UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ALFRED EDWARD MILLING, JACOB REES, and DARLENE BOOZ, on behalf of themselves and all others similarly situated,

Plaintiffs,

-against-

LOWE'S COMPANIES, INC., LOWE'S WELFARE PLAN NUMBER 511, WELFARE PLAN COMMITTEE OF LOWE'S COMPANIES, INC. and JOHN DOES 1-10

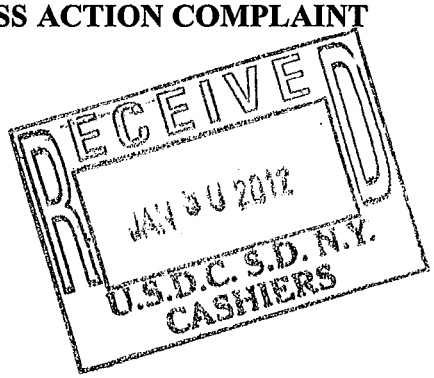
Defendants.

ECF CASE

JUDGE KARAS

C.A. No 12 CIV 0724

CLASS ACTION COMPLAINT



Plaintiffs ("Plaintiffs"), on behalf of themselves and all other similarly situated employees of the Lowe's Companies, Inc. ("Lowe's") who have been wrongfully denied comprehensive health coverage (the "Class" as defined below), make the following allegations based upon the investigation of counsel, except for those allegations pertaining to each Plaintiff, which are based upon personal knowledge. The investigation conducted by Plaintiffs' counsel included, *inter alia*, a review and analysis of: (i) publicly available news articles and reports; (ii) Plan documents; and (iii) interviews with potential members of the Class.

INTRODUCTION

1. This is a class action brought by Plaintiffs on behalf of all participants in the Group Medical Plan of Lowe's Companies Inc. Welfare Plan Number 511 (the "Plan") who have been wrongfully denied medical benefits against Defendants for violations of their fiduciary duties under the Employee Retirement Income Security Act ("ERISA"). Plaintiffs bring this as a class action pursuant to Fed. R. Civ. P. 23 on behalf of all participants in the Group Medical Plan who had their

group health plan coverage terminated by Lowe's for part or all of the 2011 calendar year (the "Class Period"). Plaintiffs seek relief on behalf of all members of the Class in the form of reinstatement of coverage, recognition of the group health plan enrollment elections of Class members on file as of December 31, 2010, equitable restitution to make them whole in the form of reimbursement of health care expenses incurred by Class members that would have been covered but for Defendants' unlawful termination of benefits and reimbursement for premiums for medical insurance coverage that would not have been incurred had the proper coverage not been cancelled.

2. As Plan fiduciaries, Defendants are required to exercise skill, care, prudence, and diligence in administering all components of the Plan, and are responsible for administering the Plan solely in the interest of Plan participants and beneficiaries.

3. In violation of their fiduciary duties to plan participants and beneficiaries, Defendants embarked upon a course of conduct that caused many employees to lose their coverage with the Lowe's Group Medical Plan.

4. Lowe's has admitted, in written correspondence to at least one class member, that it is aware of the issues with the reenrollment process as described herein but, to date, has not taken steps to notify all potential class members of the issue, to reinstate benefits, to offer compensation for unpaid claims and/or replacement coverage or to otherwise rectify the problem.

JURISDICTION AND VENUE

5. This Court has subject matter jurisdiction over this action pursuant to ERISA Section 502(e)(1), 29 U.S.C. § 1132(e)(1).

6. This Court has personal jurisdiction over Defendants pursuant to ERISA Section 502(e)(2), 29 U.S.C. § 1132(e)(2), as one or more of the Defendants may be found in this District. Lowe's maintains and operates at least one home improvement store in this District. The Court also

has personal jurisdiction over Defendants because Lowe's maintains offices in this District. Defendants systematically and continuously have done and continue to do business in this District, and this case arises out of Defendants' acts within this District.

7. Venue is proper in this District pursuant to ERISA Section 502(e)(2), 29 U.S.C. § 1132(e)(2), because this is a District where the Plan was administered, where breaches of fiduciary duty took place and/or where one or more Defendants reside or may be found.

PARTIES

Plaintiffs

8. Plaintiff Fred Milling is a resident of North Carolina and at all relevant times has been a full time employee of Lowe's in Wilmington, North Carolina. Plaintiff Milling had maintained continuous medical coverage for himself and his wife through Lowe's insurance program administered by Blue Cross Blue Shield of Alabama. Defendant Lowe's canceled Plaintiff Milling's insurance coverage as of December 31, 2010.

9. Plaintiff Jacob Rees is a resident of Maryland and at all relevant times has been a full time employee of Lowe's in Laurel, Maryland. Plaintiff Rees had maintained continuous medical coverage for himself through Lowe's insurance program administered by Blue Cross Blue Shield of Alabama. Defendant Lowe's canceled Plaintiff Rees' insurance coverage as of December 31, 2010.

10. Plaintiff Darlene Booz is a resident of North Carolina and at all relevant times was a full time employee of Lowe's in Wilmington, North Carolina. She is no longer employed by Lowe's. Plaintiff Booz had previously maintained continuous medical coverage for herself through Lowe's insurance program administered by Blue Cross Blue Shield of Alabama. Defendant Lowe's canceled Plaintiff Booz's insurance coverage as of December 31, 2010.

Defendants

11. Defendant Lowe's is a home improvement retailer with its corporate headquarters located at 1000 Lowe's Boulevard, Mooresville, North Carolina 28117. As of January 28, 2011, Lowe's operated 1,749 stores in the United States. According to Lowe's Annual Report on Form 5500 for 2009, as of December 31, 2009, there were over 175,000 participants in the overall Plan. Upon information and belief, Lowe's officials made decisions about the procedures that were required to be followed by its employees in 2010 to continue their health insurance in 2011. As such, these officials were acting as fiduciaries as that term is defined pursuant to ERISA, 29 U.S.C. §1104. They are named as defendants John Does 1-10 until such time as their identities can be ascertained.

12. Defendant Lowe's Welfare Plan Number 511 is the operative employee welfare plan for 2010. The Plan offers several health and welfare benefits as component benefits of the overall Plan. These health and welfare benefits include the Group Medical Plan, also called the Group Medical Plan Option.

13. Defendant Welfare Plan Committee of Lowe's Companies Inc.'s ("Welfare Plan Committee") is the Plan Administrator and acted as a fiduciary for all purposes as that term is defined pursuant to ERISA, 29 U.S.C. §1104.

14. Defendant Lowe's together with the Plan, the Welfare Plan Committee and John Does 1-10 are sometimes referred to as the "Defendants."

PLAINTIFFS' CLASS ACTION ALLEGATIONS

15. Plaintiffs bring this action as a class action pursuant to Federal Rule of Civil Procedure 23(a), (b)(1) and (b)(2) on behalf of the following class of persons situated (the "Class"):

All participants in or beneficiaries of the Group Medical Plan whose medical benefits were wrongfully terminated by Lowe's for all or part of the 2011 calendar year.

16. This action is properly maintainable as a class action because:

a. The members of the proposed Class in this action are dispersed geographically and are so numerous that joinder of all Class members is impracticable. While the exact number of Class members is unknown to Plaintiffs at this time and can only be ascertained through appropriate discovery, Plaintiffs believe that Class members number in the thousands (in 2009, there were over 175,000 participants in the overall Plan);

b. Plaintiffs' claims are typical of those of all members of the Class because Plaintiffs and all members of the Class lost their medical benefits as a result of Defendants' wrongful conduct in violation of ERISA as alleged herein;

c. Plaintiffs will fairly and adequately protect the interests of the Class and have retained counsel competent and experienced in class action litigation. Plaintiffs have no interests antagonistic to, or in conflict with, the Class that Plaintiffs seek to represent;

d. A class action is superior to other available methods for the fair and efficient adjudication of the claims asserted herein because joinder of all members is impracticable. Furthermore, because the relief awarded to individual members of the Class may be relatively small, the expense and burden of individual litigation makes it virtually impossible for Class members to redress the wrongs done to them. The likelihood of individual Class members prosecuting separate claims is remote;

e. Plaintiffs anticipate no unusual difficulties in the management of this action as a class action; and

f. The questions of law and fact common to the members of the Class predominate over any questions affecting individual members of the Class. Among the questions of law and fact common to the Class are:

i. whether Defendants breached their fiduciary duties;

ii. whether the Plaintiffs and other Class members were injured by such breaches;

iii. whether the Plaintiffs and other Class members are entitled to equitable restitution to make them whole.

SUBSTANTIVE ALLEGATIONS

Description of the Plan

17. The Plan is an employee welfare plan within the meaning of ERISA Section 3(1), 29 U.S.C. §1002(1) operated and established by Lowe's to provide a broad range of health and welfare benefits to participants and their beneficiaries. The effective date of the overall Plan was January 1, 1996. Each Plan year runs from January 1 through December 31.

18. Lowe's is the sponsor of Plan, as the term "sponsor" is defined by Section 3(16)(B) of ERISA, 29 U.S.C. §§ 1002(16)(B).

19. The Plan Administrator, for the purposes of ERISA reporting and disclosure, is the Welfare Plan Committee of Lowe's. According to the SPD, Lowe's "serves as the Plan Sponsor and Plan Administrator" for all of its affiliated companies (including Lowe's Home Centers, Inc.) under an intra-company management arrangement.

20. According to the Lowe's Foundations for Success Summary Plan Description ("SPD"), in the section covering the Lowe's Group Medical Plan, many Lowe's locations offer an HMO as the sole medical plan option. At other locations, employees are offered two options - the

Copay 500 and Copay 750 Options. According to the SPD, The Copay 500 Option offers "richer benefits" while the Copay 750 Option offers "cost-effective coverage at lower premiums." According to the Lowe's website, both options provide "comprehensive medical coverage and participate in a Preferred Provider Network (PPN)." All full-time employees are eligible to receive comprehensive health coverage after 89 days of continuous employment.

21. The Group Medical Plan is "self-funded" with Lowe's covering a portion of the cost for employee and dependent medical coverage. Under the heading "Cost Sharing" in the SPD, Lowe's states its purported belief that "healthcare is one of the most important benefits we can offer our employees" and that "Lowe's offer [sic] healthcare coverage so that you can protect yourself and your family from major financial burdens that can result from serious illness and injury."

22. The SPD contains a breakdown and comparison of the various costs and other provisions of the Copay 500 and the Copay 750 Medical Plan Options. Network managers for both plans, *inter alià*, are either Blue Cross Blue Shield of Alabama or Aetna. Certain administrative functions are delegated by the Plan to Blue Cross Blue Shield and to Aetna, including claims processing and appeals.

23. With respect to Annual Enrollment, the SPD states that employees will have the right each year to keep their present coverage or change to other available options. The SPD states that each employee must re-enroll annually. According to the SPD: "If you do not make new selections during future enrollment periods, you will receive the same coverage for you and your dependents that you had in the prior year...."

Administration of the Plan

24. Defendants were fiduciaries of the Plan as defined by ERISA Section 3(21)(A), 29 U.S.C. § 1002(21)(A), because they exercised discretionary authority or control of the management of the Plan or exercised discretionary authority or control respecting management or disposition of assets and had discretionary authority or responsibility in the administration of the Plan.

25. Defendants, as fiduciaries of the Plan, were required by ERISA to furnish certain information to participants. For example, ERISA Section 101, 29 U.S.C. § 1021, requires a plan's administrator to furnish a Summary Plan Description ("SPD") to the Plan's participants. ERISA Section 102, 29 U.S.C. § 1022, provides that an SPD must apprise participants of their rights and obligations under the plan.

26. The Lowe's SPD, under the heading "Prudent Actions by Plan Fiduciaries," states as follows:

> 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, or in any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare or pension benefit or exercising your rights under ERISA.

27. Among other duties, Defendants had a duty to act in accordance with Plan provisions, to not actively misinform Plan participants, to respond truthfully to inquiries from Plan participants and obtain information necessary for the proper monitoring and administration of the Plan.

Facts Relevant to a Critical Change in the Administration of the Plan

28. In or around the period from January 1, 2010 to October 1, 2010, Defendants determined that beginning October 1, 2010, it would be necessary for all participants in the Group

Medical Plan to re-enroll if they wished to maintain medical coverage for themselves and their beneficiaries. An open enrollment period was established from October 1, 2010 to December 31, 2010 to accomplish this purpose.

29. In order to communicate this critically important change in the administration of the Group Medical Plan, Defendants chose to communicate this information by word of mouth, charging managers to inform their subordinates of this change. Notices were not mailed to participant employees' homes to inform them of this critical change, nor were any internal electronic or "hard copy" memoranda sent to such employees to inform them of this change. A Summary of Material Modification was not sent to employees nor was any amendment to the SPD communicated to them.

30. No training was provided to employees to enable them to access the computer system in a manner that would ensure that those who wished to continue coverage would successfully access the system to accomplish this purpose.

31. As a result of this ad hoc method of communication chosen to relay this critical change in the administration of the Plan, upon information and belief, thousands of employees, including the Plaintiffs described below, lost their health insurance for plan year 2011.

Facts Specific to Plaintiffs

Fred Milling

32. Fred Milling is a shareholder and full time employee of Lowe's in Wilmington, North Carolina. He has maintained continuous medical coverage for himself and his wife Rita through one of the self-funded options offered through the Plan. Plaintiff Milling's program is managed by Blue Cross Blue Shield of Alabama.

33. During the course of his employment at Lowe's, Plaintiff Milling's wife was diagnosed with Stage 4 pancreatic cancer. She was told that she should immediately begin intensive chemotherapy and other related therapies. Rita received her medical care at Duke University Hospital.

34. In October 2010, Plaintiff Milling was told by Lowe's management that Lowe's now required all employees who wished to maintain coverage to reenroll during its Open Enrollment period, via an internal computer program created by Lowe's. The reenrollment process required the completion and submission of an "updated" personal and medical questionnaire that was contained within the computer program itself.

35. Plaintiff Milling completed the reenrollment process and confirmed with his Human Resources ("HR") director at that time that he had complied with all required procedures.

36. On January 5, 2011, the Millings presented for treatment at Duke where they were advised that there was a problem with their coverage. Duke immediately contacted Blue Cross Blue Shield and Lowe's which reported that there had been a "glitch" in the Lowe's computer system. Duke was told that the issue had been resolved and was assured that the Millings' coverage was in place.

37. Plaintiff Milling returned to work and continued to pay monthly premiums via payroll deductions. On several occasions during January and February, Plaintiff Milling and his wife returned to Duke for continued treatment and testing.

38. On March 14, 2011, Duke contacted Plaintiff Milling and told him that his insurance coverage had been canceled. Over the next four days, Plaintiff Milling attempted to contact Lowe's HR representatives and senior management, including Lowe's CEO Robert Niblock.

39. Plaintiff Milling first called Lowe's HR department and was told that there had been a computer glitch and that he should speak with Jennifer Rotin. Plaintiff called Ms. Rotin and received no return call. Milling called the human resources department again and was told by a woman who identified herself as "Bonnie" that he needed to speak with Bud Spain. Milling called Mr. Spain twice and did not get a response. Milling called Bonnie again and was told by Bonnie that he had no insurance and that there was nothing she could do. Bonnie then said that she would transfer Plaintiff to Bud Spain and would stay on the line. Instead, she hung up.

40. On March 17, 2011, Plaintiff called Kyle Wendt, Lowe's Vice President Benefits, and explained the issues with the insurance and the premium deductions from Plaintiff's paycheck. Mr. Wendt said that he would look into the issue. Plaintiff called Wendt two additional times on March 18, 2011, but was not able to reach Mr. Wendt. Mr. Wendt called back later that day and told Plaintiff that he could not help him because he had no confirmation of his insurance.

41. On March 18, 2011, Plaintiff also called Bob Ihrie, Senior Vice President Human Resources, and relayed his insurance issues. Mr. Ihrie said he would look into the problem and let Plaintiff know. Mr. Ihrie never called back. Plaintiff also contacted Maureen Ausura, Executive Vice President and Robert Niblock, Chief Executive Officer of Lowe's and left messages for both. Neither returned the call.

42. During the course of these conversations, Plaintiff Milling was advised that he had failed to hit the "Submit" key during open enrollment and therefore he was automatically defaulted to the "decline coverage" category by the computer system. This was confirmed to Plaintiff by Mr. Wendt in their final conversation on March 18, 2011.

43. Despite being told that he had been defaulted to "decline coverage" on the Lowe's internal computer system, Plaintiff Milling never received any type of a written notification of

cancellation from either Lowe's or Blue Cross Blue Shield. Premium payments were still deducted from Plaintiff's paycheck for January and February of 2011.

44. The Millings were understandably distraught over the course of events described above. Having been advised that these issues purportedly had been caused by a failure to press a button, the Millings' son, also a Lowe's employee, send an email to Robert Niblock, the CEO of Lowe's. The text of the email was as follows:

> Mr. Niblock, My name is Michael Milling and I work at store 2256, I have worked with the company going on 14 years. My dad works at store 1138 and has worked for the company 6 years. On June on last year we found out that my Mom has stage 4 Pancreatic Cancer, this has a survival rate of 23% for a year. This June it will be two years of her fighting this Cancer. When it was time for my Dad to re-enroll for insurance he went through the motions but apparently he did not do it right. It is saying that he declined to enroll for insurance, why would he do something like that on purpose? They found this out when Duke called on Monday 3/14/2011 and said you do not have insurance. They had been taking money out of his pay check for his insurance until the beginning of March. Since my Mom has gotten this phone call she keeps having panic attacks, back pains, stomach pains, she is scared, mad, and scared. This is her life we are talking about. I am proud to say I work for Lowe's, this is a company that does the right thing when someone needs help, I see we as a company just Donated One Million dollars to Japan but we can not fix a mistake that may cost someone their life? We need help, my dad has spoke with many people, the last person he spoke with was Mr. Kyle Wendt, and he said there is nothing that can be done. I love my Mom and am NOT ready for her to leave me and my family, I have a four year old daughter and a 16 month old son. This weekend was supposed to be a great weekend for our family as we are to celebrate my Niece's eighteenth birthday. I can not quit when someone tells me no that they can't help. There has to be someone out there that can fix a mistake. Please help our family!
>
> Thank you,
> Michael Milling
> ASM 3, Store 2256, Surf City

45. On March 21, Michael Milling received a formal response from Mr. Ihrie, writing on behalf of CEO Niblock. By this point, Lowe's position no longer was that Plaintiff Milling had failed to push a button, but now was that Plaintiff had "voluntarily elected to drop his coverage" during open enrollment. No documentation confirming this election to drop coverage was provided

or even referenced. Mr. Ihrie stated that Milling's coverage had been terminated retroactively to January 1, 2011 and that premiums that Lowe's had deducted from his paycheck for January and February 2011 would be credited back to his bank account.

46. The text of the email from Mr. Ihrie is as follows:

> Since I am the person who runs the Lowe's benefits plan, I am responding to your email on behalf of Mr. Niblock. Kyle Wendt also spoke with your father last Friday and conveyed the same information to him.
>
> As your father knows, the recently completed annual enrollment required all of our employees who wanted medical, dental, vision, or FSA plans for 2011 to re-enroll. The was a big change at Lowe's since we had previously done default enrollments (meaning if you wanted to keep the same coverage as the prior year, you did not have to do anything). As a result we extended the enrollment period from three weeks to over four weeks, had a contest giving away free medical premiums for a year to five employees, did extra publicity and provided extra reports to our HR Managers to insure that all employees were aware of the change and the need to re-enroll. Due to these efforts, we had a very successful enrollment and 121,210 employees completed their enrollment in the medical plan for 2011.
>
> Our records show your father accessed the system on October 30 and elected to waive his medical coverage. Since waiving coverage (meaning he would have no medical coverage for 2011) was a valid enrollment option, he no longer appeared on our reports of employees who had coverage in 2010, but had not yet elected coverage for 2011 that his HR Manager would have received. Per the annual enrollment materials, confirmation statements were available for printing the next day after submitting the enrollment and employees were encouraged to print off the confirmation statement to confirm their enrollment was correct and to have in case any issues such as this occurred after the fact. Since he is discovering the issue now, I presume he did not print off the confirmation statement. Or if he does have a printed confirmation statement, please forward it to me.
>
> Had he discovered the issue prior to the close of the enrollment period this would have been easy to fix. The fact it was discovered after the close of the enrollment period prevents me from being able to help him. ERISA, the Federal law covering benefit plans, requires us to treat all similarly situated employees the same or risk disqualification of our plan which would make all of the company's contributions (approximately $500 million) non-deductible and cause employee premiums to be taxable. We are required to be consistent and deny enrollment to any of the employees who have failed to finalize their enrollment for 2011.
>
> I recognize this is not the answer you or he wanted to hear, but we feel that we took all the appropriate steps to make sure this did not happen to any of our

employees and there is a certain amount of personal responsibility that each employee must assume about their benefits enrollment. As a result his coverage under the Lowe's medical plan ended on December 31, 2010 and he is not eligible for COBRA continuation coverage.

There are other sources of medical, dental and vision insurance available in the open market and I would suggest that you start by contacting your local Blue Cross plan and investigating the plans they offer. Another online source iswww.Healthcare.gov. During the next annual enrollment period in November 2011 he may elect to enroll in Lowe's plans with coverage effective January 1, 2012.

47. Throughout the month of April 2011, Plaintiff Milling asked both Mr. Wendt and Mr. Ihrie to provide copies of all documentation that Lowe's claimed he had submitted during open enrollment and purportedly relied upon in canceling his coverage. On April 20, 2011, Plaintiff Milling received a reply from Mercedes Ikard who forwarded a computer generated confirmation indicating that the system had canceled his coverage retroactively to January 1, 2011. The "Confirmation of 2011 Elections – Open Enrollment", only obtained by Plaintiff Milling after the events described above, indicates (incorrectly) that Plaintiff Milling waived all of his Lowe's benefits for 2011.

48. Rita Milling voluntarily ceased all medications, other than pain medication, in mid-April 2011. She and Plaintiff Milling were able to work out a payment arrangement with a local hospice facility. Rita Milling passed away a few weeks later.

Jacob Rees

49. Jake Rees has been employed with the Lowe's store in Laurel, Maryland for several years, and held a senior sales position as "Sales Specialist" until May 2011, when he was forced to accept a significant demotion and substantial pay-cut, or face immediate termination, due to his "poor job performance"

50. In November 2010, early in the open enrollment period, Plaintiff Rees accessed Lowe's internal computer system in order to re-enroll for his health care benefits. Plaintiff Reiss

changed his provider from Blue Cross Blue Shield to Kaiser, but otherwise maintained his health coverage exactly as it had been in 2010. He also increased the amount of his accident/life insurance during this computer session, and named his oldest son as beneficiary. He specifically recalls hitting SUBMIT when he was finished, and then seeing, "YOUR CHOICES HAVE BEEN SUBMITTED" on the screen.

51. Plaintiff Rees believes that he is somewhat "computer savvy", and has stated that there were no further "prompts" or options regarding requesting, receiving or printing a "confirmation" which he saw. According to Plaintiff Rees, the entire reenrollment process took about 20 minutes.

52. During the enrollment period, Michelle Garwo, the HR manager for the Laurel, Maryland store, made daily announcements advising which employees had not yet re-enrolled. At the end of the open enrollment period in November 2010, Garwo made a storewide announcement that their store had a 100% success rate, and that all store employees had successfully re-enrolled.

53. On December 5, 2010, Plaintiff Rees checked the system, and was concerned that it showed his re enrollment as "processed," but that his coverage was unchanged. He informed Garwo and was told that changes would appear on January 1, 2011. On January 6, 2001, Plaintiff Rees checked the computer system, and was shocked that the system said he had no health coverage. He immediately advised Garwo, who said there was a computer glitch, and that she would "look into it." Garwo subsequently advised Rees that he had "elected" to drop his health coverage and there was nothing she could do. He appealed to regional management, but received no response.

54. In early February, Plaintiff Rees developed a bad cold, which continued to worsen. Because he was uninsured, he was unable to see a doctor. Plaintiff Rees was finally forced to seek medical attention, and was diagnosed with pneumonia. After treatment with antibiotics, he was confined to bed for several days and missed work during this period. Upon his return, he was re-assigned the most difficult schedules, including opening the store at 6:00 am and closing it at 10:00 pm several nights in a row. Thereafter, he received a flurry of written notices regarding his job performance, and then was given the choice between demotion and a pay cut or termination.

55. Plaintiff Rees recently discovered inadvertently that his life/accident insurance had not been increased per his election during open enrollment. However, increased premiums for this additional coverage had been deducted from his check every pay period since January 1, 2011. To this date, Plaintiff Rees has never received any formal, written notification regarding his change in benefits or cancellation of his coverage.

56. In mid-August 2011, Plaintiff Rees was presented with a letter while he was at his workplace. The letter offered to reinstate his insurance. The letter indicated that it was being mailed but was handed to him personally by an HR director who had traveled to the Laurel, Maryland store. The letter stated that Plaintiff Rees would have ten days to review and respond to the letter but he was told that he must sign it immediately. In the letter, Lowe's admits that employees had "encountered difficulties" in finalizing their enrollment elections "due to confusion related to the layout of the online system." In the letter, Lowe's offered to recognize Rees' group health plan enrollment elections on file as of December 31, 2010 as his 2011 group health plan election enrollment elections effective as of January 1, 2011.

57. Plaintiff Rees did not sign the letter because he was not given sufficient time to review its terms. In the letter, Lowe's stated that it would be contacting all employees who had lost coverage and offering the same conditions of reinstatement. However, other Lowe's employees who lost their health care coverage in the same manner as Plaintiff Rees did not receive a copy of the letter.

58. A Confirmation of 2011 Elections – Open Enrollment, obtained by Plaintiff Rees after the events described above, indicates (incorrectly) that Plaintiff Rees waived all of his Lowe's benefits for 2011.

Darlene Booz

59. Darlene Booz was employed by Lowe's in Laurel, Maryland for approximately one to two years as a "return/intake" clerk. Because she suffers from extreme vertigo, she was assigned and remained in this position throughout her employment with Lowe's.

60. Plaintiff Booz re-enrolled for benefits in late 2010, elected to retain her health coverage as it was in 2010, hit the SUBMIT button on Lowe's computer system and does not recall seeing any prompt regarding a conformation. Plaintiff Booz heard human resources managers at the Laurel, Maryland store announce that all employees at her store had successfully reenrolled during the 2010 open enrollment period.

61. Plaintiff Booz discovered she was uninsured after a doctor's visit in January, 2011. She complained to human resources and to store management, but was told she had "screwed up" by not hitting SUBMIT, and nothing could be done. In late January 2011, Plaintiff Booz was advised that she was being re-assigned to floor sales. She requested that to remain in her position as a clerk because standing on her feet, walking the aisles, and climbing ladders were impossible for her due to her vertigo. Her request was refused and Plaintiff Booz resigned.

62. Other putative class members have described substantially similar experiences regarding reenrollment for benefits for the 2011 calendar year. Many of these descriptions were contained on a portion of the Lowe's intercompany website that has since been shut down. On that website, several other employees expressly addressed the issue of loss of health benefits due to a "system glitch." One poster reported that he has been told the error had affected "thousands" of employees. These employees were told that nothing could be done until the reenrollment period for the year 2012.

Defendants' Violations of ERISA

63. Pursuant to ERISA Section 404(a), 29 U.S.C. § 1104(a), Defendants were obligated to discharge their duties with respect to the Plan, and its participants and beneficiaries, with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and of like aims.

64. At all times relevant to this Complaint, Defendants were fiduciaries of the Plan as defined by ERISA Section 3(21)(A), 29 U.S.C. § 1002(21)(A), because they exercised discretionary authority or control with respect to monitoring and management of the Plan and had discretionary authority or responsibility in the administration of the Plan.

65. During the Class Period, Defendants modified Lowe's prior method of enrolling employees for medical benefits and put into a place a system that resulted in the termination of many employees' coverage. Defendants were aware of the issues with the computer system described herein but took no steps to notify employees of the problem, to rectify the problem or to compensate employees in any way.

66. Each of the named Plaintiffs had identical experiences. Each had their insurance cancelled by Lowe's but were not told about such cancellation until such time as he/she or one of their family members became ill. Each named Plaintiff had to actively seek out the truth regarding the cancellation of their insurance coverage and were given different stories and excuses from every Lowe's employee from whom they sought answers. Lowe's failed to give notice to any of its employees who lost coverage due to the modification of the reenrollment procedure or to inform them in any way of the loss of coverage.

FIRST CAUSE OF ACTION
(Against All Defendants)

70. Plaintiffs repeat and reallege each and every allegation contained in the above paragraphs as if fully set forth herein.

71. As a result of the failure to develop a system to ensure that participant employees and their beneficiaries could successfully re-enroll in the relevant health plans, Defendant fiduciaries failed to act solely in the interest of such participants and beneficiaries in violation of the fiduciary duties owed to them. Defendants thereby violated ERISA §1104(a) and 29 U.S.C. 1132(a)(3).

72. As such, Plaintiffs and members of the class were prevented from accessing their health insurance, and were forced to incur the payment of premiums to obtain substitute insurance, incur the payment of claims that would otherwise be covered and/or forced to forego health coverage for the entire year of 2011.

73. Plaintiffs and members of the class therefore seek a make whole remedy in the form of equitable restitution to compensate them for losses suffered as a result of Defendants' breach of fiduciary duties owed to them and members of the class.

SECOND CAUSE OF ACTION
(Against All Defendants)

74. Plaintiffs incorporate the allegations contained in the previous paragraphs of this Complaint as if fully set forth herein.

75. The SPD in effect at the time of the critical change in the enrollment system stated that "If you do not make new selections during future enrollment periods, you will receive the same coverage for you and your dependents that you had in the prior year. . . ."

76. By failing to act in accordance with the documents and instructions governing the Plan, Defendants breached the fiduciary duties they owed the Plaintiffs and members of the class, in violation of 29 U.S.C. §1104(a), 29 U.S.C. §1132(a)(3).

77. As such, Plaintiffs and members of the class were prevented from accessing their health insurance, and were forced to incur the payment of premiums to obtain substitute insurance, incur the payment of claims that would otherwise be covered and/or forced to forego health coverage for the entire year of 2011.

78. Plaintiffs and members of the class therefore seek a make whole remedy in the form of equitable restitution to compensate them for losses suffered as a result of Defendants' breach of fiduciary duties owed to Plaintiffs and members of the class.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for:

A. Declaring this action to be a proper class action pursuant to Fed. R. Civ. P. 23;

B. A Declaration that Defendants, and each of them, have breached their ERISA fiduciary duties to the members of the Class as participants and beneficiaries in the Plan;

C. An Order compelling Defendants to provide a make whole remedy to the

Plaintiffs and members of the Class in the form of equitable restitution to compensate them for losses suffered as a result of Plaintiff's breach of fiduciary duties owed to them.

D. An Order awarding costs pursuant to 29 U.S.C. § 1132(g);

E. An order awarding attorneys' fees pursuant to 29 U.S.C. § 1132(g) and the common fund doctrine; and

F. Such other and further relief that the Court deems necessary.

Dated: January 30, 2012

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