

# Understanding Your 2017 Benefits

## My Lowe's Benefits—Part Time

Part-time employees after 89 days of continuous employment.



### HEALTH

This is a limited medical plan administered by United HealthCare.

Bi-Weekly Rates	Preventive Plus Plan
	Employee Only: \$20.45 Family: \$52.23
	WHAT'S COVERED?
<b>Annual Deductible</b>	There is no annual deductible, annual out-of-pocket maximum, or coinsurance.
<b>Annual Out-of-Pocket</b>	
<b>Coinsurance</b>	
<b>Wellness &amp; Preventive</b>	100%
<b>Primary Care</b>	100%, Limited to four visits per Covered Person per calendar year.
<b>Specialty Care</b>	Not covered

### OUTPATIENT PRESCRIPTION DRUGS

Bi-Weekly Rates		
	When you enroll in the part-time medical plan, you automatically have prescription drug benefits.	
WHAT'S COVERED?	31 Day Supply (Retail)	90 Day Supply (Mail)
<b>Generic</b>	50%	
<b>Preventive Care Medications – Generic or Brand</b>	100%	

If you purchase a prescription drug from a non-network pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

### VISION

VSP (Vision Service Plan) administers the vision plan. You cannot obtain contacts and frames in the same calendar year.

Bi-Weekly Rates	Low	High
	Employee Only: \$2.34 Family: \$6.36	Employee Only: \$5.95 Family: \$16.14
	WHAT'S COVERED?	
<b>Exam every calendar year</b>	100% after \$15 copay	100% after \$10 copay
<b>Lenses every calendar year</b>	100% after \$15 copay; Progressive Lens: 100% with \$40 copay	100% after \$10 copay
<b>Frames every 2 calendar years</b>	Retail allowance up to \$150 with 20% discount above allowance.	Retail allowance up to \$220 with 20% discount above allowance.
<b>Contact lenses every calendar year</b>	100% for medically necessary. \$150 allowance	100% for medically necessary. \$220 allowance

You cannot obtain contacts and frames in the same calendar year.

### INCOME PROTECTION BENEFITS

- Critical Illness
- Fixed Indemnity
- Off-the-Job Accident Plan
- Life Insurance
- Short-Term Disability

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## DENTAL

The dental plan is administered by MetLife.

### Bi-Weekly Rates

Employee Only: \$10.25  
Family: \$24.60

WHAT'S COVERED?	Available to employees who <b>do NOT</b> reside in Louisiana, Mississippi, Montana, and Texas.		Available to employees who <b>DO</b> reside in Louisiana, Mississippi, Montana, and Texas.	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Type A – Preventive</b>	<b>100%</b>	90%	<b>100%</b>	<b>100%</b>
<b>Type B – Basic/Minor Restorative Care</b>	80%	70%	80%	80%
<b>Type C – Major Restorative Care</b>	50%		50%	
<b>Type D – Orthodontia</b>	50% (no deductible)		50% (no deductible)	
<b>Annual Deductible For Type B; Type C covered services</b>	Individual: \$100 Family: \$300	Individual: \$150 Family: \$400	Individual: \$100 Family: \$300	
<b>Annual Max Benefit For Type B; Type C covered services</b>	Individual Maximum: \$1,000		Individual Maximum: \$1,000	
<b>Orthodontia Lifetime Max</b>	Individual Max: \$1,500		Individual Max: \$1,500	