - Up to $11
- **Standard Scratch-Resistance**
  - $0
  - Up to $11
  - $0 copay for all, covered in full
  - Up to $11
- **Standard Polycarbonate**
  - $40 ($0 for dependents under age 19)
  - Up to $28
  - Up to $28
- **Standard Anti-Reflective Coating**
  - $45
  - N/A
  - Up to $32
- **Photochromatic**
  - 20% off
  - N/A
  - Up to $53
- **Transitions**
  - 20% off
  - N/A
  - Up to $53
- **Edge Coating**
  - 20% off
  - N/A
  - Up to $11
### 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></td>
<td>EyeMed Select Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<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, then you pay balance over the plan’s $40 allowance</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 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 $200</td>
<td>$0 copay</td>
<td>Up to $210</td>
</tr>
</tbody>
</table>
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 Worker’s Compensation law
- Lost or broken materials
- Corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under plan
- Plano non-prescription lenses and non-prescription sunglasses
- Two pair of glasses in lieu of bifocals
- Aniseikonic 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 available through vision care discount programs offered through your Medical Plan.

Filing Claims

When you receive services from an EyeMed Select 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 for reimbursement. Mail, fax or e-mail the completed form along with the itemized paid receipts for services and materials to:

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

If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review within 180 days of the date of a denial. The member’s written letter of appeal should include the following:

- The applicable claim number or a copy of the denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member’s eye care provider that will assist in completing its review of the member’s appeal, such as documents, records, questions or comments.

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

Your appeal for benefits will be reviewed and you will be notified in writing of the decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member Grievance Procedure

If you are dissatisfied with the services provided by an EyeMed 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 as defined within EyeMed Vision Care’s complaints and appeals process.
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.

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.

Subrogation
There is no subrogation provision within this 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 Visions 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 on the following page.

Member will receive a 20% discount on those items purchased at participating Providers that are not specifically covered by this Discount design. 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.

This Discount design is offered with the EyeMed Select panel of providers and is based on a 24-month contact term. Not valid for groups domiciled in the state of Washington.

Limitations and Exclusions for the EyeMed Vision Discount Program
• 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 Worker’s Compensation law
• Discount is not available on those frames where the manufacturer prohibits a discount

Vision Care Discount Program Through Aetna
In addition to the Vision Plan when you are enrolled under one of the Aetna medical plans, you are automatically entitled to participate in the Aetna Vision Discount program. Participating optical centers such as Sears, JCPenney, Pearle Vision stores and others, as well as selected doctor’s offices, provide discounts on products and services.

To receive the vision care discounts, simply show your Aetna ID card to participating providers. You can find a vision center or doctor’s office that participates in the Aetna Vision Discount program by calling Aetna at 1-800-793-8616 from 8 a.m. to 11 p.m. Eastern time Monday through Saturday or 11 a.m. to 8 p.m. Eastern time on Sunday.

The Aetna Vision Discount program offers discounts on LASIK. To find the closest surgeon for a LASIK procedure, call Aetna at 1-800-422-6600 from 8 a.m. to 9 p.m. Eastern time Monday through Friday or 9 a.m. to 6 p.m. Eastern time on Saturday.

If you are found to be a candidate for LASIK surgery and wish to have the procedure performed, schedule a surgery date with the provider. Then call the LASIK number above with date of your surgery and pay a deposit not to exceed $100 per eye. At that time, you will receive an authorization number in order to receive the appropriate discount. In addition, your surgeon will receive written confirmation verifying your discount and the amount of your deposit. Your discount and deposit will be deducted from the surgeon’s fee at the time of treatment. For more information, see the Aetna Vision Discount Program chart later in this 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.

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

| Standard Plastic Lenses:                      |                                                                             |
| Single Vision                                 | $50                                                                         |
| Bifocal                                       | $70                                                                         |
| Trifocal                                      | $105                                                                        |

| Frames:                                        |                                                                             |
| Any frame available at provider location      | 40% off retail price                                                        |

| Lens Options:                                  |                                                                             |
| UV Coating                                     | $15                                                                         |
| Tint (Solid and Gradient)                      | $15                                                                         |
| Standard Scratch-Resistance                    | $15                                                                         |
| Standard Polycarbonate                         | $40                                                                         |
| Standard Progressive (Add-on to Bifocal)       | $65                                                                         |
| Standard Anti-Reflective Coating               | $45                                                                         |
| Other Add-Ons and Services                     | 20% discount                                                                |

| Contact Lens Materials:                        |                                                                             |
| Disposable                                     | 0% off retail price                                                         |
| Conventional                                   | 15% off retail price                                                        |

| Laser Vision Correction**:                     |                                                                             |
| Lasik or PRK                                   | 15% off retail price - or - 5% off promotional price                        |

| Frequency:                                     |                                                                             |
| Examination                                    | Unlimited                                                                   |
| Frame                                         | Unlimited                                                                   |
| Lenses                                        | Unlimited                                                                   |
| Contact Lenses                                | Unlimited                                                                   |

* Items 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.

This is not Insurance
### Aetna Vision Discount Program

<table>
<thead>
<tr>
<th>Product or Service</th>
<th>Reduced Fee/Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyeglass Frames (retail prices)</strong></td>
<td></td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>40% off retail price</td>
</tr>
<tr>
<td><strong>Lenses per Pair (uncoated plastic)</strong></td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>$40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$60</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$80</td>
</tr>
<tr>
<td>Standard Progressive</td>
<td>$120</td>
</tr>
<tr>
<td><strong>Lens Options per Pair (add to lens price above)</strong></td>
<td></td>
</tr>
<tr>
<td>Standard polycarbonate (includes UV and scratch-resistant coating)</td>
<td>$40</td>
</tr>
<tr>
<td>Scratch-resistant coating</td>
<td>$15</td>
</tr>
<tr>
<td>Ultraviolet (UV) coating</td>
<td>$15</td>
</tr>
<tr>
<td>Solid or gradient tint</td>
<td>$15</td>
</tr>
<tr>
<td>Glass</td>
<td>20% discount</td>
</tr>
<tr>
<td>Photochromic for glass</td>
<td>20% discount</td>
</tr>
<tr>
<td>Standard antireflective coating</td>
<td>$45</td>
</tr>
<tr>
<td><em><em>Eye Exams for ALL Managed Medical Plans</em> That Do Not Cover Eye Exams</em>*</td>
<td></td>
</tr>
<tr>
<td>For eyeglasses</td>
<td>$42</td>
</tr>
<tr>
<td>For standard contact lenses</td>
<td>$82</td>
</tr>
<tr>
<td>For specialty contact lenses (i.e., Toric, Multifocal, Gas Permeable)</td>
<td>$10 off standard fee</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>15% discount on conventional lenses and 5% on disposable lenses</td>
</tr>
<tr>
<td><strong>Additional Vision-Related Items</strong></td>
<td></td>
</tr>
<tr>
<td>LASIK Procedure</td>
<td>20% discount off retail prices</td>
</tr>
<tr>
<td></td>
<td>15% off the surgeon's fee through the U.S. Laser Network</td>
</tr>
</tbody>
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**Note:** Health Net (for California residents) and HMOs throughout the country have vision care plans. Contact your Medical Plan for details about benefits.

1 Uses EyeMed Select Network.
# Spending Accounts

**U.S. Salaried & Full-Time Hourly Associates**

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<td>Decreasing Your Coverage Amount</td>
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<td>Stopping Your Contributions</td>
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</table>
Get the Most Value from Your Plan

How the Spending Accounts Work

Here’s a quick look at how the Company Spending Accounts work:

• You decide to participate when you first become eligible for benefits, at Annual Enrollment, or within 30 days of certain qualified status changes. See the Life Events chapter for more details.

However, if you are hired or have a qualified status change on or after October 1, 2009, you cannot begin participating in a spending account until you enroll in one or both of the accounts during Annual Enrollment. When you enroll during Annual Enrollment, your spending account participation begins on January 1, 2010.

• You put money into the account through regular payroll deductions. The account does not earn interest.
• You and your eligible dependents receive qualified services.
• You file for and then receive reimbursement for the qualified services from your Spending Account.
• You can use the accounts to be reimbursed for:
  —Dependent care services you received in 2009, for the dependent day care account. You have until April 30, 2010; to submit claims for qualified dependent care services received in 2009. You lose any money left in your account after April 30, 2010; and
  —Health care services received through March 15, 2010, for the health care account. You have until April 30, 2010, to submit claims for qualified health care services received through March 15, 2010. You lose any money left in your account after April 30, 2010. If you participated in this account for 2008, see How Claims for Grace Period Expenses are Reimbursed for 2008 Health Care Account Participants in this chapter.

The Company offers two Spending Accounts: one for health care and one for dependent day care. You may participate in one or both accounts, but you may not transfer money from one to the other.

What do you need? Find it here...

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get detailed guidelines on eligible health care expenses (IRS publication 502) or eligible dependent day care expenses (IRS publication 503)</td>
<td>Go to <a href="http://www.irs.gov">www.irs.gov</a>; or call 1-800-829-3676.</td>
</tr>
<tr>
<td>Estimate your eligible expenses</td>
<td>Use the online spending account calculator on Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>.</td>
</tr>
<tr>
<td>Get a spending account claim form</td>
<td>Go to SHPS at <a href="http://www.myshps.com">www.myshps.com</a>.</td>
</tr>
<tr>
<td>Submit a spending account claim form</td>
<td>Mail to SHPS at the address on the claim form; or fax to 1-866-643-2219. Include an Explanation of Benefits (EOB) or detailed receipt with your form and make a copy for your records.</td>
</tr>
<tr>
<td>Confirm receipt of your claim form</td>
<td>E-mail to your address. Provide SHPS with your e-mail address. To sign up for EFT reimbursement, get the EFT form at <a href="http://www.myshps.com">www.myshps.com</a> and complete it.</td>
</tr>
<tr>
<td>Receive your reimbursement</td>
<td>Via Electronic Fund Transfer (EFT) directly into your checking account; or have a check mailed to you.</td>
</tr>
</tbody>
</table>
Health Care Spending Account
This Spending Account is for qualified health care expenses for you and your eligible dependents not reimbursable by any other plan (such as a medical, dental or vision plan) covering you or your eligible dependents. You do not have to be enrolled in the Company's Medical Plan (or any other plan) to participate in the Health Care Spending Account.

Dependent Day Care Spending Account
This Spending Account is for qualified dependent care expenses for services that permit you and your spouse, if you are married, to work or look for work, or so your spouse can attend school full-time.

If your spouse does not work, is not disabled, or is not a full-time student, you cannot use the Dependent Day Care Spending Account.

Eligible Dependents
For the Health Spending Account, an eligible dependent is any person you claim as a dependent on your federal income tax form (contact your tax advisor about whether or not a dependent can be claimed as a dependent on your federal income tax). To be eligible, a dependent child must not provide more than half of his or her support, must have the same principal place of abode with you for more than half the year and not turn 19 (age 24, if a full-time student) by the end of the taxable year (children who are permanently and totally disabled are excluded from the age limit). Please note that there is another age limit that applies to the Dependent Day Care Spending Account (see below).

If either parent can claim a child as a dependent under the tax rules for divorced or separated parents, only one parent can use the spending account(s) based on these rules:

- The child is a dependent with respect to the parent with whom the child lived the longest during the taxable year; or
- If the time between the parents is equal, then the parent with the highest adjusted gross income treats the child as a dependent.

Same-sex domestic partners and dependents of the domestic partner are not eligible unless the associate claims the persons as dependents on his or her federal income tax return.

A dependent who does not qualify as a child may be eligible as a qualifying relative if he or she receives more than half of his or her support from you and lives in the same principal place of abode with you as a member of your household.

To be an eligible dependent for the Dependent Day Care Spending Account, a child must be under age 13. Other dependents must be physically or mentally unable to care for themselves.

Contact your tax advisor for advice regarding an individual's status as your dependent under the Internal Revenue Code.

How Spending Accounts Can Help You
Tax Advantages
A Spending Account offers you a way to pay for qualified out-of-pocket expenses with money you set aside before taxes are taken out of your paycheck. This reduces your taxable income. Without a Spending Account, you would still pay for these expenses, but you would use money remaining in your paycheck after federal taxes are withheld. Here's an example (based on 2008 tax tables):

<table>
<thead>
<tr>
<th></th>
<th>With Account</th>
<th>Without Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>$28,000</td>
<td>$28,000</td>
</tr>
<tr>
<td>Spending Account deposits</td>
<td>$1,500</td>
<td>$0</td>
</tr>
<tr>
<td>Your taxable income</td>
<td>$26,500</td>
<td>$28,000</td>
</tr>
<tr>
<td>Taxes</td>
<td>–$3,583</td>
<td>–$3,808</td>
</tr>
<tr>
<td>You pay out-of-pocket expenses</td>
<td>$0</td>
<td>$1,500</td>
</tr>
<tr>
<td>Pay, minus taxes and out-of-pocket expenses</td>
<td>$22,917</td>
<td>$22,692</td>
</tr>
<tr>
<td>Your tax savings</td>
<td>$225</td>
<td>$0</td>
</tr>
</tbody>
</table>
This example shows a typical tax savings. The example is based on filing a single return with zero exemptions. Actual savings differ for each associate depending on family income, the annual amount you choose for your Spending Account, and state and local tax rates. Please consult a tax professional for more details.

Health Care Spending Account
Most families can realize tax savings from the Health Care Spending Account. This is because only health care expenses exceeding 7.5% of your adjusted gross income can be deducted on your tax return. Using the previous example, only health care expenses exceeding $2,100 (7.5% of $28,000) would be deductible.

Dependent Day Care Spending Account
You may use the Dependent Day Care Spending Account to pay your childcare expenses on a pre-tax basis, or you may pay those expenses with after-tax dollars and receive a tax credit on your income tax return. Which option will save you the most money will depend on a number of factors, including:

- Your total income (the tax credit goes down as your income goes up)
- Your number of dependents
- The amount of dependent care expenses you incur in a year

In certain circumstances, you may be able to maximize your savings by using both the Dependent Day Care Spending Account and taking the tax credit.

Because the tax laws that determine which option is best for you are very complicated, you may want to consult a tax advisor or review the appropriate IRS tax forms and guidance before making a decision.

Other Tax Considerations
- Expenses reimbursed from your Spending Accounts cannot be claimed as deductions on your federal income tax return.
- You do not pay FICA tax on amounts you put into the Spending Accounts. This means that your Social Security benefits may be less than if you do not enroll in Spending Accounts. For most people, the difference is small.

Tax Credits Can be Contributed to a Spending Account
If you work full- or part-time and qualify for the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC), you could get back some or all of the income taxes you paid during the year. Part of the credit could come in a check from the IRS after you file your federal taxes, and part of it could be in your paychecks throughout the year.

An amount equal to any credits you receive in your paycheck throughout the year can be contributed to a Spending Account through convenient payroll deductions. This would enable you to keep the same amount in your paycheck each pay period while contributing money to a Spending Account. The Spending Account money can be used to help you offset your health care or dependent day care expenses.

If you worked at any time in 2008, you may qualify for a tax credit—depending on your income. The EITC could be:

- Up to $4,824 if you were raising two or more children in 2008 and your family earned less than $38,646 ($41,646 married).
- Up to $2,917 if you were raising one child in 2008 and your family earned less than $33,995 ($36,995 married).
- Up to $438 if you do not have children, are between the ages of 25 and 64, and earned less than $12,880 ($15,880 married) in 2008.

To qualify for the credit, a child must be your:

- Child;
- Stepchild;
- Grandchild;
- Adopted child;
- Foster child, or
- Relative that you raise as your own child.

Children must also be 18 or younger, or up to 23 if they are a full-time student, and must live with you for at least half the year. If you think you’re eligible, complete the 2008 W-5 form Earned Income Credit Advance Payment Certificate, and fax it to the HR Service Center at 1-770-384-5609 or mail it to:

HR Service Center
CSSC.1 – Mail Room
2455 Paces Ferry Road
Atlanta, Georgia 30339
Many working families can also receive the Child Tax Credit (CTC). This credit can be worth up to $1,000 for each child. To be eligible you must:

• have earned between $12,050 and $75,000 ($110,000 if you are married) in 2008;
• be able to claim a child 16 years of age and younger as a dependent on your taxes; and
• have a Social Security number or Individual Taxpayer Identification Number.

Don’t worry if you have already filed your taxes for this year; if you think you may have been eligible for the EITC or the CTC and did not claim it, you can amend your taxes. The government allows you to amend your tax returns for the previous three years.

If you didn’t file your taxes in the past because you didn’t owe taxes, you can still claim the EITC and CTC for the previous three years. Ask your tax preparer for details on how to amend your taxes or contact the IRS at 1-800-TAX-1040 or www.irs.gov.

Regarding the Tax-Savings Approaches
It’s important to note that any tax savings that may result from your participation in the Spending Accounts depend on your own personal situation and income level. Tax information included in this book is only general information.

Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax advisor if you have questions about whether to use the Spending Accounts or to take a tax deduction.

By law, the Company can’t offer you tax advice, or advise you on your Spending Account-related decisions. This law is designed to protect you by ensuring that you always get the most up-to-date advice, and that advice is only available from a qualified tax advisor.

**Built-in Budgeting**
With a Spending Account, you plan ahead and budget for qualified expenses. Careful planning is necessary to avoid cash-flow problems since you may have to pay for the expenses out-of-pocket and then file claims for reimbursement. See the Filing for Reimbursement section for more information.

You also have to be careful not to put too much into your Spending Account. If you contribute more to the account than the cost of eligible services you receive, you lose the amount that’s left over as of:

• December 31, 2009, for the Dependent Day Care Spending Account; and
• March 15, 2010, for the Health Care Spending Account.

You must submit claims for reimbursement for both accounts by April 30, 2010.

**Eligible Expenses for Spending Accounts**
The Internal Revenue Service (IRS) guidelines help determine which health care and dependent day care expenses may qualify for reimbursement under this plan.

For detailed guidelines on eligible health care expenses see IRS publication 502. To order the publication, contact the Internal Revenue Service by phone at 1-800-829-3676 or via the Internet at www.irs.gov and request a copy of Publication 502, Medical and Dental Expenses.

Keep in mind, however, that while the cost of long-term care insurance is listed as an eligible expense in IRS publication 502, it is not an eligible health care expense under the Health Care Spending Account. Insurance premiums for long-term care insurance are listed in Ineligible Health Care Expenses in this chapter.

**Health Care Spending Account**
Eligible expenses are those permitted by Section 213 and Section 125 of the Internal Revenue Code, and that are otherwise permissible under IRS regulations. Eligible expenses include, but are not limited to, the following:

• Acupuncture
• Ambulance service
• Braille books and magazines, limited to the difference between the cost of the Braille items and the cost for regular items
• Special car controls for people with disabilities
• Chiropractic, medical or podiatric expenses in excess of medical plan limits
• Cost for services by Christian Science practitioners
• Contact lenses and supplies such as saline and cleaning solutions
• Crutches
• Medical plan deductibles and coinsurance amounts
• Dental examinations, if not reimbursed under a dental plan
• Treatment for drug abuse or alcoholism, including meals and lodging if they are necessary for the treatment
• Prescription eyeglasses, including lenses, frames and exams
• Eye surgery
• Purchase of a guide dog for a blind or deaf person
• Cost for keeping a mentally retarded person in a halfway house or special home (not the home of a relative), when recommended by a psychiatrist to help the person adjust from life in a psychiatric hospital to community living
• Hearing expenses, including examinations, hearing aids and batteries required to operate a hearing aid
• Hospitalization charges in excess of the reasonable and customary fees, including private room coverage
• Laboratory fees
• Costs for medical services provided by physicians, surgeons, specialists or other medical practitioners (as long as the service is not for cosmetic reasons)
• Medicine or other prescription drugs, including birth-control pills, and certain over-the-counter drugs used primarily for medical care—see Eligible Over-the-Counter Drugs for more information.
• Expenses for medical care in a nursing home
• Nursing services when provided by a registered nurse or licensed practical nurse for medical care
• Services provided by an optometrist
• Orthodontia (braces)
• Orthopedic shoes, orthotics and braces
• Oxygen or oxygen equipment to relieve breathing problems caused by a medical condition
• Medically necessary psychiatrist and psychologist fees
• Smoking cessation programs
• Purchase or rental of special medical equipment such as wheelchairs, crutches and orthopedic shoes, if the primary purpose is medical care
• Tuition fees for a special school for a child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, when recommended by a doctor.
• Tutoring fees for a teacher specially trained and qualified to work with children with severe learning disabilities are also eligible when recommended by a doctor.
• Medical expenses paid to a special school if the main reason for using the school is relieving the medical or physical disability
• Sterilization fees
• Surgery, including experimental procedures
• Special telephone for the deaf
• Audio-display television for the deaf
• Medical expenses for therapy received as medical treatment, such as speech, occupational, physical or cardiac therapy
• Vaccinations
• Weight-loss programs prescribed by a physician to treat an existing illness, such as heart disease or diabetes
• Health club dues, if accompanied by a doctor’s diagnosis such as obesity

Eligible Over-the-Counter Drugs
The Internal Revenue Code considers many types of medications purchased without a prescription (non-prescription or over-the-counter drugs) to be eligible expenses under the Health Care Spending Account, including antacids, allergy medicines, pain relievers and cold medications.

Some types of medications are not eligible for reimbursements through the account; for example, vitamins, dietary supplements, preventative drugs, herbal supplements and personal hygiene items.

However, nutritional supplements, vitamins, herbal supplements and other natural medications are considered eligible expenses if a physician provides a letter of medical necessity verifying the items were purchased to treat a specific disease or medical condition. For example, a patient diagnosed with a type of gastrointestinal disorder may be advised by a physician to take Vitamin B12 supplements. In this case, the Health Care Spending Account claim for the cost of the B12 would be reimbursable as long as the physician provides proper documentation.
Ineligible Health Care Expenses
In general, health care expenses that do not qualify as medical deductions for federal income tax purposes are not eligible for reimbursement through a Health Care Spending Account. Examples of ineligible expenses include, but are not limited to, the following:

- Automobile insurance premiums, including any portion of the premium providing medical coverage for persons injured through an accident in or with the covered individual’s vehicle
- Bottled water
- Insurance premiums for continued coverage through COBRA and for long-term care insurance (while the cost of long-term care insurance is listed as an eligible expense in IRS publication 502, it is not an eligible health care expense under the Health Care Spending Account)
- Cosmetics, such as toiletries and toothpaste
- Cosmetic surgery, except to correct congenital abnormality, bodily injury or disfiguring disease
- Any expense covered by a health plan
- Custodial care in an institution
- Dancing or swimming lessons, even when recommended by a qualified physician for health improvement
- Expenses that you filed on a federal tax return for a tax credit or for which a deduction is taken
- Funeral and burial expenses
- Expenditures for the general health of an individual, including expenses related to exercise, fitness, nutrition, recreation, vacation, or membership in a spa or health club
- Hair removal (electrolysis)
- Hair transplants
- Health club dues, YMCA dues, steam bath, etc., if not accompanied by a doctor’s diagnosis
- Household and domestic help, even if recommended by a qualified physician due to an individual’s inability to perform physical housework
- Any expenses incurred in connection with an illegal operation or treatment
- Life insurance premiums or premiums for policies taken to provide repayment for loss of earnings or accidental loss of life, limb, sight, etc.
- Maternity clothes, diaper service, etc.
- Medical insurance premiums, including premiums for employer-provided medical and dental coverage and for contact lens insurance
- Charges by a nurse (RN or LPN) who cares for your normal, healthy newborn child
- Costs for sending a child with behavioral or disciplinary problems to a special school for benefits the child may receive from the course of study and disciplinary methods
- Transportation expenses to and from work, even if a physical condition requires a special means of transportation
- Vacation or travel, when taken for general health purposes, improvement of morale or to relieve physical or mental discomfort
- Vitamins, when taken for general health purposes
- Weight loss programs, unless prescribed by a doctor to treat an existing disease such as heart disease or diabetes
- Charges for medical care included in the tuition fee of a college or university

Dependent Day Care Spending Account
You must provide a completed statement from the care provider. The statement includes the care provider’s name, address, taxpayer identification number or Social Security number. The care provider’s statement must also include the amount of the expense you incurred. A care provider must be over 18 years of age and cannot be someone you claim as a dependent on your federal tax return.

Services provided while you are on leave of absence, even if otherwise eligible, do not qualify for reimbursement from your Dependent Day Care Spending Account.

Expenses that are eligible for reimbursement include, but are not limited to, the following:

- Expenses for an after-school program
- Amounts paid to a dependent care center, baby-sitter, nanny or nurse who cares for fewer than six individuals
- Expenses for a licensed day care center that cares for six or more unrelated individuals
Ineligible Dependent Care Expenses

Examples of ineligible expenses include, but are not limited to, the following:

- Amounts paid to a dependent you claim as an exemption on your federal income tax return
- Services for children or stepchildren provided after the child reaches age 13
- Services provided for your child if you do not have legal custody of your child
- Services provided for children or other disabled relatives who do not live with you
- Overnight camp
- Amounts for kindergarten or above
- Services provided while you are on leave of absence, even if otherwise eligible, do not qualify for reimbursement from your Dependent Day Care Spending Account.

How You Contribute to Your Spending Accounts

You decide the annual amount you want to contribute to one or both Spending Accounts. There are minimum and maximum amounts you can contribute for each Spending Account. Between the maximum and minimum, you can select any whole dollar amount.

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<tr>
<th>Spending Account Type</th>
<th>Minimum Annual Contribution</th>
<th>Maximum Annual Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care</td>
<td>$260</td>
<td>$5,000</td>
</tr>
<tr>
<td>Dependent Day Care</td>
<td>$260</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

Limitations on Your Contributions

- If you and your spouse both participate in a Dependent Day Care Spending Account and you file a joint tax return, your contributions to the accounts cannot exceed a combined maximum of $5,000 per year. This limit applies whether you have one or more dependents receiving care. If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500.
- The amount you can set aside in your Dependent Day Care Spending Account is further limited to your earned income or, if less, your spouse’s earned income.
- If your spouse is a full-time student or is disabled, the IRS treats your spouse as earning $250 monthly if you have one dependent or $500 monthly if you have two or more dependents.

Payroll Deductions

You make contributions to a Spending Account through payroll deductions. The amount of your deduction is your annual contribution divided by the number of pay periods remaining in the year.

There are 26 pay periods per year if you are paid biweekly; 52 pay periods if you are paid weekly.
Example: If you elect $260 at Annual Enrollment for your Health Care Spending Account, your biweekly payroll deduction will be $10; if you elect $2,500, your biweekly payroll deduction will be $96.15.

If you become eligible for the plan or experience a qualified status change after two pay periods have already passed and you elect $260, your biweekly payroll deduction will be $10.83; if you elect $2,500, your biweekly payroll deduction will be $104.17.

If you increase your Spending Account election during the year because of a qualified status change, the amount of the increase will be spread over the remaining pay periods in the year.

Example: If you elect $300 at Annual Enrollment for your Health Care Spending Account and then, because of a qualified status change, change your election to $600 halfway through the year (after you have paid $150 into the account), your biweekly payroll deduction for the second half of the year would be $34.62.

If you decrease your Spending Account election during the year because of a qualified status change, your remaining balance to be paid into the account will be divided over the remaining pay periods in the year. You cannot decrease your Spending Account election below the amount you have already paid into the account.

Example: If you elect $600 at Annual Enrollment and then, because of a qualified status change, change your election to $300 halfway through the year (after paying in $300), you will not have any biweekly payroll deductions for the second half of the year.

Please note that in this example you could decrease your election only to $300, because this is what you have already paid into the account. You may refer to your pay stub to see the amount you have paid into the account.

The annual amount you elect will be deducted as long as you are actively employed. See the Stopping Your Contributions section for detailed information.

• Spending Accounts have a “use it or lose it” rule. You can use the accounts to be reimbursed for:
  —Dependent care services you received in 2009, for the dependent day care account. You have until April 30, 2010, to submit claims for qualified dependent care services received in 2009. You lose any money left in your account after April 30, 2010; and
  —Health care services received through March 15, 2010, for the health care account. You have until April 30, 2010, to submit claims for qualified health care services received through March 15, 2010. You lose any money left in your account after April 30, 2010.

• During a calendar year, you can increase, start, decrease or stop contributions to your Spending Accounts only when you experience certain qualified status changes. See Stopping Your Contributions in this chapter. For additional information, see the Life Events chapter.

If Your Employment Ends

If your employment with the Company ends:

• You can’t contribute to the Dependent Day Care Spending Account. However, you can submit claims until April 30 of the following year for eligible expenses you incurred up to midnight on the last day of the pay period in which your employment with the Company ends or you no longer meet the eligibility requirements for participation in the plan.

• You can continue making contributions to your Health Care Spending Account through the end of the plan year in which you terminated by electing COBRA coverage. However, you will be making after-tax contributions, therefore no longer receiving the tax benefit of pre-tax deductions that you had during your employment.

If you don’t continue making contributions through COBRA, you can submit claims until April 30 of the following year for eligible expenses you incurred up to midnight on the last day of the pay period in which your employment with the Company ends or you no longer meet the eligibility requirements for participation in the plan.
Filing for Reimbursement

When you receive an eligible service, you complete and sign a simple claim form, attach an Explanation of Benefits (EOB) statement or detailed receipt as proof of services received, and submit your claim to SHPS, the Spending Accounts Administrator. You may submit claims at any time during the calendar year and up until April 30 of the following year. You may obtain a claim form from the SHPS Web site at www.myshps.com.

You may fax your claim to 1-866-643-2219 for reimbursement.

You will receive an e-mail confirmation that your claim was received if you provide your e-mail address to SHPS when you fax the claim.

You may submit claims for any amount. You will receive reimbursement as soon as your claims equal $25 or more.

With the Health Care Spending Account, you have access to the total amount you elected for the calendar year as soon as eligible services are received.

With the Dependent Day Care Spending Account, you can be reimbursed only up to the amount available in your account. Claims for expenses exceeding that amount will be reimbursed as additional funds accumulate in your account.

SHPS reimburses your eligible expenses from your Spending Account via Electronic Funds Transfer (EFT) or check payment. Usually you will receive your reimbursement within 10 business days of the date SHPS received your claim along with complete documentation of the eligible expense.

You may sign up for EFT reimbursement at any time by completing the EFT form, which is available in Adobe Acrobat Reader (pdf) format on the SHPS Web site at www.myshps.com.

To obtain an EFT form:
- click on Participant
- enter last name, participant ID and password
- click on Login
- click on Get Documents
- scroll down to EFT Form
- click on EFT Form and Print

If you are receiving reimbursement via EFT, you will only receive an Explanation of Benefits (EOB) statement in the mail when your claim is not paid in full. If you provide your e-mail address on the EFT form, SHPS will e-mail your EOB when the deposit into your account is made, or you may log on to the SHPS Web site to check your account activity. If you receive a reimbursement check in the mail, an EOB statement will be attached.

Additional Health Care Spending Account Reimbursement Information

Automatic Reimbursement for Prescription Drug Expenses

If you are enrolled in an Aetna medical plan and participate in the Health Care Spending Account, you will automatically be reimbursed through the account for your out-of-pocket eligible prescription drug expenses. You will not have to file a claim form. Caremark, the prescription drug plan administrator for the Aetna medical plans, will file the claim for your eligible expenses with SHPS. SHPS will automatically reimburse you as long as money is available in your account and your reimbursement totals at least $25. If you do not want this automatic reimbursement, call SHPS at 1-888-547-3539.

How Claims for Grace Period Expenses Are Reimbursed for 2008 Health Care Account Participants

This is how claims for expenses you have incurred during the grace period (January 1, 2009, through March 15, 2009) are reimbursed:

- If you are participating in the health care spending account in 2009, claims you file for expenses you have incurred during the grace period will be reimbursed through your 2009 account.
- If you are not participating in the account in 2009, claims you file for expenses you have incurred during the grace period will be reimbursed through your 2008 account.
• If you have exhausted the total amount you elected for your 2009 account, claims you file for expenses you have incurred during the grace period will be reimbursed through your 2008 account. After April 30, 2009 (the last day to file claims for 2008 and grace period expenses), SHPS will “true up” your accounts through this process:
  • Review your 2009 account to determine eligible claims you had during the grace period (January 1, 2009-March 15, 2009).
  • Review your 2008 account to determine whether or not you have a remaining balance.
  • If you have a remaining balance in your 2008 account, any claims amounts you filed for grace period expenses will be debited against your remaining 2008 balance. Claim amounts that are debited from your 2008 account will be credited to your 2009 account.

Changing Your Coverage Amount

The IRS determines when you can change the amount you’re contributing to the Spending Accounts once you have started participation. You may increase, start, stop or decrease your contributions to the Spending Accounts only at Annual Enrollment or when you have certain qualified status changes. The rules vary according to the type of Spending Account.

For a detailed listing of qualified status changes recognized by the plan and an explanation of how they may affect your Spending Accounts, see the Life Events chapter.

Increasing Your Coverage Amount

If you increase the amount of your Spending Account election due to a qualified status change, your new coverage amount is effective on the date of the status change. This means that you can submit claims only for the additional amount of your election if they were incurred after the status change.

If you want to increase your contributions to one or both Spending Accounts due to a qualified status change, contact the Benefits Choice Center at 1-800-555-4954 within 30 days of the qualifying event. The change you request will become effective as soon as administratively possible.

Example: If you elect $300 at Annual Enrollment, for your Health Care Spending Account, and then change your election to $600 effective on July 1, you can submit claims up to $300 for expenses you incurred between January 1 and December 31 (March 15 with the grace period), and $300 for expenses you incurred between July 1 and March 15 of the following year.

Decreasing Your Coverage Amount

If you decrease the amount of your spending account election due to a qualified status change, your new coverage amount is also effective on the date of your status change. Your new coverage amount must be equal to or more than the amount you have contributed through payroll deductions.

If you want to decrease your contributions to one or both spending accounts due to a qualified status change, contact the Benefits Choice Center at 1-800-555-4954 within 30 days of the qualifying event. The change you request will become effective as soon as administratively possible.

Stopping Your Contributions

You may stop your contributions to the spending accounts only when you have certain qualified status changes. The rules vary according to the type of spending account. For a detailed listing of qualified status changes and an explanation of how they may affect your spending accounts, see the Life Events chapter.

If you want to stop your contributions to one or both spending accounts due to a qualified status change, contact the Benefits Choice Center at 1-800-555-4954 within 30 days of the qualifying event. The change you request will become effective as soon as administratively possible.
## Life Insurance

**U.S. Salaried & Full-Time Hourly Associates**

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# Get the Most Value from Your Plan

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<tr>
<td>Enroll in coverage</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call the Benefits Choice Center at 1-800-555-4954.</td>
</tr>
<tr>
<td>Change your coverage amounts</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call the Benefits Choice Center at 1-800-555-4954.</td>
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<tr>
<td>Get a Domestic Partner Declaration</td>
<td>Call MetLife at 1-800-638-9909.</td>
</tr>
<tr>
<td>Designate your beneficiaries</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a> or call the Benefits Choice Center at 1-800-555-4954.</td>
</tr>
<tr>
<td>Get additional information on continuing life insurance coverage after employment at the Company ends</td>
<td>Call the Benefits Choice Center at 1-800-555-4954. You'll need to complete either a Portable Term Election form or a Conversion Application from The Benefits Choice Center within 30 days of the date you lose coverage if you wish to continue your life coverage.</td>
</tr>
</tbody>
</table>

## Home Depot-Provided Basic Term Life Insurance

The Company provides, at no cost to you, the Basic Term Life Insurance Plan if you are enrolled in a Home Depot medical plan.

If you become totally disabled while covered by Basic Term Life Insurance, a continued insurance benefit may be available (see Continued Insurance When You Are Totally Disabled later in this chapter).

## Basic Term Life Insurance for Full-Time Hourly Associates

The Basic Term Life Insurance Plan covers you for $20,000 until age 70, provided you are enrolled in a Home Depot medical plan. After age 70, your Basic Term Life Insurance benefit will be reduced. See Benefit Reductions for You and Your Family later in this chapter for more information.

## Basic Term Life Insurance for Salaried Associates

The Basic Term Life Insurance Plan covers you for $50,000 until age 70, provided you are enrolled in a Home Depot medical plan. After age 70, your Basic Term Life Insurance benefit will be reduced. See Benefit Reductions for You and Your Family later in this chapter for more information.

## Basic Life Coverage for Your Family

The Company provides, at no cost to you, the Basic Dependent Term Life Insurance Plan for full-time hourly and salaried associates, which covers each member of your family (including your same-sex domestic partner) enrolled in a Company Medical Plan with $2,000 of life insurance, payable only from a live birth.

If both you and your spouse or same-sex domestic partner work for the Company, see If You and Your Spouse or Same-Sex Domestic Partner Both Work for the Company in the Eligibility and Enrollment chapter.
Basic Life Insurance Living Benefit
In the event your life expectancy is less than 180 days, as certified by your doctor and accepted by Metropolitan Life Insurance Company (hereafter MetLife), you may be eligible for a living benefit to help with expenses incurred prior to death. You must be younger than 63 years old and be covered under the Basic Term Life Insurance Plan.

You may be eligible for a living benefit of:
- $10,000, if you are a full-time hourly associate; or
- $10,000 to $25,000, if you are a salaried associate.

If approved, the living benefit is paid to you in a lump sum. The plan will then reduce your Basic Term Life Insurance by the amount paid as a living benefit. If you recover after receiving a living benefit payment, the plan will not restore your life insurance amount to its original amount.

After a claim has been made for a living benefit, you will not be allowed to increase your Basic Term Life.

Filing a Living Benefit Claim
To make a claim for a living benefit, you must complete a form available from the Benefits Choice Center and return the form with the following information to MetLife:
- written medical diagnosis of your attending doctor and prognosis that your death is expected within 180 days due to injury or sickness; and
- your doctor’s reasons for the prognosis along with clinical, radiological, histological and laboratory evidence.

MetLife may also require you to supply a second doctor’s opinion at your expense. Your doctor may not be yourself or a member of your family. If necessary, MetLife may also request a third medical opinion from an appointed doctor. This opinion is covered at the insurance company’s expense.

MetLife reserves the right to make the final decision on payment of a living benefit. The living benefit is not available if benefits are assigned, or MetLife has been notified that all or a portion of your benefits are to be paid to another party as a result of a divorce agreement.

Voluntary Term Life Insurance
Depending on your family’s financial situation, you may decide to purchase additional protection for yourself under the Voluntary Term Life Insurance Plan and/or for your eligible family members under the Voluntary Dependent Term Life Insurance Plan. You can purchase Voluntary Dependent Term Life Insurance even if you do not purchase Voluntary Term Life Insurance for yourself.

In determining the amount of Voluntary Term Life Insurance to buy, keep in mind that Accidental Death and Dismemberment (AD&D) Insurance provides benefits only for deaths resulting from accidents, not deaths due to natural causes.

When Voluntary Life Coverage Begins
You must be actively at work for Voluntary Term Life and Dependent Term Life Insurance coverage to take effect. Actively at work means that you are performing all of the material duties of your job with the Company where these duties are normally carried out. If you were actively at work on your last scheduled working day, you will be deemed actively at work on a scheduled non-working day provided you are not disabled.
Voluntary Life Insurance Coverage for Salaried Associates
You can buy coverage equal to one to 10 times your annual base pay (rounded to the next higher multiple of $1,000, if not already a multiple of $1,000), up to a maximum of $1,000,000. Annual base pay includes your regular pay and any portion of regular pay that you defer. It does not include bonuses, premiums, incentive pay or other similar forms of Home Depot pay.

For example, if your base pay is $38,000, you can buy:
- $38,000 (1x your annual base pay);
- $76,000 (2x your annual base pay);
- $114,000 (3x your annual base pay);
continuing up to $380,000, which is 10 times your base pay. You may be required to provide a Statement of Health and be approved for coverage.

Voluntary Life Insurance Coverage for Full-Time Hourly Associates
You can buy coverage equal to one to 10 times your annual base pay (rounded to the next higher multiple of $1,000, if not already a multiple of $1,000), up to a maximum of $500,000. Annual base pay means your hourly base pay rate multiplied by 2,080 (40 hours per week times 52 weeks). Base pay does not include overtime, bonuses, premiums, incentive pay or other forms of Company pay.

For example, if your base pay is $16,650, you can buy:
- $17,000 (1x your annual base pay)
- $34,000 (2x your annual base pay)
- $51,000 (3x your annual base pay)
continuing up to $170,000, which is 10 times your annual base pay. You may be required to provide a Statement of Health and be approved for coverage.

Providing a Statement of Health For Yourself
If you are newly-eligible for benefits and electing coverage during your eligibility period:
- you may elect one, two or three times pay without evidence of good health; or
- you may increase your election by one times pay during any subsequent rolling 12-month period without evidence of good health; not to exceed three times pay; and
- you elect an amount less than $500,000.

You will be required to provide evidence of good health if:
- you elect more than three times pay at any time;
- you request an increase of more than one times pay during any subsequent 12-month period;
- you are not a new hire and you are not currently enrolled but wish to enroll for any amount;
- you do not elect Voluntary coverage during your initial eligibility period and you wish to enroll at a later date for any amount; or
- you elect an amount greater than $500,000.

To approve your request for coverage, MetLife may require a doctor’s statement and/or a physical exam. You will be responsible for any related costs. You are not eligible for the requested level of benefits until MetLife has approved your Statement of Health. You must be actively at work for any life insurance coverage to become effective, including increases in coverage you may elect during any rolling 12-month period.

Voluntary Dependent Life for Your Spouse or Domestic Partner
You may purchase coverage for your spouse (or same- or opposite-sex domestic partner) equal to $20,000 or one to 10 times your annual base pay (rounded to the next higher multiple of $1,000, if not already a multiple of $1,000), up to a maximum of $250,000. The minimum amount of insurance you can purchase for your spouse (or same- or opposite-sex domestic partner) is $20,000. If you earn less than $20,000, you can choose the minimum coverage amount of $20,000. You may be required to provide a Statement of Health and be approved for coverage.
For example, if your base pay is $38,000, you can buy:

- $38,000 (1x your annual base pay)
- $76,000 (2x your annual base pay)
- $114,000 (3x your annual base pay)
- $152,000 (4x your annual base pay)
- $190,000 (5x your annual base pay)
- $228,000 (6x your annual base pay)

You could not purchase more than six times your annual base pay because that would exceed the $250,000 maximum coverage amount.

The coverage amounts above may be adjusted by the Plan Administrator at its discretion to comply with state insurance laws.

If your base pay is $16,650, you can buy:

- $17,000 (1x your annual base pay)
- $34,000 (2x your annual base pay)
- $51,000 (3x your annual base pay)
continuing up to $170,000, which is 10 times your annual base pay.

**If You Enroll Your Domestic Partner**

For information on eligibility requirements for same- or opposite-sex domestic partners, see Voluntary Dependent Term Life Insurance (Spouse and Child) and Family Protection Plus AD&D Plans—Dependents Who Can Participate in the Eligibility and Enrollment chapter.

If you enroll your same- or opposite-sex domestic partner, you will be required to complete a Domestic Partner Declaration attesting to your domestic partnership before you receive Voluntary Dependent Term Spouse Life Insurance coverage. See the Benefits for Same-sex Domestic Partners chapter for more information.

**Provisioning a Statement of Health for Your Spouse or Domestic Partner**

If you choose to cover your spouse (or same- or opposite-sex domestic partner) for any amount above $20,000, you will need to complete a Statement of Health.

To approve your request for coverage, MetLife may require a doctor’s statement and/or a physical exam. You will be responsible for any related costs. Your spouse’s or same- or opposite-sex domestic partner’s coverage will not become effective until MetLife has approved his or her statement of health.

**Dependent Voluntary Life Insurance for Children**

You can choose from these coverage levels for each of your dependent children: $2,500, $5,000, $10,000, $15,000 or $25,000.

The coverage amounts above may be adjusted by the Plan Administrator at its discretion to comply with state insurance laws.

**Voluntary Dependent Life Benefits Payment**

Benefits will be paid to you or your estate if you and your dependent die at the same time or your dependent dies within 24 hours of your death. If there is no designated beneficiary at your death, MetLife will pay the benefit to the first of the following survivors: spouse or same- or opposite-sex domestic partner, child (including eligible children of your same- or opposite-sex domestic partner), parent or brother and/or sister. If there is no surviving relative, the amount will be paid to your estate.

**Voluntary Dependent Life Living Benefit**

In the event your dependent’s life expectancy is less than 180 days as certified by your doctor and accepted by MetLife, he or she may be eligible for a living benefit to help with expenses incurred prior to death. Your dependents must be younger than 63 years old and covered under the Voluntary Term Life Insurance Plan. The living benefit amount may be up to 50% of the elected voluntary term life benefit amount, but no more than $250,000.

If approved, the living benefit is paid to your dependents in a lump sum. The plan will then reduce the Voluntary Term Life Insurance amount by the amount paid as a living benefit. If your dependent recovers after receiving a living benefit payment, the plan will not restore your dependents’ life insurance amount to its original amount. After a claim has been made for a living benefit, your dependent will not be allowed to increase your Voluntary Term Life coverage.
**Filing a Living Benefit Claim**

To make a claim for a living benefit, you must complete a form available from the Benefits Choice Center and you must return the form with the following information to MetLife:

- written medical diagnosis of your attending doctor and prognosis that your death is expected within 180 days due to injury or sickness; and
- your doctor’s reasons for the prognosis along with clinical, radiological, histological and laboratory evidence.

MetLife may also require you to supply a second doctor’s opinion at your expense. Your doctor may not be yourself or a member of your family. If necessary, MetLife may also request a third medical opinion from an appointed doctor. This opinion is covered at the insurance company’s expense.

MetLife reserves the right to make the final decision on payment of a living benefit. The living benefit is not available if benefits are assigned, or MetLife has been notified that all or a portion of your benefits are to be paid to your former spouse as part of a divorce agreement.

**Continuing Basic/Voluntary Term Life Insurance When Coverage Ends**

You may elect to continue through portability (not available in Vermont) or conversion your Basic Term Life, Basic Dependent Life, Voluntary Term Life, and Voluntary Dependent Term Spouse Life and Voluntary Dependent Term Child Life Insurance if you meet one of the following qualifications:

- your employment has ended due to voluntary termination of employment, retirement or dismissal; or
- you cease to be in a class that is eligible for such insurance—for example, you have a change in employment status (e.g., full-time to part-time).

You must contact the Benefits Choice Center to request the forms and your application must be submitted to MetLife within 31 days after the loss of coverage.

If you are a New Hampshire resident and are not given notice, in writing, of the right to obtain a personal policy of life insurance on your own life at least 15 days before the end of the application period, you will have additional time in which to apply. You will then have 15 days from the date you are given the notice in which to apply.

For information about the differences between portability and conversion, see the chart on the following page.

To speak with a MetLife representative who can answer questions about portability, call 1-866-492-6983. To be connected with a MetLife representative who can answer questions about conversion, call 1-877-275-6387.

**Continuing Coverage through Portability**

You may elect to continue life insurance coverage on your and your dependents’ lives for the same or a lower amount of insurance that you were receiving immediately before termination under the group term life plan subject to an overall minimum of $20,000 of your term life insurance (Michigan portability is limited to a maximum of $190,900 as of July 1, 2008, and may be adjusted by the state of Michigan on an annual basis).

You must elect to continue your term life (Basic Life and/or Voluntary Term Life) in order to be able to continue the Dependent Life Insurance.

Costs may differ from your current payroll deduction but are generally less expensive than an individual permanent life policy. Coverage may continue up to age 80 for associates and up to age 70 for dependents.

**Continuing Coverage by Converting to an Individual Policy**

If you or your eligible family members lose coverage under the Term Life Insurance Plans, you may be eligible to obtain an individual life insurance policy customarily issued by MetLife for conversions (not including Term Life Insurance.) See the chart The Differences Between Portability and Conversion on the next page for more information.

The amount of coverage will equal your coverage level under the Company’s Basic Term Life, Basic Dependent Term Life, Voluntary Term Life and/or Voluntary Dependent Term Life Plans.
### The Differences Between Portability and Conversion

<table>
<thead>
<tr>
<th></th>
<th>Portability: Continue Your Group Term Life with MetLife</th>
<th>Conversion: Convert Your Group Term Life Insurance Benefits to an Individual Whole Life or Variable Universal Life Insurance Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will I have to answer medical questions?</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
| What are the minimum and maximum amounts of coverage? | The standard coverage minimum amounts are: 
  • $20,000 for employees 
  • $2,500 for spouses ($10,000 to be eligible for the Accelerated Benefits Option) 
  • $1,000 for children 
  Your coverage maximum amount is generally limited to the amount you had at the time group benefits terminated and may vary depending on the type of coverage you had. The standard maximum coverage amount is $1 million. Details about your specific coverage can be found on the Election of Portable Coverage form. | The coverage minimum under conversion is subject to the Individual Life plan features. 
  The maximum coverage amount under conversion varies based on the following: 
  • The reason group benefits ended. 
  • The amount of group insurance you have. 
  • Your eligibility for any other group benefits within 31 days after current benefits terminate. 
  • Specific state regulations. |
| Can I increase or decrease coverage amounts after the initial application period? | No—coverage cannot be increased at any time. Yes—coverage can be decreased as needed. | No—coverage cannot be increased at any time. Yes—coverage can be decreased as needed on Variable Universal Life policies. No—coverage cannot be decreased on Whole Life policies. |
| What additional features/services are available? | Accelerated Benefits Option (ABO) for Life coverage(s) only. | |
| How do I enroll/apply for coverage? | • Call the Benefits Choice Center and request an Election of Portable Coverage form. 
  • You have 31 days from the date you lose coverage to complete and return this form to MetLife. 
  • Coverage will take effect the first of the month after the election period. | • Call the Benefits Choice Center and request a Notice of Conversion form. 
  • You have 31 days from the date your coverage ends to contact MetLife to convert your coverage. You must contact MetLife within this 31-day period to begin the conversion process. 
  • A MetLife agent will consult with you on your specific needs and assist you with the application process. |
| Will the rates be different from the rates I paid while I was working? | Rates are based on your current age and differ from the rates you paid while employed. As with any group of insureds, rates may change based on the financial experience of the group. MetLife will bill you monthly for your coverage. There is a $1 administrative fee added to each monthly premium. | Rates for conversion are based on your age at the time you convert your coverage and remain level throughout the life of the policy. The MetLife agent will discuss your payment options with you. |

1 Subject to state availability.
To convert your life insurance to an individual policy, you must follow these steps:

- You must request the conversion forms from the Benefits Choice Center and submit your completed forms to MetLife within 31 days after the date your benefits end. You can obtain the proper forms from the Benefits Choice Center. If an individual policy is issued, the individual policy will be effective at the end of the 30-day period following the date your benefits end.

- Pay the required premium within 31 days following the date on which your insurance with the Company ended. MetLife will base the premium for the individual policy on the covered person’s age as of 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 your benefits end, the Plan will pay your life benefits, according to plan provisions, whether or not you have applied for an individual policy.

In the event your family member loses coverage because the group policy is canceled or changed, your family member must have been covered by the Basic and/or Voluntary Term Dependent Life Insurance Plans for at least five successive years to be eligible for conversion rights.

### Conversion for Your Spouse if You Die, Get Divorced or End a Domestic Partnership

Your spouse or same- or opposite-sex domestic partner can convert for the same or a lower amount of insurance in the event of the associate’s death or a divorce or dissolution of domestic partnership.

### Benefit Reductions for You and Your Family

The amount of your Basic Term Life Insurance and any Voluntary Term Life Insurance, as well as any Voluntary Dependent Term Life Insurance for your spouse will be reduced by:

- 35% on January 1 following your 70th birthday
- 50% on January 1 following your 75th birthday
- 70% on January 1 following your 80th birthday

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

Death benefits are not paid under the Basic Term Life, Basic Dependent Term Life, Voluntary Term Life, and Voluntary 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. This also applies to the living benefit. The living benefit never applies to sickness or injuries caused by attempted suicide and self-inflicted injury.

The living benefit is not available if benefits are assigned or MetLife has been notified that all or a portion of your benefits are to be paid to another party as a result of a divorce agreement.

If a suicide occurs within two years of the effective date of any coverage or within two years of the effective date of any increase in coverage, that coverage or increased amount of coverage will not be payable. Instead, MetLife will pay the beneficiary any contributions paid for the increased coverage amount without interest. In addition, MetLife will pay the beneficiary the amount of coverage in place the day before the effective date of an increase in coverage.

### Continued Insurance When You Are Totally Disabled

Continued Insurance is a provision that keeps a death benefit in effect for a totally disabled associate until the earlier of benefit termination, employment termination, return from leave of absence or termination of your disability benefits provided that the appropriate premiums are paid throughout the period of total disability. At the time of benefit termination, the totally disabled associate may convert to an individual policy, or port if applicable.

### Filing Claims for Benefits

The Benefits Choice Center must be notified if you or a family member dies while covered by the Basic Term Life and/or Voluntary 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 MetLife for processing.

MetLife has the right to have an autopsy performed by doctors of MetLife’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. You may appeal the denial by following the procedures in the Claims and Appeals chapter.

Designating a Beneficiary
You may designate the same beneficiary(ies) for all plans, or different beneficiaries for each plan. However, the associate is automatically the beneficiary of all dependent life insurance benefits. You can change your beneficiary(ies) at any time. To designate or change beneficiaries, you must complete a Beneficiary Designation form and return the form to the Benefits Choice Center.

You may want to change the designation of your beneficiary if you divorce, are legally separated from your spouse or end a relationship with your same- or opposite-sex domestic partner. To change your beneficiary designation go to the Your Benefits Resources Website to request a form.

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

- your spouse or your same- or opposite-sex domestic partner;
- your surviving children (including eligible children of your same- or opposite-sex domestic partner);
- your parents;
- your surviving brothers and/or sisters; or
- your estate.

However, MetLife instead can pay the benefit to your estate. Any such payment discharges all liability for the amount paid.

Benefits will not be paid to a beneficiary who has been convicted of murdering the covered person.
Disability

U.S. Full-Time Hourly Associates

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LIVE the Orange LIFE!
Get the Most Value from Your Plan

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<tr>
<th>What do you need?</th>
<th>Find it here...</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you joined the Company on or after 1/1/2001: to opt-out of STD and LTD</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call the Benefits Choice Center at 1-800-555-4954. You are automatically enrolled in both Disability Plans after completing your 90th day of service as a full-time associate.</td>
</tr>
<tr>
<td>Provide information to MetLife</td>
<td>Send a fax to 1-866-690-1264; or mail to: MetLife Disability, P.O. Box 14590, Lexington, KY 40511-4590.</td>
</tr>
<tr>
<td>File a STD or LTD claim</td>
<td>Call MetLife at 1-800-638-9909.</td>
</tr>
<tr>
<td>Check the status of a STD or LTD claim</td>
<td>Call MetLife at 1-800-638-9909. File a claim as soon as you know you’ll be unable to work for more than seven consecutive days.</td>
</tr>
</tbody>
</table>

The Disability Plans

To help ensure 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 and the Long-term Disability (LTD) Insurance Plan. Generally, you have the choice to purchase:

- short-term and long-term disability insurance
- short-term disability insurance only (not available to associates working in California, Hawaii, New Jersey and Rhode Island)
- long-term disability only (for associates working in California, Hawaii, New Jersey and Rhode Island only)

State disability plans automatically cover associates working in California, Hawaii, New Jersey and Rhode Island. These associates are eligible to participate in the Long-term Disability Plan only. Associates working in New York are also covered under a state disability plan. However, since New York’s state disability plan has limited benefits, the Company allows New York associates to participate in the Short-term Disability Plan. If you work in New York, you can begin receiving New York state disability plan benefits after completing four weeks of employment. These benefits are administered by MetLife.

If you are eligible to participate in the Company’s Short-term Disability Plan, you must participate in that plan in order to participate in the Long-term Disability Plan.

If you are not actively working on the day your coverage should begin, your coverage will be delayed until you return to work.

Enrolling in the STD and LTD Plans

If You Joined the Company Before January 1, 2001

You may enroll in STD and LTD during any rolling 12-month period beginning January 1, 2004, and a Statement of Health is required.

If You Joined the Company on or After January 1, 2001

You are automatically enrolled in both Disability Plans 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 the Your Benefits Resources Web site or by calling the Benefits Choice Center. If you opt out of the Plans, you may enroll in STD and LTD during any rolling 12-month period, but a Statement of Health is required.
Please read the Benefit Reductions section of this chapter carefully. Depending on your personal circumstances, the benefits you may receive from sources other than the STD or LTD Plans may significantly reduce any benefit that the Company’s STD or LTD Plans might provide.

Providing a Statement of Health
You must submit a Statement of Health form if you want to enroll in the Disability Plans and:

- You started work before January 1, 2001, and you did not enroll in disability coverage during your initial enrollment period.
- You were hired on or after January 1, 2001, and you opted out of automatic enrollment.

The Statement of Health form is mailed to your home following enrollment. To approve your request for coverage, Metropolitan Life Insurance Company (MetLife), the Plan’s insurance company, may require a doctor’s statement and/or a physical exam. You will be responsible for any related costs. You do not have disability coverage until MetLife receives your completed form and approves your Statement of Health form.

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

If, however, you are working in the state of New York and receive benefits under the state disability plan, taxes will be deducted for the portion of the state plan that is paid by the Company.

How the Short-term Disability Plan Works
After seven consecutive calendar days of an illness or injury during which you are unable to work, the Short-term Disability Plan will pay 60% of base pay for an approved period of disability, not to exceed 25 weeks.

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 taxes on the benefits received (unless you are working in New York, see the next section for additional information).

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 seven consecutive calendar days;
- you must be under the appropriate 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 essential duties of your regular job; and
- MetLife 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 seven consecutive calendar days that you are disabled, you may use any sick or vacation days you have available to receive pay for normally scheduled hours in accordance with Company policy. After the first seven consecutive calendar days, if approved, you will receive 60% of your base pay for the period of short-term disability, not to exceed 25 weeks.

If you are receiving income from other sources, however, your short-term disability weekly benefit will be reduced by the amount of your other income. See Benefit Reductions in this chapter for examples of other income. While an associate is receiving short-term disability benefits, the premiums required for short-term and long-term disability (if elected) are deducted from the short-term disability benefit.

If you refuse to participate in a rehabilitation program recommended by MetLife and accommodated by The Home Depot, your benefit will not be continued.
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 seven-day waiting period plus the approved period of disability of up to 25 weeks), and you do not have to complete another seven-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 seven-day waiting period plus the approved period of disability up to 25 weeks) begins, if approved. You must satisfy the seven-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 seven-day waiting period plus the approved period of disability up to 25 weeks) begins. You must satisfy the seven-day waiting period before the benefit payment can begin.

Partial Disability

If you become partially disabled immediately following a period of disability in which you were fully disabled for at least the seven-day waiting period, the Short-term Disability Plan will continue to pay the weekly benefit for the remainder of the 25-week benefit payment period, provided you remain partially disabled and provide proof of disability when requested.

The amount of the weekly benefit, when added to any compensation you may earn while partially disabled, cannot exceed 100% of your basic weekly earnings.

Partial disability means that due to injury or sickness you:

- are under the appropriate care of a doctor;
- can perform at least one of the essential functions of your job or any other job on a part-time or full-time basis; and
- are earning at least 20% less per week than your base pay prior to the injury or sickness due to that injury or sickness.

How the Long-term Disability Plan Works

After 26 consecutive weeks of illness or injury, if the disability qualifies as total disability, is expected to continue, and benefits are approved, the Long-term Disability Plan will pay 60% of base pay (reduced by other income) for the remainder of the disability, up to the maximum benefit duration. Base pay means your monthly rate of pay 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. Long-term disability benefits are paid on a semi-monthly basis.

<table>
<thead>
<tr>
<th>Age When Disability Begins</th>
<th>Benefit Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>60 months</td>
</tr>
<tr>
<td>61</td>
<td>48 months</td>
</tr>
<tr>
<td>62</td>
<td>42 months</td>
</tr>
<tr>
<td>63</td>
<td>36 months</td>
</tr>
<tr>
<td>64</td>
<td>30 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

Associates who become disabled before age 60 will receive benefits to age 65. Associates who become disabled after age 60 will receive benefits for a limited time as shown in the chart.
Exceptions
The maximum period of disability that the Plan will consider for disabilities due to mental/nervous disorders; chronic fatigue syndrome and related disorders; alcohol, drug or substance abuse or dependency; and soft tissue disorders will be 24 months from the date the disability starts. The 24-month maximum period of disability includes the six-month waiting period and 18 months of benefits.

The 24-month maximum period of disability is a lifetime maximum. This means that you can receive a maximum of 24 months of benefits for the same period during your lifetime.

The period of disability is not limited to 24 months for a disability resulting from schizophrenia, bipolar disorder, dementia, organic brain disease, seropositive arthritis, spinal tumors, malignancy, vascular malformations, radiculopathies, myelopathies, traumatic spinal cord necrosis or muscolopathies.

Mental/nervous disorder means a mental, nervous or emotional disorder or disease of any type. Soft tissue disorders are conditions which include disorders of the spine or limbs and their surrounding muscles, tendons, ligaments and other soft tissue (included are sprains and strains of joints and adjacent muscles).

Qualifying for Benefits
To qualify for long-term disability benefits, your disabling illness or injury must not be the result of a pre-existing condition that causes disability in the first 12 months after your coverage starts. For purposes of this Plan, a pre-existing condition is any injury, illness, or other incapacitating condition for which you received medical care or took prescribed drugs during the 90 days immediately before the effective date of your long-term disability coverage. The Long-term Disability Plan will not pay benefits for any disability that begins in the first 12 months of coverage if it was caused by, was contributed to, or is a result of a pre-existing condition.

Disability means that, due to an injury or sickness, you:
• require the continuous care of a qualified doctor; and
• are unable to perform all of the essential functions of your regular job or any gainful occupation for which you are reasonably qualified, taking into account your education, training and experience. Gainful employment or gainfully employed 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, and which MetLife approves and for which MetLife reserve the right to modify approval in the future.

In addition, to qualify for long-term disability benefits:
• you must continue to be under the care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses);
• MetLife must consider that you are totally disabled; and
• MetLife must receive certification with accompanying medical documentation of a disability from your attending doctor before benefits are considered for payment.

How the Plan Pays Benefits
After 26 weeks of disability, if approved for long-term disability, you will receive 60% of your base pay for the remaining period of disability, up to the maximum benefit duration. The maximum monthly benefit is $5,000; the minimum monthly benefit is $50.

If you are an At-Home Services 100% commissioned associate, your benefit is calculated based on your last 52 weeks of pretaxed earnings to include commission and bonus. The wages do not include renewal commissions, overtime pay or other compensation.

Your benefit will not change throughout your disability period. However, if you are receiving income from other sources, your long-term disability benefits will be reduced by the amount of your other income. See Benefit Reductions in this chapter for examples of other income.

While an associate is disabled and receiving long-term disability benefits, the premiums required for long-term disability are waived.
Rehabilitative Work Programs and Partial Disability

If you can return to work on a limited basis through a rehabilitative work program, you may qualify for partial disability benefits. If you qualify for partial disability, your long-term disability benefits (as described previously) will not be reduced for a 24-month period from your date of disability. Your monthly benefit, when added to any compensation you may earn while partially disabled, cannot exceed 100% of your basic monthly earnings. After 24 months, your benefit will be reduced by 50% of your rehabilitative employment earnings.

Partial disability means that while you are unable to perform all of the essential functions of your regular job on a full-time basis, you are performing at least one of the essential functions of your regular job or any other gainful work or service on a part-time or full-time basis; and you are earning currently at least 20% less per month than your Basic Monthly Earnings due to that same injury or sickness.

Rehabilitation Program means a program that has been approved by MetLife for the purpose of helping you return to work. It may include but is not limited to, your participation in one or more of the following activities:

1. return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings;
2. on-site modification/accommodation;
3. training to improve job seeking skills;
4. vocational assessment;
5. short-term skills enhancement;
6. vocational training; or
7. restorative therapies to improve functional capacity to return to work.

Limited Interruption of the Waiting Period

During the 180-day waiting period for long-term disability, limited interruption of the waiting period is allowed for up to 30 days. Any day of active work in this time will not count toward satisfying the waiting period. This limited interruption will not apply if, while you are actively at work, you become eligible for any group disability insurance.

Recurrent Disability

If, after a period of long-term disability during which you received benefits under this Plan, you resume your regular job on a full-time basis for less than six consecutive months, any recurrent disability will be part of the same initial period of disability. If you resume work for more than six months, any recurrent disability will be treated as a new period of disability and a new elimination period must be completed.

If you become eligible for coverage under any other group long-term disability policy, this recurrent disability provision will not apply. In that case, any recurrent disability will be treated as a new period of disability and a new elimination period must be completed.

In the Event of Your Death

If you are receiving long-term disability benefit payments at the time of your death, these payments will stop immediately. The Long-term Disability Plan does not provide survivor benefits.

What’s Not Covered Under the Disability Plans

The Short-term and Long-term Disability Plans do not cover a disability caused by or resulting from:

• intentionally self-inflicted injuries or attempted suicide
• war, insurrection, rebellion or active participation in a riot
• committing or attempting to commit a felony

Benefit Reductions

The Plans will reduce your short-term and long-term disability benefits to account for other income you receive while disabled. Other income includes benefits under the following:

• Workers’ compensation law, occupational disease laws or any similar state or federal law
• any compulsory disability benefits law or act
• any formal wage or salary payment plan of the Company
• disability or retirement benefits under the U.S. Social Security Act, the Railroad Retirement Act or any similar plan or act
• any dependent benefits to which you are entitled because of your disability
• benefits to which you are entitled through no-fault insurance laws
• any disability benefits for which you are eligible under any other company group or individual insurance plan, or any government retirement system
• payments from any state STD program
If at any time MetLife determines that the total amount paid on a claim is more than the total amount due, including any overpayment resulting from retroactive awards received from sources listed in Other Income Benefits, MetLife has the right to recover the excess amount from the person to whom such payment was made. MetLife may, at their option, recover the excess amount by reducing or offsetting against any future benefits payable.

Indexed Basic Monthly Earnings means Basic Monthly Earnings in effect on the date Disability began, increased by 7%. The first increase will take place on the first of the month immediately following 12 months of continuous Disability. Subsequent increases will be compounded each year and take place on the anniversary of the first increase, provided you have been continuously receiving Disability Benefits under This Plan.

Estimating Social Security Benefits
If you have not received approval or final denial of your claim from the Social Security Administration by the end of this 24 month period, we will begin reducing your Monthly Benefit by an estimate of Social Security benefits. Final denial of your claim means that you have received a “Notice of Denial of Benefits” from an Administrative Law Judge.

Filing Claims for Benefits
To file a short-term or long-term disability claim:

- Call the MetLife claims office at 1-800-638-9909, as soon as you know you will be unable to work more than seven consecutive days. MetLife will then forward any necessary forms to you and your doctor.
- If you do not submit a claim within 90 days after the end of the period for which STD benefits were payable, or within 90 days after the end of the 180-day waiting period for LTD, you may not be eligible for disability benefits.

Contact MetLife at 1-800-638-9909 to start the benefit determination process. Select option #1 to report a new claim.

You should have the following information ready when you report your absence:

- **Personal Information:** Name, address, telephone number, e-mail address, date of birth and Social Security number
- **Job Information:** Store location, telephone number, occupation, work schedule and supervisor's name/number
- **Injury/Illness Information:** How, when, and where the injury occurred, nature of the illness, and last day worked
- **Physician(s) Information:** Name(s), address(es), telephone number(s), fax number(s) and e-mail address(es). Information is needed for each treating physician.

• Your Manager's Information: Name, telephone number and e-mail address

**When to Report Your Absence**
If you are out of work for more than four days and expect your disability to last more than seven days, or if you know in advance that you will be out of work for more than seven days due to an injury, illness, or pregnancy (e.g., a scheduled surgery), call MetLife at 1-800-638-9909 immediately.

**How Your Claims Are Handled**
A MetLife disability claims management unit will handle all STD and LTD claims for the Company associates.

For important numbers and addresses see Get the Most Value From Your Plan earlier in this chapter.
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:

Metropolitan Life Insurance Company
Group Claims Review
P.O. Box 14592
Lexington, KY 40511-4592

Refund to MetLife for Overpayment of Benefits

If at any time MetLife determine that the total amount paid on a claim is more than the total amount due, including any overpayment resulting from retroactive awards received from sources listed in Benefit Reductions, MetLife has the right to recover the excess amount from the person to whom such payment was made. However, MetLife, at their option, may recover the excess amount by reducing or offsetting against any future benefits payable to such person.
Disability

U.S. Salaried Associates

Chapter Contents

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Get the Most Value from Your Plan

What do you need? | Find it here...
---|---
File an STD claim | Notify your District HR Manager or manager of your need to file a short-term disability claim or go to myApron.homedepot.com. Notify MetLife as soon as you know you’ll be unable to work for more than seven days by calling 1-888-600-7676.

File an LTD claim | Notify MetLife as soon as you know you’ll be unable to work for more than 90 consecutive days.

Check the status of an STD or LTD claim | Call MetLife at 1-800-638-9909. If you don’t submit a claim within 15 days of the first day out of work, you may not be eligible for short-term disability benefits.

Get information about the Supplemental Disability Insurance Plan | Call Balser at 1-888-329-1022; or go to Your Benefits Resources at http://resources.hewitt.com/homedepot.

The short-term disability portion of your disability benefits is not an ERISA (Employee Retirement Income Security Act of 1974) plan. ERISA rules and regulations, therefore, do not apply. Salaried short-term disability is provided under the terms of the Short-Term Disability for Salaried Associates SOP. This SPD includes a summary of those benefits, but the terms of the SOP shall govern if there is any conflict.

How the Short-term Disability Plan Works
The Home Depot provides you with short-term disability coverage for salaried associates who are unable to work due to personal illness or injury. If you are unable to perform the essential duties of your job or the duties of any suitable alternative position due to an illness or injury that is expected to last for a period of seven days or more, you will receive your regular bi-weekly pay for the period approved by the third-party administrator, up to a maximum of 90 days.

To request a leave of absence (LOA), store salaried associates should contact their District HR Manager. Non-store salaried associates should contact their Manager. He or she will provide you with the necessary information you will need to apply for this benefit.

Enrollment/Qualified Status Changes
You are automatically enrolled in short-term disability and LTD. If you are not actively working on the day your coverage should begin, your coverage will be delayed until you return to work. These benefits are provided to you by the Company at no cost.

Short-term Disability Related to Pregnancy and Childbirth
For Maternity Leave in connection with pregnancy and childbirth, you will receive full pay for the period you are physically unable to perform your job, as certified by the third-party administrator, based on medical information provided by your physician. This may be a combination of time before and after childbirth. Typically, the recovery period after childbirth is six weeks for a normal delivery and eight weeks for a cesarean section.

You will receive pay for six weeks from the start of your Maternity Leave. If you are still physically unable to perform your job, the third-party administrator will certify the disability based on medical information provided by your physician.
Upon receipt of this certification, your salary will be continued for the remaining period that you are physically unable to perform your job, up to a total maximum of 90 days. Once you are released from your physician’s care, any available Maternity Leave to care for your child will be unpaid.

For more information, see Medical Leave of Absence in the Leaves of Absence chapter.

How the Short-term Disability Plan Pays Benefits

You will receive your full pay for the period you are physically unable to work, not to exceed 90 days.

If you are receiving income from other sources, such as Workers’ Compensation or a state-mandated short-term disability plan (California, New Jersey, Rhode Island, New York or Hawaii), your pay will be reduced by the amount of your other income.

Salaried associates who work in California, New Jersey, Rhode Island, New York or Hawaii must file a claim for short-term disability benefits with their state disability office. See Benefit Reductions in this chapter for additional examples of other income.

If you refuse to participate in a rehabilitation program recommended by MetLife and accommodated by The Home Depot, your benefit will not be continued.

For more information on short-term disability benefits, see the Short-Term Disability for Salaried Associates SOP, available at myapron.homedepot.com (Click on My HR Pay & Benefits, scroll down to Benefits and Wellness and then Disability Management. In the search box enter LOA Short-Term Disability and select the Salaried HR SOP.) Or get a copy of the SOP by calling the Human Resources Service Center at 1-866-698-4347. The Short-Term Disability for Salaried Associates SOP is incorporated herein by reference.

How the Long-term Disability Plan Works

If the illness or injury for which you receive salary continuation qualifies as total disability, is expected to continue beyond 90 days, and if benefits are approved, the Long-term Disability Plan will pay the lesser of:

- 60% of base pay plus bonuses for the remainder of the disability, to the maximum benefit duration; or
- If you receive income from certain other sources (other income), the Plan will instead pay 70% of base pay reduced by your other income for the remainder of the disability, up to the maximum benefit duration.

Base pay means your monthly rate of pay, including annual bonuses, in effect as of the date of disability, and does not include overtime, premiums, incentive pay or any other form of pay from the Company. These long-term disability benefits are paid on a semi-monthly basis. The maximum monthly benefit is $25,000; the minimum benefit is $100. Your benefit will not change throughout your disability period.

Associates who become disabled before age 60 receive benefits up to age 65. Associates who become disabled after age 60 will receive benefits for a limited period of time, as shown in the chart.

### Age When Disability Begins | Benefit Duration
---|---
Less than 60 | To age 65
At age 60 but less than 61 | To age 65
At age 61 but less than 62 | 48 months
At age 62 but less than 63 | 42 months
At age 63 but less than 64 | 36 months
At age 64 but less than 65 | 30 months
At age 65 but less than 66 | 24 months
At age 66 but less than 67 | 24 months
At age 67 but less than 68 | 24 months
At age 68 but less than 69 | 24 months
At age 69 but less than 75 | 24 months
At age 75 and older | 12 months

Exceptions

The maximum period of disability that the Plan will consider for disabilities due to mental/nervous disorders, chronic fatigue syndrome and related disorders and alcohol, drug or substance abuse or dependency will be 24 months from the date the disability payments begin. The 24-month maximum period of disability does not include the 90-day waiting period.

The 24-month maximum period of disability is a lifetime maximum. This means that you can receive a maximum of 24 months of benefits for the same period during your lifetime.

Mental/nervous disorder means a mental, nervous or emotional disorder or disease of any type.
The period of disability is not limited to 24 months for a disability resulting from schizophrenia, bipolar disorder, dementia, organic brain disease, seropositive arthritis, spinal tumors, malignancy, vascular malformations, radiculopathies, myelopathies, traumatic spinal cord necrosis or musculopathies.

Qualifying for Benefits
To qualify for long-term disability benefits, your disabling illness or injury must not be the result of a pre-existing condition that causes disability in the first 12 months after your coverage starts.

For purposes of this Plan, a pre-existing condition is any injury, illness or other incapacitating condition for which you received medical care or took prescribed drugs during the 90 days immediately before the date your long-term disability coverage started. The Long-term Disability Plan will not pay benefits for any disability that begins in the first 12 months of coverage if it was caused by, contributed to, or is a result of a pre-existing condition.

Disability means that, due to an injury or sickness:
- you require the appropriate care of a doctor;
- you are unable to perform each of the material duties of your regular job; and
- after the first 24 months of benefit payments, you are unable to perform each of the material duties of any gainful occupation for which you are reasonably qualified, taking into account your education, training, past earnings and experience. **Gainful employment** or **gainfully employed** 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, and which MetLife approves and for which MetLife reserves the right to modify approval in the future.

Therefore, for you to qualify for long-term disability benefits:
- you must be unable to return to work after the initial 90-day period of disability
- you must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses)
- MetLife must receive and approve certification with accompanying medical documentation of a disability from your attending doctor before benefits are considered for payment

How the Plan Pays Benefits
After 90 days of salary continuation, if approved, you will receive the lesser of:
- 60% of base pay plus bonuses for the remainder of the disability, up to the maximum benefit duration, or
- If you receive income from certain other sources (other income—see Benefit Reductions in this chapter for examples of other income), the Long-term Disability Plan will instead pay 70% of base pay plus bonuses reduced by your other income for the remainder of the disability, up to the maximum benefit duration.

If you are approved for a long-term disability benefit, this benefit may be paid to you from an individual disability policy, the Long-term Disability Plan or a combination of both.
Rehabilitative Work Programs and Partial Disability

If you can return to work on a limited basis through a rehabilitative work program, you may qualify for partial disability benefits. If you qualify for partial disability, your long-term disability benefits (as described above) will not be reduced for a 24-month period from your date of disability. Your monthly benefit, when added to any compensation you may earn while partially disabled, cannot exceed 100% of your basic monthly earnings. After 24 months, your benefit will be reduced by 50% of your rehabilitative employment earnings.

Partial disability means that while you are unable to perform all of the material duties of your regular job on a full-time basis, you are performing at least one of the material duties of your regular job or any other gainful work or service on a part-time or full-time basis; and you are earning currently at least 20% less per month than your Basic Monthly Earnings due to that same injury or sickness.

Limited Interruption of the Waiting Period

During the 90-day waiting period for long-term disability, limited interruption of the waiting period is allowed for up to 90 days. Any day of active work in this time will not count toward satisfying the waiting period.

This limited interruption will not apply if, while you are actively at work, you become eligible for any other group disability insurance.

Recurrent Disability

If after a period of long-term disability during which you received benefits under this Plan, you resume your regular job on a full-time basis for less than 12 consecutive months, any recurrent disability will be part of the same initial period of disability. If you resume work for more than 12 months, any recurrent disability will be treated as a new period of disability and a new 90-day waiting period must be completed.

If you become eligible for coverage under any other group long-term disability policy, this recurrent disability provision will not apply. If you become eligible for coverage under any other group long-term disability policy, this recurrent disability provision will not apply. In that case, any recurrent disability will be treated as a new period of disability and a new 90-day waiting period must be completed.

In the Event of Your Death

If you are receiving long-term disability benefit payments at the time of your death, the Long-term Disability Plan will pay your surviving spouse a one-time, lump-sum payment equal to three times your gross monthly benefit. If there is no surviving spouse, the benefit is divided equally among children under age 25. If there is no spouse and no children under the age of 25, no survivor benefit is paid.

What’s Not Covered Under the Disability Plans

The Long-term Disability Plan does not cover a disability caused by or resulting from:
- intentionally self-inflicted injuries or attempted suicide
- war, insurrection, rebellion or active participation in a riot
- committing or attempting to commit a felony

For information about what’s not covered under the Short-term Disability Plan, see the Short-Term Disability for Salaried Associates SOP, available at myapron.homedepot.com (Click on My HR Pay & Benefits, scroll down to Benefits and Wellness and then Disability Management. In the search box enter LOA Short-Term Disability and select the Salaried HR SOP.) Or get a copy of the SOP by calling the Human Resources Service Center at 1-866-698-4347. The Short-Term Disability for Salaried Associates SOP is incorporated herein by reference.
Benefit Reductions

Your short-term disability and long-term disability benefits will be reduced to account for other income you receive while disabled. Other income includes benefits under the following:

- Workers’ Compensation law, occupational disease laws or any similar state or federal law
- any compulsory disability benefits law or act
- any formal wage or salary payment plan of the Company
- disability or retirement benefits under the United States Social Security Act, the Railroad Retirement Act, or any similar plan or act
- any dependent benefits to which you are entitled because of your disability
- benefits to which you are entitled through no-fault insurance laws
- any disability benefits for which you are eligible under any other group or individual insurance plan sponsored by any company or any government retirement system as a result of your job, except for Supplemental Disability Insurance as explained in this chapter
- payments from any state STD program

If at any time MetLife determines that the total amount paid on a claim is more than the total amount due, including any overpayment resulting from retroactive awards received from sources listed in Other Income Benefits, MetLife has the right to recover the excess amount from the person to whom such payment was made. MetLife may at their option, recover the excess amount by reducing or offsetting against any future benefits payable.

You are required to show proof that you have applied for Social Security benefits. If you have not received approval or final denial of your claim from the Social Security Administration by the end of this 24-month period, we will begin reducing your Monthly Benefit by an estimate of Social Security benefits.

Long-Term Disability Benefits and Taxes

Since the Company provides long-term disability coverage, the benefits you receive are taxable as ordinary income.

Filing Claims for Benefits

To file a short-term disability or long-term disability claim:

- Notify your District Human Resources Manager or manager to apply for a medical leave of absence; and
- Contact MetLife at 1-888-600-7676 to report your Short-term Disability and Long-term Disability claim; and
- Go to the Your Benefits Resources Web site at http://resources.hewitt.com/homedepot

If you do not submit a claim within 90 days of the end of the 90-day waiting period, you may not be eligible for long-term disability benefits.

Additional Information for Filing Your Disability Claim

You should have the following information ready when you report your disability:

- Personal information: Name, address, telephone number, e-mail address, date of birth and Social Security number
- Job information: Store location, telephone number, occupation, work schedule and supervisor’s name/number
- Injury/illness information: How, when and where the injury occurred, the nature of the illness and last day worked
- Physician(s) information: Name(s), address(es), telephone number(s), fax number(s) and e-mail address(es). Information is needed for each treating physician
- District Human Resources Manager (DHRM) information: Name, telephone number and e-mail address

Appealing a Claim

If your claim is denied, 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. See the Claims and Appeals chapter of this book for more information.
Supplemental Disability Insurance

The Company provides Long-term Disability (LTD) Insurance at no cost to you. Because this benefit is paid by the Company, any benefit you receive from the plan is taxable. As a result, your net benefit from the LTD plan can be less than 60% of your base pay (depending on your personal situation).

To provide you with more financial security in the case of long-term disability, the Company offers Supplemental Disability Insurance (SDI). SDI can provide an additional benefit in the case of long-term disability of up to 15% of your base pay and bonus. And because you pay for this policy, under current tax law, the benefits you receive from the SDI plan are not taxable as ordinary income. In addition, your SDI coverage is portable, which means if you leave the Company you can continue your coverage.

Coverage Cost

SDI coverage is available at a discount to the rates generally charged by the insurance carrier because of your employment with the Company.

How LTD and SDI Work Together

Below is an example of how company-paid LTD and SDI coverage work together for an associate earning $60,000 a year.

<table>
<thead>
<tr>
<th>Comparison of Disability Benefits with SDI and Without SDI</th>
<th>Actively working</th>
<th>Eligible for LTD, WITH NO SDI benefit</th>
<th>Eligible for LTD, WITH SDI benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual base pay</td>
<td>$60,000</td>
<td>$60,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>LTD benefit (60% of annual base pay)</td>
<td>n/a</td>
<td>$36,000 ($60,000 x 60%)</td>
<td>$36,000 ($60,000 x 60%)</td>
</tr>
<tr>
<td>Personal income tax (assumes a 26.65%* tax rate)</td>
<td>$15,990</td>
<td>$9,594</td>
<td>$9,594</td>
</tr>
<tr>
<td>Net income after taxes</td>
<td>$44,010 ($60,000–$15,990)</td>
<td>$26,406 ($36,000–$9,594)</td>
<td>$26,406 ($36,000–$9,594)</td>
</tr>
<tr>
<td>Tax-free* SDI benefit</td>
<td>n/a</td>
<td>n/a</td>
<td>$9,000 (60,000 x 15%)</td>
</tr>
<tr>
<td>Total after-tax LTD</td>
<td>n/a</td>
<td>$26,406</td>
<td>$35,406 ($26,406+$9,000 LTD + SDI)</td>
</tr>
</tbody>
</table>

* Assumes single filing with no dependents - 15% federal, 7.65% FICA, 4% state taxes

The purpose of this description in the 2009 Benefits Summary is to provide a general overview of the Supplemental Disability Insurance Plan. Because this benefit is provided through individual policies, individual policy details may differ from one individual plan to another. As a result, this description is intended only to help you generally understand the Plan available to you and can in no way modify the actual terms and provisions as specified in the controlling policy that defines the Plan. If there are differences between the information contained in this chapter and the provisions of the controlling legal documents, the controlling legal documents always govern.

In The Event of Your Death

If you die during a continuous period of disability and SDI benefits have been paid for 12 months or more, your designated beneficiary will receive an additional SDI benefit for three months. This monthly benefit is equal to the amount of the SDI benefit payable for the last month of your disability.

For More Information

Because SDI is offered as an individual policy, call 1-888-329-1022 or go to Your Benefits Resources at http://resources.hewitt.com/homedepot for more details.
Accidental Death & Dismemberment

U.S. Salaried & Full-Time Hourly Associates

Chapter Contents

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Get the Most Value from Your Plan

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<tr>
<th>What do you need?</th>
<th>Find it here...</th>
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<tr>
<td>Enroll in coverage</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call the Benefits Choice Center at 1-800-555-4954.</td>
</tr>
<tr>
<td>Designate your beneficiary</td>
<td></td>
</tr>
<tr>
<td>Certify your domestic partner relationship</td>
<td></td>
</tr>
<tr>
<td>Get a Domestic Partner Declaration</td>
<td>Call MetLife at 1-800-638-9909</td>
</tr>
<tr>
<td>Request a benefit be paid</td>
<td>Call the Benefits Choice Center at 1-800-555-4954 and speak with a Representative. You must provide written proof of any claim within 90 days after the date of loss.</td>
</tr>
</tbody>
</table>

**Basic AD&D Insurance**
Under the Basic AD&D Plan, you automatically receive coverage from the Company at no cost to you. You are not required to enroll in the Medical Plan to receive this benefit. This insurance covers death and injury caused solely by an accident.

**Home Depot-Provided Basic AD&D Coverage for Full-Time Hourly Associates**
Under the Basic AD&D Plan, full-time hourly associates automatically receive coverage equal to $20,000 from the Company.

**Home Depot-Provided Basic AD&D Coverage for Salaried Associates**
Under the Basic AD&D Plan, salaried associates automatically receive coverage equal to $100,000 from the Company.

**Voluntary AD&D Insurance**
You can purchase additional coverage through the Voluntary AD&D Insurance options. In deciding whether you need additional coverage, please keep in mind the following points:

- AD&D benefits are paid only when you are involved in an accident and within one year of the accident your injuries result in death or other losses as outlined in the AD&D Benefits chart.
- AD&D benefits are not paid for death as a result of natural causes.

You must be actively at work for new Voluntary AD&D Insurance coverage to take effect.

Actively at work means that you are performing all of the material duties of your job with the Company where these duties are normally carried out.

If you were actively at work on your last scheduled working day, you will be deemed actively at work:

- on a scheduled non-working day
- provided you are not disabled

If you and your spouse, or same- or opposite-sex domestic partner, work for the Company, see If You and Your Spouse or Same-Sex Domestic Partner Both Work for the Company in the Eligibility and Enrollment chapter.
Associate-Only Voluntary AD&D Option
You can buy coverage equal to one to ten times your annual base pay (rounded to the next higher multiple of $1,000, if not already a multiple of $1,000), up to a maximum of $500,000. Annual base pay means:

- For full-time hourly associates: your hourly base pay rate multiplied by 2,080 (40 hours per week times 52 weeks).
- For salaried associates: your regular pay and any portion of your regular pay that you defer.

Annual base pay does not include overtime, bonuses, premiums, incentive pay or other forms of Company pay.

For example, if your base pay is $16,650, you can buy:

- $17,000 (1x your annual base pay);
- $34,000 (2x your annual base pay);
- $51,000 (3x your annual base pay);
continuing up to $170,000, which is ten times your annual base pay.

When you are covered under the Associate-Only Voluntary AD&D Option, the Plan will pay an additional 10% of your benefit, up to a $10,000 maximum, if your death is the result of injuries from driving or riding in a private passenger car while wearing a properly fastened seat belt.

Passenger car means any validly registered four-wheel private passenger car. It does not include:

- any commercially licensed car; or
- a private passenger car, which is being used for commercial purposes.

Seat belt means any child restraint device that meets the definition of the state law in the jurisdiction of the state of residence of the individual; or any other restraint device which:

- meets published federal safety standards;
- has been installed by the car manufacturer; and
- has not been altered after such installation.

The correct position of the seat belt must be certified by the investigating officer. A copy of the policy report must be submitted with the claim. MetLife will not pay a seat belt benefit if the covered person was driving while under the influence of alcohol or drugs.

An amount equal to the full benefit amount is paid for your loss of life if your death results from unavoidable exposure to the elements and if, after one year, your body has not been found after the transportation in which you were traveling either disappeared, made a forced landing, sank or was wrecked.

After four days of hospitalization for treatment of a covered accidental injury, you will receive a benefit while hospitalized of 1% of your selected benefit amount up to a maximum of $1,000 per month, for up to 12 months.

Family Protection Plus Voluntary AD&D Option
You can purchase Voluntary AD&D coverage for yourself, your spouse, or same- or opposite-sex domestic partner, and your dependent children (from age 14 days). Your spouse, or same- or opposite-sex domestic partner, is eligible for benefits up to his or her 70th birthday. See the Eligibility and Enrollment chapter for more information on dependent eligibility.

With the Family Protection Plus Voluntary AD&D Option, you have the same coverage as you would with the Associate-Only Option, and your covered spouse and covered dependent children have the following coverage:

- Spouse’s, or same- or opposite-sex domestic partner’s, coverage equals 80% of your selected benefit amount, and each eligible dependent child’s insurance equals 10% of your selected benefit amount.
- Additional 10% of your covered spouse’s, or same- or opposite-sex domestic partner’s, benefit, and your covered dependent children’s benefits, up to $10,000 maximum per person, if death is the result of injuries from driving or riding in a private passenger car while wearing a properly fastened seat belt. See Associate-Only Voluntary AD&D Option for more information.
- Spouse’s, or same- or opposite-sex domestic partner’s, coverage is 100% of the amount you select if you and your spouse die within one year as a result of bodily injuries sustained in the same covered accident or separate accidents occurring within the same 24-hour period.
• An amount equal to the full benefit amount is paid for loss of life of your covered spouse, or same- or opposite-sex domestic partner, and your covered dependent children if death results from unavoidable exposure to the elements and if, after one year, the covered person’s body has not been found after the transportation in which the covered person was traveling either disappeared, made a forced landing, sank or was wrecked.

• If you die as a result of an accident while your spouse, or same- or opposite-sex domestic partner, is enrolled in an accredited school for the purpose of training or refreshing skills needed for employment, this option provides a benefit for costs incurred from enrolling for one year in such school (up to a maximum benefit of $5,000).

• If you die as a result of an accident, this option provides for each dependent child an annual amount equal to 2% of your selected benefit amount, but not more than $6,000 per year, if such child, on the date of the accident, was:
  — enrolled as a full-time student in a college, university or vocational school above the 12th-grade level; or
  — at the 12th-grade level and subsequently enrolls as a full-time student in a college, university or vocational school within 365 days following the date of the accident.

• The education benefit for dependent children is payable for a maximum of four consecutive years as long as the dependent child remains a full-time student as described above.

• If there are no dependent children who qualify for the education benefit for dependent children on the date of your death, an additional benefit of $1,000 is paid to your beneficiary.

• After four days of hospitalization for treatment of a covered accidental injury, a benefit for your spouse, or same- or opposite-sex domestic partner, and your covered dependent children while hospitalized will be 1% of your selected benefit amount, up to a maximum of $1,000 per month, for up to 12 months.

AD&D Benefits

If you are involved in an accident and your injuries result in death or loss of limb within one year of the date of the accident, the Plan will pay one of the following benefits:

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>% of Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of life</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of two or more members(^1)</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of speech and loss of hearing in both ears(^2)</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia(^3)</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of one member(^4)</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of speech or loss of hearing in both ears(^5)</td>
<td>50%</td>
</tr>
<tr>
<td>Paraplegia or hemiplegia(^6)</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of thumb and index finger of same hand(^7)</td>
<td>25%</td>
</tr>
</tbody>
</table>

\(^1\) Member refers to hand, foot or eyesight. Loss of a hand means that all of the hand is cut off at or above the wrist. Loss of a foot means that all of the foot is cut off at or above the ankle. Loss of eyesight means that the eye is entirely blind and that no sight can be restored in that eye.

\(^2\) Loss of speech and hearing means the entire and irrecoverable loss which has lasted continuously for 12 consecutive months following the injury.

\(^3\) Quadriplegia means total paralysis of both upper and lower limbs. Paraplegia means total paralysis of both lower limbs. Hemiplegia means total paralysis of upper and lower limbs on one side of the body. Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

\(^4\) Loss of thumb and index finger means actual severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
If your injuries result in a loss of a limb(s), you will receive the benefit payable under the Plan. If your injuries result in death, your designated benefici-ary(ies) will receive the benefit payable under the plan. See Designating a Beneficiary in this chapter, for more information on beneficiaries.

**Full Amount of Benefits Payable**

For all covered losses caused by all injuries which you sustain in one accident, or a dependent sustains in one accident, not more than the full amount will be paid.

Full amount means the amount of AD&D benefits:
- for which you are covered on the date of your accident; or
- that is in effect for that dependent on the date of that dependent's accident.

**What's Not Covered Under the AD&D Plans**

The Company AD&D Plans do not cover losses due to, contributed to, or caused by:
- physical or mental illness or diagnosis or treatment for the illness
- infection, except infection caused by an external visible wound accidentally sustained
- war or war-like action in time of peace
- service in the armed forces of any country or international authority except the U.S. National Guard
- suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane
- the use of any drug or medicine, unless used on the advice of a licensed medical practitioner
- any poison or gas, voluntarily taken, administered or absorbed
- committing or attempting to commit any assault or felony or other serious crime
- travel or flight in an experimental aircraft or aircraft designed for use beyond the earth's atmosphere
- travel or flight in any aircraft operated by a military authority other than the MAC (Military Airlift Command)
- parachuting, except for self-preservation
- operating, learning to operate or serving as a member of a crew of an aircraft. Exceptions may apply to individuals employed as a pilot or crew member for the Company.

**Filing Claims for Benefits**

The Benefits Choice Center must be notified if you or a family member covered by Basic AD&D and Voluntary AD&D Plans is injured or dies. Upon notification, a benefits representative in 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 MetLife for processing.

When a claim is pending:
- If after reviewing all available medical information, Metropolitan Life Insurance Company (MetLife) determines that an additional medical exam is necessary, MetLife will specifically request one and that exam will be paid at MetLife's expense. Any other medical examination not specifically requested by MetLife will not be paid by MetLife.
- If an autopsy has not already been performed, and MetLife determines one is necessary for claim determination purposes and not against the law, MetLife will specifically request an autopsy be performed at MetLife's expense. The beneficiary is still required to submit the autopsy report of any non-MetLife requested autopsy as necessary for a claim.

Proof of a claim for AD&D benefits must be provided to MetLife no later than 90 days after the date of loss.
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:

Metropolitan Life Insurance Company
Group Claims Review
P.O. Box 3017
Utica, NY 13504

Designating a Beneficiary
You may designate the same beneficiary(ies) for all plans, or different beneficiaries for each Plan. However, the associate is automatically the beneficiary of all dependent AD&D insurance benefits. You can change your beneficiary(ies) at any time. To designate or change beneficiaries, you must complete a Beneficiary Designation Form. To request a Beneficiary Designation Form, you can access the Your Benefits Resources Web site, or you can call the Benefits Choice Center.

When you are first eligible to enroll, the form is sent to you with your confirmation of enrollment. Complete and sign the form and mail it to the Benefits Choice Center.

You may want to change the designation of your beneficiary from time to time. To change your beneficiary designation, you must request a form by going to your Benefits Resources at http://resources.hewitt.com/homedepot or calling the Benefits Choice Center and speaking with a representative.

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

• your spouse or same- or opposite-sex domestic partner;
• your surviving children (including eligible children of your same- or opposite-sex domestic partner);
• your parents;
• your surviving brothers and/or sisters; or
• your estate.

However, MetLife instead can pay the benefit to your estate. Any such payment discharges all liability for the amount paid.

Benefits will not be paid to a beneficiary who has been convicted of murdering the covered person.

Payment of Benefits
Basic AD&D
The AD&D benefits for a covered loss will be paid when MetLife receives notice and satisfactory written proof of that loss:

• to your beneficiary for the loss of your life; and
• to you for any other covered loss sustained by you; and
• to you for the loss of life of a dependent, if you survive the dependent; if you do not survive, the benefits will be paid to your estate if:

— that dependent dies at the same time your death occurs; or
— that dependent dies within 24 hours of your death; or
— in any other instance the benefits will be paid to the dependent’s estate; and

• to you for any other covered loss sustained by a dependent, if you survive that dependent; otherwise the benefits will be paid to that dependent.

Voluntary AD&D
The Voluntary AD&D benefits for a covered loss will be paid when MetLife receives notice and satisfactory proof of that loss. Any training benefit for a spouse, or same- or opposite-sex domestic partner, will be paid to your spouse and any education benefit for dependent children will be paid to each dependent child.

All other Voluntary AD&D benefits will be paid:

• to your beneficiary for the loss of your life; and
• to you for any other covered loss sustained by you; and
• to you for the loss of life of a dependent, if you survive the dependent; if you do not survive, the benefits will be paid to your estate if:

— that dependent dies at the same time your death occurs; or
— that dependent dies within 24 hours of your death; or
— in any other instance the benefits will be paid to the dependent’s estate; and

• to you for any other covered loss sustained by a dependent, if you survive that dependent; otherwise the benefits will be paid to that dependent.
Get the Most Value from Your Plan

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</tr>
<tr>
<td>Stay on top of your future by tracking your account performance</td>
<td></td>
</tr>
<tr>
<td>Increase or decrease your contribution rate</td>
<td></td>
</tr>
<tr>
<td>Apply for a loan</td>
<td></td>
</tr>
<tr>
<td>Request a beneficiary form</td>
<td></td>
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</tbody>
</table>

What Is FutureBuilder?

FutureBuilder combines the features of a 401(k) plan with the advantages of employee stock ownership. And, 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 2009, the IRS considers an associate who earned $105,000 in 2008 to be a highly compensated employee (HCE). HCEs can contribute between 1% and 5%. The Plan’s Administrative Committee may adjust the maximum contribution percentage from time to time. For example, in 2008, the Administrative Committee increased the HCE contribution from 5% to 7% on July 18, 2008. This contribution limit will be referred to as the “HCE limit” subsequently in this chapter. For more information, go to the Your Benefits Resources Web site or call the Benefits Choice Center.

Your contributions are automatically made through convenient payroll deductions and are not subject to income tax in the year contributed. You enjoy tax-deferred growth of your entire account until you receive a distribution.

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. You must complete at least one year of service (at least 1,000 hours in a 12-month period), before your Company contributions begin.

You can invest your account in any combination of the following three tiers to develop your investment portfolio:

- **Tier One**: Barclays Global Investors (BGI) 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 accessing the Your Benefits Resources Web site 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 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 you were first hired, you are eligible to make before-tax contributions, without regard to any intervening termination, leave of absence, reemployment, etc.

Associates whose employment is governed by the terms of a collective bargaining agreement are not eligible to participate in FutureBuilder unless the agreement expressly provides for coverage in this plan or the Administrative Committee designates that such associates be covered under FutureBuilder.
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.

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 2008 until the January 2009 payroll. Because you were paid for those hours in January 2009, you will receive credit for those hours in 2009, even though you worked those hours in 2008.

If you do not work at least 1,000 hours during your first 12 months of employment with the Company, your Company matching contributions will begin after completing 1,000 hours of service during any plan year (January 1—December 31) that begins after you first become employed by the Company.

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 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. You will be mailed an enrollment kit in a few weeks before you first become eligible to enroll. To enroll, you can:

- Access the Your Benefits Resources Web site.
- Call the Benefits Choice Center, and speak to a Benefits Choice representative.

If you enroll by phone, a confirmation statement will be mailed to your home on the next business day. If you enroll through the Web site, 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.
- **Your investment elections.** You must choose where you want contributions invested. See Your Investment Options.
- **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 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

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 2008, the amount is $230,000. The 2009 amount had not been established when this Benefits Summary was published.
Changing Your Contribution Rate and Investment Elections

Once you have made your enrollment decisions, you can change your contribution rate or investment elections by using the Your Benefits Resources Web site 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 be effective for your next paycheck.

You will get a written confirmation in the mail if you make your changes over the phone. If you make your changes using the Your Benefits Resources Web site, 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.

If you are subject to the Company’s Insider Trading Policy, any change in your investment elections, including investments within the brokerage window, or contribution rate 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 accessing the Your Benefits Resources Web site 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 an estate as your beneficiary. You can designate your beneficiary(ies) by accessing the Your Benefits Resources Web site or by calling the Benefits Choice Center.

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 spouse as beneficiary, the designation will not be valid unless your spouse consents in writing on the Beneficiary Designation Form. Your spouse’s consent must be notarized.

If you do not have a valid Beneficiary Designation Form 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.

Get Professional Advice and Management Using Merrill Lynch Advice Access

If you would like professional advice on how much to save through FutureBuilder and how to invest your savings in the plan, consider using Merrill Lynch Advice Access. Merrill Lynch Advice Access provides you with professional help on determining how much to save, which investments to choose and how to monitor your progress and stay on track.

Based on your current 401(k) account information, assumptions about your retirement age and a projection of the income you’ll need in retirement, Merrill Lynch Advice Access will recommend what percentage of pay you should contribute to FutureBuilder to meet your goals. Advice Access will also recommend which FutureBuilder core investment funds you should choose and the percentage to invest in each one. You’ll receive recommendations that will help you create a portfolio specifically tailored to your financial circumstances and goals.

You can simply view the Advice Access recommendations. You can also use Advice Access to help you monitor and manage your FutureBuilder account. Advice Access offers three levels of service:

- Personal Manager will implement Merrill Lynch Advice Access recommendations and review your account approximately every 90 days. Then, it will either reallocate your account into a new investment mix to help you stay on track or rebalance your account to keep it at its current allocation if no investment changes are needed.
• Portfolio Rebalancing will implement Merrill Lynch Advice Access recommendations and rebalance your account approximately every 90 days to keep it at its original asset mix. Portfolio Rebalancing will not monitor your account or change your investments.

• One-Time Implementation will implement Merrill Lynch Advice Access recommendations with no rebalancing and no account monitoring. You would manage your ongoing investments.

If you give your approval to one of these levels, Advice Access will implement its recommendations.

For more information on Merrill Lynch Advice Access, go to the Your Benefits Resources Web site and click Merrill Lynch Advice Access or call the Merrill Lynch Advice Access Center at 1-800-843-2150.

Contributions to FutureBuilder

Your account is made up of your own before-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 to the Plan, in any whole percentage, unless you are subject to the HCE limit. Contributions are deducted automatically from your paycheck before income taxes are withheld.

When you save with before-tax dollars, you save on your 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 pre-tax basis through FutureBuilder, you have an extra $375 in take-home earnings compared to savings on an after-tax basis. The example assumes you are single, that your eligible compensation is $25,000 and you contribute 10% of that amount to FutureBuilder as pre-tax savings. The estimated federal taxes are based on the IRS 2008 tax table. In this example, the tax rate is 10% on the first $7,825 of taxable compensation, plus 15% of the amount over $7,825.

Tax Savings Comparison

<table>
<thead>
<tr>
<th>Eligible Compensation</th>
<th>Pre-tax Savings</th>
<th>After-tax Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$25,000</td>
<td></td>
</tr>
<tr>
<td>Pre-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>- $ 2,984</td>
<td>- $3,359</td>
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<tr>
<td>Eligible Compensation after Taxes</td>
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<td>$21,614</td>
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<tr>
<td>After-Tax Savings</td>
<td>N/A</td>
<td>- $2,500</td>
</tr>
<tr>
<td>Remaining Take-Home Earnings</td>
<td>$19,416</td>
<td>$19,141</td>
</tr>
</tbody>
</table>

Tax Credit for FutureBuilder Contributions

You could receive a federal tax credit equal to 10%, 20% or 50% of your annual FutureBuilder contribution, up to $1,000 if you file a:

• Single return and have annual income of $26,500 or less
• Joint return and have annual income of $53,000 or less
• Head-of-household return and have annual income of $39,750 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 $2,000.

Here’s an example of how it works. If you and your spouse had a combined income of $32,000, filed a joint tax return, and together contributed $4,000 ($2,000 each) to FutureBuilder, you’d be eligible for a 20% tax credit. You would pay $800 ($4,000 x 20%) less in income taxes for the year. Certain conditions apply so check with your tax advisor for more information.
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 contribution limits. This can help you save even more as you approach retirement.

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 2009 even if you are not yet age 50 as long as you will turn age 50 by the end of 2009.

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. Unlike your regular, before-tax contributions 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 in Future Years

For 2008, the catch-up contribution limit is $5,000. The 2009 amount had not been established when this Benefits Summary was published. It’s a good idea to annually review your contributions and make any changes that are appropriate.

How Catch-up Contributions Are Made

Like regular FutureBuilder contributions, you make catch-up contributions through convenient, automatic payroll deductions. And catch-up contributions are deducted from your paycheck before income taxes are taken out, so you will be taxed on a smaller gross income.

Generally, catch-up contributions can only be made if you reach the IRS limit on contributions to FutureBuilder. For example, in 2008, this IRS limit was $15,500. However if you qualify for catch-up contributions, you were allowed to contribute up to an additional $5,000, meaning that you could have contributed a total of $20,500 to your FutureBuilder account in 2008.

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 2008, you contributed the HCE maximum and you qualified for catch-up contributions, you could have contributed up to an additional $5,000 to your FutureBuilder account in 2008.

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) will be reclassified as a catch-up contribution if you meet the catch-up contribution age restriction. If your 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, before-tax 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%, then the Company will contribute an amount equal to 3.5% of your pay. The Company match is determined and made on the same frequency as your regular, before-tax contributions, typically on a biweekly basis. Here’s a snapshot of the boost you can get:

- **Your total FutureBuilder contributions equal this much of your pay**: 1% 2% 3% 4% 5% 6% 7%
- **The Company match will equal this percentage of your pay**: 1.5% 2% 2.5% 4% 5.5% 7% 8.5% to 53.5%

<table>
<thead>
<tr>
<th>If your contribution equals this much of your pay</th>
<th>The Company match will equal this percentage of your pay</th>
<th>Your total FutureBuilder contributions equal this much of your pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>1.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>3%</td>
<td>2.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>4%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>5% to 50%1</td>
<td>3.5%</td>
<td>8.5% to 53.5%</td>
</tr>
</tbody>
</table>

1 You’ll receive a matching contribution on up to 5% of your pay, but generally you can save as much as 50% of your eligible pay.

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>$200 x 1.5 = $300</td>
<td>$200 + $300 = $500</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>$800 x .5 = $400</td>
<td>$800 + $400 = $1,200</td>
</tr>
<tr>
<td>Next 2% of pay</td>
<td>$400</td>
<td>$0</td>
<td>$400</td>
</tr>
<tr>
<td></td>
<td>$20,000 x .02 = $400</td>
<td>$0</td>
<td>$400 + $0 = $400</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 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, the Plan will not accept any amounts representing after-tax contributions you made to a prior employer’s plan or an IRA. You may obtain more information about rollovers or request a rollover contribution form by accessing the Your Benefits Resources Web site or calling the Benefits Choice Center and speaking to a representative.

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
- 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.

Savings Limitations

Plan Limits

For 2009, the IRS considers an associate who earned $105,000 or more in 2008 to be a highly compensated employee (HCE). HCEs contributions are subject to certain limitations.

IRS Limits

The IRS places the following restrictions on contributions to FutureBuilder:

- The amount of before-tax contributions you can 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 2008 is $15,500, less any before-tax contributions you made to another eligible employer-sponsored retirement plan in the same year. If your combined contributions under FutureBuilder and another employer-sponsored plan exceed this limit 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. The amount for 2009 had not been established at the time of this book’s publication.

- 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 2008, this amount is $230,000. The amount for 2009 had not been established at the time of this book’s publication.

- 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 $46,000 for 2008, whichever is less, under federal law. The amount for 2009 had not been established at the time of this book’s publication. 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, 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.

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 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 service accumulated prior to the break in service will be recognized.

<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></td>
<td>100%</td>
<td>20%</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>7 or more</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FutureBuilder Vesting Schedule
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 once you have completed one year of service following your rehire date, if you were at least partially vested in your contributions or Company 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. For greater flexibility, you can use any combination of the three tiers to develop your investment portfolio.

The FutureBuilder Investment Committee continuously monitors the performance of each FutureBuilder fund to make sure the funds continue to be good investment options for associates, 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 visit the 401(k) page on Your Benefits Resources Web site for the most up-to-date information on your investment fund options.

Remember, you can transfer or change your investment elections at any time by accessing Your Benefits Resources Web site at http://resources.hewitt.com/homedepot or by calling the Benefits Choice Center at 1-800-555-4954.

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: Barclays Global Investors (BGI) LifePath® Portfolios—If you invest in a LifePath Portfolio, all you need to do is determine the target year when you 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, Merrill Lynch Advice Access, 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.

BGI LifePath® Portfolios

The BGI 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 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 number 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 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 number 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 on to Your Benefits Resources Web site for the most current percentage information.

<table>
<thead>
<tr>
<th>Current Age</th>
<th>LifePath Portfolio Default</th>
<th>Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or = 30</td>
<td>LifePath 2045</td>
<td>Less than or = 67</td>
</tr>
<tr>
<td>Between 31 &amp; 35</td>
<td>LifePath 2040</td>
<td>Between 63 &amp; 67</td>
</tr>
<tr>
<td>Between 36 &amp; 40</td>
<td>LifePath 2035</td>
<td>Between 63 &amp; 67</td>
</tr>
<tr>
<td>Between 41 &amp; 45</td>
<td>LifePath 2030</td>
<td>Between 63 &amp; 67</td>
</tr>
<tr>
<td>Between 46 &amp; 50</td>
<td>LifePath 2025</td>
<td>Between 63 &amp; 67</td>
</tr>
<tr>
<td>Between 51 &amp; 55</td>
<td>LifePath 2020</td>
<td>Between 63 &amp; 67</td>
</tr>
<tr>
<td>Between 56 &amp; 60</td>
<td>LifePath 2015</td>
<td>Between 63 &amp; 66</td>
</tr>
<tr>
<td>Between 61 &amp; 63</td>
<td>LifePath 2010</td>
<td>Between 63 &amp; 66</td>
</tr>
<tr>
<td>65 and greater</td>
<td>LifePath Retirement</td>
<td>Greater than or = 65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>65 and greater</td>
</tr>
</tbody>
</table>

LifePath® Retirement Portfolio

Official Fund Name: LifePath® Index Retirement Portfolio

Investment Objective

The LifePath Retirement Portfolio is designed to provide a complete 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 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, 2008, the percentage of holdings in these two asset classes was roughly 54.1% U.S. bonds and 22.9% U.S. stocks, with the balance of the portfolio in international stocks and real estate.

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 2010® Portfolio**

**Official Fund Name: BGI LifePath Index 2010® Portfolio**

**Investment Objective**

The LifePath 2010 Portfolio is designed to be a complete investment solution for investors who expect to retire between 2008 and 2012. The portfolio is weighted toward an investment mix that has potentially less risk or volatility, while still holding some growth-oriented assets such as stocks to provide a limited amount of inflation protection.

**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, 2008, the percentage of holdings in these two asset classes was roughly 58.5% U.S. bonds and 26.2% U.S. stocks, with the balance of the portfolio in international stocks and real estate. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2010. When it reaches its target year (2010), it will be at its most conservative asset mix. At that time, the assets will be blended in 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 over time, to respond to the changing needs of their investors as they age. The LifePath 2010 Portfolio has a conservative asset mix as it only has a few years to go before reaching its most conservative asset mix in 2010.

**Fees:** See FutureBuilder Investment Expenses.

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**LifePath 2015® Portfolio**

**Official Fund Name: BGI LifePath Index 2015® Portfolio**

**Investment Objective**

The LifePath 2015 Portfolio is designed to be a complete investment solution for investors who expect to retire between 2013 and 2017. The portfolio is weighted toward an investment mix that has potentially less risk or volatility, while still holding some growth-oriented assets such as stocks to provide a limited amount of inflation protection.

**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, 2008, the percentage of holdings in these two asset classes was roughly 47.3% U.S. bonds and 33.5% U.S. stocks, with the balance of the portfolio in international stocks and real estate. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2015. When it reaches its target year (2015), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended in 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 over time, to respond to the changing needs of their investors as they age. The LifePath 2015 Portfolio has a moderately conservative asset mix as it has approximately 6 years to go before reaching its most conservative asset mix in 2015.

**Fees:** See FutureBuilder Investment Expenses.

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**LifePath 2020® Portfolio**

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

**Investment Objective**

The LifePath 2020 Portfolio is designed to be a complete 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, 2008, the percentage of holdings in these two asset classes was roughly 38.1% U.S. bonds and 39.5% U.S. stocks, with the balance of the portfolio in international stocks and real estate. These percentages are adjusted over time to gradually become more conservative as the portfolio gets closer to 2015. When it reaches its target year (2015), it will be at its most conservative asset mix. At that time, the assets of this portfolio will be blended in 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 over time, to respond to the changing needs of their investors as they age. The LifePath 2020 Portfolio has an aggressive asset mix.
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 in 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 over time, to respond to the changing needs of their investors as they age. The LifePath 2020 Portfolio has a moderately conservative asset mix as it has approximately 11 years to go before reaching its most conservative asset mix in 2020.

Fees: See FutureBuilder Investment Expenses.

LifePath 2025® Portfolio

Official Fund Name: BGI LifePath Index 2025® Portfolio

Investment Objective

The LifePath 2025 Portfolio is designed to be a complete 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, 2008, the percentage of holdings in these three asset classes was roughly 26.1% U.S. bonds, 44.8% U.S. stocks and 20.4% in international stocks, with the balance of the portfolio in real estate. 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 in 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 over time, to respond to the changing needs of their investors as they age. The LifePath 2025 Portfolio has a balanced asset mix as it has approximately 16 years to go before reaching its most conservative asset mix in 2025.

Fees: See FutureBuilder Investment Expenses.

LifePath 2030® Portfolio

Official Fund Name: BGI LifePath Index 2030® Portfolio

Investment Objective

The LifePath 2030 Portfolio is designed to be a complete 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) and international equities. As of June 30, 2008, the percentage of holdings in these two asset classes was roughly 49.5% U.S. stocks, 22.4% in international equities, 23% U.S. bonds, with the balance of the portfolio in real estate. 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. At that time, the assets of this portfolio will be blended in 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 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 21 years to go before reaching its most conservative asset mix in 2030.

Fees: See FutureBuilder Investment Expenses.

LifePath 2035® Portfolio

Official Fund Name: BGI LifePath Index 2035® Portfolio

Investment Objective

The LifePath 2035 Portfolio is designed to be a complete 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 percentage in U.S. equities (stocks) and international stocks. As of June 30, 2008, the percentage of holdings in these two asset classes was roughly 53.9% U.S. stocks and 24.3% international stocks, with the balance of the portfolio in U.S. bonds and real estate. 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. At that time, the assets of this portfolio will be blended in the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

Risk and Return Characteristics

Fees: See FutureBuilder Investment Expenses.

LifePath 2040® Portfolio

Official Fund Name: BGI LifePath Index 2040® Portfolio

Investment Objective

The LifePath 2040 Portfolio is designed to be a complete 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 percentage in U.S. equities (stocks) and international stocks. As of June 30, 2008, the percentage of holdings in these two asset classes was roughly 57.9% U.S. stocks and 26% international stocks, with the balance of the portfolio in U.S. bonds and real estate. 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 in the LifePath Retirement Portfolio. All investors in this portfolio will then own units in LifePath Retirement going forward.

Risk and Return Characteristics

Fees: See FutureBuilder Investment Expenses.
LifePath 2045® Portfolio

Official Fund Name: BGI LifePath Index 2045® Portfolio

Investment Objective
The LifePath 2045 Portfolio is designed to be a complete investment solution for investors who expect to retire after 2043. 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. fixed income (bonds) and U.S. equities (stocks). As of June 30, 2008, the percentage of holdings in these two asset classes was roughly 61.7% U.S. stocks and 27.6% international stocks, with the balance of the portfolio in U.S. bonds and real estate. 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 in 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 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 36 years to go before reaching its most conservative asset mix in 2045.

Fees: See FutureBuilder Investment Expenses.

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. Generally, the risk of any investment tends to decline the longer you hold it.

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.

Stable Value Fund
Official Fund Name: JPMorgan Stable Value Fund

Investment Objective
The Stable Value Fund's objective is to preserve the value of money invested, 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 combined with investment contracts called "benefit responsive wraps." The wrap contracts which are issued by insurance companies and banks provide preservation of participant balances, regardless of market conditions. The wraps also help to stabilize the returns of the fund, even when markets are volatile. The fixed income portfolio consists of investment grade fixed income securities, primarily U.S. Treasury, agency, corporate, mortgage-backed, asset-backed, and privately placed mortgage debt.
The diagram below shows how the FutureBuilder core funds compare to each other in terms of risk and return potential.

### Risk and Return Characteristics
- **Conservative**
- **Moderate**
- **Agressive**

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 T. Rowe Price Rolling 3-Year GIC Index, which has a similar risk profile.

### Fees
See FutureBuilder Investment Expenses.

### Bond Fund
**Official Fund Name:** Barclays Global Investors (BGI) U.S. Debt Index Fund

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

**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 Lehman Brothers Aggregate Bond Index, which has a similar investment style.

**Fees:** See FutureBuilder Investment Expenses.

### Balanced Fund
**Official Fund Name:** BGI Balanced Fund

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

**Asset Allocation**
The fund invests approximately 60% of assets in the BGI Equity Index Fund (which invests in equity securities—stocks) with the remainder of the fund in the BGI U.S. Debt Index Fund (which invests in fixed income securities—bonds).

**Risk and Return Characteristics**
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. However, to further offset some of the fund’s risk, investors may wish to spread their savings among several funds that have different investment objectives and characteristics.

**Comparison Index Performance**
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. However, to further offset some of the fund’s risk, investors may wish to spread their savings among several funds that have different investment objectives and characteristics.
Comparison Index Performance
Performance of the Balanced Fund is compared to the 60% S&P 500 Index/40% Lehman Aggregate Bond Index, which have a similar investment styles.

Fees: See FutureBuilder Investment Expenses.

Equity Value Fund
Official Fund Name: Dodge & Cox Stock Fund
Investment Objective
The Equity 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. The fund may also invest up to 20% of its assets in securities of foreign issuers traded in the U.S.

Risk and Return Characteristics
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 Equity Value Fund is compared to the Russell 1000 Value Index, which has a similar investment style.

Fees: See FutureBuilder Investment Expenses.

Equity Index Fund
Official Fund Name: Barclays Global Investors (BGI) 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
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 Equity Index Fund is compared to the S&P 500 Index, which has a similar investment style.

Fees: See FutureBuilder Investment Expenses.

Equity Growth Fund
Official Fund Name: TimesSquare Mid Cap Growth Strategy Fund
Investment Objective
The Equity 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 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
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 Equity 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 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, excluding non-U.S. companies included in the S&P 500. The Fund also invests in American, European and Global Depository Receipts.

Risk and Return Characteristics

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 Company Fund
Official Fund Name: T. Rowe Price Small Cap Stock Fund
Investment Objective
The Small Company Fund’s objective is to provide long-term growth through the investment in small, fast-growing companies.

Asset Allocation
The fund’s managers focus on companies they believe offer strong potential earnings growth or are relatively undervalued. The fund may also invest up to 10% of its assets in foreign securities.

Risk and Return Characteristics
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 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 a future investment option 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
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 this right, you will want to give careful consideration to the following information that describes the importance of diversification.

In deciding whether to exercise this right, you will want to give careful consideration to the benefits of a well-balanced and diversified investment portfolio. See Importance of Diversification.

The Brokerage Window: Schwab PCRA
The Schwab PCRA (Personal Choice Retirement Account) is a brokerage account that gives you the freedom 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:

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

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 onto the Your Benefits Resources Web site (http://resources.hewitt.com/homedepot) 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 JP Morgan, 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 go to the Your Benefits Resources Website and click “Schwab PCRA” or call Schwab at 1-888-393-7272. You can also go to www.schwabpcra.com.
# FutureBuilder Investment Expenses*

<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>Equity Value Fund</th>
<th>Equity Index Fund</th>
<th>Equity Growth Fund</th>
<th>Times Square Mid Cap Strategy Fund</th>
<th>International Fund</th>
<th>Small Company Equity Fund</th>
<th>T. Rowe Price Small Cap Stock Fund</th>
<th>Home Depot Stock Fund</th>
<th>Schwab PCRA Fund</th>
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<tr>
<td>Official Fund Name</td>
<td>BGI LifePath Portfolios</td>
<td>JPMorgan Stable Value Fund</td>
<td>BGI Debt Index Fund</td>
<td>BGI Balanced Fund</td>
<td>Dodge &amp; Cox Stock Fund</td>
<td>BGI Equity Index Fund</td>
<td>BGI Equity Index Fund</td>
<td>Dodge &amp; Cox International Stock Fund</td>
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<td>Type of Fee</td>
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<tr>
<td>Investment Management Fees</td>
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<td>0.031%1</td>
<td>0.420%</td>
<td>0.025%</td>
<td>0.640%2</td>
<td>0.550%</td>
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<tr>
<td>Distribution, Service &amp; Administration Fees</td>
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<td>0.000%</td>
<td>0.020%2</td>
<td>0.020%2</td>
<td>0.100%</td>
<td>0.020%3</td>
<td>0.000%</td>
<td>0.100%3</td>
<td>0.350%4</td>
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<tr>
<td>Total Investment-related Fees</td>
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<td>0.150%</td>
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<td>0.051%</td>
<td>0.520%</td>
<td>0.045%</td>
<td>0.640%</td>
<td>0.650%</td>
<td>1.120%</td>
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<tr>
<td>Recordkeeping Add-on Fees</td>
<td>0.165%</td>
<td>0.165%</td>
<td>0.165%</td>
<td>0.165%</td>
<td>0.065%</td>
<td>0.165%</td>
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<tr>
<td>Total Investment Expenses</td>
<td>0.385%</td>
<td>0.315%</td>
<td>0.225%</td>
<td>0.216%</td>
<td>0.585%</td>
<td>0.210%</td>
<td>0.805%</td>
<td>0.715%</td>
<td>1.120%</td>
<td>0.165%</td>
<td>Variable6</td>
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</table>

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

2 The Times Square Mid Cap Strategy Fund is offered through a separate account structure. The investment management fee will vary based upon total Home Depot assets invested in the fund. The reported fee represents an estimate based upon current participant assets invested in the Mid Cap Strategy Fund. The investment management fee schedule for the Times Square strategy is: 0.80% on the first $50 million, 0.70% on the next $50 million and 0.60% on the balance.

3 Each BGI LifePath Portfolio, the BGI U.S. Debt Index Fund, the BGI Balanced Fund and the BGI Equity Index 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 BGI fund will vary but have been capped at 0.02%.

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.

5 Total investment-related fees represent estimated investment management, distribution, 12b-1 service and administration fees as of May 31, 2008, 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 deduced from performance.

6 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.

* This fee schedule became effective October 9, 2007. Additional 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.
Different Investments Carry Different Risk and Return

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 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 can 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 time to recover from market swings.

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.

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.

Keeping Track of Your Account

You can track the progress of your account by reviewing your personal statement each quarter. Just access the Your Benefits Resources Web site and print your online statement or call the Benefits Choice Center.

FutureBuilder Statements

If you are have an account balance in the Plan, you will receive a FutureBuilder account statement 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 on the Your Benefits Resources Web site. You can also request a copy of the most recent quarterly statement by contacting the Benefits Choice Center.
Your Benefits Resources Web Site and the Benefits Choice Center

Your Benefits Resources Web site and the Benefits Choice Center give you the ability to obtain information about your account, request forms, and make Plan transactions.

You can access the Your Benefits Resources Web site 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—rearrange 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.
• Change your Company match investment election—choose one or more of the Plan investment options.
• Obtain investment fund returns—obtain one-, three-, and five-year returns.
• Obtain a fund sheet or a fund prospectus that includes information about the fund, such as top portfolio holdings
• Access Morningstar 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 information—obtain the amounts you have available for a hardship withdrawal and the rules regarding hardship withdrawals, or request that a hardship application be mailed to you.
• Request an age 59½ in-service withdrawal—obtain information regarding in-service withdrawals.
• 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 the Your Benefits Resources Web site if you prefer.
• Speak to a Benefits Choice representative—whenever you need help working your way through the Your Benefits Resources Web site, or need personal assistance. Representatives are available weekdays (excluding holidays) from 9 a.m. to 7 p.m. (Eastern Time).

Confirmation of Your Transaction

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

Confirmation statements for transactions made on the Your Benefits Resources Web site will not always be mailed. It is a good idea to print your requests and confirmations for requests made on the Web site. 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. 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 Apply for a Loan

To apply for a loan from your FutureBuilder account, access the Your Benefits Resources Web site 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, use the Your Benefits Resources Web site 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 two 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, and/or matching accounts to be eligible for the minimum 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, 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 for loans. The amount available reflected on your statements and on the Your Benefits Resources Web site 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 payments left, you can pre-pay the entire outstanding balance of a loan without penalty, but you must repay the loan in full—partial payments will not be accepted. All payments of principal and interest are invested according to your existing before-tax investment elections at the time of repayment.

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:

- you cannot make the regularly scheduled payroll deduction for the loan repayment within a 90-day period; or
- 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
- you fail to pay the loan within its terms.

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 took out a loan after January 1, 2002, and 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.

If you took out a loan before January 1, 2002, and you are on military leave:

- you will have your payments resumed upon returning to active status;
- the loan period will be extended by the length of your leave period not to exceed five years; and
- no reamortization is necessary since the accrual of interest during the leave period is not required.
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). Interest will accrue at the rate applicable to their original loan agreement capped at 6% for the length of their military leave.

Please note that accrued interest will be included only for those participants whose loans originated after January 1, 2002.

**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 that are 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.

In the case of a hardship withdrawal for adoption assistance, you must first apply for assistance under the Company’s Adoption Reimbursement Program.

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 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. 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 two 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.

**Hardship Withdrawals from your PCRA Account**

Withdrawals may only be taken from your account assets invested in the core investment options and LifePath portfolios. If you wish to take a hardship withdrawal from your FutureBuilder account, you may need to transfer money from your PCRA account to the other investment options if the amount you're requesting exceeds your balance in the core funds and the LifePath portfolios. You can't take a hardship withdrawal directly from the PCRA. The amount available reflected on your statements and on the Your Benefits Resources Web site excludes the balance in the PCRA when displaying the amount available for a withdrawal.

**Tax Considerations**

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.

You may request up to two withdrawals during a rolling 12-month period in the form of cash, or a combination of cash and shares of Home Depot stock (if you already own them). If you call prior to 4 p.m. (Eastern Time) or market close if earlier, on any business day, your request will be processed that day.

Generally, you should receive your check approximately two to three weeks from the date your request is processed. If you authorize payment to be electronically transferred to a specified bank account, the proceeds will be deposited within two business days from the date your request is processed. You are responsible for ensuring the bank account number you provide is correct.

In-Service Withdrawals from your PCRA Account

Withdrawals may only be taken from the your account assets invested in core investment options and LifePath portfolios. If you wish to take an in-service withdrawal from your FutureBuilder account, you may need to transfer money from your PCRA account to the other investment options if the amount you’re requesting exceeds your balance in the core funds and the LifePath portfolios. You can’t take an in-service withdrawal directly from the PCRA. The amount available reflected on your statements and on the Your Benefits Resources Web site excludes the balance in the PCRA when displaying the amount available for a withdrawal.

Military Leave Distributions

If you are on active duty in the uniformed services for more than 30 days you will be treated as separated from service for purposes of being able to receive a distribution of before tax contributions and associated earnings. 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. This is effective January 1, 2009.

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 (only if your beneficiary is your spouse); or
- taxable distribution to himself or herself.

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 PCRS 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, access the Your Benefits Resources Web site 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 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 two business days from the date your request is processed. You are responsible for ensuring the bank account number you provide is correct.

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.

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 specific payout option to be made at least 30 days following your separation from service.

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 designated 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.

Tax Considerations
Your contributions, Company matching contributions, ESOP contributions, and investment earnings 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.

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 in addition to your regular income tax.
The 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.

It is important to note that if you receive part of 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, your tax liability will be based on any increase or decrease in the stock’s value over the original cost basis of the stock distributed to you.

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. 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 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.

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 your local IRS office, from the Internet on the IRS Web site at www.irs.ustreas.gov/formspubs/index.html, or by calling 1-800-TAX-FORM (1-800-829-3676).
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. 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 Company matching or ESOP 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 to pay Plan expenses or as a credit toward Company matching contributions for all active participants.

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:

- 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.
- 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. 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.

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 future years.

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) may be relieved of liability for losses resulting from a participant’s investment instructions.

All questions or claims about eligibility and/or benefits under the FutureBuilder must be submitted within two years of the date payment is made or the date of the complaint.

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.
### Effective Dates

<table>
<thead>
<tr>
<th>Request</th>
<th>Deadline</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Contribution rate change</td>
<td>1 a.m. (Eastern Time) on any Friday the week before your next payday</td>
<td>Contributions at your newly elected rate begin with your next paycheck.</td>
</tr>
<tr>
<td>Investment election change</td>
<td>4 p.m. (Eastern Time) or market close on any business day</td>
<td>All your future contributions after the day you call are invested according to your request.</td>
</tr>
<tr>
<td>Fund transfer (fund transfers are limited to 1 per day)</td>
<td>4 p.m. (Eastern Time) or market close on any business day</td>
<td>Your request will be processed as of the day you make the request at the closing prices on the day of your request. Transfers requested for the Schwab PCRA or through Merrill Lynch Advice Access will be processed as soon as administratively possible (within one to three business days of your request).</td>
</tr>
<tr>
<td>Hardship withdrawal request</td>
<td>Return your signed documentation to the Benefits Choice Center. When you call or access the Your Benefits Resources Web site to request this transaction, the appropriate paperwork will be mailed to you.</td>
<td>Your request is processed based on the value of your account on the day your completed documentation is received and approved; generally, you will receive your check within two weeks after approval or within two business days if you authorize payment to be direct deposited into a specified bank account.</td>
</tr>
<tr>
<td>Final distribution request (after your employment ends)</td>
<td>4 p.m. (Eastern Time) or market close on any business day</td>
<td>If you request a final distribution prior to 30 days following the termination of your employment, your request is processed based on the value of your account as of market close coinciding with or immediately following your termination date plus 30 days. 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 of your distribution processes. Generally you will receive your check within two weeks or within two business days if you authorize payment to be direct deposited into a specified bank account. For more information, see Final Distributions of Your Account.</td>
</tr>
<tr>
<td>Force-Out (vested account balances equal to or less than $1,000)</td>
<td>4 p.m. (ET) or market close on last business day of second month following termination of your employment. If you do not request a final distribution by this deadline, your balance will be paid to you automatically as a taxable distribution.</td>
<td>If you request a final distribution prior to 30 days following the termination of your employment, your request is processed based on the value of your account as of market close coinciding with or immediately following your termination date plus 30 days. 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 of your distribution processes. Generally you will receive your check within two weeks or within two business days if you authorize payment to be direct deposited into a specified bank account. For more information, see Final Distributions of Your Account.</td>
</tr>
<tr>
<td>Loan</td>
<td>4 p.m. (Eastern Time) or market close on any business day</td>
<td>Your request is processed as of the day you call, and the check should be received two to three weeks after your initial loan request is made or within two business days if you authorize payment to be direct 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 business day</td>
<td>Your request will be processed as of the day you call at the closing prices on the day you call. You should receive your check within approximately two to three weeks from the date your request is processed or within two business days if you authorize payment to be direct deposited into a specified bank account.</td>
</tr>
<tr>
<td>Rollover contribution</td>
<td>Return your signed documentation with rollover proceeds to the Benefits Choice Center. When you call or access the Your Benefits Resources Web site to request this transaction, the appropriate paperwork will be mailed to you.</td>
<td>Generally, your request is processed as of the day your completed documentation is received and approved.</td>
</tr>
<tr>
<td>Rollover distribution</td>
<td>4 p.m. (Eastern Time) or market close on any business day</td>
<td>If you request a rollover distribution to an IRA, another qualified plan, 403(b) plan, or 457 plan, following the termination of your employment, the timing of the distribution will mirror the final distribution effective date description noted above. In-kind rollovers of Home Depot stock from the Home Depot Stock Fund are available if the receiving institution accepts shares. If you have a Schwab PCRA fund balance, you may request a direct in-kind rollover to an IRA. For more information on the Schwab IRA Rollover, please contact Schwab.</td>
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<tr>
<td>Request</td>
<td>Deadline</td>
<td>Effective Date</td>
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<tr>
<td>Loan pre-payment or 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.</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 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.</td>
<td>You must appeal in writing to: Home Depot FutureBuilder Administrative Committee Benefits Department, Building C-9 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
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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 after a number of years.

**Collective/Commingled Funds**—collective funds are “pooled” vehicles that commingle the assets of multiple individuals or organizations 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), the Dodge & Cox International Stock Fund (DODFX) and the T. Rowe Price Small Cap Stock Fund (PASSX). Although you can track these funds and their prices in a newspaper’s financial pages, keep in mind that the net asset values (NAVs) and share prices may differ from those listed in newspapers 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 Strategy is 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.
Get the Most Value from Your Plan

<table>
<thead>
<tr>
<th>What do you need?</th>
<th>Find it here...</th>
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<tbody>
<tr>
<td>Change or stop your payroll deductions</td>
<td>Log on to the Your Benefits Resources Web site at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>.</td>
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<tr>
<td>Sell your ESPP shares and receive proceeds</td>
<td>Call Computershare at 1-800-843-2150, or visit their Web site at www-us.computershare.com/employee.</td>
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<td>See Stock Transactions for more information on selling shares and payment delivery options.</td>
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<tr>
<td>Withdraw or transfer shares</td>
<td>Call Computershare at 1-800-843-2150, or visit their Web site at www-us.computershare.com/employee.</td>
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<td>to get the appropriate forms.</td>
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<tr>
<td>Purchase The Home Depot stock on the open market</td>
<td>Contact Computershare for more information.</td>
</tr>
<tr>
<td>Get answers to your questions</td>
<td>Call the Benefits Choice Center toll-free at 1-800-555-4954 and follow the voice prompts for the Employee Stock Purchase Plan.</td>
</tr>
<tr>
<td>• If a Plan has not ended</td>
<td>Call your payroll department (or other department administering the ESPP, if you work for a subsidiary or a part of the Company that's outside the U.S. or Canada).</td>
</tr>
<tr>
<td>• If there is an error in the number of shares deposited to your Computershare account</td>
<td>Call Computershare at 1-800-843-2150 and speak with a representative.</td>
</tr>
<tr>
<td>If you don’t understand your payroll deduction or the amount isn’t correct</td>
<td>Call your payroll department (or other department administering the ESPP, if you work for a subsidiary or a part of the Company that's outside the U.S. or Canada).</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.</td>
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</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 stock 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. 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 July, 2007.

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 of your eligible earnings for each pay period.

At the end of a Current Plan, the Company issues you as many 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). 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 needed administrative systems. To receive shares you purchased through payroll deduction, you must be an active associate on the last day of the Plan pay period. 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 July 1, 2008 Plan is June 16, 2008 and the enrollment deadline for the January 1, 2009 Plan is December 17, 2008.

Limitation on Participation

You are not eligible to participate in The Home Depot ESPP if you own, or if you hold, options to purchase 5% or more of the common stock of The Home Depot or a subsidiary, or if the purchase of ESPP shares would cause you to become a 5% shareholder.

Enrolling in the Plan

To participate in the ESPP, you must enroll during the open enrollment period using either the Your Benefits Resources Web site, 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 and health benefits. It is important to note that this is not your Home Depot personal identification number (PIN), found on your paycheck. You also need your Social Security number. During the enrollment process, you will be asked for the percentage of your eligible earnings that you wish to have deducted each pay period.

To enroll online, log on to the Your Benefits Resources Web site at http://resources.hewitt.com/homedepot and select the ESPP link under the Topics main menu. This link will direct you to the main ESPP page. Choose an option from the drop-down menu and follow the prompts to complete your transaction. You must confirm your selection before the transaction is complete.

To enroll using the automated phone system available through the Benefits Choice Center, call 1-800-555-4954 and say English. At the main menu, say Employee Stock Purchase Plan and then follow the voice prompts to confirm your selection.

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. See 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 stock is traded on the New York Stock Exchange (NYSE).

Example:

| $35.00 | NYSE closing price |
| 5.25 | ESPP discount (15% of $35) |
| $29.75 | ESPP purchase price |
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.

<table>
<thead>
<tr>
<th>Example:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,500.00</td>
<td>Total payroll deductions during Plan</td>
</tr>
<tr>
<td>+ 29.75</td>
<td>ESPP purchase price for Plan</td>
</tr>
<tr>
<td>50.42</td>
<td>Shares purchased through Plan</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Example:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$923</td>
<td>Eligibility earnings per pay period (Based on 26 pay periods per year; eligible annual pay of approximately $24,000, or about $12 per hour)</td>
</tr>
<tr>
<td>x 5%</td>
<td>ESPP elected participation rate</td>
</tr>
<tr>
<td>$46.15</td>
<td>Payroll deduction per pay period</td>
</tr>
<tr>
<td>x 13</td>
<td>Pay periods during Plan (approximate)</td>
</tr>
<tr>
<td>$599.95</td>
<td>Total payroll deductions for Plan</td>
</tr>
</tbody>
</table>

If your hours, pay rate or salary change during a Plan, your payroll deductions will be adjusted accordingly. In other words, the percentage rate of your payroll will stay the same, unless you elect to change it as described in the next section. However, the 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 retirement plan and any before-tax payroll deductions for health and welfare benefit plans, minus reimbursements, expense allowances, fringe benefits, moving expenses, welfare benefits 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 first plan period for the next calendar year at your current participation rate, unless you elect to change your rate during that Plan’s open enrollment period.

Changing Your Payroll Deduction
Anytime before the last day of the Plan pay period, 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 last day of the Plan pay period. 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.

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 Making the Best Use This Information 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. In other words, if you stop participating in one Plan before it ends, there is no automatic enrollment in the Next Plan.

After a Plan pay period ends, the total amount of your payroll deductions during the Plan will be used to purchase shares of stock. After a Plan pay period ends, you cannot receive a refund for your payroll deductions.

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 ends before the last day of a Current Plan, your rights to purchase shares under the ESPP will be cancelled. Your contributions to the Current Plan will be automatically refunded to you approximately 45 days after your date of termination.

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 45 days later. 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 by contract or by law (for example, under the provisions of FMLA or certain Military Leaves).

If any of the special circumstances listed above (retirement, death or disability) apply, you (or the administrator of your estate, in the case of your death) will discontinue making contributions to the Current Plan and purchase shares at the end of the Current Plan with the contributions you have made to the Current Plan thus far.

If you do not make a timely election, 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 deployed 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, 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 a 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 you have your stock certificates at home or in a safe deposit box, the dividend will be mailed to your home address. If your shares are being held at Computershare, any dividends will be automatically used to purchase additional shares of The Home Depot common stock, which will be credited to your Computershare account.

<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>

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 Social Security number or Global ID, “Home Depot,” and your current address so that Computershare can begin mailing your dividend checks.

Computershare charges a commission for purchasing stock through their Dividend Reinvestment Plans. Refer to Computershare Fees for fees associated with transactions completed through Computershare.

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 a statement, twice a year, in January and July. This statement will include your current transaction or activity, your previous share balance, and your current share balance. 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 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 account and any personal investments and savings you may have.
Stock Transactions

Accessing Your Computershare Account

After you complete 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. The PIN you receive from Computershare will not be the same as the PIN on your paycheck.

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.

Computershare will accept orders to sell stock before the stock market opens (9:30 a.m. Eastern Time). Your stock will be sold at the opening price of the current day (not the closing price of the prior day, which is the price that Computershare quotes until the market opens).

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. 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 current rate.

2. Wire transfer to bank account on settlement day. You must fax the following wire transfer information to Computershare: your name, address, Social Security 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 or through their Web site.

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.

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 or for electronic share transfers. See Computershare Fees for more information.

Computershare Fees

The following fees are subject to change at any time without notice.

Selling The Home Depot Stock

• $0.03 per share
• $25 minimum charge per transaction
• $5.35 confirmation charge per transaction
• SEC charge of $0.0390 per $1,000 gross proceeds per transaction

Buying The Home Depot Stock

Computershare will purchase additional shares of The Home Depot stock for you on the open market. Purchases will be made within 72 hours after your check is received.

• Minimum investment—$100
• Discounted commission rate—$0.06 per share + $6 minimum charge

To purchase stock through Computershare on the open market, mail your check to Computershare. See Computershare Contacts for address information.
**Dividend Reinvestment Plan (DRP)**

**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 your wiring 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.

**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
P.O. Box 240
Denver, CO 80201-0240

**Online**

www-us.computershare.com/employee

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**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 form or a W-8 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 sell your shares in a Qualified Disposition, you report on your tax return 15% of the stock closing price on the last day of the Plan (the discount amount) as ordinary compensation income (or, if less, the difference between the fair market value of the ESPP shares on the date of the sale less the amount you paid for the shares). You report any remaining gain as long-term capital gains on your tax return. Long-term capital gains tax rates are generally (but not always) lower than your personal income tax rate. If your marginal tax rate is greater than the long-term capital gains tax rate, you can generally save money by holding your ESPP shares until after the 24-month long-term capital gain holding period is satisfied. Always 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. If your marginal tax rate is greater than the long-term capital gains tax rate, you can generally save money by holding your ESPP shares until after the expiration of the Holding Period. Always 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. For example, if you purchase 100 shares of stock through the ESPP in 2008, and there is a dividend of $1 on each share paid in 2008, the $100 you earn in dividends is reported as taxable income for the year 2008.

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 tax identification number (for your ESPP account, that’s your 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 129,618,750 shares of The Home Depot stock for US associates, and 22,500,000 shares for Non-U.S. associates, has been authorized for issuance under the ESPP. This number 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 the final 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

Federal law precludes and provides for substantial civil and criminal penalties, if securities are traded on the basis of material, non-public information. These prohibitions and penalties apply to the Company generally, and for purposes of this chapter, associates who participate in the ESPP. Moreover, the Company has an insider trading policy that may impose additional limits on transactions in the Company’s Common Stock. Participants should refer to The Home Depot, Inc. Securities Law Policy, available on the Company’s intranet or in hard copy by request from the Company’s Legal Compliance 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. Participants may contact the Company’s Legal Department if they are uncertain as to whether or not the Company considers them to be Affiliates.) Non-Affiliate associates who receive shares of Common Stock during the effectiveness of the registration statement to which this summary relates may generally resell shares through a stockbroker in the customary manner or to third persons without the use of a stockbroker. Associates who are Affiliates may effect re-sales of Common Stock in accordance with the requirements of Rule 144 under the Securities Act. Re-sales by Affiliates or non-Affiliates may, however, be restricted to open window trading periods. Such periods apply to certain “Designated Associates.” Participants may contact the Company’s Legal Compliance Department if they are uncertain as to whether or not the Company considers them to be a Designated Associate.

Certain officers are also subject to potential short-swing profit liability under Section 16(b) of 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, a participant’s sale of shares in the open market will usually not be exempt, and such participants must be careful about the timing of those sales versus other direct or indirect “purchases” they make of Company securities, because the sales could be “matched” with the “purchases” and the officer might be sued for certain gains the laws treat such individual as having. In addition, under the law as in effect as of the date of this prospectus, persons covered by Section 16 must report purchases and sales of ESPP shares within two business days after they occur. Persons covered by Section 16 are encouraged to coordinate any transactions in the Company’s securities with the Company’s Legal Department.

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; and

All documents filed by the Company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Exchange Act 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 shall 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 in the Registration Statement on Form S-8 registering the Shares issuable under the ESPP. 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
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 Securities and Exchange Commission (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
450 Fifth Street, N.W.
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 Web site 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 Web site.

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

They will 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:

• a copy is posted on the “Investors Relations” portion of the Company’s Web site at www.homedepot.com;
• request a copy from your Human Resource Manager;
• Write to request a copy from:
  The Home Depot, Inc.
  Investors Relations Department
  2455 Paces Ferry Road, N.W.
  Atlanta, Georgia 30339-4024
• call to request a copy from the Investors Relations Department at 1-770-433-8211
• request a copy online through the Company’s Web site at http://ir.homedepot.com/comment.cfm
• a copy is posted on the Your Benefits Resources Web site. See Enrolling in the Plan for details on accessing Your Benefits Resources Web site.

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.

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Work/Life Benefits
U.S. Salaried & Full-Time Hourly Associates

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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 out more about Medical &amp; Health Management's Building Better Health (BBH) wellness program at your store</td>
<td>Visit myApron, My HR, Pay and Benefits, Benefits and Wellness for more information and a listing of all the programs available through BBH.</td>
</tr>
<tr>
<td>Get a tuition reimbursement form and apply for reimbursement</td>
<td>Go to Your Benefits Resources at <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a>; or call 1-800-555-4954</td>
</tr>
<tr>
<td>Receive tuition reimbursement</td>
<td>Fax your completed form to the Benefits Choice Center at 1-847-883-8269</td>
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<tr>
<td>Get more information about Adoption Assistance</td>
<td>Call the Benefits Choice Center at 1-800-555-4954</td>
</tr>
<tr>
<td>Participate in Team Depot community service projects</td>
<td>Ask your supervisor or your site’s Team Depot Captain</td>
</tr>
<tr>
<td>Reach CARE/Solutions for Life</td>
<td>Call 1-800-553-3504 or go to <a href="http://www.caresolutionsforlife.com">www.caresolutionsforlife.com</a> for educational information and referrals, available 24/7</td>
</tr>
<tr>
<td>Get help from Health Advocate</td>
<td>Call 1-800-519-6689</td>
</tr>
<tr>
<td>MetDESK Planning for Special Needs Dependents</td>
<td>Call 1-800-555-4954</td>
</tr>
<tr>
<td>Beneficiary Assistance Program</td>
<td>Call 1-877-275-6387</td>
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Because the Company believes that our associates are our greatest resource, the Company offers many programs to enhance the quality of your life at work and at home.

Your Work/Life Benefits include the following:

- Building Better Health
- Tuition Reimbursement
- Team Depot
- Matching Gift Program
- CARE/Solutions for Life
- Health Advocate
- Adoption Assistance
- MetDESK—MetLife’s Division of Estate Planning for Special Kids
- Delivering the Promise—The MetLife Survivor Assistance Program
  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.

Building Better Health (BBH)

BBH is the Company’s workplace wellness program offered through the Medical & Health Management department. Through BBH, associates are offered a variety of evidence-based programs such as the annual on-site flu prevention program where associates can receive a free flu shot at their work location.

The goal of these programs is to improve the health and productivity of our associates. For more information visit myApron, My HR, Pay and Benefits, Benefits and Wellness.

Tuition Reimbursement Program

The Company’s Tuition Reimbursement Program encourages and supports associates who enroll in college, university and technical school courses in order to obtain a degree or for professional development.

If You Were Hired Before 3/1/2006

Tuition Reimbursement grandfathered rules for associates hired prior to March 1, 2006 may apply. See the Tuition Reimbursement SOP, available at myapron.homedepot.com. Or, to get a copy of the SOP, contact the Human Resources Service Center at 1-866-698-4347.
Benefits You Can Receive

The Tuition Reimbursement Program reimburses eligible associates for the following:

- 50% of the cost of tuition and class registration fees for approved courses in which the associate earns a grade of "C" or better or for pass/fail courses for which the associate earns a passing grade that is applied toward a degree; and

- 50% (up to a maximum of $250 per quarter/semester) of the cost of books required for approved courses in which the associate earns a grade of "C" or better, and is credited toward a degree.

Reimbursements count toward the annual calendar-year maximum for the calendar year in which they are received. For example, if you complete a course in 2008 and you receive reimbursement for that course in 2009, the reimbursement counts toward your 2009 annual maximum.

The Tuition Reimbursement Program reimburses eligible associates up to an annual calendar-year maximum of:

- For full-time hourly associates: $3,000
- For salaried associates: $5,000

The reimbursement amounts are as follows:

- For fall and spring semesters, the maximum reimbursement amount is:
  - For full-time hourly associates: $1,200
  - For salaried associates: $2,000

- For summer semester, the maximum reimbursement amount is:
  - For full-time hourly associates: $600
  - For salaried associates: $1,000

- For each quarter, the maximum reimbursement amount is:
  - For full-time hourly associates: $750
  - For salaried associates: $1,250

Eligibility

Eligibility for the Tuition Reimbursement Program begins on or after your anniversary date of employment. Temporary employees and more than 5% owners/shareholders are not eligible for the Program. Highly compensated employees (generally those who earned $100,000 or more in 2008) are not eligible for this tuition reimbursement program. However, highly compensated employees may receive reimbursement for tuition under different rules with different tax consequences. If you are a highly compensated employee for 2009, please contact the Benefits Choice Center at 1-800-555-4954 for more information regarding tuition reimbursement.

Courses must begin while the associate is an active employee. Eligibility ends if your employment terminates voluntarily or involuntarily before completion of courses unless it’s because of a reduction of force, your relocation at the Company’s request or your death.

Your application for reimbursement must be received by the Benefits Choice Center no later than 75 days after the completion of the course. You must be actively at work at the time payroll processes your reimbursement. For example, if you are active when the application is approved and your confirmation notice is mailed, but then you terminate before payroll has processed the reimbursement, you will not be eligible for the reimbursement.

If you are on an approved leave of absence or are on short- or long-term disability, you are eligible for reimbursement of approved coursework as long as:

- You applied before the date your leave began and your application was approved; or
- You completed the course within 30 days of the date your leave began, your application was received by the 75th day after the course ended and the application was approved; or
- You completed the course but did not apply for reimbursement before the leave began and applied for reimbursement by the 75th day after the course ended.

Otherwise, if you are on a leave of absence of any type, on short- or long-term disability or not actively employed and not on the Company’s payroll, you are not eligible for this Program until you return to active status.
Reduction in Force
If you terminate because of a reduction in force before completing a course, you are eligible for reimbursement if you are rehired within 30 days, or if you are within 30 days of completion of the course when the reduction in force occurs.

If You Relocate
If you relocate at the request of the Company before completing approved coursework, you will be reimbursed according to the guidelines of the Program.

Approval Guidelines
Major must:

• lead to an associate’s, bachelor’s, master’s, postgraduate or doctoral degree in an academic or technical discipline related to the business of the Company;
• be considered job related or be part of your career development plan with the Company at the Company’s sole discretion;
• be offered by a regionally accredited college, university or technical school;
• earn college credits at the undergraduate, graduate, associate or doctoral level; and
• be completed through traditional classes or through non-traditional programs, such as online or other distance-learning courses, and independent study or learning contracts.

Academic disciplines generally regarded as related to Company business and considered eligible for reimbursement under the Program include, but are not limited to:
• accounting
• adult education and curriculum development
• advertising and public relations
• business administration and management
• communications and graphic design
• human resource management and development
• information technology and related fields
• law
• marketing and merchandising
• organizational development and psychology
• real estate management and development
Other fields of study may be considered on a case-by-case basis.

Application/Reimbursement
To obtain a Tuition Reimbursement form, you can access the Your Benefits Resources Web site, call the automated phone system, or speak to a Benefits Choice Center representative.

You’ll need the following information to complete the Tuition Reimbursement form:
• Degree/Major
• College/University/Technical School Name
• Address of College/University/Technical School
• Phone number of Registrar (including area code)
• Degree type (e.g., bachelor’s degree)
• Course number
• Course title
• Final grade (as documented on official grade report)
• Total tuition and registration expenses per course (include valid receipts)
• Books/Fees (include valid receipts)
• Total requested reimbursement amount
• Anticipated graduation date
• Course period (e.g., semester or quarter)
• Term beginning and ending dates

If false or fraudulent information is given, the associate will be subject to discipline based on the Company’s code of conduct.

You must fax your application and documentation to the Benefits Choice Center. Your application for reimbursement and documentation must be received by the Benefits Choice Center no later than 75 days after the completion of your course.

It is important to include all of the information requested to complete the form. If your form is incomplete, your reimbursement will be delayed or may not be approved.

If your application is approved, you’ll receive a Confirmation of Reimbursement. Your reimbursement amount will be in the next paycheck, if administratively possible.
If your application is denied, you’ll receive a Reimbursement Denial Notice explaining the reason for the denial. If your request is denied for reasons such as an illegible or incomplete form or an invalid reimbursement amount, you may request another Tuition Reimbursement Form and resubmit your request as long as you are still within your 75 days after completion of your course.

**Courses and Expenses That Do Not Qualify**
- Certification or accreditation courses, workshops, seminars or other classes not taken for college credit
- Review courses taken in preparation for testing and exams
- College entrance and qualifying exams (SAT, GRE)
- Courses audited without college credit
- Courses re-taken because of loss of credit due to a transfer, unless the transfer occurs because the associate relocates at the request of the Company
- Equivalence exams or life experience credits
- Standardized tests to earn college credit by examination offered by the College Level Examination Program (CLEP), or other exams that waive a requirement
- Tools or supplies (other than textbooks) that you may retain after completing a course
- Meals, lodging or transportation
- Fees for parking, student activities, etc.
- Education involving sports, games or hobbies

**Reduction of Benefit**
The amount of the reimbursement received through the Tuition Reimbursement Program will be reduced dollar for dollar by the amount of grants, scholarships and other financial aid or course discounts which are paid directly to the institution and which the student does not have to pay back.

**Tax Considerations**
According to current IRS guidelines, up to $5,250 per calendar year paid to an employee by an employer for undergraduate and graduate-level courses is excludable from gross income. Because the annual maximum amount available to an associate is less than $5,250, reimbursement received through the Tuition Reimbursement Program is not subject to taxes or withholding.

**Limitation of Actions**
Any lawsuit relating to benefits under the Tuition Reimbursement Program must be filed no later than one of year after a claim for benefits has been denied or be forever barred.

### Team Depot
Team Depot is our associate-led volunteer force that meets community needs through hands-on service. Every year through Team Depot, associates contribute countless hours to the communities in which they live and work, truly exemplifying our value of Giving Back. Every Home Depot retail store in the U.S., Canada and Mexico has a Team Depot captain and associate-volunteers. The Team Depot captain is an amazing leadership opportunity for our associates and allows them to plan and lead transformational community service projects.

### Matching Gift Program
The Home Depot Foundation will match individual associate gifts to eligible organizations ranging from $25 to $1,000 per charity per calendar year. Gifts will be matched dollar for dollar. There is a $3,000 cap per associate each calendar year. In order to be matched, the gift must have been given solely by the associate.

The Foundation will not match pledges or monies raised from others.

After sending your gift to the organization of your choice, you have two ways to request a matching gift from the Foundation: online or via an automated phone service (U.S. only).

**Online**—Send your gift to the organization of your choice and then register your gift at www.givingprograms.com/homedepot. You may also reach this web site through the My Benefits & Rewards section of MyApron, Associate Program pages.
Automated Phone Service (U.S. only)—
Call 1-888-628-2442 and follow the prompts to
register your gift

If the match is approved, the gift will be made
from the Foundation in the next scheduled
distribution. Checks are disbursed on a quarterly
basis in January, April, July and October. You
may view the status of your request at
www.givingprograms.com/homedepot.
If you have any questions regarding the Matching
Gift program, you may contact Customer Service
by phone at 1-888-628-2442 or by e-mail at
homedepot@matchgift.com.

This program is available to U.S. and
Canadian associates.

Home Purchase Program
This Program can assist you in finding a profes-
sional and experienced real estate agent to help
purchase a new home. The Program also offers
access to national mortgage lenders who offer a $600 cash incentive for using their services. For more information on these incentives and other
details, call:
• CitiMortgage at 1-800-353-7989 or
• Wells Fargo Mortgage at 1-800-453-9348
You can also get more information on the
Home Depot Home Purchase Program at
1-800-654-0688, Ext. 83211.

CARE/Solutions for Life
CARE/Solutions for Life is a free EAP (Employee
Assistance Program) and Work/Life resource
designed to help associates successfully manage
challenges in your personal and work life. The pro-
gram is available to all Company associates, spouses,
immediate family members and domestic part-
ners, 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 will listen to your concerns, answer
questions and provide referrals to programs or agen-
cies that offer appropriate assistance for your partic-
ular situation. Any information you provide to obtain
a referral is confidential. (Exceptions to confidentiality
are required by law when there is danger to the
associate or another individual). Each year all asso-
ciates may receive up to three face-to-face counsel-
ing sessions with a local provider free of charge. You
are responsible for charges associated with any
additional services you receive through the referral.

CARE/Solutions for Life is a valuable resource when
you have concerns related to any of the following:

• Confidential Counseling—Referrals for marital,
individual, family, alcohol or drug counseling.
Associates, their immediate family members, and
domestic partners are provided with up to three
face-to-face sessions, per issue, at no cost.

• Alcohol/Depression Screening—Automated
self-assessments help you determine your potential
for depression or alcohol abuse; available 24
hours a day, seven days a week; access the
screening from the web at

• Prenatal Care—Free education kits, with product
samples, coupons and other information, available
for moms and dads

• Adoption—Information on the adoption process;
referrals to agencies and attorneys

• Child Care—Referrals to family-operated day care
centers, child care centers or in-home services

• Parenting Resources—Resources and referrals
to help you be the best parent you can be

• Summer Care—Details on day care,
day camps and sleep-away camps

• 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 cer-
tificate and degree programs, grants, scholarships
and financial aid

• Elder Care—Free elder care kit; resources and
referrals for day care, retirement and nursing homes;
information on Alzheimer’s disease and dementia
• **Financial Counseling and Legal Services**—Associates needing financial or legal services can call and talk to a financial advisor or attorney over the telephone or in person. Financial counselors provide unlimited phone counseling to help with debt management, credit, and other money concerns. The initial legal consultation is free, with attorneys providing additional ongoing services at a 25% discount off their usual fees.

• **Convenience Services**—A select group of convenience services are available to associates. Get information about entertainment, shopping, personal services, travel, recreation, household services, pet services and more.

Coverage under CARE 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.

For Internet access log on to the www.caresolutionsforlife.com Web site and access educational information and referrals.

To speak with a CARE/Solutions for Life counselor, call 1-800-553-3504.

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**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.

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**Adoption Assistance**

The Company reimburses eligible adoption expenses up to a maximum of $3,000 for associates for each qualifying adoption. With our Family Leave of Absence policy, the adoptive parent may be eligible to take up to 26 weeks of unpaid leave.

CARE/Solutions for Life provides adoption education and resources including referrals to family counselors.

All associates with one year of continuous service are eligible for adoption assistance.
**Application/Reimbursement**

To obtain an Adoption Reimbursement form, access the [Your Benefits Resources](#) Web site, call the automated phone system or speak to a Benefits Choice Center representative.

Eligible expenses for reimbursement include:

- licensed adoption agency fees
- legal fees
- pregnancy expenses for the child’s birth mother
- charges for temporary foster care before placement
- travel expenses to gain physical custody of the adopted child

Return the completed Adoption Reimbursement Form with proof of eligible expenses, your store number and a copy of the Adoption Certificate or Decree to the Benefits Choice Center. If your application is approved, you'll receive a Confirmation of Reimbursement in the mail at your home.

If false or fraudulent information is given, the associate can be subject to termination.

If your application is denied, you'll receive a Reimbursement Denial Notice explaining the reason for the denial.

For more information regarding Adoption Assistance, please call the Benefits Choice Center at 1-800-555-4954.

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**MetDESK—Planning for Special Needs Dependents**

MetDESK can assist you with the complicated process of planning for the future of your children or other dependents with special needs. Regardless of the age or disability of your dependent, trained representatives can help you navigate through financial and legal issues that are involved in providing not just lifetime care, but quality of life.

MetDESK can help you with:

- protecting future government benefit eligibility for supplemental security income and Medicaid
- preparing a will
- assigning a guardian for your child
- planning for your dependent's financial security

With MetDESK, you can take advantage of a comprehensive Web site, as well as educational workshops and one-on-one counseling.

MetDESK representatives can also steer you in the right direction for additional help that you may need.

You do not need to enroll in this benefit. You may use MetDESK at any time, and it's available at no charge to all associates and their immediate family members and domestic partners.

To learn more about MetDESK, call 1-800-555-4954 and follow the prompts for MetDESK.

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**Delivering the Promise—Beneficiary Assistance Program**

The loss of a loved one can be overwhelming. The MetLife Survivor Assistance Program, called Delivering the Promise (DTP), can help you, your family and your beneficiaries during this difficult time.

MetLife DTP specialists are available to:

- help identify the benefits for which survivors may be eligible
- assist with filing insurance and annuity claims with insurance carriers
- assist with filing for government benefits
- point out local assistance resources, including grief counseling services, government agencies and financial need assessment

MetLife DTP specialists are specially trained to handle these sensitive issues. They can provide assistance in person, at your home or by telephone, whatever you prefer. Upon notification of a death, a local DTP specialist will contact you or your beneficiaries by telephone to offer assistance.

You do not need to enroll in this benefit. You may use Delivering the Promise at any time, and it's available at no charge to all associates and their beneficiaries.

To request to be contacted by a DTP Specialist, call 1-877-ASK-MET7 (1-877-275-6387).
Time-Off Benefits
U.S. Salaried & Full-Time Hourly Associates

For information on time-off benefits see the following SOPs:
• Vacation SOP: Hourly Associates
• Vacation SOP: Salaried Associates
• Bereavement SOP: All Associates
• Jury Duty SOP: All Associates

To find these SOPs, go to myapron.homedepot.com or call the HR Service Center at 1-866-698-4347.
# Leaves of Absence

**U.S. Salaried & Full-Time Hourly Associates**

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## Get the Most Value from Your Plan

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<td>If you are a store associate, see your Human Resources Manager. If you are a non-store associate, see your Manager.</td>
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<td>Get a copy of the Leaves of Absence SOP</td>
<td>Contact the Human Resources Service Center by calling 1-866-myTHDHR (1-866-698-4347) or Store speed dial #925 or send an e-mail to <a href="mailto:myTHDR@homedepot.com">myTHDR@homedepot.com</a> or go to the Human Resources Service Center Web site at <a href="http://www.myTHDHR.com">www.myTHDHR.com</a></td>
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## Where to Find Information on Leaves of Absence

For information on leaves of absence see the HR SOP applicable to you. To find these SOPs, go to myapron.homedepot.com or call the HR Service Center at 1-866-698-4347.

## Benefits Continuation While on Military Leave

**Medical, Vision, Dental and Health Care Spending Account**

**Military Leave**

Company-subsidized coverage continues for up to 12 months

- 100% Company-paid for the first 90 days
- COBRA coverage at active associate rates for additional nine months
- COBRA coverage at full COBRA rates for remaining nine months of the 18-month COBRA period
- USERRA coverage at full COBRA rates for an additional six months (a combined total of 24 months of COBRA and USERRA coverage)

A COBRA notice will be sent to your last known address. When you elect COBRA coverage, you also will automatically elect USERRA coverage and both coverages will run concurrently. Under the COBRA law, you are required to pay the premium that you were paying plus the portion previously paid by the company. The full COBRA rate is 102% of the monthly premium. The cost of USERRA coverage will be 102% of the monthly premium.

**Basic AD&D and Voluntary AD&D**

At the end of 12 months, AD&D coverage ends.

**Basic Term Life, Basic Dependent Term Life, Voluntary Term Life and Voluntary Dependent Term Life**

For Military leave, you can continue your coverage for 12 months. At the end of 12 months or 90 days, you may be eligible to convert to an individual whole life policy or continue coverage through portability within 31 days of your coverage end date. You or your family member must immediately speak with a benefits representative at the Benefits Choice Center to apply for conversion or portability. For more information, see the Life Insurance chapter.

**Disability Insurance**

Coverage does not continue during your Military Leave. These benefits apply only to a disability incurred while actively employed. If you are enrolled in coverage at the time your Military Leave begins, coverage will end at midnight on the last day worked before your leave begins. Coverage is automatically reinstated on the day you return to active status on the payroll system.

**Auto & Home Insurance, Long-term Care Insurance, Legal Services**

If your leave continues beyond 31 days, a bill will be sent directly from MetLife to your home address for the length of your leave. If you don’t pay your premiums while on leave, coverage may be cancelled. Upon return from your leave, call 1-800-438-6388 to find out your coverage status and/or re-enrollment possibilities.

**Pet Insurance**

If your leave continues beyond 31 days, a bill will be sent directly from MetLife to your home address until your policy renews. For questions, call 1-800-438-6388.
Employee Stock Purchase Plan
If you are participating in the ESPP, you may choose one of the following options while on a leave of absence:

- Reduce contributions (available only once during the Plan).
- Stop contributions and leave the money in your account to purchase shares at the end of the Plan (no cash back).
- Stop contributions permanently and receive a refund of your cash balance.

ESPP contributions will be taken if you receive pay while on Military Leave. ESPP plans run for six months—one plan begins on January 1 and the next begins on July 1. If you’re receiving sufficient supplemental pay and participating in a current ESPP Plan, your deduction election will automatically roll over into the new Plan when the current Plan ends.

Enrollment, refund, and contribution rate change deadlines for the two plan periods each year are June 16 and December 17—no exceptions will be allowed.

If you’re on Military Leave during the open enrollment period for the ESPP, you may enroll in the next Plan while still on leave by going to the Your Benefits Resources Web site. Your contributions to the Plan will be start if you are receiving supplemental pay or when your pay resumes upon return from leave.

Benefits Continuation While on Medical, Family and Extended Family Leave
While you are and remain on an approved medical, family, or extended family leave of absence, you may continue your health care coverage under the Plan as follows:

- During the first twelve weeks of the leave, you may continue your coverage under FMLA (or COBRA if and to the extent your leave does not qualify for FMLA) at active associate rates (i.e., paying the same premiums you would pay if you were an active associate);
- Between the end of the twelfth week and the one-year anniversary of your leave, you may continue your coverage under COBRA also at active associate rates; and
- After the one-year anniversary of your leave, you may continue your coverage for the remainder of your continuation period under COBRA at full rates (i.e., paying the entire applicable COBRA premium).

Your continuation of health care coverage is conditioned on your timely payment of the applicable premiums. If you do not pay your premiums during the FMLA period by the specified due date on your bill, your coverage will be dropped for the remainder of that period. If you do not pay your COBRA premiums by the specified due date on your bill, your coverage will be dropped and cannot be reinstated.

For the duration of your leave you may also continue your life insurance coverage at active associate rates. The Benefits Choice Center will send a bill each month to your last known address and premiums will be calculated on a monthly basis. If you are unable to return to work at the end of your leave, you can continue your coverage through portability. Contact the Benefits Choice Center at 1-800-555-4954.

If you enroll for benefits during Annual Enrollment while you are on a leave of absence, coverage may be postponed for all Plans, except medical, dental, and vision if you are not actively working on the day your coverage begins (generally, January 1 following Annual Enrollment). Coverage for you and your eligible family members will be delayed until you return to work. If you are not working due to a work-related injury, coverage for you and your family will not be delayed. For more information, see Eligibility and Enrollment.

While covered under COBRA, you will enroll for health care coverage each year during the Annual Enrollment period.

Auto & Home Insurance, Long-term Care Insurance, Legal Services
If your leave continues beyond 31 days, a bill will be sent directly from MetLife to your home address for the length of your leave. If you don’t pay your premiums while on leave, coverage may be cancelled. Upon return from your leave, call 1-800-438-6388 to find out your coverage status and/or re-enrollment possibilities.
**LEAVES OF ABSENCE**

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**Pet Insurance**
If your leave continues beyond 31 days, a bill will be sent directly from MetLife to your home address until your policy renews. For questions, call 1-800-438-6388.

**FutureBuilder**
Contributions cannot be made while on unpaid Medical Leave. However, contributions will be taken if you receive payroll compensation while on leave.

**Employee Stock Purchase Plan**
If you are participating in the ESPP, you may choose one of the following options while on a leave of absence:

- Reduce contributions (available only once during the Plan).
- Stop contributions and leave the money in your account to purchase shares at the end of the Plan (no cash back).
- Stop contributions permanently and receive a refund of your cash balance.

ESPP contributions will be taken if you receive pay during your first 90 days of leave unless you reduce or stop your contributions as discussed above. If you are still on leave after 90 days, your participation in the Plan will be considered terminated on the 91st day and contributions will be refunded unless your return to work is guaranteed by law (e.g., certain military leaves) or by contract.

Enrollment, refund, and contribution rate change deadlines for the two plan periods each year are June 16 and December 17—no exceptions will be allowed.

If you’re on leave during the open enrollment period for the ESPP, you may enroll in the next Plan while still on leave by going to the Your Benefits Resources Web site. Your contributions to the Plan will start when your pay resumes upon return from leave. If you’re still on leave after 90 days, you will not be eligible to participate and no payroll deductions will be taken.

**Benefits Continuation While on Personal Leave**
For Personal Leave, all benefits will be canceled on the 31st day following the start of your leave if you have not returned to active status.

**Continuation of Coverage After Cancellation**

**Medical, Vision or Dental Coverage**
You can continue your coverage under the provisions of COBRA if:

- you remain on leave at the end of your FMLA period
- you begin a leave while you are not eligible for FMLA leave and your coverage is cancelled

A COBRA notice will be mailed to your last known address. For more information, see the COBRA Coverage chapter.

For more information, see the Eligibility and Enrollment chapter.

**Life Insurance Coverage**
You may convert your insurance to an individual whole life policy or continue coverage through portability no later than 31 days after your Company coverage ends (your “application period”) if:

- your Basic Term Life, Voluntary Term Life, Basic Dependent Term Life and Voluntary Dependent Term Life are canceled for non-payment of the premium during the FMLA leave and the leave continues beyond the FMLA period;
- you’ve reached the maximum benefit period while on leave; or
- your employment is terminated.

If you die during your application period, a death benefit will be paid to your beneficiary.

You may elect to continue through portability or conversion your Basic Term Life, Basic Dependent Term Life, Voluntary Term Life, Voluntary Dependent Term Spouse Life, and Voluntary Dependent Term Child Life. Certain rules and exclusions apply. You must contact the Benefits Choice Center at 1-800-555-4954 to request the forms, and your application must be submitted to MetLife within 31 days of the loss of these coverage(s). For coverage canceled during Military Leave, a family member may also apply for conversion or portability on behalf of the associate.
LEAVES OF ABSENCE

Coverage Upon Return from Leave

- If you return from any leave within the **same calendar year**, all canceled insurance plans will be automatically reinstated.

- If you return from any leave during the **following calendar year** (or any subsequent calendar year, up to five years, for Military Leave):
  
  — **Basic Term Life, Basic Dependent Term Life, Voluntary Term Life, Basic Dependent Term Life**, **Basic AD&D, Voluntary AD&D and Family Protection Plus AD&D, Short- and Long-Term Disability**: Coverage you had before your leave will be reinstated. If you want to add/stop or increase/decrease coverage, see the applicable chapter for requirements (**Life Insurance chapter**, **AD&D chapter** or the **Full-time Hourly Disability** or **Salaried Disability chapter**).

  — **Medical, dental and vision**: Coverage you are enrolled in when you return from leave will continue after you return from your 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 your leave.

Spending Accounts While on Leave of Absence

**Health Care**

For your Health Care Spending Account, while on a Leave of Absence, you may:

- Continue contributing
- Stop contributing

If you choose to continue contributing, your contributions can be made by mailing your regular contribution as billed. You will continue to be able to submit claims and receive reimbursement during the period you are on leave.

If you choose to stop contributing, you will not be able to receive reimbursements for services received or expenses incurred during the period you are on leave.

If you return from leave within the same calendar year, your payroll deductions will be automatically reinstated. Participation will be at the level in effect before the leave started unless you have made a change or changes based on a qualified status change experienced while you were on leave. See the **Life Events** chapter for more information on qualified status changes.

If you return from leave on a subsequent year, the Health Care spending account coverage you enrolled in during annual enrollment will start when you return from your leave.

If you return from leave and would like to reach your elected annual goal, you may increase your payroll deductions for the remainder of the calendar year by contacting the Benefits Choice Center within 30 days of your return from leave. If you did not contribute to the Plan during your leave and do not increase payroll deductions upon returning from leave, you will not reach your annual goal and contributions in effect prior to your leave will be reinstated.
Health Care Spending Account Participation After Cancellation of Coverage

You may continue your health care account under the provisions of COBRA through the end of the calendar year plus the applicable grace period if one of the following occurs:

- Your leave extends beyond the FMLA period;
- You have reached the maximum benefit period while on Personal Leave; or
- Your employment is terminated.

The COBRA period starts at the earlier of:

- the end of your FMLA period,
- the date benefits are canceled while on Personal Leave,
- the period stipulated under Home Depot’s Military Leave policy, or
- your employment termination date.

A COBRA notice will be sent to you at your last known address.

For more information on how spending accounts work, see the Spending Accounts chapter. For more information on COBRA, see the COBRA Coverage chapter.

Military Leave Distributions

If you are called to active duty in the U.S. military for a period of 180 days or more, you may request a distribution of the remaining balance in your health care spending account. You must request this distribution after the effective date of your orders but before the last day that reimbursements could otherwise be made from your account. Contact the Benefits Choice Center to request a distribution.

Dependent Day Care

While on leave, you cannot continue your contributions to the Dependent Day Care Spending Account. Your contributions will end on the last day of the pay period in which you go on leave.

If you return from leave within the same calendar year, your payroll deductions will be automatically reinstated. Participation will be at the level in effect before the leave started unless you have made a change or changes based on a qualified status change experienced while you were on leave. See the Life Events chapter for more information on qualified status changes.

If you return from leave in a subsequent year, you can enroll in the Dependent Day Care Spending Account within 30 days of your return from leave. For the Dependent Day Care Spending Account, you will need to adjust your contribution amount depending on the number of pay periods remaining in the calendar year.

If you return from leave and would like to reach your elected annual goal, you may increase your payroll deductions for the remainder of the calendar year by contacting the Benefits Choice Center within 30 days of your return from leave.

You cannot submit dependent day care expenses incurred while on a leave of absence.

Associates on Military Leave may participate in the Dependent Day Care Spending Account until the end of the calendar year in which the leave began.
COBRA Coverage
U.S. Salaried & Full-Time Hourly Associates

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Get the Most Value from Your Plan

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<thead>
<tr>
<th>What do you need</th>
<th>Find it here...</th>
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</thead>
<tbody>
<tr>
<td>To begin coverage under COBRA for family members losing coverage due to the following qualifying events: divorce, legal separation or the end of a dependent child’s eligibility</td>
<td>Call the Benefits Choice Center at 1-800-555-4954 and speak with a Benefits Choice representative.</td>
</tr>
<tr>
<td>To begin coverage under COBRA for loss of coverage due to any qualifying event other than the events listed above</td>
<td>Call the Benefits Choice Center at 1-800-555-4954 after you receive your COBRA enrollment materials in the mail.</td>
</tr>
<tr>
<td>To extend COBRA coverage for participants who are disabled during the first 60 days of COBRA coverage</td>
<td>Call the Benefits Choice Center at 1-800-555-4954 and speak with a Benefits Choice representative.</td>
</tr>
<tr>
<td>To send any required documentation to the Benefits Choice Center</td>
<td>Mail to: The Home Depot Benefits Choice Center, P.O. Box 1493, 100 Half Day Road, Lincolnshire, IL 60069-1493.</td>
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</tbody>
</table>

COBRA Continuation Coverage

Associates and qualifying beneficiaries participating in the Company Medical, Vision, and Dental Plans, CARE—Solutions for Life and the Health Care Spending Account have the right to choose continuation of coverage for certain qualifying events as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted under federal law on April 7, 1986 (Public Law 99-272, Title X).

COBRA requires that most employers sponsoring group health plans offer associates and qualifying beneficiaries the opportunity for a temporary extension of health coverage (called continuation of coverage) at group rates in certain instances (referred to as COBRA qualifying events) where coverage under the Plan would otherwise end. A qualified beneficiary is your spouse or child covered under the Plan immediately before a qualifying event or a child born to or placed for adoption with an individual who has elected COBRA. A same-sex domestic partner cannot choose COBRA coverage on his or her own as a qualified dependent. However, an eligible same-sex domestic partner can be covered as a non-qualified beneficiary by a qualified beneficiary (for example, the associate covering the same-sex domestic partner as an eligible dependent). This means a same-sex domestic partner does not have independent COBRA rights and may only keep the same COBRA coverage as the covered associate.

The continuation of coverage period allowed under COBRA begins:
- For termination of your employment, on the day following the last day of your final pay period; or
- At the end of the first 12 weeks of any medical or maternity leave under FMLA; or
- For all other qualifying events, from the date of the qualifying event.

The continued coverage under the Medical, Vision, and Dental Plans and Health Care Spending Account will be identical to those offered to similarly situated active associates, as required under COBRA.

Continuation coverage is available for a maximum of the following periods: 18 months following a loss of coverage due to a termination of employment (other than for gross misconduct) or reduction in hours; 36 months following divorce or loss of dependent status; for Medicare, it is the later of 18 months from the date coverage is lost or 36 months from the date of Medicare entitlement if Medicare entitlement occurred before the date of the COBRA coverage; 24 months for Military Leaves; and 29 months for a qualified disability (as long as the required notices are provided within required timeframes).
## COBRA Qualifying Events (which result in loss of coverage)

<table>
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<tr>
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<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 (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 is more than 90 days</td>
<td>You and your covered eligible dependents¹</td>
<td>24 months from date of qualifying event (18 months under COBRA; six additional months under USERRA)</td>
<td>• Active associate rates (first nine months after 90 days)  • 102% (next nine months, up to 18 months under COBRA)  • 102% (next six months, up to 24 months under USERRA)</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 spouse</td>
<td>36 months from date of qualifying event</td>
<td>102%</td>
</tr>
<tr>
<td>Failure to return from FMLA leave</td>
<td>You and your covered eligible dependents</td>
<td>18 months from end of FMLA period</td>
<td>102% (active associate rates during the first nine months if on an approved leave of absence)</td>
</tr>
<tr>
<td>Your child is no longer eligible</td>
<td>Your child</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>

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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 For information on COBRA coverage for same-sex domestic partners and their child(ren), see COBRA Continuation Coverage in this chapter.

3 Your cost is based on the current total monthly premium times the percentage shown above.

4 If the associate on Military Leave drops coverage, his or her spouse and/or dependents can only continue COBRA for up to 18 months. Spouse and children can continue for 24 months only if the associate on Military Leave continues for 24 months. If Military Leave ends, associate and/or dependents can continue COBRA for up to 18 months only.
If a second qualifying event occurs during your initial 18 months of COBRA continuation coverage (such as a legal separation, divorce, etc.), the continuation of coverage period may be extended for the qualified dependent for up to 36 months from the date of the first qualifying event. The total period of continuation coverage, however, will never exceed 36 months from the date of the first qualifying event.

In all cases, coverage for CARE Solutions for Life is extended for 36 months.

If you have fully insured HMO coverage, state insurance laws may mandate continuation coverage that is longer or that otherwise differs from federal COBRA continuation coverage. State law in California allows 36 months of continuation coverage if you are enrolled in an HMO. Please refer to your Medical Plan coverage booklet or call your Medical Plan for more information.

You do not have to show that you are insurable to choose continuation of coverage. However, continuation coverage is subject to your eligibility for coverage. The Plan administrator reserves the right to terminate your coverage retroactively if it is determined that you are ineligible.

By electing COBRA coverage, you can also continue to contribute to your Health Care Spending Account through the end of the year in which the qualifying event occurs. You can file claims for qualified services you receive through the end of the Plan Year plus the applicable grace period while you are participating through COBRA.

However, you cannot continue to contribute to your Dependent Day Care Spending Account while on COBRA. Associates on Military Leave are able to contribute to the Dependent Day Care Spending Account if their supplemental pay is sufficient to cover their elected contributions.

See the Spending Accounts chapter in this book for more information.

**USERRA Continuation Coverage**

Associates participating in the Company medical, vision, and dental plans, CARE – Solutions for Life, and the health care spending account have the right to choose continuation coverage as provided under the Uniformed Services Employment and Reemployment Rights Act, as amended (“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.

**Notifying the Company About a Qualifying COBRA Event**

Under federal law, you and your eligible dependents are responsible for notifying the Benefits Choice Center (including providing all required documentation) of a divorce, legal separation or the end of a dependent child’s eligibility under the Medical, Vision and Dental Plans and the health care spending account no later than 60 days after the event occurs.

You start this notification process by calling the Benefits Choice Center at 1-800-555-4954 and asking to speak with a representative. The representative will ask you to mail any required documentation to the address of the Benefits Choice Center listed in the Get the Most Value From Your Plan chart at the start of this chapter.

After you notify the Benefits Choice Center, the eligible dependents losing coverage will receive written notification advising them of their right to choose COBRA continuation coverage.

If you or your eligible dependents do not notify the Benefits Choice Center on a timely basis, you and/or your eligible dependents will forfeit their rights to continue medical, vision and dental coverage and the health care spending account under COBRA.
The Benefits Choice Center is responsible for notifying you and your covered eligible dependents of the right to choose COBRA continuation coverage for any qualifying event other than divorce, legal separation or the end of a dependent child’s eligibility under the Medical, Vision and Dental Plans and Health Care Spending Account. Notification and billing will be handled by the Benefits Choice Center at 1-800-555-4954 or by mail at:

Benefits Choice Center
P.O. Box 0700
Carol Stream, IL 60132-0700

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 leave. If payment is not received by the due date on the Billing Notice, coverage will be cancelled.

If a Disability Occurs

The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries, if the Social Security Administration determines that you or one of your covered dependents was disabled at any time prior to the qualifying event or within the first 60 days of COBRA continuation coverage. It is the disabled participant’s responsibility to inform the Benefits Choice Center with required documentation within 60 days of the later of:

- The date the letter from Social Security was issued (the issue date of the Social Security Notice of Award Letter); or
- The start date of COBRA.

If you do not provide timely notification of the Social Security determination of disability, no extension is available.

The disabled participant must provide the required documentation of disability before the end of the 18-month COBRA coverage period.

To submit the documentation establishing disability, mail or fax to:

Benefits Choice Center
P.O. Box 1493
Lincolnshire, IL 60069-1493
Fax: 1-847-883-8269

Coverage for the disabled participant and family members covered under the associate + spouse, associate + child(ren) or associate + family coverage categories may be extended up to a total of 29 months.

It is also the disabled participant’s responsibility to notify the Benefits Choice Center within 30 days if a final determination has been made that the disabled person is no longer disabled.

Disabled individuals and their covered family members will be required to pay 102% of the monthly premium for the initial 18 months of coverage. If coverage is extended to 29 months, the disabled qualified beneficiary and his or her family members covered with the disabled qualified beneficiary under the associate + spouse, associate + child(ren) or associate + family coverage categories will pay 150% of the monthly premium after the first 18 months of COBRA coverage. Any qualified beneficiaries whose COBRA coverage was extended to 29 months but who are not covered with the disabled qualified beneficiary will pay 102% of the monthly premium for all 29 months.

Paying for COBRA Coverage

You are required to pay the premium that you were paying before the qualifying event plus the portion previously paid by the Company. An additional 2% will be added to your premium for administrative costs. If the premium rate changes for active associates, your monthly cost will also change. You will be responsible for premiums from the date COBRA coverage begins.

Your initial premium is due within 45 days of the date you elect COBRA coverage. This initial premium may cover more than one month and there is no grace period after the 45 days. Subsequent premiums are due on the first day of each month. You will be given a 30-day grace period from the first of each month within which payment must be received. Your payment is considered received on the postmark date on your payment. If you fail to pay your initial premium on time or fail to pay the subsequent premiums by the end of the grace period, your and your dependents’ coverage will be terminated and cannot be reinstated.
Electing COBRA Coverage
The Benefits Choice Center will send you and your covered dependents written notification of your right to choose Medical, Vision and Dental COBRA continuation of coverage as well as continuation of your Health Care Spending Account.

This information will be provided in a personalized Enrollment Worksheet with instructions on how to enroll by calling the Benefits Choice Center.

You and/or your covered dependents must enroll no later than 60 days after the date on the notification letter.

Evidence of good health is not required to continue your Medical, Vision, Dental and Health Care Spending Account coverage under COBRA.

If you do not enroll before your enrollment period expires, you and your eligible dependents will forfeit the right to extend coverage under COBRA.

If it is determined that you are not eligible for COBRA coverage, you’ll receive a written explanation within 14 days.

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.

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 dependents.

When COBRA Coverage Starts
Provided you have complied with the requirements outlined above, COBRA continuation coverage for the Medical, Vision and Dental Plans and Health Care Spending Account starts:

- For termination of your employment, on the day following the last day of your final pay period; or
- At the end of the first 12 weeks of any medical or maternity leave under FMLA; or
- For all other qualifying events, from the date of the qualifying event.

Status Changes and COBRA
If, during the 18 months (or 24 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 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.

New Spouse
To enroll your new spouse for coverage, you must call the Benefits Choice Center or access the Your Benefits Resources Web site 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, you must call the Benefits Choice Center or access the Your Benefits Resources Web site no later than 30 days after the child’s birth, date of adoption or placement for adoption.

If you are already covered under a self-insured HMO, PPO or Out-of-Area Medical Plan with associate + family or associate + child(ren) and you add your newborn or newly adopted child (or child placed for adoption) within the first 12 months of birth, adoption or placement for adoption, coverage will be effective from the date of the birth, adoption or placement for adoption. If you are already covered under a self-insured HMO, PPO or Out-of-Area Medical Plan with associate-only or associate and spouse and add your newborn or newly adopted child:

- Within 60 days of the birth or adoption, coverage is effective from the date of the birth or adoption
- After 60 days but within six months of the birth or adoption, the coverage will be effective the date the Benefits Choice Center receives your request.
For other allowable changes after 30 days, please see the Newborn and Adopted Children section of the Eligibility and Enrollment chapter.

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 under the Medical, Vision and/or Dental Plans. 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.

**Individuals Eligible for the Federal Program Providing Trade Adjustment Assistance**

The Trade Adjustment Assistance (TAA) program is a federal program established under the Trade Act of 1974 that provides aid to workers who lose their jobs or have a reduction in hours or wages due to increased imports from or a shift in production to certain foreign countries. In 2002, the TAA program was amended to add certain tax credits for health benefits and to provide individuals eligible for this program with a second opportunity to elect COBRA continuation coverage.

Under the TAA program, either a group of employees, its union, or an authorized representative for the group must submit a petition for benefits to the U.S. Department of Labor. Petition forms can be obtained from your local State Employment Security Agency or from the U.S. Department of Labor, Division of Trade Adjustment Assistance. If the U.S. Department of Labor certifies your worker group, you must file an application for a determination of individual eligibility with your local office of the State Unemployment Insurance agency.

If you receive an individual certification of eligibility for TAA benefits, you will be eligible for the following additional rights.

First, the Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA-eligible individuals). Under the new tax provisions, TAA-eligible individuals can (pursuant to IRS regulations) either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage.

If you would like additional information about these tax provisions, you need to call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282 or refer to the information provided at www.doleta.gov.

Second, TAA-eligible individuals who did not elect COBRA continuation coverage when they first became eligible for COBRA may have a second election period to elect COBRA coverage. This second election period is a 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual (as defined in the Internal Revenue Code), but only if such election is made not later than six months after the date of the TAA-related loss of coverage.

Coverage that is properly elected during this second election period will begin on the first date of this second election period and will not include any period prior to this second election period. In addition, to the extent the plan imposes any pre-existing condition exclusion, the period beginning on the date of the TAA-related loss of coverage and ending on the first day of the second election period described above is disregarded for purposes of determining if there has been a 63-day break in coverage for calculating creditable coverage that may offset the length of the pre-existing condition exclusion.

This Plan will provide a second COBRA election period to the extent required under the Trade Act of 2002 and any applicable future laws or regulations.
When COBRA 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 by the applicable due 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).

If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage under the Company’s Medical, Vision and Dental Plans up to the date this exclusion ceases to apply

- a qualified beneficiary becomes entitled to Medicare after electing COBRA

- the Company terminates all group health coverage
- coverage is terminated for cause, such as fraudulent claim submission, on the same basis that coverage could terminate for similarly situated active employees
- 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

Certification of Creditable Coverage Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As required under HIPAA, when health coverage ends, a Certificate of Health Plan Creditable Coverage will be automatically sent to you. The Certificate of Health Plan Creditable Coverage will detail the total time you and your dependents were covered under the Company Medical Plan and the type of health plan you were covered under.

Under HIPAA, the time covered under the Company Plan (including COBRA coverage) may be used to reduce a new employer’s pre-existing condition period, as long as there is no break in coverage of 63 days or more (or longer in some states). Because your Certificate of Health Plan Creditable Coverage can be important, particularly with regard to coverage for pre-existing conditions, you should make sure that your current address is on file by informing the Benefits Choice Center at 1-800-555-4954 when any changes occur.

Keep Your Plan Informed of Any Address Changes

In order to protect your rights and those of your dependents, you should keep the Plan Administrator informed of any changes in your address or the addresses of your dependents. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Claims & Appeals

U.S. Salaried & Full-Time Hourly Associates

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Get the Most Value from Your Plan

Claiming Benefits

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under the Plan. All forms required to take any action under the plans are available from the claims administrator or plan administrator. Please refer to the appropriate section of each benefit for additional information on claiming benefits.

To be eligible for benefits, you must be covered under the 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. Suits must be brought no later than one year following the date on which the appeals process under the Plan is exhausted.

The claim administrator making claim decisions (which for the fully-insured plans is the insurance company and for FutureBuilder is the Plan Administrator) has the right and discretionary authority to interpret the provisions of the Plan under which the claim is made and to make any and all determinations regarding final eligibility for benefits both legal and factual. Its decisions will be conclusive and binding.

Filing Claims for 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:

**Fully-Insured Plans**

- Certain HMOs, Health Net POS and Out-of-Area Medical Plan, HMSA Medical Plans in Hawaii
- MetLife Dental Plans
- EyeMed Vision Plan

**Self-Insured Plans**

- Aetna Choice POS II Medical Plans;
- Aetna, CIGNA and UHC HMO Medical Plans

Filing Claims Under the Group Health Plans

If you receive covered health (medical, dental, prescription or vision) 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 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 Medical and Dental Plan Administrators in the Plan Administration chapter.
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 Life Insurance chapter for life insurance claims, the AD&D chapter for AD&D claims and the Disability chapter for disability claims.

Timely Filing of a Claim

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 or reduced, according to the claims administrator's discretion. This time limit does not apply while you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to you. The group health Plan will not reimburse third parties that have purchased or been assigned benefits by any health care provider.

Information Required for Your Claim

When you request payment of benefits from your health plan, you 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)

Payment of Health Plan Benefits

The claims administrator of your group health Plan will make a benefit determination as described below. Benefits will be paid directly to you unless either of the following is true:

- The provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider, or
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Appealing a Denied Claim Under Any Plan Other than Group Health or Disability Plan, Including FutureBuilder, Life and AD&D Insurance

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, or 180 days under special circumstances (in which case you will be notified in writing before the end of the first 90-day period of the extension, 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;
- an explanation of why such information is necessary;
- 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. 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, or 120 days under special circumstances (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 statement that you are entitled to receive, upon request and free of charge, reasonable access to pertinent documents, records, and other information relevant to your claim for benefits;

• 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 binding.

If the named fiduciary that decides claims is a committee or board of trustees that holds regularly scheduled meetings at least quarterly, the following applies.

• The named fiduciary will make a determination on claims no later than the date of the meeting of the committee or board of trustees that immediately follows the Plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a claim determination may be made by no later than the date of the second meeting following the Plan’s receipt of the request for review. If special circumstances require a further extension of time for processing, a determination must be made no later than the third meeting of the committee or board following the Plan’s receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan administrator must provide the claimant with written notice of the extension, describing the special circumstances and the date as of which determination of the claim will be made, prior to the commencement of the extension. The claimant must be notified of the results no later than five days after the claim has been evaluated.

Benefit Determination and Claims Appeals

Under the Fully-Insured Medical and Dental Plans

The fully-insured medical and dental Plans include the Health Net POS and Out-of-Area Medical Plan in California, the HMSA Medical Plans in Hawaii, the MetLife Dental Plan, the EyeMed Vision Plan and the HMOs listed below:

• BCBS—Illinois

• BCBS—Western New York

• ConnectiCare—Statewide

• GHC/Puget Sound—Seattle

• HAP—Detroit

• Health Net—California

• Kaiser—Georgia

• Kaiser—Portland

• PacifiCare—Las Vegas

The fully-insured Plans 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. 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 Self-Insured Medical Plans

The self-insured medical plans include the Aetna Choice POS II Medical Plans and the Aetna, CIGNA and UHC self-funded HMOs.

The determination of benefits varies according to the type of service or benefits requested, and the type of health Plan. The following pages provide information that describes how the various self-insured Plans determine your benefits and how to appeal denied claims.

You or an authorized representative may file claims and appeals. An authorized representative means a person you authorize, in writing and as required by the claims administrator, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. Reference to you in the sections explaining how to file claims and appeal denied claims are intended to include references to your authorized representative.

Aetna HMO and Choice POS II Medical Plans, UnitedHealthcare HMO and CIGNA HMO

Procedures Regarding Benefit Determinations

Urgent Care Claims. If the Plan requires advance approval of a service, supply, or procedure before a benefit will be payable and if the Plan or your physician determines that such service, supply or procedure is for an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the case of a pregnant woman, cause serious jeopardy to the health of the fetus; or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim.

You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier). If you fail to follow plan procedures for filing a claim, the claims administrator will notify you within 24 hours following your failure to comply.

Other Claims (pre-service and post-service). If the Plan requires you to obtain advance approval of a service, supply, or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For post-service claims (claims for benefits that are filed after medical care has been received), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period.

You will also be notified of the date by which a decision can be expected. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).
For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan’s procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

**Ongoing Course of Treatment.** If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the authorized course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. Any request to extend the preapproved course of treatment will be treated as a new claim, unless the course of treatment involves urgent care. Any request to extend your pre-approved claim that involves urgent care must be made at least 24 hours before its expiration, and you will be notified of the decision within 24 hours after receipt of the request. The claims administrator will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for concurrent care claim extension.

**Notice of Adverse Benefit Determination.** If your claim is denied in whole or in part, you will receive written notice of the denial from the Plan. The notice will include all of the following that pertain to the determination: (1) the specific reason(s) for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of such rule, guideline, protocol, or other similar criterion or a statement explaining that such rule was relied upon and that a copy will be provided to you free of charge upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; (8) your eligibility for coverage; and (9) the results of any Utilization Review activities.

**Filing an Appeal of an Adverse Benefit Determination**

As a member of the Plan, you have the right to file an appeal about coverage for service(s) you have received from your health care provider or the Plan, if you have questions, or if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Certification of health care services
- Claim payment
- Plan interpretation
- Benefit determinations
- Eligibility

If you want a reconsideration of the decision, you must file an appeal in writing to the Plan at the address provided in this booklet within 180 days from receipt of the notice of denial, for pre-service and post-service claims. Claim administrators may accept verbal appeals at their discretion. If your appeal is of an urgent nature, you may call the Plan’s Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this chapter). Your request should include the group name (that is, your employer), your name, contract number, the Explanation of Benefits form or other notice of adverse benefit determination, your reasons for making an appeal, and any comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.
Your appeal will take into account any information you submit. You may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

A representative will acknowledge your appeal as quickly as administratively possible after receipt and may call you or your health care provider to obtain medical records and/or other pertinent information.

Your appeal will afford no deference to the initial benefit determination. Your appeal will be reviewed and the decision made by someone that was neither involved in the initial decision nor the subordinate of such individual. Appeals based in whole or in part on a medical judgment will be considered by a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Upon request, any medical or vocational expert consulted will be identified, even if his or her advice is not relied upon in making the benefit determination. No health care professional consulted in connection with the initial decision on your claim or request will be consulted on appeal, nor the subordinate of such an individual.

**Standard Appeals.** With the exception of urgent care claims, you will have 180 days following receipt of an adverse benefit determination to appeal the decision to the Plan. You will be notified of the decision on appeal not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. The Member Services telephone number is on your identification card. You may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and the plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

**Second Appeal.** If you are dissatisfied with the appeal decision on a claim involving urgent care and want a reconsideration of the decision, you must file a second level appeal with the Plan. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision and want a reconsideration of the decision, you must file a second level appeal with the Plan within 180 days of receipt of the level one appeal decision. The Plan will notify you of the decision not later than 15 days (for preservice claims) or 30 days (for post-service claims) after the appeal is received.

**Notice of Benefit Determination on Appeal.** If your claim is denied in whole or in part, you will receive written or electronic notice of the denial from the Plan. The notice will include all of the following that pertain to the determination: (1) the specific reason(s) for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a statement that you are entitled to receive, upon request and free of charge, access to copies of all documents, records, or other information relevant to your claims; (4) description of the plan’s voluntary review procedures, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of such rule, guideline, protocol, or other similar criterion or a statement explaining that such rule was relied upon and a copy will be provided to you free of charge upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement explaining that such rule was relied upon and a copy will be provided to you free of charge upon request; and (7) a statement that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.
Voluntary Appeals. You may file a voluntary appeal for external review of any final standard appeal determination that qualifies. You must complete all of the levels of standard appeal described above before you can appeal for external review.

You must request this voluntary level of review within 60 days after you receive the final denial notice under the standard appeal processes.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Appeal for External Review. The Plan’s external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

- the standard levels of appeal have been exhausted,
- the appeal is made by the member or by an appropriate representative,
- the coverage denial is based on the Plan’s determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- you have received a notice of denial of your claim
- the cost of the service or supply at issue for which the member is financially responsible exceeds $500.

If upon the final standard level of appeal the Plan upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member’s physician certifies that a delay in service would jeopardize the member’s health. Expedited reviews are usually decided within 3-5 days after your request is received. The decision of the independent external expert reviewer is binding on the Plan, the Company, and the health Plan. Members will not be charged a professional fee for the review. You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the external reviewer. The claims administrator is responsible for the cost of sending the information to the external reviewer and for the cost of the external review.

Legal Action. If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable. In most instances, you may not initiate legal action until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action. Legal actions must be brought within one year of the final denial on appeal.

CVS Caremark Prescription Claim Appeals Process

When you would like a review of a drug coverage decision under The Home Depot prescription drug plan, you or your representative have the right to appeal the decision. An appeal may be filed within 180 days from the date of the claim.

Appeals must be submitted in writing to CVS Caremark at the following address or fax number:

CVS Caremark, Inc.
Appeals Department, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

In your appeal, explain the reason for the appeal, the claim or drug being appealed, your CVS Caremark ID number, name, date of birth and any documentation that you feel is appropriate in support of your appeal (a copy of your benefits booklet, a doctor’s letter, etc.).

The appeal will be reviewed based on your prescription drug benefit design. If the appeal is due to a prior authorization denial, the prior authorization criteria will also be reviewed.

Prior authorization denials are reviewed within 15 days. If your physician requests an urgent review of a prior authorization denial, it will be completed within 72 hours. Your physician may submit the request in writing to the address or fax number above or by calling 1-866-443-1183 (available only to physicians). All other appeals are reviewed within 30 days of CVS Caremark receiving complete information. For all appeals you will be notified of the determination in writing.
If the appeal is denied and you have an additional level of appeal, the appeal contact information will also be provided in your written notification.

**MetLife Dental Plans**

**Appealing the Initial Determination**

If MetLife denies your claim, you may take 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 address indicated on the claim form within 180 days of receiving MetLife’s decision. 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 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. Deference 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 you 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.

**EyeMed Vision Plans**

If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed Vision Care within 180 days of the date of a denial. The member’s written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member’s eye care provider that will assist EyeMed Vision Care in completing its review of the member’s appeal, such as documents, records, questions or comments.

The appeal should be mailed to the following address:

**EyeMed Vision Care, L.L.C.**
**Attn: Quality Assurance Dept.**
**4000 Luxottica Place**
**Mason, Ohio 45040**

EyeMed Vision Care 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.
Health Care Spending Account Claim Procedures

If your claim for reimbursement from the health spending account is denied, you will receive a written notice from the claims administrator no later than 30 days after it received the claim.

If an extension is necessary, the claims administrator will notify you in writing, within the 30-day period, of the reasons for the extension and the date by which the claims administrator expects to make a decision. The extension generally will be no longer than 15 days.

If the extension is necessary because you failed to provide all needed information, the notice of extension will describe the additional information required. You will have 45 days to provide the additional information.

If all the additional information is received within 45 days, the claims administrator will notify you of the claim decision within 15 days after the information is received. If you do not provide the needed information within the 45-day period, the claims administrator will deny the claim.

Any notification of denial will include the following information:

- specific reason(s) for the denial
- reference to the specific plan provisions on which the denial is based
- description of any additional material or information necessary to perfect the claim and explanation of why such information is necessary
- description of the plan’s appeal procedures and of your right to bring a civil action under federal law (Section 502(a) of ERISA) following the denial of an appeal

Appeals of Benefit Determinations

How to File an Appeal. If you disagree with a benefit determination and want it reconsidered, you must contact the claims administrator in writing to formally request an appeal. You have 180 days from receipt of the notice of denial to file an appeal. All appeals must be in writing. You may submit comments, documents, and other information in support of your appeal.

The review on appeal will take into account any information you submit, even if not submitted or considered as part of the initial determination. Also, upon request and free of charge, you also will be provided reasonable access to and copies of all documents, records, and information relevant to your claim.

Review of Appeals. The claims administrator is responsible for reviewing appeals. The review of the appeal will afford no deference to the initial benefit determination. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the appeal.

The claims administrator will provide you written notification of the determination not later than 30 days after receipt of your request for an appeal.

If your appeal is denied, the notification from the claims administrator will include the following information:

- specific reasons for the denial
- reference to the specific plan provisions on which the determination is based
- statement that you are entitled to receive, upon request and free of charge, reasonable access to, or copies of, all documents, records, or other information relevant to the claim
- description of any voluntary appeal procedures offered by the plan and statement of your right to bring civil action under federal law (Section 502(a) of ERISA)

Legal Action. You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on the final, mandatory appeal. In most instances, you may not initiate legal action until you have completed the appeal process. Legal actions must be brought within one year of the final denial on appeal.
Claims Involving Disability Benefits and Disability Determinations

If MetLife denies your claim, you may appeal the decision. 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.

Metropolitan Life Insurance Company
Group Claims Review
P.O. Box 14592
Lexington, KY, 40511-4592

Appeals must be in writing and must include at least the following information:

1. Name of Employee
2. Name of the Plan
3. Reference to the initial decision
4. An explanation why you are appealing the initial determination

As part of your 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, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, 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 medicine involved in the medical 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 a reasonable period of time, but no later than 45 days after MetLife’s receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 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 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife’s notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you 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.
Employee Assistance Program
Claim Determinations

Magellan 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 Magellan cannot decide while on the initial call, Magellan will decide within five calendar days of your request for services or of notice to Magellan of a circumstance that affects the availability of further EAP services. Magellan will inform you by telephone of its determination within one business day after it decides.

If you are receiving an ongoing course of EAP counseling, Magellan will notify you in advance if it intends to terminate or reduce the number of EAP sessions that can be provided so that you will have an opportunity to appeal the decision before the termination or reduction takes effect.

If Magellan determines that you need Urgent Care, Magellan will provide telephonic crisis counseling and make an appropriate referral to your benefit plan and/or emergency resources in the community. Magellan does not make Claim determinations relating to Urgent Care.

Because Magellan 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, Magellan 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, Magellan 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;
• explain the review procedure, including time limits for appealing the decision and to sue in federal court;
• identify your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol or similar criterion relied on in making the decision;
• identify your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate).

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 Magellan 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, Magellan 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 Magellan’s receipt of the request for appeal;
- If the case involves a post-service adverse determination relating to reimbursement, within sixty days of Magellan’s receipt of the request for appeal.

**Appeal Decisions**

Magellan 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, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate);
- 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 Magellan, you may bring a lawsuit in federal district court. You cannot bring legal action unless your Claim has been reviewed and denied by Magellan.

**Limitation of Actions**

No lawsuit 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 appeal procedures set forth in this chapter. Any lawsuit must be filed no later than one year after the earlier of the date your claim arises or the date your claim is denied.
Plan Administration

U.S. Salaried & Full-Time Hourly Associates

Chapter Contents

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283 Qualified Domestic Relations Order (QDRO) Under FutureBuilder
283 Qualified Medical Child Support Order
284 Provider Networks
284 Plan Legal Matters
284 Plan Year
284 Plan and Employer Identification Numbers
284 How the Plans Are Funded
285 Amending or Terminating the Plans
285 Authority and Control

285 Your Rights Under the Employee Retirement Income Security Act (ERISA)

285 Receive Information About Your Plan and Benefits
285 Continue Group Health Plan Coverage
286 Prudent Actions by Plan Fiduciaries
286 Enforce Your Rights
286 Assistance With Your Questions

286 Limitation of Actions

286 Plan Termination and Amendment
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288 Medical, Dental and Vision Claim Administrators
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>• Request a copy of the official plan documents for the Plans</td>
<td>Contact the Plan administrator at:</td>
</tr>
<tr>
<td>• Receive a copy of the written procedures for determining whether a QMCSO is</td>
<td>Home Depot U.S.A., Inc., Benefits Department, Building C-9,</td>
</tr>
<tr>
<td>valid</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>administrator phone numbers and addresses.</td>
</tr>
<tr>
<td>Get answers to questions about your rights under ERISA or help in obtaining</td>
<td>The Plan Administrator and the Claims Administrator often are two different</td>
</tr>
<tr>
<td>documents</td>
<td>companies.</td>
</tr>
</tbody>
</table>

Benefit Plans 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. 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 Medical Child Support Order

The Plan provides coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO) 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. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. 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 or an order or a judgment from a state court or administrative body directing the Company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. 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.

Qualified Domestic Relations Order (QDRO) Under FutureBuilder

If you are a 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.
Provider Networks
Certain benefit options under the Medical, Vision and Dental Plans have provider networks which vary among the options. Benefits are generally greater when services are provided by a network provider. There is no guarantee that the same doctors, hospitals and other health care providers will be included in your Plan’s provider network from year to year. You should read your enrollment material very carefully to ensure that your network isn’t changing in the next plan year. Before you call for an appointment each year, you should confirm the doctor’s, hospital’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. Associates may also access up-to-date provider lists and directories through Web sites of the individual plans, and through their toll-free Member Services numbers.

For Medical Plans, a Web site and Member Services directory is provided in the Medical chapter. For the Vision Plan, the information is provided in the Vision chapter. For Dental Plans, 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 Plan is administered. Service may also be made upon the Plan Administrator or Trustee at:

Home Depot U.S.A., Inc.
Benefits Department BL C-9
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 Plan Administrator 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.

How the Plans Are Funded
The Company and its associates make contributions to the Plans in amounts determined by the Company from time to time. The Company’s contributions will be made to the appropriate Plan’s trust or insurance policy, where required, as specified by the Plan’s funding policy.

An associate’s contributions will be made to the appropriate Plan’s trust or insurance policy, where required, as soon as administratively practical after such contributions have been received from the associate or withheld from the associate’s pay. Benefits are provided directly from the appropriate Plan’s trust or insurance policy, where required, as applicable or from the Company’s general assets. The Spending Account contributions are not held in trust.

The Company provides benefits for The Home Depot Basic Term Life, Basic Dependent Term Life, Basic AD&D, Voluntary Term Life, Voluntary Dependent Term Life, Voluntary AD&D, Disability, the Legal Services Plan (MetLaw), and Long-term care Insurance Plans through a group insurance policy underwritten by Metropolitan Life Insurance Company. The Spending Account benefits are administered by SHPS.

The Company provides benefits for the Medical Plans, including prescription benefits, a portion through self-funding, and a portion through contracts of insurance. Vision benefits under the Vision Plan are provided through a group insurance policy underwritten by EyeMed.

The Home Depot FutureBuilder is a tax-qualified defined contribution retirement Plan. Benefits under FutureBuilder are not insured under Title IV of ERISA because the Plan is not a defined benefit pension plan.
Amending or Terminating the Plans
Although the Company established its benefit plans with the intention that they be maintained indefinitely, the Plans may be amended, terminated or discontinued at any time. In the event the plans are terminated, you and all other covered associates will be provided in a timely manner with written notice of such termination and your rights.

Authority and Control
The Plan Administrator (or, for the fully insured benefits, the insurance carrier) has the full power and authority in its absolute discretion to determine all questions of eligibility for and entitlement to benefits, and to interpret and construe the terms of the plans. Benefits under each plan will be paid only if the Plan Administrator (or, for the fully insured benefits, the insurance carrier) decides in its discretion that the applicant is entitled to them.

The claims administrator or insurer has the full power and authority in its absolute discretion to determine whether a claim is payable under the Plan and to interpret and construe the terms of the Plan. The claims administrator or insurer retains the full power and discretionary authority to interpret all other aspects of the Plan, and its decisions on those matters, including factual determinations, are final and binding.

Benefits under each Plan will be paid only if the Plan Administrator (or, for the fully insured benefits, the insurance carrier) decides in its discretion that the applicant is entitled to the benefits. The Plan Administrator retains the full power and discretionary authority to interpret all other aspects of the Plan, and its decisions on those matters, including factual determinations, are final and binding.

Your Rights Under the Employee Retirement Income Security Act (ERISA)
As a participant in the Medical and Dental Plans, the Vision Plan, the Welfare Benefits Plans and the portion of the Cafeteria Benefit Plan providing the Health Care Spending Account, and 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 worksites, 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 medical, vision, dental and/or Health Care Spending Account coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. See the COBRA Coverage chapter for more information.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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 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.

Limitation of Actions
No lawsuit 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 appeal procedures set forth in the Claims and Appeals chapter. Any lawsuit must be filed no later than one year after a claim is denied or be forever barred.

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.

The Plan Sponsor may also increase or decrease its contributions or the participants’ contributions to the Plans.

If the Plans are terminated while you are employed by the Company, you will not have any further rights other than the payment of benefits for covered losses or expenses incurred before the Plans are terminated. The amount and form of any final benefit you or your beneficiary receives will depend on any contract provisions affecting the Plans and the Plan Sponsor’s decisions. If there are any Plan assets remaining in trust following termination, the use of such Plan assets shall be governed by the terms of the applicable trust.

Currently, the trust for the Medical and Dental Plan allows for the distribution of such assets to participants in the Plans or for the use of such assets to provide additional welfare benefits.

The following chart summarizes important information about the Company benefit Plans.
## Plan Administration Summary

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Plan Type</td>
<td>A welfare plan for reimbursement of non-occupational medical care claims (a portion through self-funding and a portion through contracts of insurance), prescription drugs and dental care claims (a portion through self-funding and a portion through contracts of insurance) and employee assistance benefits</td>
<td>A welfare plan for reimbursement of vision care claims through a contract of insurance</td>
<td>A welfare plan for payment of accidental death and dismemberment, life, disability, long-term care and pre-paid legal benefits through contracts of insurance</td>
<td>A benefit plan allowing associate contributions for medical, dental and vision coverage to be made on a pre-tax basis and providing health care and dependent day care spending accounts and pre-tax contributions to a Health Savings Account</td>
<td>A qualified defined contribution retirement plan, with associate and company contributions</td>
</tr>
<tr>
<td>Plan Number</td>
<td>501</td>
<td>511</td>
<td>502</td>
<td>506</td>
<td>001</td>
</tr>
<tr>
<td>Plan Trustee</td>
<td>Carol Tomé, Executive VP, Chief Financial Officer</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>The Northern Trust Co. 50 S. LaSalle St. Chicago, IL 60675</td>
</tr>
<tr>
<td>Plan Administrator*</td>
<td>The Administrative Committee Benefits Department, Building C-9 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>The Administrative Committee Benefits Department, Building C-9 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>The Administrative Committee Benefits Department, Building C-9 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>The Administrative Committee Benefits Department, Building C-9 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
<td>The Home Depot FutureBuilder Administrative Committee Benefits Department, Building C-9 2455 Paces Ferry Road Atlanta, GA 30339-4024 1-770-433-8211</td>
</tr>
<tr>
<td>Claims Administrator, Insurer or Recordkeeper</td>
<td>See list on following page for Medical and Dental Plan claims administrators</td>
<td>EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111 Fax: 1-866-293-7373</td>
<td>Metropolitan Life Insurance Company P.O. Box 3016 Utica, NY 13504-3016 1-800-638-9909 Hyatt Legal Services (pre-paid legal) 1111 Superior Ave. Cleveland, OH 44114 1-800-423-0300</td>
<td>SHPS, Inc. 11405 Bluegrass Pkwy Louisville, KY 40299 1-502-267-4900</td>
<td>The recordkeeper is: Hewitt Associates LLC 3350 Riverwood Pkwy Atlanta, GA 30339-3370 1-770-956-7777</td>
</tr>
</tbody>
</table>

The insurer and claims administrator is the Named Fiduciary for decisions on claims and appeals for all Plans other than FutureBuilder.
## HMO Medical Plans

<table>
<thead>
<tr>
<th>Plan Provider</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna HMO</td>
<td>PO Box 14079, Lexington, KY 40512-4079</td>
<td>1-800-594-9372</td>
<td><a href="http://www.aetnanavigator.com">www.aetnanavigator.com</a></td>
</tr>
<tr>
<td>CIGNA HMO</td>
<td>PO Box 182223, Chattanooga, TN 37422-7223</td>
<td>1-800-433-3926</td>
<td></td>
</tr>
<tr>
<td>ConnectiCare, Inc.—HMO</td>
<td>PO Box A3694, Chicago, IL 60690-1364</td>
<td>1-800-892-2803</td>
<td></td>
</tr>
<tr>
<td>BCBS—HMO W. New York</td>
<td>PO Box 14240-0159, Buffalo, NY 14240-0159</td>
<td>1-800-544-2583</td>
<td></td>
</tr>
<tr>
<td>BCBS—HMO Illinois</td>
<td>PO Box 14072, Lexington, KY 40512</td>
<td>1-800-847-3991</td>
<td></td>
</tr>
<tr>
<td>Group Health Plan—HMO</td>
<td>PO Box 34585, Seattle, WA 98124</td>
<td>1-888-901-4636</td>
<td></td>
</tr>
<tr>
<td>Health Alliance Plan—HMO</td>
<td>2850 W. Grand Blvd, Detroit, MI 48202</td>
<td>1-313-872-8100</td>
<td></td>
</tr>
<tr>
<td>Health Net HMO</td>
<td>Health Net Select POS</td>
<td>P.O. Box 14702, Lexington, KY 40512</td>
<td>1-800-847-3991</td>
</tr>
<tr>
<td>Health Net HMO</td>
<td>HMO Claims Administration</td>
<td>P.O. Box 34585, Seattle, WA 98124</td>
<td>1-888-901-4636</td>
</tr>
<tr>
<td>CMSA (HMO and PPO)</td>
<td>P.O. Box 860, Honolulu, HI 96808-0860</td>
<td>1-808-948-6111 (PPO)</td>
<td>1-808-948-6372 (HMO)</td>
</tr>
<tr>
<td>Kaiser California—HMO</td>
<td>(Northern California)</td>
<td>Department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 7004, Downey, CA 90242-7004</td>
<td>1-800-611-1811</td>
<td></td>
</tr>
<tr>
<td>Pacificare—HMO</td>
<td>4601 E. Hilton Ave, Phoenix, AZ 85034</td>
<td>1-800-347-8600</td>
<td></td>
</tr>
<tr>
<td>UHC HMO Massachusetts</td>
<td>P.O. Box 740800, Atlanta GA 30374-0800</td>
<td>1-800-347-8600</td>
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</tbody>
</table>

## Medical Plans

<table>
<thead>
<tr>
<th>Plan Provider</th>
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</tr>
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<tbody>
<tr>
<td>Aetna—POS</td>
<td>PO Box 981106, El Paso, TX 79998-1106</td>
<td>1-800-695-9744</td>
<td><a href="http://www.aetnanavigator.com">www.aetnanavigator.com</a></td>
</tr>
<tr>
<td>Health Net PPO</td>
<td>PO Box 14702, Lexington, KY 40512</td>
<td>1-800-847-3991</td>
<td></td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>Attn: Claims Department P.O. Box 52196, Phoenix, AZ 85072-2196</td>
<td>1-800-847-3991</td>
<td>1-800-847-3991</td>
</tr>
<tr>
<td>CARE/Solutions for Life</td>
<td>Manager, Appeals and Comments</td>
<td>Magellan Health Services P.O. Box 2128, Maryland Heights, MO 63043</td>
<td>1-800-553-3504</td>
</tr>
<tr>
<td>MetLife Dental Claims</td>
<td>P.O. Box 981282, El Paso, TX 79998-1282</td>
<td>1-800-838-9909</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.metlife.com/dental">www.metlife.com/dental</a></td>
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</table>

## Dental Plan

<table>
<thead>
<tr>
<th>Plan Provider</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>EyeMed Vision Care</td>
<td>Attn: OCN Claims P.O. Box 8504, Mason, Ohio 45040-7111</td>
<td>1-866-293-7373</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:oonclaims@eyemedvisioncare.com">oonclaims@eyemedvisioncare.com</a></td>
<td></td>
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</tr>
</tbody>
</table>
Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Home Depot has determined that the prescription drug coverages offered by Home Depot that are listed in the Creditable Coverage column of the table below are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Home Depot has determined that the prescription drug coverages offered by Home Depot that are listed in the Non-Creditable column of the table below are, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. This is important because most likely you will get more help with your drug costs if you join a Medicare drug plan than if you only have coverage from Home Depot.

Read this notice carefully—it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Creditable Coverage Notice
If you elected prescription drug coverage that is listed as Creditable Coverage in the following table, please read this notice carefully—it may contain important information about your eligibility for Medicare prescription drug benefits.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium if you later decide to enroll in Medicare coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium as long as you have Medicare prescription drug coverage. However, if you have creditable prescription drug coverage through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave Home Depot coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your Home Depot coverage will not be affected.
### Your Prescription Drug Coverage: Creditable or Non-Creditable

<table>
<thead>
<tr>
<th>Plan</th>
<th>Creditable</th>
<th>Non-Creditable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPO and Out-of-Area Options</strong></td>
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<tr>
<td>Caremark $50 Deductible/Mail Copy Option</td>
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<tr>
<td>Caremark $50 Deductible/Coinsurance Option</td>
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<tr>
<td>Caremark $100 Deductible/Coinsurance Option</td>
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<tr>
<td><strong>California Medical Options</strong></td>
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<tr>
<td>Select POS Network (California)</td>
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</tr>
<tr>
<td>Health Net HMO–Basic and Standard (California)</td>
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<tr>
<td>Kaiser Permanente Basic and Standard HMO</td>
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<tr>
<td><strong>Hawaii Medical Options</strong></td>
<td></td>
<td></td>
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<tr>
<td>HMSA Preferred Provider Plan (Hawaii)</td>
<td></td>
<td></td>
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<tr>
<td>HMSA Health Plan Hawaii Plus (Hawaii)</td>
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<tr>
<td><strong>HMOs</strong></td>
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<tr>
<td>Aetna HMO (TX, NJ)</td>
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<tr>
<td>BCBS IL–Standard Option</td>
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<tr>
<td>BCBS IL–Basic Option</td>
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<tr>
<td>BCBS Western New York–POS Lite</td>
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<tr>
<td>CIGNA HMO (TX, NC)–Standard Option</td>
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<tr>
<td>ConnectiCare–Standard Option</td>
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<tr>
<td>ConnectiCare–Basic Option</td>
<td></td>
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<tr>
<td>GHC/Puget Sound–Seattle–Standard Option</td>
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<td></td>
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<tr>
<td>GHC/Puget Sound–Seattle–Basic Option</td>
<td></td>
<td></td>
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<tr>
<td>HAP Detroit-Standard Option</td>
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</tbody>
</table>
Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Home Depot and don’t enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than the base beneficiary premium. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about your current prescription drug coverage...

Contact the Benefits Choice Center for further information at 1-800-555-4954. NOTE: You’ll get this notice each year. You will also receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

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

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage after you first become eligible, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

You may request another copy of this notice by going to Your Benefits Resources at http://resources.hewitt.com/homedepot.

Date: November 1, 2005

The Home Depot
Vice President—Benefits
2455 Paces Ferry Road, NW
Atlanta, GA 30339-4024
1-770-433-8211 (Benefits Department)

Non-Creditable Coverage Notice
If you elected prescription drug coverage that is listed as Non-Creditable Coverage in the preceding table, please read this notice carefully—it may contain important information about your eligibility for Medicare prescription drug benefits.

You might want to consider enrolling in Medicare prescription drug coverage.

You can keep your coverage from Home Depot, regardless of whether it is as good as the Medicare drug plan. However, because the coverage you have with the Plans is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, you may pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium as long as you have Medicare prescription drug coverage. However, if you lose or decide to leave Home Depot coverage, you will be eligible to join a Part D plan at that time using a special enrollment period.

You need to make a decision. When you make your decision, you should compare your current coverage, including which drugs are covered with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your Home Depot coverage will not be affected.

If you enroll in a Medicare drug plan and drop your Home Depot prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

If you don’t enroll in Medicare prescription drug coverage when you first become eligible for Medicare and change your mind later, you may pay more.

If you enroll after you first become eligible for Medicare, your monthly premium for a Medicare prescription drug plan could be much higher than it would have been if you had enrolled when you first became eligible for Medicare. If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage, your premium will go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. You will have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. In addition, you may have to wait until the following November to join.
For more information about this notice or your current prescription drug coverage...
Contact the Benefits Choice Center for further information at 1-800-555-4954.

NOTE: You’ll get this notice each year. You may receive this notice at other times in the future, such before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Home Depot changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage will be available in the Medicare & You handbook from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. You’ll get a copy of the handbook in the mail. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048
- For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

You may request another copy of this notice by going to Your Benefits Resources at http://resources.hewitt.com/homedepot.

Date: November 1, 2005

The Home Depot
Vice President—Benefits
2455 Paces Ferry Road, NW
Atlanta, GA 30339-4024
1-770-433-8211 (Benefits Department)
The Home Depot Health Benefits Notice of Privacy Practices

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 medical, dental, prescription drug, vision and health care spending account benefits through group health plans (collectively, the “Plan”) offered by Home Depot U.S.A., Inc. and its participating subsidiaries (the “Plan Sponsor”). The Plan uses and discloses personally identifiable health information about you and other participants in the Plan (“Participants”). This personal information is referred to as protected health information (“PHI”). The Plan is required by law to protect the privacy of your PHI. As required by law, this provides you with notice of the Plan’s legal duties, its use and disclosure of PHI, your privacy rights, your right to file a complaint and whom to contact for additional information. It 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.

Uses and Disclosures for Treatment, Payment and Health Care Operations

The Plan may use, disclose or share between the plans and benefits listed above 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 the treatment of Participants. 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 Plans. 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 Plans, 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.

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.
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 a Participant 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. The Plan may release PHI 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.

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 Participants; 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 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 the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

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, which you may revoke in writing at any time. 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.

Regulatory Requirements

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 regarding your PHI:

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.

Confidential Communications. You have the right to request that communications of PHI to you from 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 e-mail rather than regular mail. Your requests must be made in writing. The Plan will accommodate your reasonable requests.
**Right to Inspect.** 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 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), 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.

If you believe your privacy rights with respect to your PHI have been violated, you may complain to the Plan by contacting the individual designated below and submitting a written complaint. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. The Plan will in no manner penalize you or retaliate against you for filing a complaint regarding Plan’s privacy practices.

**Contact Person**

Complaints, submissions required to be in writing, inquiries and questions with respect to your privacy rights should be directed to:

**Senior Director—Corporate Compliance**
**Privacy Officer**
**The Home Depot**
**2455 Paces Ferry Road, NW, C-19**
**Atlanta, Georgia 30339-4024**

For questions about the Notice of Privacy Practices or the Company’s privacy rules, contact:

**Vice President—Benefits**
**The Home Depot**
**Benefits Department, C-9**
**2455 Paces Ferry Road, NW**
**Atlanta, Georgia 30339-4024**

**Effective Date:** April 14, 2003
# Benefits Contact List

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<thead>
<tr>
<th>General Assistance</th>
<th>Phone Number</th>
<th>Internet Address</th>
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</thead>
<tbody>
<tr>
<td>Benefits Choice Center: Benefits questions &amp; enrollment</td>
<td>1-800-555-4954</td>
<td>Your Benefits Resources™  <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a></td>
</tr>
<tr>
<td>HR Services: HR/Pay questions</td>
<td>1-866-myTHDHR (1-866-698-4347)</td>
<td><a href="http://www.myTHDHR.com">www.myTHDHR.com</a></td>
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<tr>
<td>U.S. Full-Time Hourly/Salaried Medical and Prescription Drug Plan Providers</td>
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<tr>
<td>Aetna Choice POS II: 24/7 Nurse Line</td>
<td>1-800-695-9744</td>
<td><a href="http://www.livethehealthyorangelifecom">www.livethehealthyorangelifecom</a></td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>1-866-490-3376</td>
<td><a href="http://www.caremark.com">www.caremark.com</a></td>
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<tr>
<td>California Medical Plan Providers</td>
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<tr>
<td>Health Net</td>
<td>1-800-847-3991</td>
<td><a href="http://www.healthnet.com/homedepot">www.healthnet.com/homedepot</a></td>
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<tr>
<td>Kaiser Permanente</td>
<td>1-800-464-4000</td>
<td><a href="http://my.kp.org/homedepot">http://my.kp.org/homedepot</a></td>
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<tr>
<td>Hawaii Medical Plan Provider</td>
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<tr>
<td>HMSA</td>
<td>1-808-948-4672</td>
<td><a href="http://www.hmsa.com">www.hmsa.com</a></td>
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<tr>
<td>U.S. Part-Time Medical Plan Providers</td>
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<tr>
<td>Aetna/SRC</td>
<td>1-800-508-4015</td>
<td><a href="http://www.livethehealthyorangelifecom">www.livethehealthyorangelifecom</a></td>
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<tr>
<td>Dental Care Plan Provider</td>
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<tr>
<td>MetLife</td>
<td>1-800-638-9909</td>
<td><a href="http://www.metlife.com/dental">www.metlife.com/dental</a> or go to Your Benefits Resources for single sign-on</td>
</tr>
<tr>
<td>Vision Care Plan Provider</td>
<td></td>
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<tr>
<td>EyeMed Vision Care</td>
<td>1-888-203-7447</td>
<td><a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a></td>
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<tr>
<td>Flexible Spending Accounts</td>
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<tr>
<td>SHPS</td>
<td>1-888-547-3539</td>
<td><a href="http://www.myshps.com">www.myshps.com</a></td>
</tr>
<tr>
<td>Life Insurance/Accidental Death &amp; Dismemberment</td>
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<tr>
<td>MetLife</td>
<td>1-800-638-9909</td>
<td><a href="http://www.metlife.com">www.metlife.com</a> or go to Your Benefits Resources for single sign-on</td>
</tr>
<tr>
<td>Disability</td>
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</tr>
<tr>
<td>Hourly and Salaried STD</td>
<td>1-888-600-7676</td>
<td><a href="http://www.metlife.com">www.metlife.com</a> or go to Your Benefits Resources for single sign-on</td>
</tr>
<tr>
<td>Hourly and Salaried LTD</td>
<td>1-888-600-7676</td>
<td><a href="http://www.metlife.com">www.metlife.com</a> or go to Your Benefits Resources for single sign-on</td>
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<tr>
<td>To Learn About...</td>
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<tr>
<td>Associate Discounts</td>
<td></td>
<td><a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a> and select the Associate Discounts tab</td>
</tr>
<tr>
<td>CARE/Solutions for Life</td>
<td>1-800-553-3504</td>
<td><a href="https://careers.homedepot.com/cg">https://careers.homedepot.com/cg</a></td>
</tr>
<tr>
<td>CareerDepot</td>
<td></td>
<td>www-us.computershare.com/employee; For enrollment: <a href="http://resources.hewitt.com/homedepot">http://resources.hewitt.com/homedepot</a></td>
</tr>
<tr>
<td>ESPP (Employee Stock Purchase Plan)</td>
<td>1-800-843-2150</td>
<td></td>
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<tr>
<td>Health Advocate</td>
<td>1-800-519-6689</td>
<td></td>
</tr>
<tr>
<td>The Home Depot Awareness Line: Report workplace concerns</td>
<td>1-800-286-4909</td>
<td></td>
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<tr>
<td>Merrill Lynch</td>
<td>1-800-843-2150</td>
<td><a href="http://www.bol.ml.com">www.bol.ml.com</a></td>
</tr>
<tr>
<td>The Homer Fund (An independent public charity)</td>
<td>1-770-433-8211 Ext. 12611</td>
<td><a href="http://www.thdhomerfund.org">www.thdhomerfund.org</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>
</tbody>
</table>
# 2009 Health Care Plan Eligibility and Bi-Weekly Payroll Deductions

<table>
<thead>
<tr>
<th>MEDICAL PLAN OPTIONS</th>
<th>Full-Time Hourly &amp; Salaried Associates: U.S. Excp CA</th>
<th>Full-Time Hourly &amp; Salaried Associates: CA Only</th>
<th>Part-Time Hourly Associates: U.S.</th>
<th>Associate-Only</th>
<th>Associate+Spouse</th>
<th>Associate+Children</th>
<th>Associate+Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna $550 Deductible*</td>
<td>$74.25</td>
<td>$220.75</td>
<td>$139.50</td>
<td>$254.00</td>
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</tr>
<tr>
<td>Aetna $750 Deductible*</td>
<td>$64.00</td>
<td>$200.25</td>
<td>$120.25</td>
<td>$225.50</td>
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</tr>
<tr>
<td>Aetna $1,000 Deductible*</td>
<td>$59.25</td>
<td>$190.50</td>
<td>$111.00</td>
<td>$212.00</td>
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<td></td>
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</tr>
<tr>
<td>Aetna/$RC $10,000 Max</td>
<td>$55.57</td>
<td>$111.14</td>
<td>$100.03</td>
<td>$177.83</td>
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<tr>
<td>Aetna/SRC $20,000 Max</td>
<td>$72.54</td>
<td>$145.09</td>
<td>$130.58</td>
<td>$232.15</td>
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<tr>
<td>Health Net Select POS</td>
<td>$88.00</td>
<td>$252.75</td>
<td>$165.25</td>
<td>$293.00</td>
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<tr>
<td>Health Net Basic HMO</td>
<td>$65.75</td>
<td>$200.50</td>
<td>$124.50</td>
<td>$222.50</td>
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<tr>
<td>Health Net Standard HMO</td>
<td>$75.25</td>
<td>$220.50</td>
<td>$140.00</td>
<td>$253.25</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente Basic HMO</td>
<td>$65.75</td>
<td>$200.50</td>
<td>$124.50</td>
<td>$222.50</td>
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<td></td>
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<td>$140.00</td>
<td>$253.25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PRESCRIPTION DRUG OPTIONS (Prescription drugs are included in U.S. Part-Time Hourly and California Medical Plans)

| Caremark $50 Deductible/Mail Copay | $11.00 | $22.50 | $18.50 | $34.50 |
| Caremark $50 Deductible/Coinsurance | $8.00 | $16.50 | $13.00 | $25.75 |
| Caremark $100 Deductible/Coinsurance | $4.75 | $10.00 | $7.00 | $16.25 |

DENTAL PLAN OPTIONS

| MetLife $500 Annual Maximum | $5.00 | $10.01 | $10.01 | $15.01 |
| MetLife $1,000 Annual Maximum | $10.43 | $20.86 | $20.86 | $31.29 |
| MetLife $2,000 Annual Maximum | $12.93 | $25.86 | $25.86 | $38.80 |

VISION PLAN OPTIONS

| EyeMed Select $120 | $2.08 | $3.64 | $3.78 | $6.32 |
| EyeMed Select $150 | $4.32 | $7.73 | $8.10 | $12.71 |

SPENDING ACCOUNTS

For all other benefit premiums log on to Your Benefits Resources at http://resources.hewitt.com/homedepot or call the Benefits Choice Center at 1-800-555-4954.

*A separate election is no longer required for office visits. It is now included in your medical plan option. However, you will need to select a prescription drug option.

- For weekly rates, take the biweekly rates above, multiply by 26, then divide by 52.
- 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.
- 100% Commissioned associates: please reference Your Benefits Resources Web site for the specific options and pricing available to you.
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Remember!
NO Enrollment = No Coverage!!

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. 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 St. Thomas, who receive different versions of the 2009 Benefits Summary.

Your Benefits Resources™ Web site
- 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

Creating your benefits password
The first time you log on to the Your Benefits Resources Web site or call the Benefits Choice Center, you’ll create a password. You’ll use this password each time you call or access the Web site. 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: Social Security number, birth date, home ZIP code and date of hire.

What if you forget your password?
- If you use the Your Benefits Resources Web site, 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 the Your Benefits Resources Web site and the automated telephone system to request a new password. You will receive a temporary password in the mail within 7–10 days.

Your Benefits Resources™ Web site
LOG ONTO YOUR BENEFITS RESOURCES AT http://resources.hewitt.com/homedepot
The purpose of this book, called the Summary Plan Description (SPD), is to describe and explain benefit plans available to full-time hourly and salaried associates working in the United States of America. The SPD is intended only to help you understand the benefits plans available to you and can in no way modify the actual terms and provisions as specified in the legal documents (the Plan documents) that define those benefit plans. If there are differences between the information contained in the SPD and the provisions of the legal documents, the legal documents always prevail. Legal documents include the 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-9, 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, online, and through an automated phone response system. 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 obtain the required documentation and other information from a designated third party. Providing false information may result in exclusion (i.e., loss of eligibility) from all Company-sponsored written benefit plans and/or disciplinary action against you, in accordance with the Company’s Code of Conduct.

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