BENEFITS

U.S. BENEFITS PLAN DESCRIPTION 2020–2021

Effective October 1, 2020

Your guide to Starbucks health coverage, stock and savings plans, education benefits, time off benefits and more.

STARBUCKS®

About This Book

The compensation and benefits arrangements described in this book are generally referred to as Starbucks benefits, each of which is governed by the terms and conditions of a formal plan, program or policy document. This book is intended as a single resource for communicating all Starbucks benefits. This book serves as the formal document or includes a summary of a formal document, as follows:

- **Starbucks Corporation Welfare Benefits Plan** (including health coverage, life and disability coverages and reimbursement accounts): This book is the formal document for the plan, as required by Section 402 of the Employee Retirement Income Security Act, or ERISA. In addition, this book serves as the plan's "summary plan description" within the meaning of ERISA Section 102.
- **Starbucks Corporation 401(k) Plan:** This book includes the plan's "summary plan description" within the meaning of ERISA Section 102. The plan document is set forth in a separate document.
- **Starbucks Stock Investment Plan and *Bean Stock*:** This book summarizes these compensation plans. The plan documents for these plans are set forth in separate documents.
- **Other Starbucks Benefits** (including Employee Assistance Programs, time off, Family Expansion Reimbursement, College Achievement Plan, and commuter benefits): This book summarizes these benefit plans, programs and policies.

The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), requires Starbucks, as the Plan's sponsor and official administrator (the "Plan Sponsor" and "Plan Administrator, respectively), to issue a "Summary Plan Description" for the Plan. A Summary Plan Description must describe who is eligible for coverage, what is covered, what is excluded, when coverage starts and ends, continuation provisions, and the claims and appeal process, along with certain administrative and other information about the Plan.

The following documents (the "benefit plan materials") are incorporated into this summary, which means that the information set forth in those documents is considered to be part of this summary:

- Any evidence-of-coverage booklets, certificates of coverage, and/or subscriber certificates and/or agreements, which have been prepared by the Insurance Carriers (as defined below), with respect to the fully insured benefits available under the Plan; and
- Any summary plan descriptions or other summaries or descriptions of benefits that have been prepared by or on behalf of Starbucks, with respect to the self-insured benefits available under the Plan.

The benefit plan materials that are in effect as of October 1, 2020 are listed in Appendix A. The benefit plan materials may be updated from time to time.

Starbucks also may designate from time to time certain employee communications, such as benefits enrollment materials, as documentation that is incorporated into and part of this summary (the "designated SPD materials").

This summary, together with the benefit plan materials and any designated SPD materials, collectively constitute the Plan's Summary Plan Description (the "SPD"), as required by ERISA.

Please read the summary (including the applicable benefit plan materials and any designated SPD materials that are incorporated into the summary) carefully, and keep them for future reference.

PLAN DETAILS - For detailed Plan benefit information, please refer to:

- Appendix A for a list of the benefit plans and related benefit plan materials that are in effect as of October 1, 2020;
- Appendix B for claims and appeals administration, funding, and other contact information; and
- Appendix C for Plan administration information.

Please note that you must refer to the applicable benefit plan materials for more details on specific items such as eligibility requirements, benefit coverage, definitions, coordination of benefit rules, reimbursement/subrogation rules, claims and appeal procedures, and exclusions and limitations on benefits, and other terms, conditions and restrictions under the Plan.

The applicable benefit plan materials will be provided to you free of charge electronically or by mail, in some cases. If you don't receive these materials or need duplicate copies, contact Starbucks Benefits Center (see Where to Find Information below for contact information).

IMPORTANT: This summary provides no guarantee that you are eligible to participate in every benefit plan. Each benefit plan may have different eligibility requirements, so be sure to review the applicable benefit plan materials carefully.

WHERE TO FIND INFORMATION - When you have questions or need more information about the Plan, help is just a phone call or click away.

ALL BENEFIT PLANS - General information about the benefits offered under the Plan is provided in this summary. For more detailed information on each benefit plan, however, please read the related benefit plan materials. (The benefit plan materials in effect as of October 1, 2020 are listed in Appendix A.) Be sure to keep this summary, your benefit plan materials and any designated SPD materials together in a safe place and refer to them first when you need to understand how your Plan benefits work. You should also tell a family member where you keep these important documents.

If you have questions or need help with any aspect of your Plan benefits, refer to Appendix B for a list of contacts.

Important Notes

Plan benefits are provided pursuant to group Insurance Contracts entered into between Starbucks and insurance carriers, and/or health maintenance organizations ("HMOs") (collectively, the "Insurance Carriers") from time to time (the "Insurance Contracts'), and pursuant to other governing written Plan documents adopted by Starbucks from time to time (the "Plan Documents"). (See Appendix B for a list of the Insurance Carriers in effect as of October 1, 2020.)

This summary (and the benefit plan materials and any designated SPD materials incorporated into the summary) do not contain all of the terms and conditions of the Insurance Contracts and the Plan Documents (together, the "Official Plan Documents"). To the extent that the terms and conditions of the Plan as described in this summary (and in the benefit plan materials and any designated SPD materials incorporated into the summary) or in any oral or other descriptions provided about your Plan benefits conflict with the provisions of the Official Plan Documents (or are missing from the summary, the benefit plan materials or any designated SPD materials), the wording of the Official Plan Documents will control, unless otherwise set forth in this summary or required by applicable law.

The Official Plan Documents are available for your review during normal business hours in Starbucks Benefits Department.

You have no vested rights to any benefits under the Starbucks Corporation Welfare Benefits Plan. Starbucks or its authorized delegate, in its absolute and unlimited discretion, may change the cost of coverage or amend or terminate any of the benefit plans or any provision of the Plan at any time and for any reason.

No participant or beneficiary in any benefit plan will have any right to a benefit beyond that specifically described in the Official Plan Documents.

FUNDING METHOD AND TYPE OF ADMINISTRATION - Some benefits under the Welfare Plan are self-insured (that is, they are funded from the general assets of Starbucks) and other Welfare Plan benefits are fully insured (that is, they are funded through Insurance Contracts with the Insurance Carriers. (See Appendix B for a list of the funding methods for the various benefits offered under the Welfare Plan.)

Starbucks is solely responsible for paying any covered benefits with respect to the self-insured benefit plans. Starbucks general assets and partner contributions are the sole source of self-insured benefits under the Plan. Starbucks assumes no liability or responsibility for payment of such benefits beyond that which is provided in the self-insured benefit plans.

The Insurance Carriers, not Starbucks, are solely responsible for paying any covered benefits with respect to the fully insured benefit plans. Starbucks does not assume any liability or responsibility for any fully insured benefit and you may look only to the Insurance Contracts for payment of any covered benefits. You will not have any claim for any fully insured benefits against the Plan Administrator, Starbucks or its affiliates or any employee, officer or director of Starbucks or its affiliates. You (or, in the case of your death, your beneficiary as that term is defined in the applicable Insurance Contract) will be entitled to receive only the insured benefit for which provision is actually made under such contract.

PLAN ADMINISTRATION IN GENERAL - Starbucks is the Plan Administrator. The Plan Administrator may, in its discretion, delegate to any other individual or entity the authority to perform for and on behalf of the Plan Administrator one or more of its duties and/or responsibilities under the Plan.

The Plan Administrator and its delegates have the maximum discretionary authority permitted by law to interpret, construe and administer the Plan, to make determinations, including factual determinations, regarding Plan participation, enrollment and eligibility for benefits, to evaluate and determine the validity of benefit claims, to grant or deny benefits, and to resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive benefits and payments pursuant to the Plan.

The Plan Administrator and its delegates have the authority to require participants and/or covered dependents to furnish them with such information as they deem necessary or appropriate for the proper administration of the Plan, including, for example, proof of eligibility. The Plan Administrator also may adopt such rules and procedures as it deems desirable for the administration of the Plan.

The self-insured benefit plans are administered on behalf of the Plan Administrator by Claims Administrators pursuant to administrative services agreements between the Plan Sponsor and the Claims Administrators.

See Appendix B for the Plan Administrator's and Claims Administrators' contact information.

All actions, interpretations and decisions of the Plan Administrator and its delegates will be conclusive and binding on all persons and entities, and will be given the maximum possible deference permitted by law.

Named Fiduciary

Pursuant to ERISA and except as otherwise described below, the Plan Administrator is the named fiduciary of the Plan.

For each of the fully-insured benefit plans, the Insurance Carrier for the benefit plan is the named fiduciary pursuant to ERISA with respect to decisions regarding whether any claim for benefits will be paid under the respective Insurance Contract.

For each of the self-insured benefit plans, the Claims Administrator for the benefit plan has been delegated the authority by the Plan Administrator to decide claims and appeals under such plans. Solely for this purpose, the Claims Administrators are named fiduciaries pursuant to ERISA.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES - In order to protect your family's rights, you should keep the Plan Administrator and COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and the COBRA Administrator. See Appendix B and Appendix C for the COBRA Administrator's and Plan Administrator's contact information.

RESOURCE	HOW TO CONTACT
All Health Plan Carriers	See Appendix B
Benefits Website: mysbuxben.com • For general benefits information, benefit plan websites, and additional resources	Via phone: Starbucks Benefits Center (877) 728-9236

Responding to Life's Changes

Your Starbucks benefits are there to help. Actions to take and deadlines to meet:

GETTING MARRIED OR STARTING A DOMESTIC PARTNERSHIP?

You have 45 days following your marriage or beginning of your domestic partnership to add your spouse or domestic partner to health coverage and to make other related changes to your benefits. Log in to **mysbuxben.com** or call Starbucks Benefits Center at (877) SBUXBEN.

MOVING?

It is important we have correct contact information for you. To update your address and phone number log in to My Partner Info (MPI) or call Starbucks Partner Contact Center at (888) SBUX-411. Don't know if we have your current address? View your address and other personal information on MPI through the Partner Hub.

GETTING A DIVORCE, LEGALLY SEPARATING OR ENDING A DOMESTIC PARTNERSHIP?

You have 45 days following your divorce, legal separation or end of your domestic partnership to remove your spouse or domestic partner from Starbucks coverage and make other related changes to your benefits. Log in to **mysbuxben.com** or call Starbucks Benefits Center at (877) SBUXBEN.

Your ex-spouse or ex-domestic partner is not eligible for Starbucks benefits coverage, even if your divorce agreement says you will continue to provide health coverage and/or life insurance. You must remove your ex-spouse or ex-domestic partner from Starbucks health coverage and dependent life insurance.

Here are other changes to consider:

- Change the amount of your life insurance
- Update your life insurance and savings beneficiaries

EXPECTING A NEW CHILD?

Congratulations! Be sure to add health coverage for your new family member by logging in to **mysbuxben.com** or calling (877) SBUXBEN within 60 days of the birth, adoption or placement for adoption.

You have just 60 days to make other benefit changes. Consider these:

- Enrolling in or increasing your life insurance
- Enrolling in child life insurance
- Increasing your Health Care Reimbursement Account contributions and enrolling in or changing your Dependent Care Reimbursement Account (for retail management and nonretail partners)

You will also need to apply for leave of absence to cover your time away from work.

Call (866) 206-6769.

Also visit the Partner Hub to help you prepare for your new child and find resources available through your health coverage and Starbucks Employee Assistance Programs.

If you are expanding your family through adoption, surrogacy or Intrauterine Insemination, be sure to review our Family Expansion Reimbursement program. See **page 186**.

CHANGE IN STATUS OF YOUR DEPENDENT

You have 45 days from your dependent's status change to make changes to your health and life coverage. A change in status may include your spouse or child losing or gaining other coverage through their employer or any other plan, such as coverage through the military or a state program. Call Starbucks Benefits Center at (877) SBUXBEN to see if your situation qualifies.

Your complete guide to Starbucks benefits

Use this Benefits Plan Description to answer your questions and learn more about your benefits. The more you know, the more valuable your benefits will be to you and your family. This guide is designed to help you find the information you need quickly and easily.

Here are several tips for getting the most out of this guide:

Main table of contents: You can start using this book by referring to the main table of contents on page 1.

Chapter table of contents: Each chapter of this book also has its own table of contents. Once you know which chapter you need to see, the chapter table of contents can help you get to the specific information you need quickly.

Dive in and explore. You will find answers to a wide range of questions with this book. If you need help, you have several sources and they're all described for you in detail under **Where to Get Help on page 2**.

Main Table of Contents

Where To Get Help

General resources	Address	Phone	Web or email
Starbucks Benefits Center • Eligibility and enrollment • Information on health coverage • Starbucks Advocacy Services • Add or remove a dependent • Commuter Benefits • Reimbursement Accounts • Health Savings Account • Obtain a Certificate of Coverage for life insurance • Change beneficiaries for life and AD&D • COBRA administration • Aflac voluntary benefits • Fitness Reimbursement	Eligibility & Enrollment Department S-6607 100 Half Day Road P. O. Box 1540 Lincolnshire, IL 60069-1540	(877) SBUXBEN 7:30 a.m. – 4 p.m. Pacific Time, Weekdays Relay and language translation services available Fax: (847) 883-8272	mysbuxben.com
Starbucks Partner Contact Center • Your paycheck • Your payroll taxes and deductions • Paid time off • File a life insurance or AD&D claim • CUP Fund	Starbucks Corporation P.O. Box 34067 S-PSS Seattle, WA 98124-1067	(888) SBUX-411 5 a.m. – 5 p.m. Pacific Time, Weekdays	For address and personal information changes, go to My Partner Info on the Partner Hub or Retail Portal.
Lyra Mental Health Benefit • Find qualified mental health therapists and coaches • Up to 20 mental health therapy and coaching sessions at no cost • Support for stress, anxiety, depression, relationship issues, sleep disorders, and other challenges • Access support for legal services, identity theft and financial coaching (called work-life services)	Lyra Health 287 Lorton Avenue, Burlingame, CA 94010 Phone: (800) 505-5972	(844) 643-1263 24 hours a day, seven days a week TTY: dial 711 and provide Lyra phone number	lyrahealth.com/starbucks care@lyrahealth.com
Care@Work by Care.com • Backup care for adults and children • Senior care planning	Care.com 77 4th Avenue, 5th Floor Waltham, MA 02451	(866) 500-5170	care.com/starbucks starbucks@care.com

General resources	Address	Phone	Web or email
Starbucks Benefits Department • Submit a review for eligibility • Apply for Family Expansion Reimbursement, DACA Reimbursement • Exercise your rights under the Health Insurance Portability and Accountability Act (HIPAA)	Starbucks Coffee Company Mailstop S-HR3 P.O. Box 34067 Seattle, WA 98124-1067	Access through Partner Contact Center (888) SBUX-411 5 a.m. – 5 p.m. Pacific Time, Weekdays Fax: (206) 594-6752	Benefitsadmin @starbucks.com

For medical, dental and vision insurance carrier contact information effective October 1, 2020, see Appendix B.

Future Roast 401(k) Savings Plan	Address	Phone	Web or email
Fidelity • Questions • Enrollment • Changes to investments or contribution amounts • Loans and withdrawals • Rollovers • Beneficiary designations	Please call to get appropriate address, as there are several mailing addresses depending on the service	(866) 697-1048 or (800) 587-5282 (Spanish line) 5:30 a.m. – 9 p.m. Pacific Time, Weekdays Translation and relay service available	netbenefits.com
Fidelity® Personalized Planning & Advice • Professional management of the investments in your Future Roast 401(k) Plan account (optional fee-based service)		(866) 697-1048 or (800) 587-5282 (Spanish line) 5:30 a.m. – 5:30 p.m. Pacific Time, Weekdays	netbenefits.com

Stock Plans (S.I.P and *Bean Stock*)	Address	Phone	Web or email
Fidelity • Ask questions • Activate your stock account • Enroll in S.I.P. • Sell shares • Manage your account	Please call to get appropriate address, as there are several mailing addresses depending on the service	(866) 697-1048 5:30 a.m. – 9 p.m. Pacific Time, Weekdays Translation and relay service available	Your Stock account: netbenefits.com Bean Stock info: starbucksbeanstock.com

Where To Get Help

Life insurance, leave of absence, and disability	Address	Phone	Web or email
Hartford Life and Accident Insurance Company • Portability or conversion options • Evidence of Insurability (EOI) For general questions about life or AD&D, first call Starbucks Benefits Center at (877) SBUXBEN. To file a claim, call the Partner Contact Center at (888) SBUX-411.	Claims: Hartford Life Attn: Group Life Claim Unit P.O. Box 2999 Hartford, CT 06104-2999 Group number for life insurance: GL-43135	Claims: (888) 563-1124 5 a.m. – 3 p.m. Pacific Time, Weekdays Portability and conversions: (877) 320-0484 6 a.m.– 2 p.m. Pacific Time, Weekdays	thehartford.com
Sedgwick • Initiate a leave of absence • Short Term Disability (STD)	Sedgwick P.O. Box 14424 Lexington, KY 40512-4424	(866) 206-6769 7 a.m. – 8:30 p.m. Central Time, Weekdays	claimlookup.com/starbucks
Unum • Long Term Disability (LTD) • New York Disability (NY DBL)	Claims address: Disability Benefits Center P.O. Box 100158 Columbia, SC 29202-3158 Group number for Long Term Disability plan: 358533	(800) 858-6843 Fax: (800) 447-2498 5 a.m. – 5 p.m. Pacific Time, Weekdays	unum.com
Hawaii TDI Pacific Guardian • Hawaii Temporary Disability Insurance (TDI) For general questions or to file a claim, call Sedgwick at (866) 206-6769.	Starbucks Coffee Company Attn: HR Operations, S-SPSS P.O. Box 34067 Seattle, WA 98124-1067	(866) 206-6769 7 a.m. – 8:30 p.m. Central Time, Weekdays	

Education	Phone	Web or email
Starbucks College Achievement Plan	(855) 795-9397	starbucks.asu.edu

Government benefits	Phone	Web or email
Medicare • Contact the Health Care Financing Administration (HCFA) for information about Medicare	(800) MEDICARE	medicare.gov
Social Security Administration • Learn about Social Security benefits and how to apply • Understand how Social Security works • Request your free Personal Earnings and Benefit Estimate • Locate an office in your area	(800) 772-1213	ssa.gov
Healthcare.gov • Learn about Health Care Reform (the Affordable Care Act)		healthcare.gov

Eligibility and Enrollment

At Starbucks, we offer health coverage and other benefits to eligible part-time as well as full-time partners.

BENEFITS ELIGIBILITY

As a Starbucks partner, you must meet certain criteria to become eligible and maintain eligibility for Starbucks benefits. Your eligibility depends on your position and where you work, Hawaii or the U.S. mainland. Unless otherwise noted, the information in this chapter will apply to both Hawaii and U.S. mainland partners.

This section covers eligibility for purposes of medical, dental, vision and other Starbucks benefits, but does not address eligibility for the Future Roast 401(k) Savings Plan, *Bean Stock* or S.I.P. See the **401(k) Savings Plan** and **Stock chapters** for eligibility provisions and other information related to the 401(k) and stock plans.

To be eligible for Starbucks benefits:

- You must be working for Starbucks or a participating company (a company that is wholly or partially owned by Starbucks Corporation and has elected to participate in this plan) and
- Be a partner on the U.S. payroll of such company

You are not eligible to participate in Starbucks benefits if you are:

- Covered by a collective bargaining agreement that does not specifically provide for participation in this plan
- A non-partner worker engaged by Starbucks, including a contingent worker, independent contractor, or service provider
- Not on the U.S. payroll — such as a nonresident alien with no U.S. source of income
- Assigned to work overseas permanently or indefinitely
- Not classified by Starbucks as an employee, regardless of how you might be classified by the government

Temporary employees

Temporary employees are defined as a partner (employee) hired for a specific duration of time not to exceed 6 months, or in an internship role not to exceed 12 months. Temporary employees are eligible only for the following benefit programs:

- Medical, dental, vision coverage*
- Partner life insurance*
- Spouse, domestic partner or child life insurance*
- Accidental Death and Dismemberment (AD&D) Insurance*
- Partner and Family Sick Time
- Parental Leave*
- All other leaves of absence where required by law*
- Short and Long Term Disability*
- Lyra
- Headspace
- Care@Work by Care.com
- Free food item while working (retail stores only)
- Partner Discount and Markout benefit
- Starbucks Coffeegear

* assuming eligibility requirements are met

In certain situations, your eligibility for various Starbucks benefits may be determined by your position. Starbucks recognizes the following partner classifications:

- **Retail Hourly** — includes café attendant, barista, shift supervisor, team lead, team member, operations lead, commessa, mixologist, kitchen baker, savory and pastry chef, porter and assembler roles
- **Retail Management** — Store-based salaried partners including store managers, assistant store managers, associate managers, Roastery and Reserve specialists, management trainees, and Princi operations managers, head savory chefs, head pastry chefs and head bakers
- **Shift Managers** — Store-based hourly partners in certain states
- **Nonretail Partners** — Non-store based partners in locations such as regional offices, support centers, roasting plants, distribution centers, Evolution Fresh juicery partners, and Princi nonretail roles not listed above

For purposes of the Affordable Care Act and determining initial benefits eligibility only, all roles are considered full-time except for the variable hour roles defined below. Moving between roles may have an impact on the benefits you are eligible to receive.

Initial benefits eligibility

Your benefits eligibility is determined based on whether you work in the U.S. mainland or Hawaii, the hours for which you are paid, your position, and/or your length of employment. The details for determining initial benefits eligibility – or becoming eligible for benefits for the first time – for U.S. mainland partners are outlined below. For Hawaii partners, see **page 9** for eligibility information.

U.S. mainland variable hour partners

For purposes of the Affordable Care Act the following Starbucks positions are included in the variable hour eligibility group:

- Barista
- Café attendant
- Team lead
- Team member
- Commessa
- Roastery and Reserve Porter
- Variable hour part-time Roasting plant, Juicery or distribution center manufacturing positions

As a variable hour partner working in the U.S. mainland, you will become eligible for benefits for the first time (called "initial eligibility") the first day of the second month after you have received at least 240 total hours over three consecutive, full calendar months.

Total Hours for Initial Eligibility

Total hours for initial benefits eligibility for all U.S. partners include Benefit (BEN) hours to account for worked hours paid on pay dates that occur between the first day through the last Friday of that calendar month, as well as Leave of Absence (LOA) hours to account for time while on approved, eligible leave. Remember, hours worked at the end of a month are generally paid in the following calendar month. For more information on LOA hours, see the "**Benefits Eligibility While on an Approved Leave of Absence**" section on page 25. Please note that a partner cannot gain initial eligibility with only LOA hours.

Starbucks will calculate your total hours for the initial eligibility period on the last Friday of every month until you attain initial benefits eligibility. Once you have established initial benefits eligibility, an enrollment kit will be mailed to your home address prior to your benefits eligibility date.

To check on the status of your paid hours for initial benefits eligibility, call Starbucks Partner Contact Center at (888) SBUX-411.

Here are a few examples as to how initial eligibility works for a variable hour partner:

Partner hired on	If 240 total hours received on pay days during	Benefits enrollment kit mailed to home in early	Benefits eligibility and coverage begins
September 15	October, November, December	January	February 1
October 1	October, November, December	January	February 1
October 2	November, December, January	February	March 1
November 30	December, January, February	March	April 1

Here are two detailed examples of how initial eligibility works. In this example, the partner was hired April 1, and received 80 total hours in April, 80 hours in May and 80 hours in June.

U.S. Mainland Variable Hour Partner

Hire date	April 1
Total hours for benefits eligibility	240 total hours (80 in April + 80 in May + 80 in June)
Enrollment period - benefits enrollment kit mailed to your home	Early July
Eligible for benefits	August 1

Another example:

U.S. Mainland Variable Hour Partner

Hire date	March 16
Total hours for benefits eligibility	200 total hours (40 in April + 80 in May + 80 in June) - did not meet the 3-month minimum of 240 total hours 240 total hours (80 in May + 80 in June + 80 in July) - met the 3-month minimum of 240 total hours
Enrollment period - benefits enrollment kit mailed to your home	August
Eligible for benefits	September 1

U.S. mainland full-time partners

Positions expected to work 30 or more hours per week on the U.S. mainland, which are referred to as the full-time eligibility group, will be initially eligible for benefits the first day of the month after they reach 60 days of employment, or coincident with the 60th day of employment, if the 60th day falls on the first of the month. For purposes of determining initial eligibility, the following Starbucks positions are considered to be full-time:

- **Retail Management** — Store-based salaried partners including store managers, assistant store managers, associate managers, Roastery and Reserve specialists, management trainees, and Princi operations managers, head savory chefs, head pastry chefs and head bakers
- **Shift supervisors and shift managers** — Also includes other retail hourly positions not listed under the variable hour partner section (operations lead, kitchen baker, savory and pastry chef, mixologist, Princi porter, and assembler roles)
- **Nonretail Partners** — Non-store based partners in locations such as regional offices, support centers, roasting plants, distribution centers, Evolution Fresh juicery partners, and Princi nonretail roles not listed above

Once you have established initial benefits eligibility, an enrollment kit will be mailed to your home address prior to your benefits eligibility date.

Here is an example of how initial eligibility works for a full-time partner:

U.S. Mainland Full–Time Partner

Hire date	April 16
Total hours for benefits eligibility	Not a consideration
Length of employment reaching 60 days	June 15
Enrollment period - benefits enrollment kit mailed to your home	Early June
Eligible for benefits	July 1

Hawaii partners

For Hawaii partners, your benefits eligibility is determined based on your total hours, your position, and/or your length of employment, in accordance with the Hawaii Prepaid Healthcare Act.

Here is when you become eligible for benefits for the first time (called "initial eligibility") following hire:

Retail hourly partners working in Hawaii	Retail management/nonretail partners working in Hawaii
The first day of the month after you have completed four consecutive weeks of employment and received at least 80 total hours in a single calendar month. Hours must be received by the last Friday of the month to count for eligibility.	The first day of the month following your most recent hire date.

Starbucks will calculate your total hours and weeks of employment on the last Friday of every month until you attain initial benefits eligibility. Once you have established initial benefits eligibility, you will be sent an enrollment kit to your home address as soon as reasonably possible.

To check on the status of your total hours for initial benefits eligibility, call Starbucks Partner Contact Center at (888) SBUX-411. In this example, the partner was hired April 2 and received 80 total hours in April.

Here is an example of how initial eligibility works for partners in Hawaii. In this example, the partner was hired April 2 and received 80 total hours in April.

	Retail hourly partners working in Hawaii	Retail management/nonretail partners working in Hawaii
Hire date	April 2	April 2
Total hours for benefits eligibility	80 in April	Not a consideration
Length of employment	Four weeks by end of April, met four-week minimum	Not a consideration
Eligible for benefits	May 1	May 1

Let's look at another example. The partner was hired April 16, received 20 total hours in April and 100 hours in May.

	Retail hourly partners working in Hawaii	Retail management/nonretail partners working in Hawaii
Hire date	April 16	April 16
Total hours for benefits eligibility	20 hours in April, did not meet 80 hour minimum 100 hours in May, met 80 hour minimum	Not a consideration
Length of employment	Seven weeks by end of May, met four-week minimum	Not a consideration
Eligible for benefits	June 1	May 1

Enrollment deadline

Benefits are regulated by federal law and, in the case of insured plans, state law. As a result, there are limits on the timeframe in which you must enroll and when you can make changes. Your enrollment kit will be mailed to the home address we have on record for you. It is important that you immediately review your benefit options and take action as outlined in your enrollment kit. Use your enrollment guide to understand your options available to you at Starbucks, or beyond Starbucks with the plans that were created by the Affordable Care Act.

Affordable Care Act

All Starbucks health plans are considered affordable under the Affordable Care Act. If you are eligible for Starbucks benefit coverage you and your eligible dependents will not be eligible for any federal premium subsidies in the Insurance Marketplace.

If you move, it is important that you update your address through My Partner Info or by calling the Partner Contact Center at (888) SBUX-411 to avoid any delays in receiving important benefits information, and to make sure your health coverage options are accurate.

Coverage effective date

If you enroll in benefits, your coverage goes into effect on the same day you become initially eligible. For Starbucks-paid life insurance and disability coverage, you must also be actively at work on the day your coverage begins. See the **Life Insurance and AD&D**, **Short Term Disability** and **Long Term Disability** chapters, as well as **Benefits Eligibility on page 6** for more information.

Ongoing benefits eligibility

Once you have established initial eligibility, you maintain your eligibility by remaining an active partner at Starbucks and meeting the minimum total hours criteria. The approach for determining ongoing eligibility depends on where you work, the U.S. mainland or Hawaii. If you meet the ongoing benefits eligibility criteria, then your eligibility and coverage remain intact.

Total Hours For Ongoing Eligibility

Total hours for ongoing benefits eligibility include Benefit (BEN) hours that you are paid on paychecks that are received between the first and last day of the measurement period, as well as Leave of Absence (LOA) hours to account for any time on approved leave during the measurement period. It is important to remember that hours worked or leave time approved toward the end of a measurement period are generally paid or recorded in the following measurement period. Questions about eligibility? Call Starbucks Benefits Center at (877) SBUXBEN.

Here is how ongoing benefits eligibility works, based on your location.

U.S. mainland

To maintain benefits eligibility, you must receive at least 520 total hours during each six-month measurement period. Eligibility audits will be conducted on January 6 and July 6 to determine if you have received the 520 total hours needed to maintain your eligibility. If you meet the total hours requirement, benefits eligibility and coverage will continue through the next 6-month stability period. If you do not meet the total hours requirement, benefits eligibility and coverage will end.

A typical semi-annual measurement period has 13 paychecks (26 for partners paid on a weekly basis). If there is a year in which a semi-annual measurement period has fewer paychecks, then the total hours needed to maintain eligibility will be adjusted as needed. If the semi-annual measurement period has more than 13 paychecks, the total hours needed will remain at 520.

See below for the audit dates and total hour requirements for the 2021 - 2022 eligibility audits:

Pay cycle	January 6, 2021 audit	July 6, 2021 audit	January 6, 2022 audit
	Last Paycheck Included in the Audit		
B1	Dec 24, 2020 (520 total hours)	June 25, 2021 (520 total hours)	Dec 24, 2021 (520 total hours)
B2	Dec 31, 2020 (520 total hours)	July 2, 2021 (520 total hours)	Dec 31, 2021 (520 total hours)
Weekly	Dec 31, 2020 (520 total hours)	July 2, 2021 (520 total hours)	Dec 31, 2021 (520 total hours)

B1 pay cycle includes the following states: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY

B2 pay cycle includes the following states: AL, AR, DC, DE, FL, GA, IA, IL, IN, LA, KS, KY, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE, NH, NJ, OH, OK, PA, SC, SD, TN, TX, VA, VT, WI, WV

Weekly pay cycle includes the following states: CT, NY, RI

Here is when the eligibility audits are held, and how they affect your benefits eligibility and coverage.

Total hours must equal at least 520 by the last pay date in the semi-annual measurement period	Semi-annual benefits eligibility audit performed on	The months (stability period) for which you are maintaining benefits eligibility and coverage
July 6 - January 5 January 6 - July 5	January 6 July 6	April, May, June, July, August, September October, November, December, January, February, March

*Please refer to the Benefits Eligibility Audit Dates document on the Partner Hub or in your store to confirm if there will be an audit with an adjusted total hours requirement due to the number of pay periods in the measurement period.

Remember, Starbucks pay periods end on Sunday. Therefore, the last day you can work or request paid time off that will be counted on your paycheck is the Sunday prior to your pay date. Your total hours will accumulate every pay date within the measurement period and are displayed on your pay statement as "Benefit Hours (BEN)" and "Leave of Absence Hours (LOA)." BEN and LOA hours are refreshed to zero at the beginning of each new measurement period.

Note: If you transfer pay cycles during the semi-annual measurement period, your pay dates may change, and you may need to increase your hours to maintain your benefits.

Once you gain initial eligibility you will transition to the ongoing eligibility audit process. You must have been hired on or before the start of the measurement period in order to be subject to the ongoing audit. The table below provides you information about which eligibility audit would be the first in which you will need to have 520 total hours in order to maintain eligibility.

Partners who gain eligibility for the first time in the months of:	Are subject to the first ongoing audit occurring on:
November, December, January, February, March, April (if hired on or before January 6)	July 6
May, June, July, August, September, October (if hired on or before July 6)	January 6

Losing benefits eligibility due to a reduction in total hours

If, based on the eligibility audit, it is determined that your total hours fell below the minimum of 520 hours required to maintain ongoing eligibility, your benefits eligibility, coverage and payroll deductions will end as outlined below.

If you receive fewer than 520 total hours during	Semi-annual eligibility audit performed on	Your benefits eligibility and coverage will end
July 6 - January 5 January 6 - July 5	January 6 July 6	March 31 September 30

*Please refer to the Benefits Eligibility Audit Dates document on the Partner Hub or in your store to confirm if there will be an audit with an adjusted total hours requirement due to the number of pay periods in the measurement period.

Re-establishing benefits eligibility

If you lose eligibility because your total hours fell below the minimum required, you can re-establish eligibility in a subsequent semi-annual measurement period. If your total hours during a subsequent measurement period meet or exceed the minimum required for ongoing benefits eligibility, you will re-establish eligibility for benefits as shown below. You may not re-establish eligibility if you only have Leave of Absence (LOA) hours during the measurement period.

If you receive a minimum of 520 total hours during	Semi-annual eligibility audit performed on	Your benefits eligibility will begin
July 6 - January 5	January 6	April 1
January 6 - July 5	July 6	October 1

*Please refer to the Benefits Eligibility Audit Dates document on the Partner Hub or in your store to confirm if there will be an audit with an adjusted total hours requirement due to the number of pay periods in the measurement period.

If you re-establish eligibility during a semi-annual audit, a new benefits enrollment kit will be mailed to your home address. If you want benefit coverage, you will need to re-enroll either by logging in to Starbucks Benefits Center at **mysbuxben.com**, or by calling (877) SBUXBEN by the deadline shown on your enrollment letter. No action will mean no coverage.

Ongoing eligibility for partners in Hawaii

If you are a partner working in Hawaii, you must receive at least 80 total hours during each month to maintain benefits eligibility. Monthly eligibility audits are performed on the last Friday of each calendar month. During the audit, your total hours within the current calendar month are tallied. Your total hours will accumulate every pay date within the month and are displayed on your pay statement as “BEN Hours” and “Leave of Absence Hours (LOA).” BEN and LOA Hours are refreshed to zero at the beginning of each new month.

If you receive fewer than 80 total hours in a calendar month, your benefits eligibility and coverage will end on the last day of that month.

You can re-establish eligibility in a subsequent month as long as you have remained an active Starbucks partner and receive 80 total hours or more in a subsequent calendar month. You can re-establish benefits eligibility the first of the month following the month in which your total hours equal or exceed 80.

If you lose eligibility, then subsequently re-establish eligibility within the same plan year, your prior enrollment elections and payroll deductions are automatically reinstated. A *Confirmation Statement* of your prior benefit elections will be mailed to your home shortly after your eligibility resumes.

Re-establishing eligibility in a new plan year

If you re-establish eligibility in a new plan year, we will mail a new benefits enrollment kit to your home. If you want benefit coverage, you will need to re-enroll either online by logging in to Starbucks Benefits Center at **mysbuxben.com**, or by calling (877) SBUXBEN by the deadline shown on your enrollment letter.

Eligibility for rehired partners

If you separate employment from Starbucks and are rehired after 13 weeks, you will be treated as a newly hired partner for purposes of gaining initial benefits eligibility. See **initial benefits eligibility** for details.

If you separate from employment and are rehired within 13 weeks, your previous benefits eligibility status will resume (to the same status at time of separation) the first of the month following your rehire date. If your eligibility had been scheduled to end due to failing an eligibility audit, your eligibility will still end as previously expected.

Below are examples:

Partner separates	Partner rehired	Did partner pass the July 6 eligibility audit?	Benefits eligibility reinstatement date
July 23	August 30	Yes	September 1
July 23	August 30	No - eligibility scheduled to end September 30	September 1 - eligibility will end September 30
August 15	September 20	No - eligibility scheduled to end September 30	n/a

If you are rehired within the same plan year and maintained benefits eligibility, your previous benefit coverage will be reinstated the first of the month following your rehire date. Starbucks Benefits Center will notify you of the reinstatement. If you do not wish to have your coverage reinstated, you must call Starbucks Benefits Center at (877) SBUXBEN within 45 days of the date of the notification.

If you are rehired within a new plan year and maintained benefits eligibility, you will need to elect coverage. It will not be automatically reinstated and you will receive an enrollment notification with instructions and enrollment deadline.

For ongoing benefits eligibility, you will be subject to the next ongoing eligibility audit performed after your rehire date. When determining ongoing benefits eligibility, you will only be subject to a 20 hours per week requirement from the first full pay period following your rehire, through the end of the current measurement period. You will have a reduced total hours requirement for the measurement period based on the number of full pay periods you were active in the measurement period.

If you transfer between Hawaii and the mainland

It's important to know how your initial and ongoing benefits eligibility will be affected following a transfer between Hawaii and the mainland:

	From Hawaii to the mainland	From the mainland to Hawaii
If you have not yet established initial benefits eligibility	Your total hours in Hawaii will count toward the initial eligibility calculation that applies to partners working on the mainland as of your transfer date. For full-time partners, your length of employment in Hawaii will count toward the requirement that applies to full-time mainland partners.	Your total hours on the mainland will count toward the initial eligibility calculation that applies to partners working in Hawaii. For full-time partners, your length of employment on the mainland will count toward the requirement that applies to full-time Hawaii partners.
If you have established initial eligibility	Your total hours in Hawaii will count toward the mainland ongoing eligibility audit. You will be subject to the first audit that coincides with or immediately follows the date your transfer is recorded in the payroll system, depending on when you gained initial eligibility. See **page 13** for details.	Your total hours on the mainland will count toward the Hawaii monthly eligibility audit. You will be subject to the first monthly audit that coincides with or immediately follows the date your transfer is recorded in the payroll system.

Your benefits eligibility may also be affected when you take a leave of absence. Information about benefits eligibility while on a leave of absence begins on **page 25**.

What happens when you lose benefits eligibility?

Coverage will end when your eligibility ends. Some benefits may be continued. See below for more information.

Coverage	What happens
Health Coverage	Coverage (and coverage for your enrolled dependents) ends when your benefits eligibility ends. You may elect to continue your coverage under COBRA and pay the full cost of the coverage plus a 2% administration fee. You will be sent a COBRA enrollment kit shortly after your coverage ends. See the **Your Rights and Responsibilities chapter** for more information. You may have other options to enroll in coverage - through a spouse, parent or other employer, or with the options available to you in the State Insurance Marketplace created under the Affordable Care Act. To learn more about coverage options, and subsidies that may be available, link to the State Marketplace Information Center from **mysbuxben.com.**
Short Term and Long Term Disability	Coverage ends when your benefits eligibility ends. If you have been approved for disability benefits effective prior to this date, your disability benefits will continue per plan provisions.
Life Insurance	Coverage (and coverage for your enrolled dependents) ends when your benefits eligibility ends, unless under **Compassionate Benefits**, or you have applied and been approved for **Waiver of Premium**. You have 31 days from the date your coverage ends to convert or port any Starbucks-paid life insurance coverage to an individual policy, and to convert or port your supplemental life coverage. See the **Life Insurance chapter** for more information about converting and porting your coverage.
Accidental Death and Dismemberment Insurance	Coverage ends when your benefits eligibility ends.
Dependent Care and Health Care Reimbursement Accounts	Participation ends as of your final contribution. If you have amounts remaining in your account, you may elect to continue your Health Care Reimbursement Account participation through the remainder of the plan year on an after-tax basis through COBRA. See the **Your Rights and Responsibilities chapter** for more information.
Health Savings Account	Payroll contributions to your Health Savings Account will cease, but you may contribute directly to your account (as long as you do not exceed your maximum annual contribution amount), provided you are still enrolled in a high deductible health plan.
Aflac Voluntary Benefits	Coverage ends on the last day you are actively at work at Starbucks.
Starbucks College Achievement Plan	If you are benefits eligible or it is determined by Starbucks that you will become benefits eligible at any time during the session, you are considered eligible for the entire session in order to qualify for the scholarship and reimbursement. Losing eligibility after courses begin will not impact that semester's benefit.
Family Expansion Reimbursement	Eligible expenses incurred while you are not benefits eligible will not be eligible for reimbursement.

BENEFITS ENROLLMENT

You can enroll for benefit coverage upon reaching initial eligibility, during the annual benefits enrollment period (described on **page 22**) or anytime you have a qualified status change (see **Making Changes on page 21**). The eligibility, enrollment and participation requirements may vary depending on the particular benefit plan. You must satisfy the eligibility, enrollment, and participation requirements of a particular benefit plan in order to participate and receive any covered benefits under that plan. Please be sure to review the eligibility, enrollment and participation information carefully.

Initial benefits enrollment

Once you have established initial benefits eligibility at Starbucks, you can enroll for the benefits you choose, and you can also enroll your eligible dependents. To help you make your enrollment decisions, a benefits enrollment kit is mailed to your home address, as recorded in Starbucks payroll system, prior to your eligibility date (shortly after your eligibility date for Hawaii partners). Your benefits enrollment kit includes a personalized enrollment letter with your enrollment deadline.

When you receive your benefits enrollment kit, log in to Starbucks Benefits Center at **mysbuxben.com**, where you can explore information, compare and shop for your health coverage options, use available tools to help you choose coverage, and enroll in coverage. If you have questions or need help enrolling, call Starbucks Benefits Center at (877) SBUXBEN. If you want coverage, you must enroll by the deadline shown on your enrollment letter.

If you are incapacitated and unable to call to enroll, an individual with your power of attorney may call on your behalf to enroll you in benefit coverage.

The coverage you elect will remain in place through the end of the plan year — the plan year is October 1 through September 30 — unless you have a qualified status change or lose eligibility during the year. For more information see **Making Changes on page 21.**

Confirmation statement

If you enroll by speaking with a Benefits Center representative, we will mail you a *Confirmation Statement* reflecting your benefit enrollment elections. Be sure to review your *Confirmation Statement* and report any corrections to Starbucks Benefits Center immediately. If you enroll online, you can print a *Confirmation Statement* after completing your enrollment. If you have set your preferences to receive email communications from mysbuxben.com, you will receive a *Confirmation Statement* via email. If you did not enroll for benefits by the deadline shown on your enrollment worksheet, you will have a limited amount of time in which to call and enroll for benefits.

If you do not enroll by the deadline

If you do not enroll by your deadline, you will not be covered for the remainder of the plan year — through September 30. Your next chance to enroll will be during the next annual benefits enrollment period.

However, if you have a qualified status change during the year, you may be able to change your benefits during the plan year, provided you call within 45 days of your status change. For details on the kinds of changes you are allowed to make, see **Making Changes on page 21.**

What Is The Plan Year?

The plan year for Starbucks benefits begins on October 1 and ends the following September 30.

HC–5 requirement for partners working in Hawaii

If you choose to waive Starbucks medical coverage, the state of Hawaii requires you to complete the HC-5 form upon your initial election to waive coverage as well as annually in December. If you do not return this form and continue to be eligible for Starbucks benefits, you will be automatically enrolled in Starbucks HMSA Gold partner-only medical coverage and will be responsible for any applicable payroll contributions.

COVERAGE CATEGORIES

You can choose to cover eligible dependents (see **Eligible Dependents** below) under medical, dental and vision coverage if you also enroll for these plans. You have four coverage categories to choose from:

1. Partner only
2. Partner plus spouse or domestic partner
3. Partner plus child(ren)
4. Partner plus family

You can choose a dependent coverage category for each different type of coverage. For example, you can choose “partner only” medical coverage and “partner plus child(ren)” dental coverage. The cost of each benefit option varies depending on the coverage category you choose, what coverage level and insurance carrier you elect.

When you enroll a dependent in any health coverage, such as medical, dental or vision, you must also be enrolled in that same plan. In other words, you must choose the same medical coverage for yourself and your enrolled dependents.

If you enroll your dependents when you initially enroll, their coverage begins when your coverage begins. If your eligibility lapses because you did not maintain your ongoing total hours requirement, coverage for your eligible dependents will also lapse. When your coverage ends, their coverage will also end.

ELIGIBLE DEPENDENTS

These are the people we consider eligible for coverage under Starbucks benefits:

- Your spouse
- Your domestic partner
- Your children up to the end of the month in which they reach age 26. When applicable law requires child coverage beyond these dates, Starbucks will comply with the law(s).

No Dual Coverage

You may not be covered under Starbucks benefits plans as both a partner and a dependent. No child may be covered as a dependent of more than one Starbucks partner.

Your Spouse

To be covered under Starbucks benefits, your spouse must be your *lawful* spouse, which means you must be legally married. A spouse from whom you are legally separated is not eligible. If you live in a state that recognizes common-law marriages, we recognize your common-law spouse as your lawful spouse.

Your domestic partner

Starbucks covers same- or opposite-sex domestic partners as defined below. In order for your domestic partner to qualify for health coverage, you and your domestic partner must be registered as domestic partners in a state which recognizes such relationships, or must satisfy all of the following requirements:

- Are age 18 or older
- Are not in another domestic partnership, civil union or marriage
- Are not blood-related
- Are committed to one another
- Live together permanently
- Are jointly responsible for fiscal and legal matters

If your relationship satisfies the above requirements and you choose to enroll a domestic partner in Starbucks health coverage, you will be required to attest to the authenticity of your relationship either online or over the phone with Starbucks Benefits Center. If your relationship ends or changes in such a way that you can no longer meet the above requirements, you will be required to provide notice of the change in the relationship to Starbucks by contacting Starbucks Benefits Center at (877) SBUXBEN.

If it is determined at any time that you have enrolled an individual in coverage who does not meet the eligibility criteria for domestic partner, you may be subject to corrective action, including but not limited to recovery of premiums and claims paid on your behalf, and separation from employment.

If you cancel health coverage and/or life insurance coverage for your domestic partner during a plan year due to your relationship ending, and you subsequently commence a second relationship with the same individual (as a domestic partner), your domestic partner may not be eligible for coverage under Starbucks benefit coverage until the next plan year (October 1).

Domestic partner limitations

Most Starbucks benefits consider your domestic partner as your qualified dependent, as long as your domestic partnership meets the definition described in this section. However, there are some exceptions.

- **Reimbursement Accounts and Health Savings Account**: Expenses incurred for your domestic partner who is not considered your tax dependent may not be reimbursed through the Health Care and Dependent Care Reimbursement Accounts, and Health Savings Account.

Taxation of domestic partner benefits

When you enroll your domestic partner or your domestic partner's children in Starbucks health coverage, you will be taxed on the value of their coverage, as required by the Internal Revenue Service (IRS), unless the covered individuals satisfy the Internal Revenue Code definition of dependent. State income taxes may also apply. Your payroll deduction and the amount that Starbucks contributes towards your domestic partner's coverage are taxable to you. This is called imputed income.

When you have elected domestic partner coverage, the imputed income is reflected on your paycheck each pay period. For more information, call Starbucks Benefits Center at (877) SBUXBEN to speak with a Benefits Center representative.

Your children

Your children are eligible for benefits until the end of the month in which they turn age 26. Your "child" includes your son or daughter, stepchild, adopted child (eligible at the time the child is placed in the home), or eligible foster child (eligible at the time the child is placed in the home).

Proof of Dependent Status

If you enroll a dependent in Starbucks benefit coverage, we may ask you at any time for proof that your dependent meets the definition of an eligible dependent as outlined above. Partners will be chosen at random to participate in a dependent audit. Examples of acceptable documentation to establish your dependent's relationship include but are not limited to:

- Marriage certificate
- Domestic partner order
- Birth certificate
- Adoption order

If it is determined that the individual(s) you enrolled does not qualify as a dependent, Starbucks will take corrective action, which may include separation from employment. All dependent audit documentation that is received is processed electronically and handled securely.

In addition to the dependent children described above, the following dependents are eligible for coverage if they meet the conditions below.

- Dependent grandchildren or individuals for whom you are the legal guardian may be considered dependents if you have physical custody during the greater portion of the year, you provide more than 50% of their financial support during the calendar year, and they are under the age of 26.
- Mentally or physically disabled children may continue to be covered past the maximum age limit of 26 if they are fully disabled. Fully disabled means your child cannot earn a living because of intellectual disability or a physical handicap that started before they reached the maximum age for dependent children. The child must depend primarily on you for support and maintenance (and meet the IRS requirements for tax dependents), and at the time the child became disabled, either the child was covered under this plan as an eligible dependent or the parent who would be enrolling the child for coverage under this plan was not yet employed by Starbucks or not an eligible partner. Also, the plan may require certification of the child's disability from time to time. To apply for coverage, contact your insurance carrier directly for information on covering disabled children.
- A limited number of U.S. states require that fully-insured health plans provide an opportunity to continue coverage for children over age 26. For information on the maximum age limit for children who can be covered under the Fully Insured Health Plan, please refer to the related benefit plan materials (see Appendix A).
- Children who are covered under a Qualified Medical Child Support Order (QMCSO) are eligible dependents for health coverage, even if you are not able to otherwise claim them as dependents for federal income tax purposes. A QMCSO is a formal court order or administrative order, and usually issued as part of a divorce decree or child support agreement that requires a parent to enroll dependent children under his or her health coverage. Upon receipt of a valid QMCSO, Starbucks may enroll the dependent child(ren) in

accordance with the court order. If you are not enrolled in a Starbucks health coverage but are benefits eligible and we receive a valid QMCSO, Starbucks will enroll you and the dependent child in accordance with the court order. Because this order requires you to provide health coverage for these children, they will be enrolled until the court order is removed or until they no longer meet the other eligibility requirements. For more information about QMCSOs, see **Qualified Medical Child Support Order on page 276** or call Starbucks Benefits Center at (877) SBUXBEN.

Parents, Roommates, and Siblings Are Not Dependents

Your parents, roommates, sisters and brothers – even if they live with you – do not qualify as dependents under Starbucks benefit coverage. Nor do your grandparents, nieces, nephews or anyone else who does not meet Starbucks definition of an eligible dependent.

COST SHARING

This table shows how benefit costs are shared between you and Starbucks. When you share the cost for coverage, your portion of the cost is taken through payroll deductions. For more information on how payroll deductions, deductibles and copays are applied under each benefit plan, see the individual chapters within this guide.

Starbucks pays 100% of the cost	You elect coverage and you and Starbucks share the cost	You elect coverage and pay 100% of the cost
• Lyra • Short Term Disability • Long Term Disability for retail management partners, nonretail partners and shift managers • Basic Life Insurance • Starbucks College Achievement Plan (upon completion of certain milestones) • Family Expansion Reimbursement • Headspace	• Health coverage (medical, dental and vision)	• Health Savings Account contributions, Reimbursement accounts (for retail management and nonretail partners) • Long Term Disability for retail hourly partners • Supplemental Partner Life Insurance • Dependent Life Insurance • Partner Accidental Death and Dismemberment (AD&D) Insurance • Commuter benefits • Aflac voluntary benefits

Payroll deductions

Your contributions for benefits such as medical, dental and vision are taken from your paycheck each pay period — in the form of payroll deductions — before taxes are taken out. This reduces your taxable earnings, and you pay less in income taxes.

For other benefits, such as spouse or domestic partner or child life insurance, your contributions are deducted on an after-tax basis. Check out the individual plan chapters for information about how your portion is deducted from your paycheck.

Costs for each plan may vary from year to year, and you will be notified of any changes during the annual benefits enrollment period. In the meantime, visit Starbucks Benefits Center at **mysbuxben.com** or call (877) SBUXBEN for information on current payroll deduction amounts.

Missed payroll deductions

You pay for the cost of your benefit coverage (including taxes on imputed income and additional contributions) through automatic payroll deductions. If you do not receive a paycheck because of your absence, your missed

deductions will be taken from your next available paycheck. Benefit contributions are not deducted from any disability benefits or military allowance payments you may receive.

Paying for benefits while on leave

While on leave, you will receive a monthly invoice from Starbucks Benefits Center outlining the amount you owe for your benefit contributions. You will continue to pay the same total benefit contribution amount while on leave; however, you pay monthly instead of each paycheck as you did when actively at work. The process to pay your monthly benefit contribution while on leave of absence is called "direct billing."

Direct billing will begin the first of the month following or coincident with (if on the first day of the month) the start of your leave with your payment due by the first of the following month. **If you do not make your benefits payment by the deadline, your coverage will be cancelled back to the end of the last month for which you paid in full.**

Upon completion of your leave, you will return to payroll-deducted benefit contributions the first of the month following or coincident with (if on the first day of the month) your return to work. Benefit contributions cannot be collected from Short or Long Term Disability payments.

For leaves beginning mid-month, any missed payroll deductions during the month your leave started will be collected via payroll deductions when you return to work. For example, if you were on leave August 5 through September 30, your August benefit contributions would be deducted from your paycheck upon your return to work or from any pay you receive while on leave (excluding Short or Long Term Disability pay). Starbucks Benefits Center would bill you for September contributions, and your payroll deductions would begin again effective October 1.

If your coverage is cancelled due to non-payment, you have a once per lifetime reinstatement option allowing you to reinstate your coverage by paying your outstanding balance in full. Your request for a one-time reinstatement must be received within 31 days of the mailing date reflected on your coverage notification showing coverage was dropped. You may request this once per lifetime reinstatement option by contacting Starbucks Benefits Center at (877) SBUXBEN.

If your benefits are cancelled due to non-payment and you return to work, your coverage and payroll contributions will automatically resume the first of the month following your return from leave. You can call Starbucks Benefits Center at (877) SBUXBEN within 45 days of your return to work if you would like to cancel the automatic reinstatement. If your coverage had been cancelled due to non-payment and you return to work after a new plan year has begun, you will need to make new health coverage elections and will be given an opportunity to enroll.

MAKING CHANGES

When you enroll in or waive benefits — whether you are initially eligible or during an annual benefits enrollment period — your choices remain in effect for the entire plan year, which runs from October 1 through September 30. There are several situations that could automatically change some of your benefits or allow you to make changes to your enrollment. They are:

- During the annual benefits enrollment period
- When you change positions from retail hourly to retail management or nonretail
- When you change positions from retail management or nonretail to retail hourly

- When you have what is called a qualified status change
- When you experience an event that creates a special enrollment right
- When you move to a new location
  - If you move to a new location where your elected medical or dental option is no longer available, you may be moved to the lowest-cost insurance carriers at the same coverage level. If your elected medical or dental option has a different cost in the new location, call Starbucks Benefits Center at (877) SBUXBEN to make certain changes to your coverage.

Annual benefits enrollment

Benefits enrollment is a time when you may make changes to your benefit elections for yourself and your eligible dependents. Changes you can make include, but are not limited to, changing your health coverage options, adding or dropping eligible dependents, re-enrolling in a Reimbursement Account, and increasing or decreasing your life insurance coverage amount.

Each year, the annual benefits enrollment period takes place during the summer — typically for three weeks in August. Enrollment changes are in effect the following plan year, from October 1 through September 30.

During benefits enrollment, we will mail information to you at your home address on record in Starbucks payroll system. Review this information and make any changes to your benefit elections. In order to receive your benefits enrollment materials in a timely manner, and to make sure your available health coverage.

Must Re-Enroll in Reimbursement Accounts

If you are enrolled in the Health Care or Dependent Care Reimbursement Accounts, you will need to re-enroll each year during benefits enrollment to continue your reimbursement accounts in the next plan year.

Annual benefits enrollment HC-5 requirement for partners working in Hawaii

If you choose to waive Starbucks medical coverage, the state of Hawaii requires you to complete the HC-5 form upon your initial election to waive coverage as well as annually in December. If you do not return this form and continue to be eligible for Starbucks benefits, you will be automatically enrolled in Starbucks HMSA Gold partner-only medical coverage and will be responsible for any applicable payroll contributions.

Changing positions from retail hourly to retail management or nonretail

The following highlights what happens to your coverage when you change from a retail hourly position to a retail management or nonretail position. Please refer to the specific coverage chapters for more details:

- You become eligible to enroll in the Health Care and Dependent Care Reimbursement Accounts.
- You are eligible for personal days and your vacation schedule may change.
- You are automatically enrolled in Long Term Disability (LTD) coverage, paid for by Starbucks. Your elected LTD coverage as a retail hourly partner will end.
- Your Starbucks-paid basic life insurance will change from $10,000 to one times your annual base pay.
- Your elected supplemental life insurance and AD&D coverage options change from flat dollar amounts to multiples of your annual base pay. Your coverage as a retail hourly partner will end and you must re-enroll to continue coverage (including dependent life coverage).

Changing positions from retail management or nonretail to retail hourly

The following highlights what happens to your coverage when you change from a retail management or nonretail position to a retail hourly position. Please refer to the specific coverage chapters for more details:

- You are no longer eligible to participate in the Health Care or Dependent Care Reimbursement Accounts. However, you may elect to continue participation in your Health Care Reimbursement Account on an after-tax basis through COBRA for the remaining of the current plan year. See the **Your Rights and Responsibilities chapter** for more information about COBRA.
- You are no longer eligible for personal days and your vacation schedule may change.
- Your Starbucks-paid Long Term Disability (LTD) coverage ends. You can enroll in and pay for retail hourly LTD insurance.
- Your Starbucks-paid basic life insurance will change from one times your annual base pay to $10,000.
- Your elected supplemental life insurance and AD&D coverage options change from multiples of pay to flat dollar amounts. Your coverage as a retail management or nonretail partner will end and you must re-enroll to continue coverage (including dependent life coverage).

If you transfer positions prior to gaining initial benefits eligibility, your status when the monthly initial eligibility audit runs will determine whether you are evaluated as a full time or variable hour partner.

Qualified status changes

If you have what is called a qualified status change during the year, you may be able to change your benefit elections midyear if one of the following events occurs, but only if the election is consistent with the change in your status. Your changes must also correspond to any changes your spouse, domestic partner or child makes to his or her coverage under another employer's plan.

For these events, your enrollment change goes into effect on the date of the event:

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death
- Change in your job status, such as transferring from a retail hourly to salaried partner, which results in new coverage options

For these events, your enrollment change goes into effect on the first day of the month following the event:

- Gain or loss of health coverage under another employer's plan, or Medicare, Medicaid or TRICARE or Marketplace (ACA, or any other government or foreign plans)
- Gain or loss of eligibility for a dependent under a Starbucks plan
- Change in legal marital or domestic partnership status, including marriage, divorce, start or end of a domestic partnership, legal separation or annulment of a marriage
- Loss of benefits eligibility or coverage for your spouse or domestic partner or children, or loss of all contributions by another employer for coverage
- End of the maximum period of COBRA coverage through another employer, if COBRA was in effect when your last benefit election went into effect (enrollment limited to health coverage, if no other status change occurs)
- Employment status changes for your spouse or domestic partner or children (specifically, starting or ending employment; starting or returning from an unpaid leave, a strike or lockout; or a change in a family member's work site)
- Gain or loss of benefits eligibility due to an ongoing eligibility audit
- Starting or returning from an approved leave of absence, as permitted under Starbucks leave policies

- Medicare or Medicaid entitlement or loss of Medicare or Medicaid coverage (changes limited to health coverage and Health Care Reimbursement Account) for you, your spouse or domestic partner or children
- You, your spouse or domestic partner or child gaining a new benefit option
- Qualified court order requiring health coverage for a child (see page 276 for specifications of a qualified court order)
- A benefit change under another employer's plan elected by your spouse or domestic partner or children during the annual benefits enrollment (or at other times in accordance with IRS rules)
- Your child becoming ineligible for dependent care reimbursements, such as reaching age 13 (your change is limited to changing your Dependent Care Reimbursement Account contribution)
- An increase in the cost of dependent care, resulting, for example, from a change in day care providers, an increase in the fees of a provider who is not a relative, increasing a nanny's pay or other similar reasons (your change is limited to increasing your Dependent Care Reimbursement Account contribution)
- You or your dependents qualify for premium assistance under your state's medical assistance program or Children's Health Insurance Program (CHIP)
- You or your dependents no longer qualify for health coverage under your state's medical assistance program or CHIP

For this event, your enrollment change goes into effect on the date we receive notification of your change:

- Moving to a location that changes your health coverage elections or per-paycheck costs

To see whether your situation is eligible for a change in benefits, or to make changes to your benefit elections, log in to **mysbuxben.com,** or call (877) SBUXBEN within 45 days after your change in status, including death of a covered spouse or dependent. If you are adding a newborn or adopted child to your coverage, you have 60 days from their birth date or date the adopted child is placed in your home to make the change. If the 45th or 60th day falls on a Saturday or Sunday or on a Starbucks Benefits Center recognized holiday, you must call on the next following business day. If you do not call and make your changes within 45 days (60 days for a newborn or adopted child), you will not be able to change your benefits election due to that status change until the next benefits enrollment period. In certain situations of late notification, such as death of a covered spouse or dependent, the change in coverage will take effect 60 days prior to the date of notification.

Special enrollment rights

You have special enrollment rights under federal law when you decline enrollment for yourself or your eligible dependents in Starbucks coverage because of other health insurance or group health coverage. These are very similar to the qualified status changes highlighted above:

- If you or your dependents lose eligibility for that other coverage, you may request enrollment in Starbucks coverage within 45 days after your or your dependents' other coverage ends.
- If an employer stops contributing toward the cost of your or your dependents' coverage, you may request enrollment in Starbucks coverage within 45 days after the employer stops contributing toward the other coverage.
- If you marry or form a domestic partnership, or you give birth, adopt or have a child placed with you for adoption, you may be able to enroll yourself and your dependents. You must request enrollment within 45 days after the marriage or formation of domestic partnership, or 60 days after the birth or placement for adoption.

State medical assistance and Children's Health Insurance Program

Partners and dependents who are eligible as described in the **Eligible Dependents** section have special enrollment rights under this plan if one of the statements below is true:

- The partner qualifies for premium assistance under the state's medical assistance program or Children's Health Insurance Program (CHIP).
- The partner no longer qualifies for health coverage under the state's medical assistance program or CHIP.

To be covered, the eligible partner or dependent must take action to enroll no more than 60 days from the date the applicable statement above is true. An eligible partner who elected not to enroll in this plan when they initially became eligible must enroll in this plan in order for eligible dependents to be enrolled in accordance with this provision. Coverage for the partner will start on the date the dependent's coverage starts.

To see whether your situation qualifies or to request special enrollment by the deadlines indicated above, call Starbucks Benefits Center at (877) SBUXBEN.

BENEFITS ELIGIBILITY WHILE ON AN APPROVED LEAVE OF ABSENCE

If you are eligible for Starbucks benefits at the start of your leave, your benefit coverage will continue provided you pay your required benefit contributions and remain eligible. To maintain your benefits eligibility while on leave, you will be required to pass the ongoing benefits eligibility audits.

While you are on an approved leave, you may be given credit of up to 20 hours per week during your leave (to the maximum number of weeks described on the next page). These hours will count towards the eligibility requirement and will be reflected as LOA (Leave of Absence) hours on your pay statement. Your BEN (Benefit) hours plus your LOA hours must total at least 520 for the 6-month measurement period to pass the semi-annual audit and maintain your benefits eligibility. (The total hour requirement may be adjusted if the measurement period contains fewer pay periods; please refer to the Benefits Eligibility Audit Dates document on the Partner Hub or in your store to confirm the required hours needed for each audit.) If you are a partner in Hawaii, your BEN hours plus LOA hours must total at least 80 to pass the monthly eligibility audits.

For purposes of calculating your weekly hours, your BEN or LOA hours are measured from Monday to Sunday.

As a reminder, all approved Workers Compensation leaves are subject to the same eligibility and benefit payment rules described in this document.

Below is an example of how ongoing benefits eligibility is determined for a U.S. mainland partner on approved leave during the January 6th – July 5th measurement period:

Payroll weeks	Ben hours (reflecting paid hours)	LOA hours (reflecting time on approved leave)
Weeks 1 – 12 (partner is actively at work and works 20 hours per week)	240 (12 weeks x 20 hours)	0
Weeks 13 – 20 (partner is on approved LOA)	0	160 (8 weeks x 20 hours)
Weeks 21 – 26 (partner is actively at work and works 20 hours per week)	120 (6 weeks x 20 hours)	0
Total hours on July 6th Audit	**360 BEN hours**	**160 LOA hours**

The partner's total hours equal 520, and the partner passes the audit.

Here is a different way to look at the chart on the previous page:

Vacation and/or sick time paid during your leave of absence are included and reflected as BEN hours on your pay statement. If you are paid vacation and/or sick time while on an approved leave of absence, your pay statement will show both LOA hours and BEN hours. The maximum number of LOA hours you may receive in a week is 20; the maximum number of combined LOA and BEN hours in a week is also 20. For example:

- If you were paid 5 hours for work in a week, you would receive 5 BEN hours. If you were on approved, eligible leave for the remainder of the week, you would receive 15 LOA hours for a maximum of 20 combined BEN and LOA hours.
- If you used 10 vacation hours in a week, you would receive 10 BEN hours. If you were on approved, eligible leave for the remainder of the week, you would receive 10 LOA hours for a maximum of 20 combined BEN and LOA hours.
- If you were on approved, eligible leave during the week and were paid 30 vacation hours, you would receive 30 BEN hours. You would receive 0 LOA hours, because your BEN hours for the week were greater than 20.

If your combined BEN and LOA hours do not meet the hours requirement during the ongoing eligibility audit, your benefit coverage will end at the conclusion of the current stability period.

The maximum duration for which you can receive LOA hours depends on the type of leave as outlined below:

Type of leave	Maximum weeks for LOA hours
Any combination of Family Medical Leave, Medical Leave, Parental Leave, State Leave, Pregnancy Disability Leave, Accommodation Leave, Caregiver Leave, and any Workers Compensation Leave classified as Family Medical Leave or State Leave	Up to 26 weeks
Career Coffee Break	Up to 52 weeks
Military Leave (partners with less than 6 months of service)	Up to 52 weeks
Military Leave (partners with at least 6 months of service)	Up to 78 weeks
Personal Leave	Up to 30 days

For additional details on the ongoing benefits eligibility process, please refer to **page 11**. If you have questions on benefits eligibility, contact Starbucks Benefits Center.

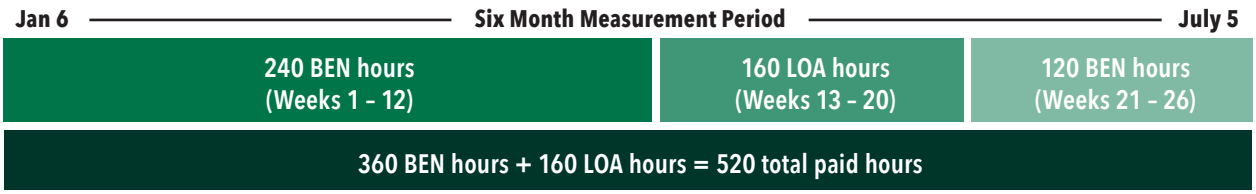
The following leaves are not eligible to receive LOA Hours:

- Unapproved Leave
- Pending Leave

Benefits eligibility upon return to work

Assuming you passed the ongoing benefits eligibility audit, your benefits eligibility will continue upon your return to work. If your combined BEN and LOA hours did not meet the hours requirement during an ongoing eligibility audit, your benefit coverage will end at the conclusion of the current stability period. See **page 13** for the stability period dates.

If you return from an approved, eligible long leave (meaning your leave lasted longer than your maximum duration of LOA hours) and you lost eligibility as a result of failing a semi-annual audit while on leave, you will receive benefits eligibility the first of the month following your return from leave.



If you lost eligibility in the previous plan year, you will need to re-enroll in health coverage when you regain eligibility. A notice of enrollment will be sent to you at the time you regain eligibility. If you do not enroll, you will not have coverage.

If you return from an unapproved status after a long leave of absence (meaning your leave lasted longer than your maximum duration of LOA hours) and have lost eligibility, you may re-establish benefits eligibility by passing a future ongoing eligibility audit. If you return from an approved long leave and have lost eligibility, your measurement period will be shortened, depending on the date you returned from leave. You will need to have at least 20 total hours for each full week between your return and the next eligibility audit.

Initial benefits eligibility while on leave of absence

If a partner is on an approved, eligible leave of absence prior to gaining initial benefits eligibility, you may receive a credit of up to 20 hours per week to account for the time you are not working. If your BEN hours plus your LOA hours meet the minimum requirement to gain initial eligibility, you will be eligible for benefit coverage based on your role and location. A partner cannot gain initial eligibility with only LOA hours. For additional details, see the **Initial Eligibility section on page 7**.

Impact to benefits

The impact to your benefits enrollment depends on your benefits eligibility status during the leave and, in some cases, the length of your leave. The following provides a general summary of the impact for Family Medical, Medical, Parental, State, Pregnancy Disability, Accommodation, Caregiver, Personal, and Career Coffee Break leaves. The impact to your benefits as a result of a Military Leave is addressed on **page 28**. For specific details, refer to "If you take an approved leave of absence" within the specific coverage chapters of this guide.

Your Starbucks coverage will continue as outlined below, as long as you remain benefits eligible:

- **Medical, dental and vision**: Current coverage continues while considered benefits eligible. You will be required to continue your benefit contributions.
- **Health Savings Account (HSA)**: Pre-tax payroll contributions to your HSA will be suspended the first of the month after your leave begins, and will be reinstated upon your return to work. You may make post-tax contributions to your HSA and declare them when you file your federal tax return to receive the tax benefit.
- **Partner and dependent life insurance, Accidental Death and Dismemberment insurance**: Current coverage continues while considered benefits eligible. You will be required to continue making contributions for coverage you elected. When coverage ends, you can elect to continue coverage through conversion or portability options. The maximum coverage continuation during a Career Coffee Break is 12 months.
- **Disability coverage**: Current coverage continues while considered benefits eligible, except that Short Term Disability (STD) coverage ends upon commencement of your Career Coffee Break. Retail hourly partners must continue making premium payments to continue Long Term Disability (LTD) coverage. If you become disabled while on a leave, LTD benefits will not begin until after the 26-week elimination period.

- **Dependent Care Reimbursement Account (DCRA)**: Participation is suspended effective the start of your leave. Participation is reinstated upon your return to work unless you return in a new plan year.
- **Health Care Reimbursement Account (HCRA)**: While you are on a leave of absence your HCRA contributions will be billed along with your medical, dental and vision coverage. As long as you continue timely payments your annual contribution election remains available to you, and eligible expenses you incur while on leave may be reimbursed. If you would like to stop contributions for HCRA while on your leave contact Starbucks Benefits Center at (877) SBUXBEN within 45 days of the start of your leave. If you choose to suspend your HCRA contributions during your leave of absence, when you return from your leave your per-paycheck contributions will be increased to maintain your annual contribution amount. If you elect to suspend contributions, any healthcare expenses incurred while on your leave of absence will not be eligible for reimbursement.
- **Lyra**: Benefits continue.
- **Care@Work by Care.com**: Benefits continue.
- **Headspace**: Benefits continue.
- **Family Expansion Reimbursement**: Benefit continues while considered benefits eligible.
- **Starbucks College Achievement Plan**: Benefits continue while considered benefits eligible.
- **Partner discount and markout**: Benefits continue.

Making changes to benefits while on leave

Generally, changes to your Starbucks coverage while on leave are not allowed unless you experience a qualified status change (see **Making Changes on page 21**) or during annual benefits enrollment. Changes to life insurance (including spouse or domestic partner), Aflac Voluntary Benefits, Accidental Death and Dismemberment insurance, and retail Long Term Disability elections are only allowed when you are actively at work. For the birth of a child or placement of an adopted child, you are allowed to make changes to child life insurance while on approved leave of absence - call Starbucks Benefits Center to do so.

If you wish to discontinue any or all of your benefit coverage during your leave, contact Starbucks Benefits Center within 45 days from the start of your leave. If you want to make other changes to your benefit coverage, you must experience a qualified status change (such as the birth or adoption of a baby). If you experience a qualified status change while on leave and would like to change your elections, access **mysbuxben.com** within 45 days of the event (or 60 days of a birth or adoption). Otherwise, changes can be made only during annual benefits enrollment.

Military Leave

If you are called to military duty your Starbucks coverage, if eligible when your leave begins, will continue as outlined below.

- **Medical, dental and vision**: Coverage will stay the same provided you continue to pay your premiums and remain eligible for benefits. If you return to work after eligibility has ended, you will need to regain eligibility. See the **Benefits Eligibility Upon Return To Work section** for details.
- **Health Savings Account (HSA)**: Pre-tax payroll contributions to your HSA will be suspended the first of the month after your leave begins, and will be reinstated upon your return to work. You may make post-tax contributions to your HSA and declare them when you file your federal tax return to receive the tax benefit.
- **Partner and dependent life insurance, Accidental Death and Dismemberment, and disability coverage**: Remains the same provided you continue to pay your premiums and remain eligible for benefits. When coverage ends, you may elect to continue coverage through conversion or portability options. See the **Life Insurance chapter** for more information.

- **Dependent Care Reimbursement Account (DCRA)**: Participation is suspended effective the start of your leave. Participation is reinstated upon your return to work unless you return in a new plan year.
- **Health Care Reimbursement Account (HCRA)**: While you are on a leave of absence your HCRA contributions will be billed along with your medical, dental and vision coverage. As long as you continue timely payments your annual contribution election remains available to you, and eligible expenses you incur while on leave may be reimbursed. If you would like to stop contributions for HCRA while on your leave contact Starbucks Benefits Center at (877) SBUXBEN within 45 days of the start of your leave. If you choose to suspend your HCRA contributions during your leave of absence, when you return from your leave your per-paycheck contributions will be increased to maintain your annual contribution amount. If you elect to suspend contributions, any healthcare expenses incurred while on your leave of absence will not be eligible for reimbursement.
- **Lyra**: Benefits continue.
- **Care@Work by Care.com**: Benefits continue.
- **Headspace**: Benefits continue.
- **Family Expansion Reimbursement**: Benefit continues while considered benefits eligible.
- **Starbucks College Achievement Plan**: Benefits continue while considered benefits eligible.
- **Partner discount and markout**: Benefits continue.

Making changes to benefits while on Military Leave

You have 45 days from the start of your Military Leave to request cancellation of your Starbucks coverage. You can re-enroll in coverage upon your return from an approved Military Leave and must do so within 45 days of your return. Contact Starbucks Benefits Center at (877) SBUXBEN to make changes to your benefit elections.

If you do not request cancellation of your Starbucks coverage within 45 days, you will be responsible for making payment for coverage while on leave. If you do not make your benefits payment by the deadline, your coverage will be cancelled back to the end of the last month for which you paid in full.

COMPASSIONATE BENEFITS FOR TERMINALLY ILL PARTNERS

Being diagnosed with a terminal illness can be devastating emotionally as well as financially. To alleviate the financial burden of the cost of health coverage and life insurance for a benefits eligible partner diagnosed with a terminal illness, Starbucks provides special assistance.

If, while you are employed with Starbucks, you are diagnosed as terminally ill (life expectancy of 24 months or less) and are unable to work, you are eligible for three unique benefits:

- Continued life insurance coverage for up to six months:
    - Partners age 60 and under may be eligible for waiver of premium after six months
    - Partners over age 60 may be eligible to port or convert their coverage after six months
- Continued health coverage, fully paid for by Starbucks for you and your enrolled dependents, if any, until you are no longer eligible for benefits; and
- After benefit eligibility ends, continued health coverage through COBRA, fully paid for by Starbucks, for the duration of your eligibility for COBRA coverage (see below).

Continued life insurance

Your employment status will be deemed to be continued for the minimum period of time required to establish eligibility for waiver of premium under the Hartford Life and Accident Insurance Company contract, typically six months following the date your disability began. Refer to the **Life Insurance Chapter** for more information about life coverage continuation and waiver of premium.

Health coverage continuation

If your health coverage benefits terminate while you are still employed, you may elect to continue your health coverage for yourself and any enrolled dependents through COBRA. If you elect COBRA continuation, Starbucks will pay the full cost of COBRA coverage you have elected. Upon separation from employment, Starbucks will pay the full cost of COBRA coverage you have elected until your COBRA coverage period expires, you become eligible for Medicare or your death, whichever occurs first. For three months following your death, Starbucks will pay for the cost of continued COBRA coverage for your enrolled dependents. If, however, COBRA coverage would have terminated because you or your dependents reached the maximum COBRA continuation coverage period, then coverage will end when COBRA expires.

Future Roast 401(k) distribution

You may also be eligible to receive a total distribution of your Future Roast 401(k) account. See **If you leave Starbucks due to a permanent and total disability on page 92**.

WHEN YOUR EMPLOYMENT ENDS

The following chart outlines what happens when your employment at Starbucks ends. You will also find how your loss of eligibility affects your benefit coverage within each individual chapter of this guide.

Benefit	Impact
Medical, Dental and Vision Coverage	Coverage ends on the last day of the month in which your separation is processed by payroll. You may elect to continue your coverage under COBRA, unless you have been separated due to gross misconduct. For more information about COBRA, see the **Your Rights and Responsibilities chapter.**
Dependent Care Reimbursement Account	Your participation ends as of your final contribution.
Health Care Reimbursement Account	Your participation ends on the last day of the month in which your separation is processed by payroll. If you have amounts remaining in your account, you may elect to continue your participation through the end of the plan year in which you participate on an after-tax basis through COBRA. For more information about COBRA, see the **Your Rights and Responsibilities chapter.**
Health Savings Account	Any funds remaining in your Health Savings Account at the time of separation are yours to keep. Your Health Savings Account will convert to an individual account and you will be responsible for paying the associated administrative fees.
Short Term and Long Term Disability	Coverage ends on the last day you are actively at work at Starbucks. If you have been approved for disability benefits prior to your last day worked, your disability benefits will continue according to plan provisions.

Benefit	Impact
Life Insurance	Coverage ends on the last day of the month in which your separation is processed by payroll. You have 31 days from the date you separate to convert or port your Starbucks paid life insurance, and to convert or port your supplemental life coverage. If you are permanently and totally disabled and have received a waiver of premium, your life insurance coverage continues at no cost to you.
Accidental Death and Dismemberment (AD&D) Insurance	Coverage ends on the last day of the month in which your separation is processed by payroll.
Lyra	Benefits are available for 18 months after your separation.
Care@Work by Care.com	Eligibility ends when you are no longer employed by Starbucks.
Headspace	Benefits continue until the end of the month in which your separation is processed by payroll.
Family Expansion Reimbursement	You must be employed at the time your reimbursement is processed by payroll to be eligible to receive a reimbursement.
Starbucks College Achievement Plan	Eligibility for enrollment ends when you are no longer employed by Starbucks. If you separate from Starbucks after a reimbursement has been approved but prior to payment, the payment will not be made.
Commuter Benefit Program	You lose eligibility to participate in the program and your selections are cancelled when you leave Starbucks. Any pass or commuter card that you have in your possession, or is mailed to you after your separation, is yours to keep and use. Outstanding deductions, if any, will be taken from your last paycheck. If you are re-hired before the end of the year and there is an outstanding deduction on record upon re-hire, the amount owed will be deducted from your first paycheck. Any amounts owed that remain uncollected at year-end or after you leave will show up on your W-2 as a taxable benefit
Aflac Voluntary Benefits	Coverage ends on the last day you are actively at work at Starbucks. You may convert your coverage to an individual policy after separation.
DACA Fee Reimbursement	You must be employed at the time your reimbursement is processed by payroll to be eligible to receive a reimbursement.
Fitness Event Reimbursement	You must be employed at the time your reimbursement is processed by payroll to be eligible to receive a reimbursement.
Partner Discount and Markout	Eligibility ends when you are no longer employed by Starbucks.

Health Coverage

Starbucks offers you a choice of medical (including prescription drugs), dental and vision plans. The plans vary in terms of how medical expenses are covered, how much the plans cost you out of your paycheck and out of pocket, and where they are available. You decide which plan best meets your needs.

For details, limitations and exclusions of your medical, prescription drug, dental, and vision coverage, see the Certificate of Coverage statements on the insurance carriers' websites.

What you pay

You and Starbucks share the cost of medical benefits for you and your enrolled dependents. Your contributions for coverage are automatically deducted from your paycheck each pay period, as outlined in the **Eligibility and Enrollment chapter.** In addition to these payroll deductions, you may have some out-of-pocket costs when you receive care. These costs include deductibles, copays, coinsurance and expenses for non-covered services and supplies.

ID Cards

When you enroll in a medical, dental or vision plan, ID cards will be mailed to your home. You need to present this card whenever you visit your doctor, medical facility or participating pharmacy for services. Not all carriers will provide or require ID cards to use the coverage. If you do not receive an ID card within a month after enrolling, or if you need additional or replacement ID cards, call or go online to request a new ID card. See Appendix B for contact information.

MEDICAL COVERAGE

Starbucks offers five coverage levels available from multiple insurance carriers, depending on where you live.

Bronze - A basic, high-deductible Preferred Provider Organization (PPO) plan with a Health Savings Account (HSA) and prescription drug coinsurance.

Bronze Plus - A buy-up to the Bronze option – a high-deductible PPO plan with a Health Savings Account (HSA) and prescription drug coinsurance.

Silver - A PPO plan with doctor's office and prescription drug copays

Gold - A PPO plan with doctor's office and prescription drug copays.

Platinum - A PPO plan with doctor's office and prescription drug copays, that offers limited benefits for out-of-network care (or, for some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, a Health Maintenance Organization [HMO] plan with prescription drug copays that covers in-network care only).

Each coverage level is available from different insurance carriers at different costs.

Hawaii partners have the choice of Gold and Platinum coverage levels offered by HMSA and Kaiser Hawaii.

Do you live in California? Your plans might be a little different, depending on the insurance carrier you choose. See **page 38** for details.

Do you live outside the service area? Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area plan at either the Silver or Gold coverage level. Aetna will be the insurance carrier for all out-of-area plans.

Annual deductible – U.S. mainland

The deductible is what you pay out of pocket before your insurance starts paying its share of your in-network costs; you have a separate deductible for any out-of-network costs. The deductible doesn't include amounts taken out of your paycheck for health coverage. Here's how the deductible works if you have family coverage:

BRONZE PLUS	BRONZE, SILVER, GOLD	PLATINUM
The Bronze Plus coverage level has a "true family deductible."* This means that the entire family deductible must be met before your insurance will pay benefits for any covered family member. There is no "individual deductible" in this plan when you have family coverage.	The Bronze, Silver, and Gold coverage levels have a traditional family deductible*. Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member. Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.	The Platinum coverage level does not have an in-network deductible. Keep in mind that as a trade-off for no deductible, the Platinum plan is usually the most expensive plan per paycheck.

* Partners in California: Kaiser and Health Net have a traditional family deductible for Bronze Plus coverage.

Annual Deductible (individual/family)	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
IN-NETWORK	$3,300/$6,600	$2,450/$4,900	$1,000/$2,000	$800/$1,600	N/A
OUT-OF-NETWORK	$3,300/$6,600	$2,450/$4,900	$2,000/$4,000	$1,600/$3,200	$5,000/$10,000

This chart does not take into account how each plan covers state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information.

Going out of network?

Keep in mind: Out-of-network charges will not count toward your in-network annual deductible or out-of-pocket maximum. The same goes for in-network charges – they will not count toward your out-of-network annual deductible or out-of-pocket maximum.

Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Annual out–of–pocket maximum – U.S. mainland

The out-of-pocket maximum is the most you and your covered family members would have to pay in a year for in-network costs; you have a separate out-of-pocket maximum for any out-of-network costs. The out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

BRONZE PLUS	BRONZE, SILVER, GOLD, PLATINUM
The Bronze Plus coverage level has a "true family out-of-pocket maximum."* This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" in this plan when you have family coverage. However, in no event will an individual be required to meet an out-of-pocket maximum that is greater than the individual out-of-pocket maximum required by the Affordable Care Act.	The Bronze, Silver, Gold, and Platinum coverage levels have a traditional out-of-pocket maximum*. Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

* Partners in California: Kaiser and Health Net have a traditional family out-of-pocket maximum for Bronze Plus coverage.

Annual Out-of-Pocket Maximum (individual/family)	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
IN-NETWORK	$6,400/$12,800	$3,900/$7,800	$5,300/$10,600	$3,600/$7,200	$1,600/$3,200
OUT-OF-NETWORK	$12,800/$25,600	$11,500/$23,000	$10,600/$21,200	$7,200/$14,400	$11,500/$23,000

This chart does not take into account how each plan covers state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information.

Annual deductibles and out–of–pocket–maximum – Hawaii

The deductible is what you pay out of pocket before your insurance starts paying its share of your costs. The out-of-pocket maximum is the most you and your covered family members would have to pay in a year for in-network healthcare costs; you have a separate out-of-pocket maximum for any out-of-network healthcare costs. The deductible and out-of-pocket maximum don't include amounts taken out of your paycheck for health coverage.

HMSA GOLD, KAISER GOLD	HMSA PLATINUM, KAISER PLATINUM
The HMSA Gold and Kaiser Gold options have a traditional deductible. Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member. Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.	The HMSA Platinum and Kaiser Platinum options don't have an in-network deductible. Keep in mind that as a trade-off for no deductible, the Platinum coverage level is usually more expensive per paycheck.

Annual Deductible (individual/family)	HMSA GOLD	KAISER GOLD	HMSA PLATINUM	KAISER PLATINUM
IN-NETWORK	$200/$600	$200/$400	N/A	N/A
OUT-OF-NETWORK	$200/$600	$200/$400	$100/$300	Not Covered
Annual Out-of-Pocket Maximum (individual/family)	HMSA GOLD	KAISER GOLD	HMSA PLATINUM	KAISER PLATINUM
IN-NETWORK	$2,200/$6,600	$2,200/$4,400	$2,500/$7,500	$2,500/$7,500
OUT-OF-NETWORK	$2,200/$6,600	N/A	$2,500/$7,500	N/A

Hawaii partners: If you choose HMSA as your insurance carrier, you'll have a separate and additional out-of-pocket maximum for prescription drugs. That means your medication costs will not count toward your medical out-of-pocket maximums, and vice versa.

In-network benefits – U.S. mainland

Benefit	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
PREVENTIVE CARE	Covered 100%, no deductible		Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%
DOCTOR'S OFFICE VISIT	You pay 25% after deductible		You pay $30 for PCP visit with no deductible You pay $50 for specialist visit with no deductible	You pay $25 for PCP visit with no deductible You pay $40 for specialist visit with no deductible	You pay $25 for PCP visit with no deductible You pay $40 for specialist visit with no deductible
EMERGENCY ROOM	You pay 25% after deductible		You pay $150, then 30% after deductible	You pay 25% after deductible	You pay $200
URGENT CARE	You pay 25% after deductible		You pay 30% after deductible	You pay 25% after deductible	You pay $50
INPATIENT CARE	You pay 25% after deductible		You pay 30% after deductible	You pay 25% after deductible	You pay $350
OUTPATIENT CARE	You pay 25% after deductible		Cost share based on place of service	Cost share based on place of service	Cost share based on place of service

In-network benefits – Hawaii

Benefit	HMSA GOLD	KAISER GOLD	HMSA PLATINUM	KAISER PLATINUM
PREVENTIVE CARE	100% covered; deductible waived	100% covered; deductible waived	100% covered	100% covered
DOCTOR'S OFFICE VISIT	You pay $12	You pay $15	You pay $12	You pay $15
EMERGENCY ROOM	You pay 20% after deductible	You pay 20%; deductible waived	You pay 20%	You pay $75
URGENT CARE	You pay $12	You pay $15	You pay $12	You pay $15
INPATIENT CARE	You pay 20% after deductible	You pay 10% after deductible	You pay 10%	You pay $75 per day
OUTPATIENT CARE	Cost share based on place of service	Cost share based on place of service	Cost share based on place of service	Cost share based on place of service

The charts above are high-level illustrations of commonly covered benefits across all available carriers and coverage levels. These charts are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to standardized plan benefits. However, individual carriers may offer coverage that differs slightly from the standard coverage reflected here. For further information, refer to your carrier's Certificates of Coverage (see Appendix A).

Coverage for partners in California

The plans available to partners in California might be different, depending on the medical insurance carrier you choose. Each insurance carrier in California has the option to offer each coverage level either as a plan that offers in- and out-of-network benefits (e.g., a PPO) or a plan that offers in-network benefits only (e.g., an HMO).

Insurance carriers also have the option to offer either the standard Gold plan or a Gold II plan – not both. The Gold II plan only offers in-network benefits. The Gold plan is offered by Aetna and Premera Blue Cross. The Gold II plan is offered by Cigna, Health Net, Kaiser Permanente, and UnitedHealthcare.

Annual Deductible (individual/family)	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
IN-NETWORK	$3,300/$6,600	$2,450/$4,900[1]	$1,000/$2,000	$800/$1,600	N/A	N/A
OUT-OF-NETWORK	$3,300/$6,600	$2,450/$4,900[1]	$2,000/$4,000	$1,600/$3,200	N/A	$5,000/$10,000
Annual Out-of-Pocket Maximum (individual/family)	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
IN-NETWORK	$6,400/$12,800	$3,900/$7,800[2]	$5,300/$10,600	$3,600/$7,200	$5,400/$10,800	$1,600/$3,200
OUT-OF-NETWORK	$12,800/$25,600	$11,500/$23,000[2]	$10,600/$21,200	$7,200/$14,400	N/A	$11,500/$23,000
	Out-of-network care not covered if you choose Health Net (Northern California) or Kaiser Permanente as your insurance carrier.				Out-of-network care not covered.	Out-of-network care not covered if you choose Cigna, Health Net or Kaiser Permanente as your insurance carrier.

1 Under Health Net and Kaiser Permanente, if you cover dependents under the Bronze Plus coverage level, no covered member pays more than $2,800 toward the family deductible. Also, these options feature a traditional annual deductible.

2 Under Health Net and Kaiser Permanente, these options feature a traditional annual out-of-pocket maximum.

In-network benefits (California partners)

Benefit	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
PREVENTIVE CARE	Covered 100%, no deductible		Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%
DOCTOR'S OFFICE VISIT	You pay 25% after deductible		You pay $30 for PCP visit with no deductible You pay $50 for specialist visit with no deductible	You pay $25 for PCP visit with no deductible You pay $40 for specialist visit with no deductible	You pay $25 for PCP visit You pay $40 for specialist visit	You pay $25 for PCP visit You pay $40 for specialist visit
EMERGENCY ROOM	You pay 25% after deductible		You pay $150, then 30% after deductible	You pay 25% after deductible	You pay 30%	You pay $200
URGENT CARE	You pay 25% after deductible		You pay 30% after deductible	You pay 25% after deductible	You pay 30%	You pay $50
INPATIENT CARE	You pay 25% after deductible		You pay 30% after deductible	You pay 25% after deductible	You pay 30%	You pay $350
OUTPATIENT CARE	You pay 25% after deductible		Cost share based on place of service after deductible	Cost share based on place of service	Cost share based on place of service	Cost share based on place of service

The charts above are high-level illustrations of commonly covered benefits across available carriers and coverage levels. This chart is intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to standardized plan benefits. However, individual carriers may offer coverage that differs slightly from the standard coverage reflected here. For further information, refer to your carrier's Certificates of Coverage (see Appendix A).

Is a primary care physician required?

You must designate a primary care physician to coordinate your care if you:

- Choose Kaiser Permanente as your insurance carrier;
- Live in Northern California and choose Health Net as your insurance carrier; or
- Live in Southern California and choose Health Net as your insurance carrier and Gold II or Platinum as your coverage level.

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided through your insurance carrier's pharmacy benefit manager. Your prescription drug coverage depends on the medical coverage level you choose and your medical insurance carrier. Below is an overview of the in-network coverage levels.

U.S. mainland

Coverage	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
PREVENTIVE DRUGS (determined by the insurance carrier, as required by the Affordable Care Act)	You pay $0 You must have a doctor's prescription for the medication – even for products sold over the counter (OTC) – and you must use an in-network retail pharmacy or mail-order service.				
30-DAY RETAIL SUPPLY					
Tier 1: Generally lowest cost options	You pay 100% until you've met the deductible, then you pay 25%		You pay $12	You pay $10	You pay $8
Tier 2: Generally medium cost options	You pay 100% until you've met the deductible, then you pay 25%		You pay $50	You pay $40	You pay $30
Tier 3: Generally highest cost options	You pay 100% until you've met the deductible, then you pay 25%		You pay $70	You pay $60	You pay $50
90-DAY MAIL-ORDER SUPPLY					
Tier 1: Generally lowest cost options	You pay 100% until you've met the deductible, then you pay 25%		You pay $30	You pay $25	You pay $20
Tier 2: Generally medium cost options	You pay 100% until you've met the deductible, then you pay 25%		You pay $125	You pay $100	You pay $75
Tier 3: Generally highest cost options	You pay 100% until you've met the deductible, then you pay 25%		You pay $175	You pay $150	You pay $125

If you live in California and you're eligible for coverage under the Gold II coverage level, note that prescription drug coverage is the same as for the Gold coverage level shown above.

Hawaii

Coverage	HMSA GOLD	KAISER GOLD	HMSA PLATINUM	KAISER PLATINUM
PREVENTIVE DRUGS (determined by the insurance carrier, as required by the Affordable Care Act)	You pay $0 You must have a doctor's prescription for the medication – even for products sold over the counter (OTC) – and you must use an in-network retail pharmacy or mail-order service.			
Prescription Drug Annual Out-of-Pocket Maximum (individual/family)	$3,000/$7,200	Included in medical out-of-pocket maximum	$3,000/$5,700	Included in medical out-of-pocket maximum
30-DAY RETAIL SUPPLY				
Tier 1: Generally lowest cost options	You pay $7	You pay $5 for generic maintenance drugs; $10 for other generic drugs	You pay $5	You pay $5 for generic maintenance drugs; $10 for other generic drugs
Tier 2: Generally medium cost options	You pay $35	You pay $35	You pay $30	You pay $35
Tier 3: Generally highest cost options	You pay $75	Not covered	You pay $70	Not covered
90-DAY MAIL-ORDER SUPPLY				
Tier 1: Generally lowest cost options	You pay $14	You pay $10 for generic maintenance drugs; $20 for other generic drugs	You pay $10	You pay $10 for generic maintenance drugs; $20 for other generic drugs
Tier 2: Generally medium cost options	You pay $70	You pay $70	You pay $60	You pay $70
Tier 3: Generally highest cost options	You pay $150	Not covered	You pay $140	Not covered

MEDICAL INSURANCE CARRIERS

Depending on where you live, you may be able to choose from the following carriers. If you live outside of the service areas of all the insurance carriers, an out-of-area plan through Aetna at the Silver or Gold coverage level will be your only choice.

Which carriers are available to me?

Your specific options are based on where you live, so it's important to make sure your address on record with Starbucks is correct before you enroll. You'll be able to see the options available to you when you enroll.

- Aetna
- Cigna
- Dean Health (generally available in WI)
- Geisinger (generally available in PA)
- Hawaii Medical Service Association (HMSA) (available in HI)
- Health Net (generally available in CA and OR)
- Kaiser Permanente (generally available in CA, CO, DC, GA, HI, MD, VA, OR, and WA)
- Premera Blue Cross
- UnitedHealthcare National (available nationally excluding CA)
- UnitedHealthcare California (available in CA)
- UPMC Health Plan (generally available in PA)

Do You Have Dependents Living In Another Area?

If you need to cover eligible dependents who live in a different state, you will need to make sure you elect an insurance carrier that covers both locations. Need help? Call a Starbucks Advocate at (877) SBUXBEN.

DENTAL COVERAGE

Starbucks offers four coverage levels available from multiple insurance carriers, depending on where you live.

Bronze - A basic Preferred Provider Organization (PPO) plan that covers in- and out-of-network care, but does not cover major or orthodontic expenses.

Silver - A buy-up to the basic PPO plan that covers in- and out-of-network care, including coverage for major services and, for children up to age 19, orthodontic expenses.

Gold - An enhanced PPO plan that covers in- and out-of-network care, including coverage for major services and orthodontic expenses for children and adults.

Platinum - A Dental Health Maintenance Organization (DHMO) plan that covers in-network care only, including orthodontic expenses for children and adults (not available in North Dakota and some other limited areas).

Considering Platinum?

It may cost less than some of the other options, but you must get care from a dentist who participates in the insurance carrier's Platinum dental network. The network could be considerably smaller, so be sure to check the availability of local in-network dentists before you enroll. If you don't use an in-network dentist, you'll pay for the full cost of services.

Annual deductible and plan limits

The deductible is what you pay out of pocket before your insurance carrier starts paying its share of your costs. The annual maximum is the most the insurance carrier will pay in a year for in-network dental costs. The orthodontia lifetime maximum is the total amount the insurance carrier will pay per covered person.

	BRONZE	SILVER	GOLD	PLATINUM[1]
Annual Deductible (individual/family)	$100/$300	$100/$300	$50/$150	None
Annual Maximum (excludes orthodontia)	$1,000 per person	$1,500 per person	$2,500 per person	None
Orthodontia Lifetime Maximum[2]	Not covered	$1,500 per child	$2,000 per person	Varies by insurance carrier

1 May not be available in some areas. Only the coverage levels for which you are eligible will show as options when you enroll online.
2 If you switch insurance carriers, any orthodontic expenses you've already incurred under your current carrier will count toward your new carrier's orthodontia lifetime maximum.

Is a primary care dentist required?

You must designate a primary care dentist to coordinate your care if you choose the Platinum coverage level. If you don't designate a primary care dentist when you enroll, one may be assigned to you. To change your primary care dentist, you will need to contact the insurance carrier directly.

In-network benefits

	BRONZE	SILVER	GOLD	PLATINUM[1]
PREVENTIVE CARE	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Varies by insurance carrier; generally covered 100%
MINOR RESTORATIVE CARE (e.g., root canal treatment, gum disease treatment, and oral surgery)	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	Varies by insurance carrier
MAJOR RESTORATIVE CARE (e.g., implants, dentures)	Not covered	You pay 40% after deductible	You pay 20% after deductible	Varies by insurance carrier
ORTHODONTIA	Not covered	You pay 50%, no deductible; children up to age 19 only	You pay 50%, no deductible; for children and adults	Varies by insurance carrier

1 May not be available in some areas. Only the coverage levels for which you are eligible will show as options when you enroll online.

The charts above are high-level illustrations of commonly covered benefits across available carriers and coverage levels. These charts are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to standardized plan benefits. However, individual carriers may offer coverage that differs slightly from the standard coverage reflected here. For further information, refer to your carrier's Certificates of Coverage (see Appendix A).

DENTAL INSURANCE CARRIERS

Depending on where you live, you may be able to choose from the following carriers.

Which carriers are available to me?

Your specific options are based on where you live, so it's important to make sure your address on record with Starbucks is correct before you enroll. You'll be able to see the options available to you when you enroll.

- Aetna
- Cigna
- Deltacare USA
- Delta Dental of WA
- MetLife
- UnitedHealthcare

Do You Have Dependents Living In Another Area?

If you need to cover eligible dependents who live in a different state, you will need to make sure you elect an insurance carrier that covers both locations. Need help? Call a Starbucks Advocate at (877) SBUXBEN.

VISION COVERAGE

Starbucks offers three coverage levels available from multiple insurance carriers, depending on where you live.

Bronze - Exam-only option that provides in-network discounts for certain materials.

Silver - A Preferred Provider Organization (PPO) that covers in- and out-of-network care.

Gold - An enhanced PPO plan that covers in- and out-of-network care.

In–network benefits

Coverage	BRONZE	SILVER	GOLD
ROUTINE VISION EXAM (once per plan year)	Covered 100%[1]	You pay $20	You pay $10
FRAMES (once per plan year)	Discount may apply	$100 allowance[2]	$200 allowance[2]
LENSES (once per plan year; premium lenses may cost more)			
Single Vision			
Bifocal			
Trifocal	Discount may apply	You pay $20	You pay $10
Standard Progressive[3]			
Lenticular			
LENS ENHANCEMENTS			
UV Treatment		You pay $15	You pay $15
Tint (solid and gradient)		You pay $15	You pay $15
Standard Plastic Scratch-Resistant Coating		You pay $15	You pay $15
Standard Anti-Reflective Coating	Discount may apply	You pay $45	You pay $45
Standard Polycarbonate – Adults		You pay $40	You pay $15
Standard Polycarbonate – Children		You pay nothing	You pay nothing
Other Add-Ons		Discount only	Discount only
CONTACT LENSES			
Medically Necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$100 allowance[2]	$200 allowance[2]
Fit and Evaluation	Discount may apply	You pay $20	You pay $10
LASER SURGERY	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

1 $45 allowance for exams received out of network
2 Allowance can be used for frames or elective contact lenses, but not both.
3 Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.
The chart above is a high-level illustration of commonly covered benefits across all available carriers and coverage levels. This chart is intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to standardized plan benefits. However, individual carriers may offer coverage that differs slightly from the standard coverage reflected here. For further information, refer to your carrier's Certificate of Coverage (see Appendix A).

VISION INSURANCE CARRIERS

Depending on where you live, you may be able to choose from the following carriers.

Which carriers are available to me?

Your specific options are based on where you live, so it's important to make sure your address on record with Starbucks is correct before you enroll. You'll be able to see the options available to you when you enroll.

- EyeMed
- MetLife
- UnitedHealthcare
- VSP

> **Do You Have Dependents Living In Another Area?**
>
> If you need to cover eligible dependents who live in a different state, you will need to make sure you elect an insurance carrier that covers both locations. Need help? Call a Starbucks Advocate at (877) SBUXBEN.

STARBUCKS ADVOCACY SERVICES

Starbucks Advocates, individuals who are knowledgeable about health coverage, are available to help you regarding complex health coverage questions and claims. Advocates are a free and confidential service provided by Starbucks Benefits Center. While Starbucks Advocates can help with coverage questions, health coverage decisions are ultimately your responsibility. Call Starbucks Benefits Center at (877) SBUXBEN to speak with an Advocate.

IF YOU TAKE AN APPROVED LEAVE OF ABSENCE

Your medical, dental or vision coverage may continue during an approved leave of absence. See **page 5** for more information. However, you will be required to continue to pay for your coverage during your leave. Contributions for coverage will be collected (depending on your length of leave) through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make payments while on leave, your coverage will be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

WHEN COVERAGE ENDS

If you are no longer a Starbucks partner, your medical, dental and vision coverage ends on the last day of the month in which your separation is processed by Starbucks.

If you lose benefits eligibility due to an ongoing eligibility audit, your medical, dental and vision coverage ends as described in the Eligibility and Enrollment chapter.

If you are on a leave of absence and do not make payment by your deadline, your coverage will end at the end of the month in which you last made full payment.

You can elect to continue your coverage through COBRA as outlined in Your COBRA Rights on **page 261.**

HOW TO FILE A CLAIM

Claim procedures will vary depending on the insurance carrier. See **Your Rights and Responsibilities** section and your carriers' websites for more details. See Appendix B for insurance carrier contact information.

TRANSGENDER MEDICAL BENEFITS

Starbucks Transgender Medical Benefits are based on the Standards of Care published by the World Professional Association for Transgender Health (WPATH). In order to be eligible for coverage or reimbursement of transgender medical benefits, you must be enrolled in and covered under Starbucks medical coverage at the time the qualifying medical expense was incurred.

Because the Covered Services below may be paid by the Starbucks medical coverage you chose during enrollment or by Starbucks supplemental insurance coverage, you are required to work with a Starbucks Advocate who will assist you. Starbucks Advocates are trained to coordinate your care with Starbucks insurance carriers and your providers to ensure you understand what to expect and how to utilize the benefits.

COVERED SERVICES – Eligible Transgender Medical Benefits

All transgender services that meet the prior approval requirements are subject to the most current Standards of Care published by WPATH. The below reflects those Standards of Care as contained in Version 7, published in 2012. This list is not exhaustive; any services listed in the most recent WPATH Standards of Care and WPATH Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the United States will be covered. There is no lifetime maximum for covered services as outlined below and in the WPATH Standards of Care. The claim and appeal procedures applicable to transgender medical benefits are set forth in the **Your Rights and Responsibilities** section of this booklet.

A. Prior approval requirements:

- **Category A**: Must have received a clinical diagnosis of gender dysphoria, transsexualism, or gender identity disorder.
- **Category B**: One letter of referral for surgery or procedure from a licensed mental health professional or other health professional who is trained in behavioral health. The referral letter must include:
  - The individual's general identifying characteristics;
  - Results of the individual's psychosocial assessment, including any diagnoses;
  - The duration of the mental health professional's relationship with the individual, including the type of evaluation and therapy or counseling to date;
  - Clinical rationale for supporting the individual's request for surgery or procedure;
  - A statement about the fact that informed consent has been obtained from the individual;
  - A statement that the referring health professional has reviewed the WPATH Standards of Care section "Tasks Related to Assessment and Referral"; and
  - A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

- **Category C**: Two letters of referral for surgery, dated within the past 12 months, from two licensed mental health professionals. One referral should be from the individual's psychotherapist, and the second referral should be from a mental health professional who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (if practicing within the same clinic) may be sent. The referral letters must include:
  - The individual's general identifying characteristics;
  - Results of the individual's psychosocial assessment, including any diagnoses;
  - The duration of the mental health professional's relationship with the individual, including the type of evaluation and therapy or counseling to date;
  - Clinical rationale for supporting the individual's request for surgery;
  - A statement about the fact that informed consent has been obtained from the individual;
  - A statement that the referring health professional has reviewed the WPATH Standards of Care section "Tasks Related to Assessment and Referral"; and
  - A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.
- **Category D**: You must have had genital or breast/chest surgery to change gender within the past two years.
- **Category E**: Prescription from a doctor for hormone therapy (for replacement or maintenance).

B. Covered medical benefits

1. Mental Health

Male to Female or Female to Male: Covered Service

- Visits for purposes of assessment, diagnosis, referral letters and treatment of gender dysphoria, transsexualism, or gender identity disorder

2. Hormones (Category of prior approval required – A & E)

Male to Female or Female to Male: Covered Service

- Hormone therapy
- Laboratory tests to monitor hormone levels

3. Breast/Chest Surgery (Category of prior approval required – A & B)

Male to Female: Covered Service

- Breast augmentation
- Nipple/areola complex reconstruction

Female to Male: Covered Service

- Mastectomy
- Mastectomy with liposuction of the chest wall
- Nipple/areola complex reconstruction

4. Genital Surgery (Category of prior approval required – A & C)

Male to Female: Covered Service

- Penectomy
- Orchiectomy
- Clitoroplasty
- Labiaplasty (of labia minora and majora)
- Vaginoplasty (Vaginoplasty may be performed with penile inversion technique, intestinal vaginoplasty, or with the use of skin grafts/flaps)
- Urethroplasty

Female to Male: Covered Service

- Scrotoplasty
- Vulvectomy
- Colpectomy/vaginectomy
- Colpocleisis
- Perineoplasty
- Phalloplasty (with or without urethral lengthening/urethroplasty), including glansplasty
- Metoidioplasty (with or without urethral lengthening/urethroplasty)
- Hysterectomy/oophorectomy (no mental health assessment or letters are required for hysterectomy/oophorectomy alone, but these procedures may be performed in conjunction with genital reconstruction in some cases)
- Staged (secondary) procedures following phalloplasty/metoidioplasty: these procedures do not require additional mental health assessments (i.e., letters)
- Secondary procedures (following phalloplasty or metoidioplasty): testicular implants, urethroplasty
- Secondary procedures (following phalloplasty): penile prosthesis, urethroplasty

5. Hair Removal (Category of prior approval required – A & B)

Male to Female or Female to Male: Covered Service

- Laser
- Electrolysis
- Topical anesthetic

6. Hair Grafts (Category of prior approval required – A & B or A & D)

Male to Female: Covered Service

- Hair grafts

7. Facial Reconstruction/Contouring (Category of prior approval required – A & B or A & D)

Male to Female: Covered Service

- Thyroid chondroplasty
- Brow lift
- Forehead contouring
- Malar (cheek) implants
- Jaw and/or chin re-shaping
- Lip shortening
- Scalp (hairline) advancement
- Rhinoplasty

Female to Male: Covered Service

- Augmentation thyroid chondroplasty (Thyroid cartilage augmentation)
- Chin implant and/or genioplasty
- Jaw implant

8. Body Reconstruction/Contouring (Category of prior approval required – A & B or A & D)

Male to Female: Covered Service

- Lipofilling of hips, thighs, buttocks
- Buttocks implant

Female to Male: Covered Service

- Mons lift/mons reduction
- Pectoral implants
- Calf implants

9. Voice (Category of prior approval required – A)

Male to Female or Female to Male: Covered Service

- Voice therapy
- Voice modification surgery – only after voice therapy has been proven ineffective as attested to by providing voice therapist

10. Initial/Pre-Op, Preventative and Follow-Up Care

- Initial doctor physical exams, visits, and pre-op tests
- Post-operative follow-up visits with surgeon(s) or primary care provider(s) as needed to ensure proper healing and adjustment
- Routine medical care, with periodic laboratory tests to monitor hormone levels (quarterly for the first 12-18 months and annually thereafter) and annual physical examinations that are respectful of and attentive to the particular physical make-up of transgender, transsexual, and gender-nonconforming bodies
- Prescription drugs and any mental health services as an individual prepares for and recovers from gender affirmation surgery

QUESTIONS?

For answers to your questions about medical, dental or vision coverage or if this Benefits Plan Description or your insurance carrier's guide to benefits does not contain complete information about the service or supply you need, contact your insurance carrier directly. See Appendix B for insurance carrier contact information.

Reimbursement Accounts and Health Savings Account

Reimbursement Accounts and Health Savings Account

Starbucks offers eligible partners the opportunity to participate in Health Care and Dependent Care Reimbursement Accounts, and a Health Savings Account. With these accounts, you can set aside before-tax dollars up to defined limits to pay for qualifying healthcare and dependent care expenses.

HOW THE PLANS WORK

To participate in reimbursement accounts, you must be a retail manager or nonretail partner and eligible for Starbucks benefits. Once you establish eligibility, you can enroll in the Health Care Reimbursement Account (HCRA), the Dependent Care Reimbursement Account (DCRA), or both. The two plans are similar in how they work, but they are separate accounts and differ in some important ways.

If you enroll, Starbucks will automatically deduct your contributions from your paychecks before taxes are withheld and deposit them in your reimbursement account(s). You do not pay taxes on the money you put into the account or on the money taken out of the account in the form of eligible reimbursements (including Social Security and Medicare [FICA] taxes, federal income tax and, in most areas, state and local income taxes).

The dollars you contribute to the accounts are not taxed, and therefore the IRS imposes limits on how those dollars may be reimbursed to you. For example, the IRS determines what is considered a qualifying expense, the last day you can file your claims and who is considered a qualifying dependent.

For the Health Care and Dependent Care Reimbursement Accounts, the plan year runs from October 1, 2020 through September 30, 2021. The last day to submit claims for the plan year is the December 31 immediately following the end of the plan year.

The Health Savings Account (HSA) may be used only with the election of the Bronze or Bronze Plus medical coverage levels. For information about the HSA, please see **page 61.**

Evaluating the best tax advantage

Before you enroll in a reimbursement account, weigh the tax advantages. You may find that it is more tax advantageous for you to claim a deduction or credit on your federal income tax rather than use a reimbursement account. For example, if you have medical expenses totaling more than 7.5% of your adjusted gross income each year, you may be able to deduct them as medical expenses on your tax return. If you have dependent children, you may already be taking advantage of the federal child and dependent care tax credit.

To see whether Starbucks reimbursement accounts make more sense for your personal tax situation, obtain a copy of the *IRS publications 502 (Medical and Dental Expenses)* and *503 (Child and Dependent Care Expenses)* and talk with a tax advisor. These publications are available online at **irs.gov**.

There are several tax considerations to keep in mind when deciding whether or not to participate in Starbucks reimbursement accounts:

- You cannot claim a tax deduction or take a tax credit for the same expenses that you have been reimbursed for through your reimbursement account.
- Tax credits and tax deductions reduce your income tax at the time you file your tax return. Reimbursement accounts reduce your income tax withholding throughout the year.
- Participating in a reimbursement account may reduce your future Social Security benefits.

Reimbursement Accounts and Health Savings Account

Tax laws require Starbucks to review reimbursement account contributions to ensure the accounts do not favor highly compensated partners. Depending on the results of this review and your pay, some or all of the contributions made by highly compensated partners during the plan year may become taxable (see **Nondiscrimination testing on page 59** for more information). Starbucks will notify you if this applies to you.

Which method is best for you: reimbursement accounts, tax credits or deductions? It all depends on your personal tax situation. You may want to talk to a tax advisor before you make a decision.

Participating in the plans

When you are first eligible for benefits, enrollment materials that guide you through the enrollment process will be mailed to your home address.

Estimate the amount you will spend on qualifying healthcare and dependent care expenses in a plan year and determine if reimbursement accounts make more sense than using the medical expense deduction or child care tax credit.

If you initially establish benefits eligibility in the middle of a plan year or you have a qualified status change, your maximum contribution amount will be adjusted based on the remaining pay periods in the plan year. Remember to forecast your expenses and contributions over fewer pay periods. Your maximum contribution will be based on an annual maximum.

What Is the Plan Year?

The plan year is October 1 through September 30. You can be reimbursed for healthcare or dependent care expenses incurred during the plan year, as long as Starbucks Benefits Center receives your claims and all supporting/ substantiation documentation by the December 31 immediately following the end of the plan year. A plan year differs from a calendar year, so you will need to keep this in mind when planning your annual healthcare or dependent care enrollment and when you are preparing your income tax returns.

If you enroll in reimbursement accounts, your calendar-year-to-date contributions will appear on your pay statement beginning one or two pay periods following the date your enrollment was processed. Your total contribution amount for the calendar year will appear on your W-2 form at the end of the year. You can check your account balance and view statements online 24 hours a day, 7 days a week when you log in to your reimbursement accounts at **mysbuxben.com** or through the "Reimburse Me" mobile app.

If you experience a *qualified status change* during the year, such as adding a newborn or changing dependent care providers, you may be able to change your reimbursement account contributions. See **Making Changes on page 21**.

Annual benefits enrollment

Each year, during the annual benefits enrollment period, you have the opportunity to participate in reimbursement accounts for the upcoming plan year. During this time, you can enroll for the first time or re-enroll. If you do not enroll, you will not participate in the next plan year. Even if you do not want to make any changes to the amount you are contributing, *you must re-enroll each annual benefits enrollment* period to continue participation.

Rules you should know

Certain IRS rules apply to reimbursement accounts:

- **Use it or lose it**. If you have money left in your reimbursement accounts at the end of the plan year, you lose that balance. You cannot apply the balance to the next plan year or receive a refund.
- **Submit your claims before December 31**. The money you contribute during a plan year — October 1 to September 30 — must be used for eligible expenses incurred during that same plan year. Starbucks Benefits Center must *receive* your claims for the previous plan year's eligible expenses by December 31.
- **You cannot combine accounts**. You cannot apply your healthcare contributions toward dependent care expenses, or vice versa.

HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)

If you have healthcare expenses not covered by your medical, dental or vision plan, you may be able to pay for these expenses with before-tax dollars through the HCRA. You can participate in the HCRA even if you are not enrolled in a Starbucks medical plan.

Each year, you can contribute up to $2,700 to an HCRA. Only specific types of expenses can be reimbursed by your account and unused balances are forfeited at the end of the year.

What the account covers

You can be reimbursed for qualifying healthcare costs (medical, prescription drugs, dental and vision) for you, your children and your spouse — even if you or they are not covered by Starbucks health coverage. Healthcare expenses for your domestic partner are reimbursable only if your domestic partner also qualifies as your dependent for federal tax purposes.

Qualifying healthcare expenses are those you have incurred that are not covered under any health plan you are enrolled in. They may include, but are not limited to:

- Deductibles, coinsurance amounts and copays for medical, prescription drug, dental and vision coverage
- Artificial limbs and eyes
- Braille books and magazines for the visually impaired if they cost more than regular books
- Contact lenses and contact lens supplies
- Crutch purchase or rental
- Eye care and eyewear (excluding accessories)
- Guide dogs or other animals trained to assist a visually- or hearing-impaired individual
- Unreimbursed hearing-aid expenses
- Unreimbursed prescribed contraceptives (birth control pills, etc.)
- Special education for mentally impaired or physically disabled individuals
- Syringes, needles or other medical supplies
- Travel and lodging to receive medical care
- Unreimbursed orthodontia expenses
- Wheelchairs used for the relief of sickness or disability

For specifics on what your HCRA will cover, view *IRS publication 502 (Medical and Dental Expenses)* online at **irs.gov**.

Special Rule for Orthodontia

Typically, treatment for orthodontia ranges from a few months to several years. The IRS has recognized that orthodontia billing practices differ from other healthcare billing practices. One orthodontia invoice may include expenses for multiple visits, often well into the future. For this reason, the IRS allows you to submit orthodontia claims for reimbursement at the time you pay the invoice, even if all the treatment sessions have not yet occurred. However, the expenses on the invoice must be related to the current plan year (October 1 through September 30).

What is not covered

Some expenses that cannot be reimbursed by the HCRA include:

- Expenses incurred before your enrollment begins or after it ends
- Expenses incurred while on a leave of absence, unless you have continued to make your contributions during your leave
- Health coverage premiums
- Items covered under a plan you or your family is enrolled in at the time the expense is incurred
- Over-the-counter medications unless prescribed by a physician; a copy of the prescription will be required
- Cosmetic surgery or services
- Health club membership dues
- Dietary supplements, including vitamins
- Special education for mentally impaired or physically disabled persons if the education is intended to relieve the disability
- Long-term care or insurance premiums

Reimbursement Following an Election Change

If you change your HCRA election midyear due to a qualified status change, you will be reimbursed up to your annual contribution election in effect at the time your expenses were incurred.

If you take a leave of absence

If you want to stop your HCRA participation while on leave, you must call Starbucks Benefits Center within 45 days from your leave start date. Electing this option suspends your HCRA participation through the remainder of the plan year and any healthcare expenses incurred during the suspended time will not be eligible for reimbursement.

Upon your return from leave, you can request to resume your HCRA participation by contacting Starbucks Benefits Center at (877) SBUXBEN within 45 days from your leave return date. If you elect to resume your participation, it will start the first of the month following your return from leave.

Upon your return to work, you may be eligible to change your contributions if you had a qualified status change during your leave. You must make your enrollment change within 45 days of your return to work. For more information, see **Making Changes on page 21.**

When coverage ends

If you are no longer a Starbucks partner, your payroll deductions for the HCRA automatically end. You can submit claims against your remaining annual contribution election for eligible services incurred before your separation date. Claims must be filed by December 31 following the end of the plan year.

If you lose benefits eligibility due to an ongoing eligibility audit, your contributions will be suspended as described in the **Eligibility and Enrollment chapter.**

Continuing participation through COBRA

You can continue your HCRA coverage through COBRA as described in **Your COBRA Rights on page 261.** You may only continue coverage for your HCRA through the end of the plan year if you have amounts remaining in your account as of the date of your separation. If your HCRA is "overspent" (you have received reimbursements in excess of the amount that you have contributed), you cannot continue coverage.

If you choose to continue your HCRA contributions through COBRA, your annual goal amount remains the same and you can continue to submit claims and be reimbursed for services incurred during the period you are covered through COBRA. Your COBRA contributions will include a 2% administration fee and the contributions are on an after-tax basis.

How to file an HCRA claim

Three ways to file a claim for reimbursement	Debit Card: You will be issued a Your Spending Account (YSA) Visa Debit Card to access your HCRA funds prior to the beginning of the plan year. This allows you to easily and conveniently access up to your plan year election amount without having to pay up-front yourself and be reimbursed. Many claims will be auto-substantiated and will not require documentation to show they were eligible (like prescription drugs or office visit co-pays), but some will. It is important to keep your receipts in case substantiation is required. If you have more than $100 in unsubstantiated expenses, your card will be suspended. Online – log in to **mysbuxben.com** and select "Health Care Spending Account." From the summary page, select "Get Reimbursed," then "Create a Claim." Follow the steps on the screen to enter information about your claim. When you submit your claim online, you'll be prompted to print a cover sheet and fax it, along with your claim receipts, to the number shown on the form. You may also download the "Reimburse Me" mobile app to submit claims, update documentation, view your balance and more. Mobile App - You may also download the "Reimburse Me" mobile app to submit claims, update documentation, view your balance and more.
Filing a claim for eligible over-the-counter medications and supplies	Follow the above instructions for submitting a manual claim. You can submit your claim online or file a paper form. Remember that you'll also need to submit an itemized receipt and a copy of the prescription when you're filing a claim for over-the-counter medications and supplies.
When you can submit a claim	As soon as you incur expenses and have an itemized receipt, but no later than the December 31 immediately following the end of the plan year (September 30).
How much is reimbursed	The amount of your qualifying expenses up to the amount you elected to contribute for the full plan year (October 1 through September 30), even if your expense exceeds your year-to-date contributions. If you are reimbursed for the full-year amount before the end of the plan year, your payroll contributions will continue through September 30.

Two options for reimbursement	Direct deposit into your personal checking or savings account. By check. Your reimbursement check will be mailed to your home address on file, regardless of the address listed on your claim form.
Frequency of claim processing	Claims are processed daily.
Viewing your account balance and claim status	The online account management center is available 24 hours a day, 7 days a week. You may also download the "Reimburse Me" mobile app to view your balance or claim status.
Claim filing deadline	Claims must be received by Starbucks Benefits Center no later than the December 31 following the prior plan year (October 1 to September 30) to be considered for reimbursement.
If your claim is denied, in whole or in part	You can appeal a claim denial within certain time limits. To file an appeal, you must submit a formal request in writing to Starbucks Benefits Center, stating the reasoning for the appeal. A decision will be made within 60 days of when your appeal is received. See the Your Rights and Responsibilities chapter for more information.

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

Starbucks Dependent Care Reimbursement Account includes a reimbursement account you can contribute to through your paycheck as well as childcare and membership services through Care@Work. If you have dependent care expenses for your child(ren) under age 13 or a disabled adult family member, you can enroll in the DCRA and pay for these expenses with before-tax dollars.

Each year, you can contribute up to the following limits to your DCRA (unless you meet the definition below of a highly compensated partner):

- Up to $5,000 per plan year if you are married and file a joint federal tax return, or if you are single
- Up to $2,500 per plan year if you are married and file a separate return

Partners earning more than $130,000 per calendar year at Starbucks are typically considered highly compensated by the Internal Revenue Service (IRS); however, this is subject to change. See **Nondiscrimination testing on page 59** for more information. Due to IRS and/or benefit plan regulations, if you meet the definition of a highly compensated partner as stated above you can contribute:

- Up to $800 per plan year, whether you are single, married and filing a joint tax return, or married and filing a separate return

Here is what that looks like on a pay-period basis:

Frequency of paycheck	Minimum	Maximum if single or married filing jointly	Maximum if married filing separately
Weekly	$1.92	$96.15	$48.07
Biweekly	$3.84	$192.30	$96.15

Only qualified dependent care expenses may be reimbursed by your DCRA and any unused balances are forfeited at the end of the year.

Reimbursement Accounts and Health Savings Account

What the reimbursement account covers

You can use the DCRA to pay for dependent care costs that allow you — and your spouse or domestic partner — to work outside of your home, attend school full time or look for work.

The dependent care services may be provided in your home or another location, but not by someone who is your child under age 19 or considered your dependent for income tax purposes. If the services are provided by a dependent care facility that cares for more than six people, it must be licensed and meet state and local regulations. Services must be for the physical care of your dependent(s), not for things like education, meals, etc.

You can use the account to pay for the dependent care costs of:

- Your dependent child(ren) under age 13 who must be your "qualifying child" tax dependent (as defined by the IRS) or — if there has been a divorce or other legal separation of the parents — you must be the custodial parent
- Your spouse who is physically or mentally incapable of caring for himself or herself and spends at least eight hours a day in your home
- Any other person who is physically or mentally incapable of caring for himself or herself, spends at least eight hours a day in your home and is also your tax dependent or a child for whom you are the custodial parent

Eligible expenses include:

- Costs for a day care center, if the center complies with all state and local laws
- Tuition for nursery school, if the school complies with all state and local laws
- Costs for family or adult day care facilities
- Wages paid to a nanny or companion in or outside of your home

For more information on what your DCRA may reimburse, review *IRS publication 503 (Child and Dependent Care Expenses)* at **irs.gov**.

Paying for Services in Advance

Many day care providers require payment in advance of providing services. This plan does not allow reimbursement for dependent care services until they have been incurred. So, if your dependent care provider bills in advance for future services, you will need to wait until that billing period has passed before you submit your claim. In these instances, you may want to request that your provider bill you more frequently in order to receive more timely reimbursements.

Day Care Rates

You may be able to change your contribution amount midyear if your day care costs change, for example, because you change day care providers, you experience a change in your day care provider's or nanny's rates, or the hours of care change. When your day care costs change, call Starbucks Benefits Center at (877) SBUXBEN within 45 days.

What is not covered

Your DCRA will not reimburse:

- Wages for dependent care paid to someone whom you claim as a dependent on your federal income tax return
- Dependent care given during your (and your spouse's or domestic partner's) nonscheduled work hours
- Any school costs for a dependent of school age, including kindergarten and summer school services (if the cost of schooling cannot be separated from the child care aspect of the program, the entire cost may be eligible)
- Overnight camp
- Nursing home expenses for dependents who do not live with you
- Dependent care for a child age 13 or over, unless they are incapacitated

Child and Dependent Care Tax Credit

In some cases, you may get a better tax advantage with the federal child and dependent care tax credit than with the Dependent Care Reimbursement Account. See a tax advisor to find out which works best for your situation.

If you take a leave of absence

While on your leave of absence, your contributions are suspended. You will not be able to be reimbursed for expenses incurred during your leave of absence. Once you return from your leave, your prior goal amount will be reinstated and your per-paycheck contributions will be increased to account for the missed contributions during your leave. Note: If you return from your leave in a new plan year (October 1 or later), you will have the opportunity to re-enroll in DCRA upon your return from leave.

You may be eligible to change your DCRA contributions upon your return to work if you had a qualified status change during your leave. You must make your enrollment change within 45 days of your return to work. For more information, see **Making Changes on page 21**.

Nondiscrimination testing

What Nondiscrimination Testing Entails

Each year, Starbucks is required to test the DCRA for compliance with IRS discrimination regulations. These regulations place limits on the percentage that highly compensated partners (as defined by the IRS) can contribute to the plan as compared to non-highly compensated partners. In order to pass this test, the maximum contribution highly compensated partners can make to the DCRA is limited and any use of the Care@Work benefit is considered taxable.

Starbucks conducts a forecast test early in the plan year to see if the plan is expected to pass the test. If the plan fails the forecast test, highly compensated partner contributions may be reduced further until the forecast test is passed. You will be notified if your contributions must be adjusted.

Although limiting the amount highly compensated partners can contribute to the DCRA and using a forecast test are proactive efforts by Starbucks, it does not guarantee that at the end of the plan year the DCRA plan will pass the discrimination test. If the plan fails the test, some or all of the contributions made by highly compensated partners during the plan year may become taxable.

Impact of Nondiscrimination Testing

Due to IRS and/or benefit plan regulations:

- Most partners will be taxed (imputed income) if the combined total of their contributions to Starbucks DCRA and the value of childcare services provided through our Care@Work benefit exceeds $5,000 per year, unless
- The partner's total annual compensation with Starbucks is $130,000 and above. These highly compensated partners may contribute up to $800 to their Starbucks DCRA per year and they will be taxed (imputed income) on the full value of any use of the Care@Work benefit.

Partners will receive notification in Q2 if they have used Care@Work and are newly identified as having a total Starbucks annual income above the threshold set by the IRS.

Starbucks will track the value of childcare services and DCRA participation on partner paychecks and apply appropriate taxation as follows:

- "Care PreTax" tracks benefit usage throughout the year for partners eligible for tax-free use of the Care@Work benefit; upon reaching the maximum tax-free benefit, or for highly compensated partners, you will see
- "Care Taxable," which represents any Care@Work benefit use that is subject to treatment as taxable income

Please note: For any partner that has created an account for the Care@Work benefit, the $147 annual value of a Care.com membership is reported on a partner's pay statement once a year, but the partner will continue to see the amount listed in the YTD column throughout the calendar year.

When coverage ends

If you are no longer a Starbucks partner, your DCRA payroll deductions automatically end. You can continue to submit claims incurred through your separation date. Any expenses incurred after you leave Starbucks are not eligible for reimbursement.

If you lose benefits eligibility due to an ongoing eligibility audit, your contributions will be suspended as described in the **Eligibility and Enrollment chapter.**

How to file a DCRA claim

To file a manual claim for reimbursement	To submit a DCRA claim to Starbucks Benefits Center, choose one of the following two claims submission methods. Be sure to have your dependent care provider's tax identification number handy, along with any other appropriate dependent care claim documentation. Online: Log in to **mysbuxben.com** and select "Dependent Care Reimbursement Account." From the summary page, select "Get Reimbursed," then "Create a Claim." Follow the steps on the screen to enter information about your claim. When you submit your claim online, you'll be prompted to print a cover sheet and fax it, along with your claim receipts, to the number shown on the form. Mobile App: You may also download the "Reimburse Me" mobile app to submit claims, update documentation, view your balance and more.
Obtain a claim form	Access your DCRA account via **mysbuxben.com**.
When you can submit a claim	As soon as you incur expenses and have an itemized receipt, but no later than the December 31 immediately following the end of the plan year (September 30).

How much is reimbursed	The amount of your eligible expenses up to your current account balance (what you have contributed to date). If your claim exceeds your account balance, the remainder will be reimbursed once additional payroll contributions are recorded in your account.
Two options for reimbursement	Direct deposit into your personal checking or savings account. By check. Your reimbursement check will be mailed to the address on file, regardless of the address listed on your claim form.
Frequency of claim processing	Claims are processed weekly.
Viewing your account balance and claim status	The online account management center is available 24 hours a day, 7 days a week. Log in to your account to get account balance(s), check claim status, enter a new claim, enroll in direct deposit, change your reimbursement payment setting, and more. You may also download the "Reimburse Me" mobile app.
Claim filing deadline	Claims for the plan year (October 1 through September 30) must be received by Starbucks Benefits Center no later than the December 31 immediately following the last day of the plan year to be considered for reimbursement.
If your claim is denied, in whole or in part	You can appeal the claim denial within certain time limits. To file an appeal, you must submit a formal request in writing to Starbucks Benefits Center, stating the reasoning for the appeal. A decision will be made within 60 days of when your appeal is received. See the Your Rights and Responsibilities chapter for more information.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account, or HSA, is a special account designed to help you save money for healthcare costs and reduce your taxes along the way. You can use your HSA to pay for out-of-pocket healthcare expenses and save the money you don't use for future healthcare costs, all the way through retirement. The money is always yours — it's not subject to "use it or lose it" rules like reimbursement accounts.

If you enroll in a high-deductible health plan (Bronze or Bronze Plus coverage levels), an HSA will be automatically opened for you. For the 2021 tax year, you can contribute up to $3,600 in before-tax dollars to your account if you cover yourself only, or up to $7,200 if you cover dependents. If you turn 55 or older in 2020, you can contribute an additional $1,000 to your HSA. You don't pay taxes when you use your HSA to pay for out-of-pocket healthcare costs. Your tax savings can be significant and you can build a strong safety net for the future.

Eligibility for an HSA

You can only open an HSA if you enroll in the Bronze or Bronze Plus medical coverage levels. There are also a few other eligibility requirements you need to know:

- You cannot be covered by any other health plan (such as Medicare, Medicaid or TRICARE, a military health system) or be covered as a dependent on a spouse's non-high-deductible health plan.
- You cannot be enrolled in a Health Care Reimbursement Account (flexible spending account), either yours or your spouse's.
- You cannot be claimed as a dependent on another person's tax return.

It's your responsibility to make sure you're eligible for an HSA and that you use the account to only pay for eligible expenses. A full list of eligible expenses can be found in IRS publication 502 available at **irs.gov.**

Eligible healthcare expenses

You can use your HSA to pay for these expenses for you and your eligible dependents:

- Your deductible
- Coinsurance amounts (the percentage of an expense you pay after the deductible)
- Out-of-pocket dental and vision costs

In some situations, expenses for a domestic partner may be eligible for reimbursement. For more information, including a complete list of eligible expenses can be found in IRS publication 502 available at **irs.gov.**

Accessing your account

UMB Bank is the custodian for your HSA and your HSA will be administered by Your Spending Account (YSA). YSA provides administrative services, online access and more. To view your account online, log in to **mysbuxben.com** and select "Health Savings Account."

You can pay your provider with your YSA Payment Card or online. Log in to Starbucks Benefits Center via **mysbuxben.com** and use the Click to Pay feature in the Reimbursement Account section. Remember to always keep your receipts, as you may need them if you are audited by the IRS.

Using your payment card

Partners will receive a YSA Card to use to pay for eligible medical expenses. If you don't have sufficient funds in your HSA, you can also pay for eligible expenses with any other form of payment and request reimbursement from your HSA once sufficient funds are available.

Investing your HSA funds

The HSA gives you the opportunity to save tax-free for future health expenses. The money in your HSA is easy to access and is federally insured. Your HSA earns interest just like a regular savings account, so it can make money above and beyond what you contribute.

You may also choose to invest your HSA dollars in the UMB HSA Saver Investment Portal. If you currently have a balance of $1,000 in your account, you have access to 30 mutual fund options and services that include:

- Investing through a self-directed platform with a broad selection of mutual funds
- Unlimited trades ($3 per month fee)
- Electronic statements

Once you have $1000 in your HSA, you will have the investment portal options available to you.

Please note: The savings account is FDIC-insured up to $250,000. But if you choose to invest in an investment vehicle, such as a mutual fund or money market, know that the funds are not FDIC-insured. As with any investment, the value of your fund(s) may increase or decrease. Before investing, please carefully consider your objectives, risk and expenses.

QUESTIONS?

For answers to your questions about reimbursement accounts or Health Savings Account, call Starbucks Benefits Center at (877) SBUXBEN.

Future Roast 401(k) Savings Plan

REFERENCE GUIDE

Fidelity NetBenefits℠

Log on to Fidelity NetBenefits® (NetBenefits℠) via **netbenefits.com** or call Fidelity to speak with a Service Representative for more information about Future Roast 401(k), such as:

- Eligibility
- Enrollment
- Rollovers
- Account balance
- Investment options and fund prospectuses
- Investment changes
- Loans
- Changing beneficiaries
- Withdrawals and distributions
- Qualified domestic relations orders

Link to Fidelity NetBenefits℠ via **netbenefits.com** or **mysbuxben.com**

Virtually 24/7

For help with preparing Future Roast 401(k) Qualified Domestic Relations Orders, link to **qdro.fidelity.com**

Fidelity

(866) 697-1048 or (800) 587-5282 (Spanish line)

Representatives available weekdays
5:30 a.m. – 9 p.m. Pacific Time

Language translation and relay services available

Fidelity® Personalized Planning & Advice

Professional management of the investments in your Future Roast 401(k) Plan account (optional fee-based service)

Log into **netbenefits.com/plan** for information on the fee-based managed account advisory service available through Fidelity.

(866) 811-6041

Fidelity representatives available weekdays
5:30 a.m. – 9 p.m. Pacific Time

Savings Team at Starbucks

Available to answer your specific questions about the Future Roast 401(k) Plan

savings@starbucks.com
(888) 796-5282 option 8, ext. 85653 or 86105

Starbucks Partner Contact Center

Call Starbucks Partner Contact Center for information about:

- Your paycheck
- Your payroll deductions
- Your payroll taxes
- Your change of address or other personal changes

Starbucks Coffee Company
P.O. Box 34067
Seattle, WA 98124-1067

(888) SBUX-411 weekdays
5 a.m. – 5 p.m. Pacific Time

Social Security Administration

Call the Social Security Administration or access its website to:

- Learn about Social Security benefits and how to apply
- Understand how Social Security works
- Request your free Personal Earnings and Benefit Estimate Statement
- Locate an office in your area

(800) 772-1213

socialsecurity.gov

PLAN HIGHLIGHTS

New CARES Act provisions	Future Roast 401(k) has implemented certain Coronavirus Aid, Relief, and Economic Security Act (CARES Act) provisions in response to the COVID-19 pandemic, including CARES Act withdrawals, suspension of loan repayments, and waiver of 2020 required minimum distributions.
Eligibility	Partners on the Starbucks or a participating company's U.S. payroll who: • Are at least age 18 and • Have completed 90 days of employment with Starbucks or any related company
Pre-tax 401(k) contributions and/ or Roth after-tax contributions	You can choose to contribute from 1% to 75% of your eligible pay each pay period, in a combination of 401(k) pre-tax and/or Roth after-tax contributions up to the annual IRS limit, $19,500 for calendar year 2020. For partners age 50 or older in 2020, the IRS limit is $26,000.* Any Starbucks Match contributed to your account does not count toward these dollar limitations. Your 401(k) pre-tax contributions and/or Roth after-tax contributions are deducted from your pay and are credited to your account at Fidelity. *The 2021 contribution limits have not been released by the IRS by the effective date of this document. When available, they will be communicated to partners and posted on netbenefits.com.
Enrollment	Partners will be able to enroll online or by phone starting approximately 75 days prior to attainment of eligibility. Payroll contributions will start within one to two pay periods after the later of the date you enroll or the date you meet the Plan's eligibility requirements (90 days of employment, age 18 and on the Starbucks or a participating company's U.S. payroll).
Starbucks Match (Safe Harbor Match)	Eligible partners who contribute to Future Roast 401(k) will receive matching contributions. As of January 1, 2020, and for future calendar years (unless changed by Starbucks), the Starbucks Match is 100% of the first 5% of eligible pay* contributed by eligible participants each pay period. The Starbucks Match will be contributed along with your 401(k) pre-tax contributions and/or Roth after-tax contributions each pay period. For any pay period in which you do not make 401(k) pre-tax contributions and/or Roth after-tax contributions, you will not receive the Starbucks Match. Eligible participants should consider contributing at least 5% of eligible pay* (in a combination of 401(k) pre-tax and/or Roth after-tax contributions) each paycheck throughout the calendar year to maximize the Starbucks Match. The Starbucks Match will be shown in your account as Safe Harbor Match contributions. * The maximum amount of eligible pay that will be taken into consideration when calculating 401(k) pre-tax and or Roth after-tax contributions and match for any calendar year is subject to IRS limits ($285,000 for calendar year 2020).
Vesting	You are always 100% vested in all your accounts under the Plan, including 401(k) pre-tax, Roth after-tax, Match (pre-2011), Starbucks Match, and any discretionary profit-sharing and rollover accounts.

Future Roast 401(k) Savings Plan

Investment options	The Plan offers a variety of investment options within the following categories or tiers: 1) target date investment options, 2) U.S. and foreign equity investments, 3) bond and stable value investments, and 4) ESG sustainable investment options. You may select any one or combination of the investment options offered under the Plan. The default investment option is the Vanguard Target Retirement Trust Plus with the target year closest to the year you will reach age 65. You can change your investment choices or move your existing account balance to different investment choices any time (subject to frequent trading restrictions).
Plan loans	You can borrow up to 50% of your account balance, but no more than $50,000 (reduced by your highest outstanding loan balance in the last 12 months). The minimum loan amount is $500 and fees are assessed for each loan. Two types of loans are permitted: General purpose loan (maximum 5-year loan) or primary residence loan (maximum 15-year loan). You may have no more than one loan of each type outstanding at the same time.
Portability/rollovers	You can transfer (roll over) your account to a new employer's eligible retirement plan or an individual retirement account (IRA) when you leave Starbucks. You can roll over your account from another employer's eligible retirement plan and/or an IRA into the Future Roast 401(k) any time after you are hired if you are on the Starbucks or a participating company's U.S. payroll.
Tax savings	Your 401(k) pre-tax and match accounts (including earnings) accumulate on a tax-deferred basis. No federal income taxes are due until withdrawn. A 10% early withdrawal penalty may apply in some instances (generally applicable if you are under age 59½ or if you are separated from Starbucks before age 55 and you take a lump-sum distribution). You can continue to defer taxes and avoid the early withdrawal penalty by rolling over your account balance to another employer's eligible retirement plan or a traditional IRA. (Rollover from your pre-tax and match accounts to a Roth IRA will result in immediate taxation but the early withdrawal penalty will not apply.) Roth after-tax contributions are made on an after-tax basis and are included in current taxable income. However, Roth after-tax contributions, and, in certain cases, the earnings on those contributions, are not subject to income taxes when distributed to you. In order for the earnings to be tax-free, the distribution must be a qualified distribution. A qualified distribution is a distribution that is taken after you have had a Roth after-tax account in the Plan for at least five years and after you have (a) reached age 59½, (b) become disabled, or (c) died. In applying the five-year rule, you count from January 1 of the year your first Roth after-tax contribution was made to the Plan (or, if earlier, to another eligible employer plan if such amount was directly rolled over into this Plan). For example, if you make your first Roth after-tax contribution to the Plan on November 30, 2020, your five-year period will end on December 31, 2024. It is not necessary to make Roth after-tax contributions in each of the five years. While amounts held in your Plan accounts must be paid out during your lifetime (generally starting after age 72), if you roll your Roth after-tax account out of the Plan and into a Roth IRA prior to that time, you will not be required to take distributions from your Roth IRA during your lifetime. This means that your Roth amounts, including any earnings on those amounts, can continue to be tax-free and distributions from the Roth IRA can be postponed until after your death.

USING THE PLAN

Transaction	When	How	Effective date
Enroll/start contributing	Partners will be able to enroll online or by phone starting approximately 75 days prior to attainment of eligibility	Go to **netbenefits.com** or call Fidelity at (866) 697-1048 or (800) 587-5282 (Spanish line), weekdays 5:30 a.m. to 9 p.m. Pacific Time	Payroll contributions will start within one to two pay periods after the later of the date you enroll or the date you meet the Plan's eligibility requirements (90 days of employment, age 18 and on the Starbucks or a participating company's U.S. payroll)
Starbucks Match	The Starbucks Match is 100% of the first 5% of eligible pay contributed each pay period. This match rate is in effect for future calendar years unless changed by Starbucks.	The Starbucks Match is credited to participants' accounts along with their 401(k) pre-tax contributions and/or Roth after-tax contributions	The Starbucks Match is deposited to your account in the Plan as soon as administratively possible after each pay period in which you make 401(k) pre-tax contributions and/or Roth after-tax contributions (subject to IRS limits)
Change or stop contributions	Any time after you start making 401(k) pre-tax and/or Roth after-tax contributions	Go to **netbenefits.com** or call Fidelity	As soon as administratively possible following the request (usually within 1 to 2 pay periods)
Roll over a pre-tax and/or Roth after-tax balance from another employer's eligible retirement plan or an IRA	Any time after you are hired and are on the Starbucks or a participating company's U.S. payroll	Go to **netbenefits.com** or call Fidelity to obtain a rollover form	As soon as administratively possible
Change investment direction for future contributions	Any time after you start making 401(k) pre-tax and/or Roth after-tax contributions	Go to **netbenefits.com** or call Fidelity Professional management of your Plan account is available through Fidelity® Personalized Planning & Advice, **netbenefits.com/plan**	The day you make the change online or by phone (if before 4 p.m. Eastern Time or by the daily market close); otherwise, the next business day excluding NYSE holidays
Change existing investment elections; rebalance or exchange your current account balances	Any time after you have a rollover, 401(k) pre-tax and/or Roth after-tax account balance in the Plan (frequent trading restrictions apply)	Go to **netbenefits.com** or call Fidelity Professional management of the investments in your 401(k) account is available through Fidelity® Personalized Planning & Advice, **netbenefits.com/plan** (optional fee-based advisory service)	The day you make the change online or by phone (if before 4 p.m. Eastern Time or by the daily market close); otherwise, the next business day excluding NYSE holidays

Future Roast 401(k) Savings Plan

Transaction	When	How	Effective date
Request a loan	When your account balance is at least $1,000	Go to **netbenefits.com** or call Fidelity	General purpose loan – a check is generally mailed or via EFT 3-5 business days after your loan request is processed Residential loan – application paperwork mailed to you; check is generally mailed or via EFT 3-5 business days after request is received in good order
Request an age 59½ withdrawal	Annually from your 401(k) pre-tax and/or Roth after-tax account if you have attained at least age 59½ and you are actively employed	Go to **netbenefits.com** or call Fidelity	A check is generally mailed or via EFT 3-5 business days after request is processed
Request a rollover account withdrawal	Annually from your pre-tax rollover account and annually from your Roth after-tax rollover account if you are actively employed	Go to **netbenefits.com** or call Fidelity	A check is generally mailed or via EFT 3-5 business days after request is processed
Request a CARES Act withdrawal	Before December 31, 2020, if you are a Qualified Individual (as defined on **page 89**)	Go to **netbenefits.com** or call Fidelity	A check is generally mailed or via EFT 3-5 business days after request is processed
Request a hardship withdrawal	When you qualify for and apply for a hardship withdrawal due to an immediate, heavy financial need (as defined in the Plan document). You are no longer required to take a Plan loan to qualify for a hardship withdrawal. In addition, you are no longer subject to a six-month suspension of your contributions to the Future Roast 401(k) Plan, Stock Investment Plan and Management Deferred Compensation Plan following receipt of a hardship withdrawal.	Go to **netbenefits.com** or call Fidelity	Hardship withdrawals are generally processed within one business day and mailed or sent via electronic funds transfer the next business day
Request a final distribution	When you leave Starbucks and any related company for any reason, you may take a distribution of your account (in a lump-sum, partial withdrawal or installment payments) or roll over your account into another employer's eligible retirement plan or into an IRA	Go to **netbenefits.com** or call Fidelity	As soon as administratively possible after Fidelity has been notified of your separation, usually within 2-4 weeks after your change in status

FUTURE ROAST 401(k)

The Starbucks Future Roast 401(k) Savings Plan (also referred to in this chapter as the "Future Roast 401(k)" or the "Plan") can help you build financial security for your retirement and future needs. Through Future Roast 401(k), you can save part of your eligible pay before it is taxed for federal (and in most cases state) income taxes (referred to as your "401(k) pre-tax contributions"). You can also elect to save part of your eligible pay *after* it has been taxed for federal and state income taxes (referred to as your "Roth after-tax contributions"). The amount you save is subject to FICA taxes. Plus, Starbucks matches a portion of your 401(k) pre-tax and/or Roth after-tax contributions each pay period. See the section titled **Contributions to Your Future Roast 401(k) Account on page 74** for more details about matching contributions.

You decide how your entire Future Roast 401(k) account (including your 401(k) pre-tax, Roth after-tax, Match (pre-2011), Safe Harbor Match, any discretionary profit-sharing, any rollover and any prior merged plan accounts) is invested among a variety of available investment funds. You do not pay federal (and in most cases state) income taxes or penalties on the pre-tax money in your Future Roast 401(k) account until it is distributed to you. If you timely roll your pre-tax account balance into a traditional IRA or another employer's eligible retirement plan when you separate from Starbucks and any related company, you can continue to defer income taxes on your pre-tax account balance. Distributions of your Roth after-tax contributions are tax- free. However, distribution of the earnings on those contributions will be subject to income tax unless they are part of a qualified distribution. A qualified distribution is one that is taken after you have had a Roth after-tax account in the Plan for at least five years and after you have (a) reached age 59½, (b) become disabled, or (c) died. In applying the five year rule, you count from January 1 of the year your first Roth after-tax contribution was made to the Plan (or, if earlier, to another eligible employer plan if such amount was directly rolled over into this Plan). For example, if you make your first Roth after-tax contribution to the Plan on November 30, 2020, your five-year period will end on December 31, 2024. It is not necessary to make Roth after-tax contributions in each of the five years.

This chapter serves as the summary plan description (SPD) for the Future Roast 401(k) and summarizes the Plan's most important provisions as in effect on October 1, 2020. It applies to employees of Starbucks and any participating company (as defined on **page 107**) who are eligible on or after that date. If your employment with Starbucks or a participating company has terminated, portions of this SPD may not apply to you. Within the SPD, references to "Starbucks" is intended to include Starbucks and any participating company. Generally, your rights to benefits are governed by the terms of the Plan as in effect at the time your employment terminated.

Please keep in mind that this SPD is only a summary of the principal features of the Plan. Although every effort has been made to make this SPD as complete and accurate as possible, it is not a substitute for the Plan document itself. The detailed provisions of the Plan document, not this SPD, govern the administration of the Plan and the actual rights and benefits to which you are, or may become, entitled. Accordingly, in case of any conflict between this SPD and the terms of the Plan document, the Plan document will control.

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan conforme al Plan de Ahorro 401(k) Starbucks Future Roast. Si tiene problemas para entender cualquier apartado de este folleto, envíe sus preguntas a **Savings@starbucks.com**. También puede escribirle a la Sra. Lisa Coutts, Savings and Retirement Plan Administrator, Starbucks Corporation, 2401 Utah Ave S., MS: HR-3, Seattle, WA 98134. Asimismo, puede llamar al despacho de la administradora del plan al +1 (888) 796-5282 opción 8, ext. 85653 u 83012 para solicitar ayuda. Horarios de atención: de lunes a viernes, de 7:30 a.m. a 4:30 p.m., hora del Pacífico.

WHY SAVE IN FUTURE ROAST 401(k)?

The Future Roast 401(k) offers several important advantages over typical savings accounts:

- Your taxable pay is reduced because your 401(k) pre-tax contributions are not subject to federal and, in most cases, state income taxes until they are withdrawn.
- While Roth after-tax contributions are made on an after-tax basis, the earnings are tax-free if they are part of a qualified distribution.
- If you meet the eligibility requirements and contribute to the Plan, you will share in the Starbucks Match. The Starbucks Match is contributed each pay period when you make 401(k) pre-tax contributions and/or Roth after-tax contributions from your eligible pay[1].
- Your 401(k) pre-tax contributions and any Starbucks matching contributions — plus any earnings — are not subject to federal (and in most cases state) income tax unless you take a lump-sum distribution of your balance and do not timely roll it over.
- You may be eligible for a federal tax credit on your tax return of up to 50% on the first $2,000 you contribute ($4,000 if married filing jointly) to Future Roast 401(k) (certain income limits apply). For more information about this special tax credit, see **Tax credit for eligible savers on page 77**.

Future Roast 401(k) is completely portable — meaning you can take your money with you if you are no longer employed by Starbucks and any related company. If you withdraw your account balance as a lump-sum cash-out upon your separation, the taxable portion of your distribution may be subject to 20% mandatory withholding and possibly a 10% early withdrawal penalty. Upon your separation, you may also be able to roll over (transfer) your account balance into another employer's eligible retirement plan, such as a 401(k) plan, 403(b) plan or 457 plan, or to a traditional or Roth individual retirement account (IRA). Except for a rollover of your pre-tax balance into a Roth IRA, when you roll over your Future Roast 401(k) account to another eligible retirement plan, you postpone paying federal (and in most cases state) income taxes on your pre-tax money until required by the IRS (i.e., upon lump-sum withdrawal or age 72 required minimum distribution payout). See **Paying income taxes on page 97** for more information.

ELIGIBILITY

In general, you are eligible to contribute to Future Roast 401(k) if you satisfy each of the following conditions:

- Are on the Starbucks or a participating company's U.S. payroll
- Are at least age 18, and
- Have completed 90 days of employment with Starbucks or any related company.

Different eligibility requirements may apply if you are employed by an entity that was recently acquired. See **Special eligibility rules for employees of acquired companies on page 72** for more information.

You are not eligible to contribute to Future Roast 401(k) if you are:

- Under age 18,
- Covered by a collective bargaining agreement, unless your bargaining agreement provides for participation in Future Roast 401(k),
- Treated by Starbucks as an independent contractor or consultant,
- Leased as an employee from another company,
- Not on the Starbucks or a participating company's U.S. payroll — such as a nonresident alien with no U.S. source of income,

1 The maximum amount of eligible pay that will be taken into consideration when calculating 401(k) pre-tax and/or Roth after-tax contributions and the Starbucks Match for any calendar year is subject to IRS limits ($285,000 for calendar year 2020).

- Assigned to work overseas or in a foreign country permanently or indefinitely, or
- Not classified by Starbucks as an employee even if it is later determined that you were an employee.

A participating company is one that is wholly owned or partially owned by Starbucks Corporation and that has adopted Future Roast 401(k) for its eligible partners.

If you are rehired

If you leave before 90 days of employment and are rehired

If you leave Starbucks and any related company before you have completed 90 days of employment and are rehired within 12 months of leaving Starbucks and any related company, your time away counts toward the 90-day eligibility requirement. If you are rehired after 12 months of leaving Starbucks and any related company, your time away does not count for service credit. However, you still receive credit for the days you had originally worked. Special rules may apply if you were separated from Starbucks or a participating company for more than five years.

In certain circumstances, if you enroll prior to your eligibility date and subsequently separate employment and rehire within 30 days of your date of termination, your prior enrollment election will apply to your future eligible pay until changed by you. This 30-day period may be longer depending on your actual rehire date and processing dates. If you believe this situation applies to you, you may contact Fidelity for confirmation of your election status or to make another election.

Please contact the Starbucks Savings team via email at **Savings@starbucks.com** for more information.

Special eligibility rules for employees of acquired companies

Certain prior service for acquired companies is counted for purposes of eligibility as follows:

- **Pasqua Coffee** — Prior service counted for partners who were employed by Pasqua Coffee on March 1, 1999.
- **Tazo, LLC** — Prior service counted for partners who were employed by Tazo, LLC on January 20, 1999.
- **Tympanum, Inc. (Hear Music)** – Prior service counted for partners who were employed by Tympanum, Inc. on October 18, 1999.
- **Seattle's Best Coffee LLC and Terrefazione Italia LLC** – Prior service counted for partners who were employed by Seattle's Best Coffee LLC or Terrefazione Italia LLC on July 14, 2003.
- **Coffee Equipment Company** — Prior service counted for partners who were employed by Coffee Equipment Company on or before April 1, 2008.
- **Evolution Fresh** — Prior service counted for partners who were employed by Evolution Fresh, Inc. on November 10, 2011.
- **Bay Bread, LLC and The New French Bakery, Inc.** — Prior service counted for partners who were employed by Bay Bread, LLC or the New French Bakery, Inc. on January 1, 2013.
- **Teavana** — Prior service counted for partners who were employed by Teavana Corporation on March 8, 2013.

If you are rehired and were previously eligible

If you left Starbucks and any related company after meeting the Plan's eligibility requirements, you may be immediately eligible to begin contributing to Future Roast 401(k) upon your rehire by a participating company. Special rules may apply if you were separated from Starbucks or a participating company for more than five years and in certain other situations. Please contact the Starbucks Savings team via email at **Savings@starbucks.com** for more information if this applies to you.

ENROLLING IN FUTURE ROAST 401(k)

You can enroll starting approximately 75 days prior to attainment of eligibility. Your payroll contributions will start within one to two pay periods after the later of the date you enroll or the date you meet the Plan's eligibility requirements (90 days of employment, age 18 and on the Starbucks or a participating company's U.S. payroll).

Fidelity will mail a welcome letter containing enrollment instructions and information to your home before you are expected to meet the eligibility requirements and if you have not yet enrolled. If you meet the eligibility requirements and you do not receive the welcome letter, contact the Starbucks Savings team via email at **Savings@starbucks.com**. You will need your Social Security number (Customer ID) in order to set up your Personal Identification Number (PIN) when you enroll via the NetBenefits℠ website or by phone. If you already have an account with Fidelity, you will use the same Customer ID and PIN to enroll.

To enroll:

- **Go online** via the NetBenefits℠ website at **netbenefits.com** 24 hours a day, seven days a week
- **Speak** with a Fidelity representative at (866) 697-1048 or (800) 587-5282 (Spanish line), weekdays from 5:30 a.m. to 9 p.m. Pacific Time, or
- **Go to the Partner Hub** under "Stock and Retirement Plans" on the Benefits tab. Click on "Future Roast 401(k)" to access Plan information and to link to NetBenefits℠ to enroll.

Once you have completed your Future Roast 401(k) enrollment, your elections generally take effect within two paychecks after the later of the date you meet the Plan's eligibility requirements or the date you enroll.

Beneficiary designations

When you enroll, you must name one or more beneficiaries for your Future Roast 401(k) account. Your beneficiary receives your account balance if you die. If you are married, your spouse is automatically your beneficiary unless your spouse agrees in writing, with a notarized consent, to name another beneficiary. Your spouse for purposes of Future Roast 401(k) means your "spouse" for federal income tax purposes.

Review, designate or change your beneficiary information online by accessing the NetBenefits℠ website at **netbenefits.com**, or by speaking with a Fidelity Representative at (866) 697-1048 or (800) 587-5282 (Spanish line) to request a beneficiary designation form. If, at the time that you make your beneficiary designation, you confirm that you are legally married, a spousal consent form will automatically be mailed to you for your spouse's signature if you name someone other than your spouse as your beneficiary. Your properly completed beneficiary designation will become effective once the spousal consent is received by Fidelity.

If you do not have a valid beneficiary designation at the time of your death (i.e., you do not name a beneficiary, you improperly complete the beneficiary designation form, you didn't obtain any required spousal consent or your designated beneficiary predeceases you) your Future Roast 401(k) account balance will be distributed based on the following "hierarchy" or order:

1) Your spouse at the time of your death will automatically be your primary beneficiary (if you are married at the time of your death),

2) In the event no such spouse survives you, your children (including natural and adopted children) will be entitled to equal shares,

3) In the event no such spouse or child survives you, your estate will receive the balance of your Future Roast 401(k) account.

Refer to the **Death benefit on page 95** for more information.

CONTRIBUTIONS TO YOUR FUTURE ROAST 401(k) ACCOUNT

Your account can include several types of contributions:

- Your 401(k) pre-tax and/or Roth after-tax contributions deducted from your paycheck,
- Starbucks matching contributions,
- Rollover contributions, including (but not limited to) pre-tax, Roth after-tax, and tax-exempt Thrift Savings Plan (TSP) contributions that you rolled over into this Plan,
- Contributions from another 401(k) plan that was merged into this Plan,
- Qualified non-elective contributions,
- Qualified matching contributions, and
- Starbucks discretionary profit-sharing contributions.

401(k) payroll contributions

In general, you can contribute from 1% to 75% of your eligible pay to Future Roast 401(k) each pay period, in a combination of 401(k) pre-tax and/or Roth after-tax contributions, up to the annual IRS limit, $19,500[1] for calendar year 2020. For partners age 50 or older in 2020, the IRS limit is $26,000[1]. These additional contributions for partners age 50 or older are called “catch-up” contributions. These limits apply to only your 401(k) pre-tax and Roth after-tax contributions (and not to any of the other types of contributions listed above). For example, if you are age 45 and you make 401(k) contributions in calendar year 2020 totaling $19,500 and you receive Starbucks Match of $5,000, you have not exceeded the limits. Your 401(k) pre-tax contributions and/or Roth after-tax contributions are deducted from your pay and are credited to your account at Fidelity. Note that "catch-up" contributions do not require a separate election. Based on your contribution rate, and during any year in which you are at least age 50, your payroll contributions will simply continue until you reach the higher IRS limit applicable to partners who are "catch-up" eligible.

Your 401(k) pre-tax contributions are deducted from your eligible pay before federal (and in most cases state) income taxes are calculated and withheld. This means you defer paying income taxes on your 401(k) pre-tax account balance until you withdraw it. Your Roth after-tax contributions are deducted each pay period from your eligible pay after your income taxes are taken out. Therefore, your take home pay will be less if you are making Roth after-tax contributions than it would be if you were making the same amount of 401(k) pre-tax contributions. The annual IRS limit applies to your combined 401(k) pre-tax and Roth after-tax contributions in the Plan, and your pre-tax and Roth after-tax contributions to all other retirement plans (e.g., other 401(k) plans, 403(b) plans and 457 plans) during the calendar year. The maximum amount of eligible pay that will be considered annually when calculating your 401(k) pre-tax contributions and/or Roth after-tax contributions and Starbucks Match is $285,000[1] for calendar year 2020. Some additional contribution limits may apply, depending on your contribution rate, pay or position. These limitations are described in more detail in the following pages.

1 These IRS limits are subject to annual cost of living adjustments published by the IRS.

Future Roast 401(k) Savings Plan

Starbucks Match

The Future Roast 401(k) provides for a matching contribution (as described below and on the following page).

Eligible partners who contribute to Future Roast 401(k) will receive the Starbucks Match. For the 2020 calendar year and for future calendar years (unless changed by Starbucks), the Starbucks Match is 100% of the first 5% of eligible pay contributed by eligible participants each pay period. For any pay period in which you don't make 401(k) pre-tax or Roth after-tax contributions, including those pay periods in which your contributions are suspended due to reaching an IRS or Plan limit, no Starbucks Match will be contributed. Starbucks Match is referred to as "Safe Harbor Match" in your account at netbenefits.com.

Your contribution as percentage of eligible pay	Starbucks Match - 100% of the first 5% of eligible pay per pay period. Maximum match = 5%
1%	100% match
2%	
3%	
4%	
5%	

The Starbucks Match will be contributed along with each participant's 401(k) pre-tax and/or Roth after-tax contributions each pay period to his or her account. All Starbucks Match contributions are immediately 100% vested. This means you own Starbucks Match contributions as soon as they are deposited to your account.

Eligible pay

Eligible pay[1] for purposes of determining your 401(k) pre-tax and/or Roth after-tax contributions, Starbucks Match and Starbucks discretionary profit-sharing contributions is generally defined as your regular salary or wages, overtime and cash bonuses (except sign-on bonuses). Excluded from eligible pay are (1) distributions from the Management Deferred Compensation Plan and taxable distributions from an unfunded, nonqualified plan of deferred compensation, (2) CUP Fund payments, (3) tips, (4) allowances, (5) gifts and awards (unless designated by Starbucks as includable in eligible pay at the time of the award), (6) severance pay, (7) non-U.S. source income, (8) amounts paid after the first pay period following severance from employment, (9) child day care scholarships, (10) short-term and long-term disability payments, (11) differential wage payments paid to partners in qualified military service, (12) any compensation for services paid to a nonresident alien who is not a participant, (13) any amounts that would not be payable in cash, and (14) any other items excluded from eligible pay as provided by the Plan document.

401(k) pre-tax and/or Roth after-tax contributions to Future Roast 401(k) are deducted from your eligible pay each pay period according to your enrollment election. These deductions typically begin as soon as administratively possible after the later of the date you enroll or the date you meet the Plan's eligibility requirements (usually within one to two pay periods). You can change, stop and restart your contributions at any time without penalty. Contribution changes typically occur within two paychecks of your request.

Exceeding IRS limits in a calendar year

Controls are in place to appropriately limit your combined 401(k) pre-tax and/or Roth after-tax contributions under the Future Roast 401(k) each calendar year. These controls are set to the appropriate IRS limit applicable to you based on whether you will attain at least age 50 during the calendar year. However, in the event your total 401(k) pre-tax and/or Roth after-tax contributions to the Future Roast 401(k) for a calendar year exceed the IRS dollar limit for that year, the excess amount (referred to as "excess deferrals") will automatically be

1 The maximum amount of eligible pay that will be taken into consideration when calculating 401(k) pre-tax and/or Roth after-tax contributions and the Starbucks Match for any calendar year is subject to IRS limits ($285,000 for calendar year 2020).

distributed to you, adjusted for gains or losses. Starbucks matching contributions relating to any returned excess deferrals will be forfeited.

Excess deferrals may also occur if you participated in both the Future Roast 401(k) and in a retirement plan such as a 401(k), 403(b) or 457(b) plan maintained by another employer in the same calendar year. In this situation, the monitoring and determination of whether an excess has occurred is your responsibility. The excess amount, adjusted for gains or losses, is subject to federal (and in most cases state) income tax (to the extent the excess is not attributable to Roth after-tax contributions) and must be returned to you by April 15 of the following year to avoid adverse tax consequences. If this situation applies to you:

- You will need to decide which plan you wish to designate as the plan with the excess amount. To designate the Future Roast 401(k), contact Fidelity at (866) 697-1048 by March 15 following the calendar year in which your excess deferrals were made and request the Return of Excess Contributions form. You may also find this form on netbenefits.com or on Partner Hub, under Benefits, then Future Roast 401(k). Your excess deferrals will be returned to you, adjusted for gains or losses, by April 15 following the calendar year in which your excess deferrals were made. 401(k) pre-tax contributions will be returned before Roth after-tax contributions unless you elect otherwise. Applicable federal (and state) income taxes on any pre-tax amounts being returned to you will be withheld. Starbucks matching contributions relating to any returned excess deferrals will be forfeited along with any related gains or losses.
- If you fail to request the distribution of your excess deferrals by March 15 (resulting in the inability for the Plan to process this refund by April 15), the excess amount is prohibited from being distributed until the rest of your account is distributed. In this instance, you may end up paying income tax on the pre-tax portion of any excess twice – once in the year in which the excess deferrals were made and again when such excess amount is actually distributed to you.

If you feel this situation may apply to you, please contact Fidelity directly at (866) 697-1048.

If you are considered a highly compensated partner (as defined below), you may be further limited in the amount you can contribute to Future Roast 401(k) in the event the Plan does not qualify for Safe Harbor status in any given year. You will be notified if this applies to you.

Highly compensated definition for 2020

Partners are considered by the IRS to be highly compensated employees (HCEs) in 2020 if they earn more than $125,000 gross pay (excluding Management Deferred Compensation Plan deferrals) in the prior calendar year (2019) or if they are more than a 5% owner of Starbucks. This compensation threshold is determined annually by the IRS and may be increased in future years based on inflation.

Your 401(k) pre-tax and/or Roth after-tax contributions to your Future Roast 401(k) account will automatically be suspended during the plan year when your total Future Roast 401(k) contributions have reached the maximum allowed by law or the Plan. Beginning with the first paycheck of the following plan year, your 401(k) pre-tax and/or Roth after-tax contributions will automatically resume at the rate they were when they were discontinued unless you elect otherwise.

Safe Harbor Plan qualification

In any year in which the Starbucks Match (Safe Harbor Match) is made and the Plan meets the requirements to qualify as a Safe Harbor Plan, the Future Roast 401(k) will automatically pass the applicable nondiscrimination tests. This means that highly compensated partners will not have additional refunds or limits imposed on them due to nondiscrimination test results for the applicable year.

Discrimination test annual limit

In any year in which Starbucks is required to test the Plan for compliance with IRS nondiscrimination regulations, limits may be imposed on certain highly compensated partners or refunds may be required. The nondiscrimination regulations place limits on the amount that highly compensated partners can contribute to Future Roast 401(k) as compared to contributions by non-highly compensated partners. If the limits are exceeded, the Plan may be required to return to certain highly compensated partners a portion of their 401(k) pre-tax and/or Roth after-tax contributions (and associated earnings), called excess contributions, made during the plan year. A portion of Starbucks matching contributions, if any, (and associated earnings) may also be considered excess contributions. You will be notified if these limits apply to you.

As an alternative, Starbucks may choose to make a 100% vested qualified non-elective contribution to the Plan to satisfy all or a portion of the nondiscrimination regulations. Such contribution will be allocated to any or all of the members of the non-highly compensated group who have met the eligibility requirements as determined by Starbucks in accordance with the nondiscrimination regulations.

Tax credit for eligible savers

In addition to the tax advantages of participating in Future Roast 401(k), by contributing to the Plan you may be eligible to receive a federal tax credit called the Saver's Credit. The Saver's Credit is up to 50% of your Plan contributions depending on your adjusted gross income on your federal tax return (certain income limits apply). Since the Saver's Credit is not a deduction, it is used to reduce your tax payment to the IRS dollar for dollar. The Saver's Credit applies to the first $2,000 you contribute ($4,000 if married filing jointly). Certain plan distributions in the same year may offset or limit your Saver's Credit. A taxpayer who is younger than 18, a full-time student, or who is claimed as a dependent on someone else's return is not eligible for the Saver's Credit.

For more information, contact your tax advisor or financial planner.

Rollover contributions

If you participated in a prior employer's eligible retirement plan or if you have an individual retirement account (IRA), you may be able to roll over the taxable portion of your account in that plan or IRA into the Future Roast 401(k) as soon as you are hired at Starbucks. Your rollover account is always 100% vested and belongs to you. You will need to select your investment options at the time of your rollover.

Amounts that you can roll over[1] include:

- Pre-tax balances from your previous employer's eligible retirement plan, including a Code Section 401(a) qualified plan, a federal Thrift Savings Plan, a Code Section 403(b) annuity contract, or a Code Section 457(b) eligible deferred compensation plan,
- Direct rollover of Roth after-tax contributions from your previous employer's eligible retirement plan, including a Code Section 401(a) qualified plan, a federal Thrift Savings Plan, a Code Section 403(b) annuity contract, or a Code Section 457(b) eligible deferred compensation plan,
- Direct rollover of tax-exempt amounts in uniformed services accounts in the Thrift Savings Plan for federal employees,
- Balances from a traditional IRA, including conduit, SEP and Simple IRAs,
- Eligible retirement plan distributions that you receive as a surviving spousal beneficiary or as an alternate payee under a Qualified Domestic Relations Order (QDRO), and
- Distributions from 403(a) annuity plans.

1 Subject to change. Please refer to the current Rollover Contribution Instructions and Application for eligible rollover sources

Some payments that are not eligible for rollover into Future Roast 401(k) include:

- Periodic payments made to you from a previous employer's eligible retirement plan that are scheduled to last over a period of 10 years or more,
- Required minimum distribution (usually due to reaching age 72 or retiring) from previous employers' eligible retirement plans,
- Non-taxable distributions received from previous employers' eligible retirement plans (these are also called after-tax contributions — pay you put into a savings plan after you have paid income taxes on it),
- Amounts held in a Roth IRA or a Coverdell Education IRA,
- Hardship withdrawals,
- Distributions from retirement plans of foreign countries, and
- In-kind distributions of employer stock.

For more information about rollover contributions, or to request a rollover contribution form, log on to NetBenefits℠ at **netbenefits.com**, on Partner Hub or call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative).

Starbucks discretionary profit-sharing contributions

In any plan year, Starbucks may choose to make a profit-sharing contribution to Future Roast 401(k). Any profit-sharing contribution is solely at Starbucks discretion.

Partners eligible to participate in Future Roast 401(k) are eligible for a profit-sharing contribution, even if they have never enrolled in Future Roast 401(k) or are not currently making 401(k) pre-tax and/or Roth after-tax contributions. However, discretionary profit-sharing contributions will only be allocated to partners who are actively employed by Starbucks or any participating company on the last day of the plan year (December 31) and to partners who terminated employment during the plan year due to death, disability or retirement at or after age 65.

The amount of any profit-sharing contribution allocated to an eligible partner's account will be a percentage of the total profit-sharing amount allocated to Future Roast 401(k). The eligible partner's percentage will be determined by dividing the partner's eligible pay by the total eligible pay of all eligible partners. Eligible pay, for purposes of allocating profit-sharing contributions, is the same as eligible pay for purposes of determining your 401(k) pre-tax and/or Roth after-tax contributions and calculating the Starbucks Match as described in **Eligible pay on page 75**, and is subject to the annually indexed IRS compensation limit ($285,000 for calendar year 2020).

If a profit-sharing contribution is approved, more information will be provided at the time the contribution is made to participant accounts.

INVESTMENT OPTION TIERS

The Future Roast 401(k) Savings Plan offers a variety of investment options under four different categories or tiers as provided below. You may choose to invest your account balance in any one or combination of such investment options.

Tier 1 – Target Date Retirement Investments

To help you meet your investment goals, the Plan offers target date investment options (with different allocations of stocks, bonds, and short-term investments) that vary in risks and returns. The year in the trust name refers to the approximate year (the target date) when an investor in the trust would retire. For instance, if you were born in 1980, you might choose the 2045 Target Retirement Trust because that is the year in which you will attain age 65 (retirement). The trust will gradually shift its emphasis from more aggressive investments (stocks) to more conservative ones (bonds and short-term reserves) based on its target date. Investment performance in a Target Retirement Trust Plus is not guaranteed at any time, including on or after the target date.

Each Target Retirement Trust Plus is designed so that it can be selected as a single stand-alone age-appropriate investment based on the participant's default date of retirement (although there is no requirement for the participant to select it as his or her only investment under the Plan).

A Target Retirement Trust Plus is not a mutual fund. It is a collective trust available only to tax-qualified plans and their eligible participants. Investment objectives, risks, charges, expenses, and other important information should be considered carefully before investing. The collective trust mandates are managed by Vanguard Fiduciary Trust Company, a subsidiary of The Vanguard Group, Inc.

Tier 2 – U.S. and Foreign Equity Investments

The funds in this category primarily focus their investments in the stock of public companies of varying sizes. Depending on the fund, the companies can be based in the United States or internationally. Both actively managed funds and passively managed index funds are included in this tier.

Tier 3 – Bond and Stable Value Investments

The funds in this category primarily focus their investments in bonds and other debt instruments. Depending on the fund, investments are predominantly issued in the U.S. and may include government, corporate, or inflation-protected bonds. Both actively managed funds and passively managed index funds are included in this tier.

Tier 4 – ESG Sustainable Investments

These options take into consideration ESG (Environmental, Social and Corporate Governance) factors along with financial factors in their investment decision making process. Both actively managed funds and a passively managed index fund are included in this tier.

By selecting a combination of investment funds from the various tiers above, you can create an investment mix that best suits your investment goals, time horizon and tolerance for risk. Each fund has a different objective and strategy.

Future Roast 401(k) Savings Plan

Tier 1 - Target Date Retirement Investments

Vanguard Target Retirement Income Trust Plus
Vanguard Target Retirement 2015 Trust Plus
Vanguard Target Retirement 2020 Trust Plus
Vanguard Target Retirement 2025 Trust Plus
Vanguard Target Retirement 2030 Trust Plus
Vanguard Target Retirement 2035 Trust Plus
Vanguard Target Retirement 2040 Trust Plus
Vanguard Target Retirement 2045 Trust Plus
Vanguard Target Retirement 2050 Trust Plus
Vanguard Target Retirement 2055 Trust Plus
Vanguard Target Retirement 2060 Trust Plus
Vanguard Target Retirement 2065 Trust Plus

Tier 2 - U.S. and Foreign Equity Investments

Winslow Large Cap Growth Fund Class I
Vanguard Institutional 500 Index Trust
Boston Partners Large Cap Value Equity Fund Class D
William Blair Small-Mid Cap Growth Fund Class I
Goldman Sachs Small Cap Value Fund Class R6
Vanguard Small Cap Index Fund Institutional Shares
MFS Institutional International Equity Fund
Vanguard Institutional Total International Stock Market Index Trust

Tier 3 - Bond and Stable Value Investments

PIMCO Real Return Fund Institutional Class
Dodge & Cox Income Fund
Vanguard Institutional Total Bond Market Index Trust
Wells Fargo Stable Value Fund E

Tier 4 - ESG Sustainable Investments

Legal & General Future World Developed Climate Change CIT Class A
Hartford Global Impact Fund Class R6
Nuveen Core Impact Bond Fund Class I

The investment options listed above are current as of October 1, 2020 and are subject to change. You can find more detailed information about the current investment options by visiting NetBenefits℠ at **netbenefits.com** or by calling Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative).

Your total account balance is affected by the performance of your Future Roast 401(k) investments.

The importance of diversifying the investment of your accounts

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 loss. 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 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 savings, you should consult your personal advisor and take into account all of your assets, including any savings outside of the Plan. 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.

It is also important to periodically review your investment portfolio, your investment objectives and the investment options to help ensure that your savings will meet your goals. You are solely responsible for investment decisions under the Plan. Refer to **Responsibility for investment decisions on page 101** for more information.

The Future Roast 401(k) default investment

If you are participating in the Plan but you did not choose specific investment options, the Plan automatically invests your existing balance and future contributions in the "default" investment option unless and until you make an investment choice. The designated default investment option is the Vanguard Target Retirement Trust Plus with the target year closest to the year you will reach age 65.

For more information

More information about all of the investment options available in the Future Roast 401(k) can be obtained:

- On NetBenefits℠ via **netbenefits.com** by clicking on the "Investment Performance and Research" link under "Quick Links."
- By speaking with a Fidelity representative at (866) 697-1048 or (800) 587-5282 (Spanish line) weekdays from 5:30 a.m. to 9 p.m. Pacific Time.
- By calling (866) 811-6041 to inquire about Fidelity® Personalized Planning & Advice, an optional fee-based managed account advisory service, or by logging on to **netbenefits.com/plan**.

Things to consider

Starbucks cannot provide investment advice. Each individual has their own unique investment time horizon and risk tolerance. It is important for you to review the prospectus, the descriptions of the investment options offered within the Future Roast 401(k) and all other available materials and resources to help you make well-informed choices. You can access this information as well as tools for helping you determine the right investment mix based on your needs by logging on to **netbenefits.com**. Additionally, partners have access to enroll in professional management of their Future Roast 401(k) investments through Fidelity® Personalized Planning & Advice, a fee-based managed account advisory service. Go to **netbenefits.com/plan** for more information.

All investing is subject to risk. Investments in bond funds are subject to interest rate, credit, and inflation risk. Diversification does not ensure a profit or protect against a loss in a declining market.

Each individual should carefully consider their investment objectives, risk tolerance, and the expenses and charges associated with any option before investing.

Valuing your Future Roast 401(k) account

When you and Starbucks contribute to your Future Roast 401(k) account and you direct this money into the investment funds, these funds can earn interest, dividends and capital gains (generally referred to as earnings or gains). Sometimes your investment funds will record losses. These gains and losses are determined and applied proportionately to your account through a process known as valuation.

Your account will typically be valued every business day the U.S. stock and bond markets are open. The gain or loss from each of your funds is calculated based on the change in value of the underlying securities each fund owns and any additional income since the previous day's valuation. Fund expenses – such as management fees, brokerage and transaction costs – are then subtracted, and the net gain or loss is allocated proportionately to the number of shares you hold in your account.

In addition to your investment fund value changes, your account value is adjusted for contributions, withdrawals and loan repayments. On occasion, Starbucks may need to delay or temporarily stop daily valuation for special activities, such as changing Plan record keeping or investment funds.

Making your investment elections

Before making your investment choices, be sure to read the detailed fund descriptions and prospectuses available through NetBenefits℠ at **netbenefits.com** or by calling Fidelity at (866) 697-1048 or (800) 587-5282 for a Spanish speaking representative. Also refer to **Responsibility for investment decisions on page 101**. You can choose to invest in any one or combination of the investment options offered under the Plan. Your investment elections must be made in whole percentages and must add up to 100%. If you choose to invest in the target date investment options, it is recommended that you select the option that is closest to the date you will reach age 65, although it is not required.

If you fail to make a valid investment election when you enroll, your account will be invested in the default investment option, which is the Vanguard Target Retirement Trust Plus with the target year closest to the year you will reach age 65. Any Starbucks Match and discretionary profit-sharing contributions (if any) are invested in the same funds you elect for your 401(k) pre-tax and/or Roth after-tax contributions.

Making changes to your investment elections

As with all investment decisions, participants are encouraged to review their own specific goals and risk tolerance prior to investing in any fund(s).

Future contributions

You can change your investment elections for your future contributions at any time. Your investment election changes will go into effect and apply to contributions starting within one to two business days of your election.

Existing account balance

The Future Roast 401(k) allows participants to change the investment of their existing account balance by using the following transfer options:

- Change Future Investment Elections
- Exchange One Investment
- Exchange/Rebalance Multiple Investments

Change Future Investment Elections: You may elect to choose how your future contributions will be invested. Your contribution sources, i.e, pre-tax, Roth after-tax, rollover accounts, Starbucks Match, Pre-2011 match are all invested the same way, with the investment fund choices and percentages applied based on your investment election.

Exchange One Investment: The exchange feature allows you to move a specific dollar amount or specific percentage of a single fund to one or more funds. Exchanges are allowed at any time; however, there are certain limitations and restrictions. For more information on Fidelity's frequent trading policies, see **Frequent trading on page 84**.

Exchange/Rebalance Multiple Investments: The rebalance feature allows you to change the allocation of your existing account balance among the investment options on a percentage basis. When rebalancing, you would consider your entire account balance and determine the percentage that you would like to invest in each fund, so that in total 100% of your account balance is reallocated among the funds you choose. Rebalancing is allowed at any time; however, there are certain limitations and restrictions. For more information on Fidelity's frequent trading policies, see **Frequent trading on page 84**.

Investment changes to your existing account balances received by stock market close (typically 1:00 p.m. Pacific Time) will take effect the same business day. Investment changes received after market close will transact the next business day. Investment changes you make to your existing account balances will apply

to all your Future Roast 401(k) accounts, including any merged plan account and discretionary profit-sharing contribution account.

You may make separate investment elections for your core accounts, which include your 401(k) pre-tax, Roth after-tax and matching accounts (i.e. Match (pre-2011) and Safe Harbor Match) including earnings. Separate investment elections may also be made for any rollover accounts including any pre-tax rollover account, Roth after-tax rollover account and tax-exempt TSP rollover account.

How to make a change

You can make investment option changes, obtain additional information including fund performance and expense and fee information, or access updated information about your Future Roast 401(k) accounts by:

- Logging on to NetBenefits℠ at **netbenefits.com.**
- Calling Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative), weekdays 5:30 a.m. to 9 p.m. Pacific Time.
- You can also access NetBenefits℠ via the Partner Hub under "Stock and Retirement Plans" on the Benefits tab. Click on "Future Roast 401(k)" to access Plan information and to link to NetBenefits℠ to enroll. Or log into **mysbuxben.com** and click on the "Other Benefits" tab on the top, then click on "Your 401(k) & Bean Stock" to link to NetBenefits℠.

Partners can elect to enroll in professional management of their Future Roast 401(k) investments through Fidelity® Personalized Planning & Advice, a fee-based managed account advisory service. Go to **netbenefits.com/plan** for more information.

MANAGING YOUR ACCOUNT

You can request the following transactions online via NetBenefits℠ at **netbenefits.com** or by contacting Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative):

- Review your account balances.
- Review, increase or decrease your contribution percentage rate.
- Review fund information.
- Review or change your investment choices.
- Exchange or rebalance your account balances among the available investment funds.
- Designate your beneficiary.
- Manage a rollover.
- Request a loan.
- Request a hardship withdrawal.
- Request a non-hardship withdrawal (i.e., age 59½, rollover account, or CARES Act withdrawal) or a distribution (following disability or separation from employment).

You can also review a summary of Future Roast 401(k) provisions by accessing "Plan Information and Documents" under "Quick Links" on NetBenefits℠ at **netbenefits.com**.

Account statements

Each quarter, Fidelity will make available a Future Roast 401(k) account statement online at **netbenefits.com**. You will receive notification from Fidelity via email or postcard about the availability of your statement online. The statement details all activity and investment results for your account during the quarter. You can also go online via NetBenefits℠ at **netbenefits.com** and elect to receive a paper statement of your Future Roast 401(k) account at any time.

Frequent trading

Future Roast 401(k) has a long-term objective: to help you build enough savings for you to live on when you stop working. While you can transfer your Future Roast 401(k) account balance among the available investment options on any business day, neither the Plan nor its investment options were designed for frequent trading. Frequent or "excessive" trading is the purchase and subsequent sale (or vice versa) of a mutual fund within a short period of time. Short-term and other excessive trading by shareholders can adversely affect a fund's performance by disrupting the portfolio manager's investment strategy, by increasing expenses (such as trading commissions) or by allowing some investors to capitalize on stale pricing at the fund's expense.

To help protect the interests of fund investors who are seeking long-term returns on their investments, Fidelity monitors excessive trading and limits the number of times investors exchange in and out of its funds, as well as other investment products offered as options in workplace retirement plans as directed by the fund managers or sponsors of the retirement plans.

Fidelity's monitoring is based upon the concept of a "roundtrip" within a fund. In retirement plans, a roundtrip transaction occurs when a partner exchanges in and then out (purchase and sale) of a fund option within 30 days. For the purposes of its excessive trading policies, purchases and sales do not include systematic contributions or withdrawals (i.e., regular contributions, loan payments, hardship withdrawals) as permitted by the Plan; they only include partner-initiated exchanges greater than $1,000.

Under Fidelity's excessive-trading policies, partners are limited to one roundtrip transaction per fund within any rolling 90-day period, subject to an overall limit of four roundtrip transactions across all funds over a rolling 12-month period.

The first roundtrip in any fund results in a warning letter. Partners with two or more roundtrip transactions in a single fund within a rolling 90-day period will be blocked from making additional purchases of the fund for 85 days. Any four roundtrips in one or more funds in a 12-month rolling period will result in the partner being limited to one exchange per quarter for 12 months. This applies to all investments subject to Fidelity's excessive trading policies. Once the 12-month exchange limitation expires, any additional roundtrip in any fund in the next 12-month period will result in another 12-month limitation of one exchange per quarter.

Trading suspensions do not restrict a partner's ability to make loan repayments, transact withdrawals from Plan accounts, make investment exchanges out of the fund or continue to allocate employee and employer contributions to the fund. In other words, the right to redeem (sell) is not affected by these policies, but the ability to make subsequent exchanges into the fund will be.

Fidelity's excessive trading limit and other short-term trading policies are subject to change by Fidelity. Information about frequent trading restrictions and investment options including expenses and historical returns is available at **netbenefits.com** in the "Investment Performance and Research" section under "Quick Links."

Loans

Future Roast 401(k) is designed for long-term savings with a clear emphasis on planning for the future. However, life sometimes involves pressing financial needs — short-term needs that may seem more important than your long-term goals. That is why Future Roast 401(k) offers a loan option for partners who have a Future Roast 401(k) account balance and are actively employed by Starbucks or a participating company at the time the loan is taken.

When borrowing money from your Future Roast 401(k) account balance, there are no tax penalties (provided you pay the loan back as scheduled), and the interest you pay goes right back into your own Future Roast 401(k)

account. In general, you may borrow up to 50% of your vested account balance up to a maximum of $50,000, whichever is less. This amount will be reduced by your highest outstanding loan balance in the past 12 months.

When you take out a loan, you pay yourself back with interest. The interest rate is set at the time that you take the loan and is the Wall Street Journal Prime Rate plus 1%. The current rate is available by calling Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish-speaking representative). The current interest rate is also displayed when you model a loan on NetBenefits℠ at **netbenefits.com**.

Future Roast 401(k) offers two types of loans: a general purpose loan and a primary residence loan. You can take a general purpose loan for any reason for a maximum repayment period of five years. A primary residence loan can only be obtained for the purchase of a home you are going to live in with a maximum repayment period of 15 years. Primary residence loans, like general purpose loans, are not tax-deductible. Only one outstanding loan of each type is permitted at any time. Your account balance is the security collateral for your loan.

You are not eligible to take a loan if you:

- Do not have an account balance
- Have a loan of the same type outstanding
- Have defaulted on a loan within the last two years (see **Repaying your loan on page 86**), or
- Have terminated employment with Starbucks and any participating company.

If you are an active partner and have a rollover balance in Future Roast 401(k), you may obtain a loan from your rollover account regardless of whether you are eligible to participate in Future Roast 401(k).

In general, 15 days must elapse between the final payment on one loan and obtaining a new loan.

Minimum and maximum loan amounts

The minimum amount you may borrow from your Future Roast 401(k) account balance is $500. The maximum amount you may borrow is 50% of your account balance, up to a loan amount of $50,000. The $50,000 limit is adjusted for the highest combined outstanding loan amounts you may have had in the past 12 months — including those loans you have paid in full.

Applying for a loan

You can model different loan scenarios and/or request a loan by calling Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative), or by accessing the NetBenefits℠ website at **netbenefits.com** and clicking on “Loans, Rollovers and Withdrawals” under “Quick Links.” To request a loan to purchase a primary residence, you must provide documentation as proof of intent to purchase (i.e., a signed purchase agreement).

Again, there are no tax penalties when you take a Future Roast 401(k) loan, provided you repay it as scheduled. Once you have requested a loan, a promissory note is available to you at the NetBenefits℠ website or, if your loan was requested via a representative, mailed to you within three to five business days following your request. Loan proceeds are generally processed within three to five business days after your loan request is received by Fidelity. By using your customer ID and PIN to complete the loan request, you agree to the terms of the loan agreement. You also agree to any deemed or actual distribution of your loan if you fail to make timely payments (default) on your loan.

Your loan is funded by withdrawing your approved amount from your accounts (as applicable) in the following order:

- Prior plan or merged accounts (from acquired companies)
- Starbucks prior match account
- Starbucks discretionary profit-sharing account
- Match (pre-2011) account
- Safe Harbor Match account
- Pre-tax rollover account
- Roth after-tax rollover account
- Tax-exempt Thrift Savings Plan (TSP) rollover account
- 401(k) pre-tax account
- Roth after-tax account
- Qualified non-elective contributions account
- Other accounts as designated within the Loan Policy

Amounts withdrawn from these accounts are taken proportionately from your investment funds.

Loan fees

Your Future Roast 401(k) account will be charged a $35 loan initiation fee plus an annual $15 maintenance fee, deducted quarterly (i.e., $3.75 per quarter), until your loan is paid off. This fee may be adjusted based on the actual per-participant fee assessed by Fidelity.

Repaying your loan

CARES Act and suspension of loan repayments

The CARES Act allows Qualified Individuals (as defined on page 89) to delay loan repayments that otherwise would be due between March 27, 2020, and December 31, 2020. You may elect this option online at netbenefits.com through September 22, 2020. If you separate employment and you elected to delay your loan payments under CARES Act, that delay will continue through December 31, 2020. If you are on an approved qualified leave, at any time prior to September 22, 2020, you may also elect to delay your loan repayments through December 31, 2020, online at **netbenefits.com**. For participants who elect to delay loan repayments, Fidelity will reamortize your loan with interest accrued in the suspension period and provide you with a new loan payment amount in January 2021.

Repaying your loan through payroll deductions

Your loan payments will be set up as automatic payroll deductions and are invested in the Future Roast 401(k) investment fund options you have selected for your current contributions. Unlike your Future Roast 401(k) pre-tax contributions, these payments are deducted after taxes are withheld.

If your paycheck does not cover your loan payment

You will need to send a certified check, cashier's check or money order for any loan payments you miss or fail to pay in full because your paycheck was not sufficient to cover your loan payment. Make your certified check, cashier's check or money order payable to FIIOC. Write your name and Social Security number on your certified check, cashier's check or money order and mail it to Fidelity Investments, P.O. Box 770001, Cincinnati, OH 44277-0008.

If you do not make up your missed loan payments sufficiently, you may be considered in default by the end of the calendar quarter following the quarter in which you failed to make the necessary loan payments. If your loan is considered in default, your pre-tax unpaid loan balance, plus accrued interest, will be subject to taxation. This means you will be required to pay income taxes on the amount of your pre-tax unpaid loan balance and you may be subject to a 10% penalty tax. See **Paying income taxes on page 97** for more information.

If you default on a loan due to non-payment, you may not request a new loan for two years. If, after two years, you wish to take out a new loan, you are required to first pay off your prior loan balance, plus any accrued interest.

If you take an approved unpaid leave of absence

If you are on an approved unpaid leave of absence, you may choose either to continue making loan payments or to suspend your loan payments for up to one year or for the period of your approved leave, whichever is less. You will have the opportunity to make loan payments by enrolling in electronic loan repayments through ACH debit from your bank account during your approved leave of absence. Consistent loan payments during your absence enable you to avoid additional accrued interest and re-amortization of your loan upon your return.

If you do not make loan payments while on your approved leave, we will assume you have elected to suspend your loan payments. The maximum suspension for an approved non-military leave of absence is 12 months, the end of the loan term or the end of your approved leave, whichever occurs first. After your approved leave ends (or when your approved non-military leave exceeds one year), you must make up your missed payments, with accrued interest. Your remaining loan payments will be increased (re-amortized) to cover your missed payments and interest so that the total length of your loan does not exceed your original loan term of five years for a general purpose loan or 15 years for a residence loan).

If your approved non-military leave exceeds one year (or extends beyond the end of the loan term, if sooner) and you do not make payments on your loan, you will be considered in default. Your outstanding loan balance, plus accrued interest, will be considered a taxable distribution to you. You will be required to pay income taxes on the pre-tax unpaid amount of your loan, including accrued interest and you may be subject to a 10% penalty tax. For more information, see **Paying income taxes on page 97**.

If you default on a loan due to non-payment, you may not request a new loan for two years. If, after two years, you wish to take out a new loan, you are required to first pay off your prior loan balance, plus any accrued interest.

If you take an approved military leave of absence

Loan repayments are not required during approved military leave. You will have the opportunity to make loan payments by enrolling in electronic loan repayments through ACH debit from your bank account during your leave. Depending on the interest rate of your outstanding loan, you may be eligible for a reduction in the interest rate of your loan during your military leave. If this is the case, your electronic loan repayments will reflect this lower rate. Making consistent loan payments during your absence enables you to avoid additional interest accrual and re-amortization of your loan upon your return. If you do not make loan payments while on your approved military leave, we will assume you have elected to suspend your loan payments during the length of your approved military leave.

After your approved military leave ends, you may either increase the amount of your loan payments to pay it off by the original payoff date or make payments at the previous level for an extended period. The loan period can be extended by adding the period of time that you were on approved military leave to the original loan payoff date. The maximum loan payoff date for an extended general purpose loan is five years from the original loan inception date plus the period of military service and 15 years from the original loan inception date plus the period of military service for a primary residence loan. If, upon your return from approved

military leave, you do not make payments on your loan, you will be considered in default by the end of the calendar quarter following the quarter in which you failed to make the necessary loan payments. If your loan is considered in default, your pre-tax unpaid loan balance, plus accrued interest, will be subject to taxation. This means you will be required to pay income taxes on the amount of your pre-tax unpaid loan balance and you may be subject to a 10% penalty tax. See **Paying income taxes on page 97** for more information.

If you default on a loan due to nonpayment, you may not request a new loan for two years. If, after two years, you wish to take out a new loan, you are required to pay off your prior loan balance, plus any accrued interest.

If your employment terminates

If your employment with Starbucks and any related company terminates and you have an outstanding loan balance, you may continue to repay the outstanding balance on the loan until the earliest of the following dates:

(A) The date on which you request a distribution of your Future Roast 401(k) account

(B) The date on which a distribution is made to you without consent (such as distributions of accounts that are $1,000 or less, or required minimum distributions), or

(C) The last day of the calendar quarter following the calendar quarter in which your payments were not sufficient to avoid default.

Loan repayments after your employment ends shall be made by a cashier's check, certified check or money order directly to Fidelity, by an electronic bank transfer through ACH debit from your bank account to Fidelity, or by other means as the Plan may specify. If your employment has ended, full or partial prepayment of the loan may be made in the same manner.

If you do not repay the loan by the earliest of one of the dates above, you will be considered in default. Your Future Roast 401(k) account balance will be reduced by the amount of the loan balance, plus accrued interest, and will be treated as a loan offset distribution to you, and you may be subject to a 10% penalty tax on the pre-tax portion of the distribution. You will be required to pay income taxes on the unpaid pre-tax amount of your loan and accrued interest. For more information, see **Paying income taxes on page 97**.

To continue loan payments after separation, call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative).

More about loan defaults

Loan defaults are considered withdrawals from Future Roast 401(k) and the pre-tax portion of such loan default will be taxed as ordinary income. The pre-tax portion of such loan default may also be subject to a 10% early withdrawal penalty if it occurs before you reach age 59½ and you are still working for Starbucks or any related company, or if you terminated employment from Starbucks and any related company before age 55.

If you default on a loan, you may not receive another loan for a minimum of two years and not until you repay the defaulted loan. This applies even if your defaulted loan was considered a distribution to you and you have been taxed on it (called a "deemed distribution").

Early loan payoff

At any time, you may pay the full outstanding balance of your loan without penalty. You may also prepay a loan in part (if greater than or equal to the periodic payment amount) at any time without penalty. Partial prepayment will not reduce the amount of any subsequent periodic payment (except, possibly, the final periodic payment), but may reduce the number of such periodic payments required to repay the loan. Call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative) to notify them of your intent to repay your loan in full or in part. You may also request your loan payoff on NetBenefits℠ at

netbenefits.com by accessing your existing loan and clicking on "Payoff Loans." To complete your partial or full loan payoff, you must:

- Obtain a money order, certified check or cashier's check for the payoff amount, made payable to FIIOC (Fidelity Investments Institutional Operating Company).
- Enclose a note providing your name, Social Security number, plan ID (21053) and loan number.
- Send your loan payoff to Fidelity Investments, P.O. Box 770001 Cincinnati, OH 44277-0008.

Alternatively, the Plan may allow you to arrange for ACH debit from your bank account for the partial or full payoff amount. If allowed, you will first need to establish your bank account information by accessing NetBenefits and clicking on "Electronic Payments" under "Quick Links." After you have submitted your bank information, you are required to wait six days until the prenote period is complete. At that time, you may click on "Loans and Withdrawals" under "Quick Links." Choose the loan you wish to payoff and click on the link "Pay Off Loan" to use the bank information you have established.

WITHDRAWALS DURING EMPLOYMENT

CARES Act Withdrawal – Effective April 7, 2020

The CARES Act allows partners who are active, on approved qualified leave or separated and who are Qualified Individuals[1] to take a distribution of up to $100,000 from your Future Roast 401(k) account before December 31, 2020. The 10% early withdrawal penalty tax will not apply to these distributions. However, 10% income tax withholding will apply unless you elect not to have tax withheld. You can elect to spread the taxation of any CARES Act distribution evenly over three years. You can also elect to recontribute any CARES distribution back to Future Roast 401(k) if you are an active partner or, if you are separated, to an IRA or your new employer's eligible retirement plan (if allowed for in that plan) within that three-year period.

Hardship withdrawals

If you find yourself in a serious financial situation, you may be eligible for a hardship withdrawal from your Future Roast 401(k) account. You must be actively employed at Starbucks or a participating company and not eligible for an age-59½ or rollover account withdrawal (explained on page 91) to receive a hardship withdrawal.

Unlike a loan where you pay yourself back, when you withdraw all or a portion of your account balance as part of a hardship withdrawal, you permanently remove your savings from Future Roast 401(k). Income taxes and a 10% early withdrawal penalty may apply on the amount you withdraw (see Paying income taxes on page 97 for more information).

1 You are eligible as a Qualified Individual under the CARES Act if:
1. You, your spouse, or your dependent is diagnosed with COVID-19;
2. You experience adverse financial consequences as a result of you, your spouse, or a member of your household (someone who shares your principal residence):
   - being quarantined, furloughed or laid off, or having work hours reduced due to COVID-19,
   - being unable to work as a result of a lack of child care due to COVID-19, or
   - having a reduction in pay (or self-employment income) due to COVID-19 or having a job offer rescinded or a start date for a job delayed due to COVID-19; or
3. You experience adverse financial consequences as a result of the closing of or a reduction in hours of a business that is owned or operated by you, your spouse or a member of your household due to COVID-19.

What qualifies as a hardship

You can request a hardship withdrawal for situations the IRS considers immediate and serious financial needs that cannot be met by:

- Taking a non-hardship distribution from your Future Roast 401(k) (i.e., from your rollover account or age 59½ withdrawal, if applicable), and
- Taking a hardship/financial emergency withdrawal from your Management Deferred Compensation Plan (MDCP), if applicable.

Future Roast 401(k) Plan hardship withdrawal rules were modified as follows:

- A Plan loan is not required before receiving a hardship withdrawal,
- Earnings on your Plan contributions can be withdrawn as part of a hardship withdrawal, and
- You will not be subject to a six-month suspension of contributions to the Plan, the Stock Investment Plan or the Management Deferred Compensation Plan following a receipt of a hardship withdrawal.

The IRS considers only the following events as qualifying for hardship withdrawals:

- Unreimbursed medical expenses incurred or necessary to obtain medical care for you, your spouse, children, dependents or a primary beneficiary designated by you under the Plan.
- Purchase of your primary residence.
- College tuition and related educational fees for up to the next 12 months for you, your spouse, children, dependents or a primary beneficiary designated by you under the Plan.
- Expenses to prevent eviction from your primary residence.
- Expenses to prevent foreclosure on your mortgage on your primary residence.
- Payment of funeral or burial expenses for your deceased parent, spouse, child, dependent or a primary beneficiary designated by you under the Plan.
- Payment for repair of damage to your primary residence that would qualify for a casualty loss deduction on your federal income tax return (without regard to whether the loss is attributable to a federally declared disaster or exceeds 10% of adjusted gross income).
- Expenses and losses (including loss of income) incurred by you on account of a FEMA-declared disaster, provided that your home or workplace at the time of the disaster is located in an area designated by FEMA for individual assistance with respect to the disaster.
- Any other immediate and heavy financial need as determined based on IRS regulations.

Maximum hardship withdrawal

The maximum you may withdraw from your Future Roast 401(k) account for a financial hardship is the lesser of the amount needed to cover your qualified financial need or 100% of your account balance available for hardship withdrawals. Your account balance available for hardship withdrawals includes the following (as applicable):

- 401(k) pre-tax contributions and/or Roth after-tax contributions (including earnings).
- Match (Pre-2011) account (excluding any balance in the Safe Harbor Match source).
- Starbucks Prior Match account.
- Pre-tax and Roth after-tax rollover accounts.
- Prior Plan account.

The hardship withdrawal cannot be for more than the amount you need to meet your financial hardship, including taxes and penalties you will incur on your hardship withdrawal. Hardship withdrawals are not subject to the mandatory 20% federal income tax withholding; however, elective federal and state income

tax withholding applies. The pre-tax portion of the hardship withdrawal is subject to federal (and state, if applicable) income taxes, and the 10% early withdrawal penalty may apply. For more information, see **Paying income taxes on page 97**.

Hardship withdrawals cannot be rolled over to another eligible retirement plan or individual retirement account (IRA). A hardship withdrawal can be requested online via **netbenefits.com** or by calling Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative). You will be required to provide documentation showing that your situation qualifies as a financial hardship and to represent that you do NOT have sufficient cash or other liquid assets reasonably available to satisfy the financial need.

HEART Act (active military) withdrawals

If you are on an approved military leave and have completed at least 30 days of military service, you are eligible for a withdrawal under the HEART Act. If eligible, you can take a full distribution of your entire account balance, but if you do so, you may not make 401(k) pre-tax or Roth after-tax contributions to the Plan, nor will you receive any Starbucks Match for six months following the distribution. The withdrawal may be subject to the 10% early withdrawal penalty tax if you are under age 59 1/2.

Age 59½ withdrawals

If you are age 59½ or older and still actively employed by Starbucks or a related company, you can take a withdrawal from your pre-tax accounts once a year. There are no early withdrawal penalties for this type of distribution. You may roll over a pre-tax distribution to another eligible retirement plan or traditional or Roth IRA. If you directly roll over your pre-tax distribution to a Roth IRA, the taxable portion of the distribution is subject to income tax in the year in which the direct rollover occurs. To the extent that you do not timely roll over the pre-tax distribution to another eligible retirement plan or IRA, the pre-tax distribution is subject to federal income tax, and 20% of the taxable portion of the distribution will be withheld to apply against your federal income tax liability. For more information, see **Paying income taxes on page 97**.

If you are age 59½ or older and still actively employed by Starbucks or a related company, you can also take a withdrawal from your Roth after-tax account once a year. There are no early withdrawal penalties for this type of distribution. You will also not be taxed on distributions of your Roth after-tax contributions, and the earnings on those contributions will not be taxed if the distribution is taken after you have had a Roth after-tax account in the Plan for at least five years. In applying the five year rule, you count from January 1 of the year your first Roth after-tax contribution was made to the Plan (or, if earlier, to another 401(k) plan if such amount was directly rolled over into this Plan). For example, if you make your first Roth after-tax contribution to the Plan on November 30, 2020, your five-year period will end on December 31, 2024. It is not necessary to make Roth after-tax contributions in each of the five years.

To request an age 59½ withdrawal, call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative) or go online via NetBenefits℠ at **netbenefits.com**.

Withdrawals from your rollover account

You are permitted to take one in-service withdrawal per plan year from each of your pre-tax rollover account, your Roth after-tax rollover account (if any) and any tax-exempt TSP rollover account. A rollover account withdrawal can be a full or partial withdrawal. To request a withdrawal from your rollover account(s), call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative) or request a withdrawal form by accessing NetBenefits℠ at **netbenefits.com**.

Total distribution from Future Roast 401(k)

Total Future Roast 401(k) account balances are usually distributed for one of the following reasons:

- You are disabled.
- You terminate employment with Starbucks and any related company, or
- Your death.

If you are disabled

If you are disabled (as defined below), you are eligible to receive a total distribution of your Future Roast 401(k) account. Refer to **Paying income taxes on page 97** to learn about taxation of your distribution.

Under Future Roast 401(k), in general, you are "disabled" if:

- You have a medically determinable physical or mental impairment that can be expected to result in death or last for 12 continuous months or more,
- You are incapable of continuing your usual and customary employment with Starbucks, and
- You are receiving income replacement benefits for a period of not less than three months from Starbucks or a participating company's long-term disability plan (or if you are not eligible to participate in such plan, you are unable to engage in any substantial gainful activity by reason of such impairment).

The Plan Administrator shall determine, at its discretion, whether a partner is disabled under the terms of the Plan, except that any partner who is approved for long-term disability payments under Starbucks' or a participating company's long-term disability plan and is a separated partner will be deemed disabled for purposes of the Plan.

IF YOU TERMINATE EMPLOYMENT WITH STARBUCKS AND ANY RELATED COMPANY

You have several options available for your Future Roast 401(k) account balance when you leave Starbucks and any related company.

Termination withdrawals

CARES Act withdrawal

The CARES Act allows separated participants who are Qualified Individuals (as defined on **page 89**) to take a distribution of up to $100,000 from their Future Roast 401(k) account before December 31, 2020. The 10% early withdrawal penalty tax will not apply to these distributions. However, 10% income tax withholding will apply unless elected otherwise. You can elect to spread the taxation of any CARES Act distribution evenly over three years. You can also elect to recontribute any CARES distribution back to an IRA or your new employer's eligible retirement plan (if allowed for in that plan) within that three-year period.

If you have a balance in Future Roast 401(k), you can request payment of your account balances after termination of employment with Starbucks for any reason. If you are separated and have an account balance greater than $1,000, you can elect an unlimited number of withdrawals each year. Your withdrawal can be taken as:

1. A lump-sum payment,
2. A roll over into another eligible retirement plan or individual retirement account,
3. Partial payments as requested from time to time, or

4. Systematic withdrawal (installment) payments limited to the life expectancy of you and your beneficiary at the time payments commence.

All withdrawals (other than direct rollovers) will be paid in cash.

Termination Withdrawal requests can be changed or stopped at any time with the exception of Systematic Withdrawal (Installment) Payments. Once started, the amount of your Installment Payment can be increased, but it cannot be decreased or stopped. You retain the ability to choose a full payout as a lump sum or rollover even after initiating Installment Payments. It is important that you discuss and understand all your withdrawal options with Fidelity (866) 697-1048 prior to making an election.

You generally must pay federal (and in most cases state) income taxes on your withdrawals from the Future Roast 401(k) unless the withdrawal is rolled over or is a "qualified distribution" of Roth after-tax contributions. You may also be subject to a 10% early withdrawal penalty if you are younger than age 59½ at the time of the withdrawal or if you leave Starbucks and any related company prior to attaining age 55. If you are rehired before your account is distributed to you, you will not receive a distribution of your account.

If you leave Starbucks and any related company and have a vested account balance of $1,000 or less (or at any applicable valuation date thereafter) in Future Roast 401(k) (including your pre-tax and/or Roth after-tax rollover accounts, if any), you will automatically receive a lump-sum payment of your account. After leaving Starbucks and any related company, you will be notified and will be provided an opportunity to request a rollover to another employer's eligible retirement plan or IRA as described in **Rollover distributions into another plan on page 94**. If you do not make a rollover election within the time stated in the notice, your account will be paid to you in a lump-sum, less 20% of your pre-tax account balance for mandatory income tax withholding, and mailed to your home address of record. The pre-tax portion of the distribution is subject to federal (and state, if applicable) income taxes. Also, if you are under age 55 when you leave Starbucks and any related company, the pre-tax portion of the distributed amount will generally be subject to a 10% early withdrawal penalty.

If you have a vested account balance of more than $1,000 (including your pre-tax and/or Roth after-tax rollover account balances, if any), you may request a withdrawal of your account as described under Termination Withdrawals or leave it in the Plan (as long as it remains more than $1,000 as of any applicable valuation date thereafter) until April 1 following the calendar year in which you reach age 72. At that time, you will be required to begin receiving annual distributions from your account (required minimum distributions). You may also roll over your account balances to a Roth IRA to avoid required minimum distributions of those amounts.

Any termination withdrawal of pre-tax amounts (excluding earnings in your Roth after-tax accounts if the distribution is a qualified distribution) is subject to federal (and state, if applicable) income tax in the year in which the distribution is made. Federal income tax will be withheld from your pre-tax distribution at a mandatory 20% rate on the portion of your distribution that is not a required minimum distribution (following attainment of age 72). A 10% early withdrawal penalty tax may also apply if you are under age 55 at the time you leave Starbucks.

A termination withdrawal of Roth after-tax contributions, and in certain cases, the earnings on those contributions, are not subject to federal (and state, if applicable) income taxes when distributed to you. For the earnings to be tax-free, the distribution must be a qualified distribution. A qualified distribution is one that is taken after you have had a Roth 401(k) account in the Plan for at least five years and after you have (a) reached age 59½, (b) become disabled, or (c) died. In applying the five-year rule, you count from January 1 of the year

your first Roth after-tax contribution was made to the Plan (or, if earlier, to another 401(k) plan if such amount was directly rolled over into this Plan). For example, if you make your first Roth after-tax contribution to the Plan on November 30, 2020, your five-year period will end on December 31, 2024. It is not necessary to make Roth after-tax contributions in each of the five years.

For more information, see **Paying income taxes on page 97**.

Deferred payment

If you leave Starbucks and any related company, you can choose to leave your money in your Future Roast 401(k) account if your account balance is more than $1,000 (including any pre-tax, Roth after- tax and/ or tax-exempt TSP rollover accounts). However, you must begin receiving your required minimum distributions (RMDs) no later than April 1 of the calendar year following (a) the calendar year you attain age 72, or (b) if later, the calendar year you leave Starbucks and any related company. You may roll over your account balances to a Roth IRA to avoid required minimum distributions of those amounts.

Required Minimum Distributions (RMDs): The CARES Act waived the RMD rules for 401(k) plans and IRAs for calendar year 2020, providing relief to individuals who would otherwise be required to withdraw funds from such retirement accounts. The waiver applies to initial RMDs due by April 1, 2020 (and not paid in 2019), RMDs due by December 31, 2020, and initial RMDs due by April 1, 2021. Some participants who received an RMD in early 2020 can contact Fidelity if they wish to understand options that they may have to mitigate the tax effect of the 2020 distribution. Participants who actively chose to receive 2020 RMDs, will continue to receive payments unless they contact Fidelity to stop those payments.

Even though you may no longer be employed by Starbucks and any related company, which means you will not be making any contributions to your Future Roast 401(k) account, you can still make changes to your investment elections by calling Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative) or by accessing NetBenefits℠ at **netbenefits.com** and clicking on “Change Investments” under “Quick Links”. See **Plan Funding and Expenses on page 104** for fees that apply to separated participants.

Rollover distributions into another plan

To continue to defer income taxes and continue earning on your investments if you leave Starbucks and any related company, you may decide to transfer (roll over) all or a portion of your Future Roast 401(k) pre-tax account balance to another employer’s eligible retirement plan — if the new plan permits — or to a traditional or Roth IRA. Except for a rollover of pre-tax amounts to a Roth IRA as described on the following page, the rollover is not subject to federal (and in most cases state) income tax nor subject to the 10% early withdrawal penalty tax (if applicable) until you withdraw it from your eligible retirement plan or IRA.

Pre–tax rollover to a Roth IRA

If you directly roll over a pre-tax distribution to a Roth IRA, the taxable portion of the distribution is subject to income tax for the taxable year in which the distribution occurs.

Examples of plans that may qualify for rollovers are:

- Your new employer’s 401(a), 401(k), 403(b) or 457 plan — if those plans accept rollover contributions
- Conduit IRAs, traditional IRAs, or Roth IRAs

If you do not directly roll over your account balance into an eligible retirement plan or IRA, the taxable portion of your distribution is subject to federal (and state, if applicable) income tax in the year in which the

distribution is made. Federal income tax will be withheld from the taxable portion of your distribution at a mandatory 20% rate unless the distribution is a required minimum distribution (following attainment of age 72). A 10% early withdrawal penalty may also apply to the taxable portion of your distribution if you are under age 55 at the time you leave Starbucks and any related company. For more information, refer to **Paying income taxes on page 97**.

Two ways to roll over your account balance

1. Direct rollover: When you request a direct rollover, you will receive your Future Roast 401(k) account balance in the form of a check made out to the eligible retirement plan or IRA financial institution. For most partners, a direct rollover is most advantageous since no federal income taxes are withheld. However, if you complete a direct rollover of only a portion of your Future Roast 401(k) account, you will be subject to federal income tax withholding, as described in paragraph 2 below, on the pre-tax portion of the distribution paid to you. Also, if you elect a direct rollover of only a portion of your Roth Account, with the remaining balance paid to you, each of the payments will include an allocable portion of the earnings in your Roth account. To request a direct rollover of your Future Roast 401(k) account balance, call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative). You may also request a withdrawal form by accessing NetBenefits℠ at **netbenefits.com**. If you request a rollover through any other method, including submission of a form from your new plan or IRA, your request will not be accepted.

2. 60-day rollover: You can request a lump-sum cash distribution of your Future Roast 401(k) balance made payable to you. You will be subject to federal income tax withholding on the pre-tax portion of the distribution (including earnings on your Roth after-tax contributions if the distribution is not a qualified distribution) at a mandatory 20% rate; consequently, your distribution will reflect 80% of your pre-tax Future Roast 401(k) account balance plus your Roth after-tax contributions. You have 60 days to deposit the money into another employer's eligible retirement plan or IRA. If you have a Roth account, you can only do a 60-day rollover into a Roth IRA, unless the distribution is a nonqualified distribution, in which case you can do a 60-day rollover of the earnings in the Roth account to a Roth account in an employer's eligible retirement plan, with the balance of the distribution to a Roth IRA if you wish. To roll over 100% of your taxable distribution, you would need to use your own funds to replace the 20% withheld for income taxes.

Most distributions qualify for a rollover, but certain distributions may not. Future Roast 401(k) distributions that may not be rolled over include:

- Hardship withdrawals.
- Certain portions of your distribution if your distribution begins after you reach age 72.
- Refund of excess deferrals (amounts over the IRS 401(k) dollar limitation).
- Refund of excess contributions (refer to **Discrimination test annual limit on page 77**).

Requesting a rollover or withdrawal

To initiate a rollover or request a withdrawal, call Fidelity at (866) 697-1048 (or (800) 587-5282 for a Spanish speaking representative), or access a withdrawal form at NetBenefits℠ at **netbenefits.com**. Generally, once requested, distribution of your Future Roast 401(k) benefits will be processed within 10 business days.

Death benefit

If you die while employed by, or after leaving, Starbucks and any related company and still have a Future Roast 401(k) account, your beneficiaries will be entitled to 100% of your vested Future Roast 401(k) account balance.

- **If you are married when you die**, your spouse will automatically be your beneficiary unless you have elected otherwise, in writing with your spouse's notarized consent, on a Future Roast 401(k) beneficiary form. Your death benefit will be paid to your spouse in a single lump-sum at the time described below under **Timing of death benefit distributions**.
- **If you are not married, you are divorced or your spouse cannot be found**, your death benefit will be paid to your designated beneficiaries in a single lump-sum at the time described under **Timing of death benefit distributions**.
- **If you have a domestic partner whom you would like to be your beneficiary**, you must complete the beneficiary designation procedure. Due to federal law, a domestic partner will not be automatically designated as your beneficiary upon your death.
- If no beneficiary has been properly designated, or if all of your designated beneficiaries are deceased, distribution of your account balance will be paid out as described under **Timing of death benefit distributions** and based on the following "hierarchy" or order:

    1. Your spouse at the time of your death will automatically be your primary beneficiary (if you are married at the time of your death),
    2. In the event no such spouse survives you, your children (including natural and adopted children) will be entitled to equal shares,
    3. In the event no such spouse or child survives you, your estate will receive the balance of your Future Roast 401(k) account.

Timing of death benefit distributions:

In instances where a participant passes away on or after January 1, 2020, and where the participant's account balance is more than $1,000, the Setting Every Community Up for Retirement Enhancement (SECURE) Act modified the maximum payout term. In general, beneficiaries must be paid out by the end of the 10th calendar year following the year of the participant's death. However, a surviving spouse, a minor child, chronically ill beneficiaries, and beneficiaries who are not more than 10 years younger than the deceased, are excepted from this rule, and such a beneficiary may generally stretch distributions out over his or her life or life expectancy.

The following applies to participants whose death occurs prior to January 1, 2020:

- **If your legal spouse is your sole beneficiary and your account balance is more than $1,000** (including any pre-tax, Roth after-tax, and/or tax-exempt TSP rollover accounts), distribution must be made by December 31 of the calendar year immediately following the calendar year of your death or, if later, by December 31 of the calendar year in which you would have reached the required minimum distribution age of 72 (or age 70½ if you attained such age before 2020). Alternatively, you or your beneficiary may elect to have your account balance distributed by December 31 of the calendar year containing the fifth anniversary of your death. The distribution will be made in a lump-sum. If your account is $1,000 or less (including any pre-tax, Roth after-tax and/or tax-exempt TSP rollover accounts), the value of your account will be distributed to your spouse as soon as practicable after your death.
- **If your legal spouse is not your sole beneficiary and your account balance is more than $1,000** (including any pre-tax, Roth after-tax, and/or tax-exempt TSP rollover accounts), distribution of your Future Roast 401(k) account must be made by December 31 of the calendar year immediately following the calendar year of your death. Alternatively, you or your beneficiary may elect to have your account balance distributed by December 31 of the calendar year containing the fifth anniversary of your death. However, distribution must be made by December 31 of the calendar year immediately following the calendar year of your death if your beneficiary wishes to roll over the distribution to an inherited IRA and retain the option to have benefits paid out over his or her life expectancy. If your account balance is $1,000 or less (including

any pre-tax, Roth after-tax, and/or tax-exempt TSP rollover accounts), the value of your account will be distributed to your beneficiary as soon as practicable after your death.

A beneficiary may choose to "disclaim" or deny receipt of payment of a death benefit. If they do so, that beneficiary will be treated as predeceasing the participant for purposes of distributing the account.

NOTE: Amounts set aside for an alternate payee (see **Qualified domestic relations order on page 101**) will be paid to the alternate payee. Except as otherwise provided by the qualified domestic relations order, if there is no surviving alternate payee, then amounts set aside for that alternate payee will be paid to the alternate payee's beneficiary, or if none, to the alternate payee's estate.

Beneficiary designation

You may make a beneficiary designation, or request a Future Roast 401(k) beneficiary designation form with spousal waiver if you are married and are naming someone other than your spouse as primary beneficiary, by accessing **netbenefits.com**. To request a beneficiary designation form, call Fidelity at (866) 697-1048 or (800) 587-5282 for a Spanish speaking representative.

ADMINISTRATIVE INFORMATION

Your rights and responsibilities

The Starbucks Future Roast 401(k) Savings Plan ("Future Roast 401(k)" or "Plan") is governed by legal Plan documents that ensure the program complies with federal and state laws. In this section, you can see at a glance who serves as the administrator or trustee of the Plan, how the Plan is financially structured and what your rights and responsibilities as a Plan member are under ERISA and other laws.

This chapter serves as a summary plan description of the Future Roast 401(k). In all cases, the legal Plan documents are the final authority.

Paying income taxes

General income tax rules

Future Roast 401(k) is intended to meet the requirements of Section 401(a) of the Internal Revenue Code. Meeting these requirements means that you do not pay federal (and in most cases state) income taxes on any of the pre-tax funds in your Future Roast 401(k) account until you receive a direct distribution (check is made payable to you).

Except for qualified distributions from your Roth after-tax account and Roth rollover account as described below, when you receive a direct distribution from your Future Roast 401(k) account, you must pay federal (and in most cases state) income taxes on your 401(k) pre-tax contributions, pre-tax contributions you rolled over from your previous employer's eligible retirement plan or conduit IRA, Starbucks matching and profit-sharing contributions, merged plan contributions and all earnings in your Future Roast 401(k) accounts.

Qualified Distribution of Roth Accounts

A *qualified distribution* from your Roth after-tax account and Roth rollover account is not subject to federal (and in most cases state) income taxes when distributed to you, nor is it subject to a 10% early withdrawal penalty. A qualified distribution is one that is taken after you have had a Roth 401(k) account in the Plan for at least five years and after you have (a) reached age 59½, (b) become disabled, or (c) died. In applying the five-year rule, you count from January 1 of the year your first Roth after-tax contribution was made to the Plan (or, if earlier, to another 401(k) plan if such amount was directly rolled over into this Plan). For example, if you make

your first Roth after-tax contribution to the Plan on November 30, 2020, your five-year period will end on December 31, 2024. It is not necessary to make Roth after-tax contributions in each of the five years. If you are under age 59½ and you take a withdrawal from your Roth after-tax account or your Roth rollover account, any earnings included in the withdrawal will be subject to the 10% penalty tax described below unless one of the exceptions listed below applies.

10% Penalty Tax

If you are under age 59½, you may be required to pay an additional 10% early withdrawal penalty tax on the pre-tax distribution amount when you:

- Take a hardship withdrawal.
- Default on loans against your account.
- Take a direct distribution after terminating your employment from Starbucks and any related company before age 55.

The exceptions to this penalty include, in general, the following situations:

- You are a Qualified Individual (as defined on page 89) and take a CARES Act withdrawal before December 31, 2020 (see Withdrawals During Employment and/or Termination Withdrawals).
- You are age 59½ or older when taking a withdrawal.
- You leave Starbucks and any related company after you reach age 55 and take a distribution.
- You receive your distribution after becoming totally disabled as defined by the IRS.
- You take the distribution to pay for tax-deductible medical expenses.
- Your account is distributed due to your death.
- Your account is distributed to an alternate payee in connection with a qualified domestic relations order (QDRO).
- You make an indirect rollover into an eligible retirement plan, traditional IRA or Roth IRA within 60 days of the withdrawal or distribution (any amount not rolled over may be subject to the 10% penalty).
- You receive a corrective distribution of contributions that exceed tax law limitations.

You should consult your personal tax advisor if you have any questions about the penalty or the exceptions.

Contributions

In computing its federal income tax liability, Starbucks and any participating company is entitled to deduct the amounts set aside for contributions to Future Roast 401(k) paid on your behalf.

You are not subject to federal income tax on 401(k) pre-tax contributions made to your Future Roast 401(k) account or any earnings on any contributions until you take a direct distribution of these account balances. You are, however, subject to federal income tax on excess deferrals you make to Future Roast 401(k) that exceed the annual dollar limits set by the IRS and excess contributions that must be returned to comply with the nondiscrimination tests. See **Contributions to Your Future Roast 401(k) Account on page 74** for more information about IRS contribution limits and **Discrimination test annual limit on page 77** for more information about the nondiscrimination tests.

Hardship withdrawals and taxes

Most pre-tax hardship withdrawals are taxable according to the regular income tax rate in effect during the calendar year you make the withdrawal. You may also be subject to an additional 10% penalty tax unless you meet the criteria outlined in **Paying income taxes on page 97**.

Hardship withdrawals cannot be rolled over to any other plan or IRA.

Loans and taxes

Generally, a loan from Future Roast 401(k) is not considered a true distribution because repayment is anticipated. So, as long as you are repaying the loan as scheduled, you will not pay income taxes on the amount you borrowed. However, if you stop repaying the loan and do not resume making payments on a timely basis (you default), the loan then becomes a true distribution, and you will pay federal (and state, if applicable) income taxes on the pre-tax loan balance as well as any penalties described in **Paying income taxes on page 97**.

Rollovers

You (or, in the case of your death, your surviving spouse or your beneficiaries) may defer income taxation on the taxable amount of your lump-sum distribution by rolling it over directly or transferring it within 60 days (if your distribution was paid directly to you) to an IRA (other than a Roth IRA) or another eligible retirement plan. Roth after-tax accounts may only be directly rolled into a designated Roth account in another employer's eligible retirement plan or to a Roth IRA. (Non-spouse beneficiaries may only elect a direct rollover of their benefits to an inherited IRA, which is established in accordance with rules prescribed by the IRS.) Rollovers of pre-tax amounts to Roth IRAs are subject to immediate taxation as described on the following page. If you roll over only a portion of the pre-tax distribution to a traditional IRA or eligible retirement plan, the balance of the pre-tax distribution not rolled over will be taxable as ordinary income. If you or your beneficiary receives any portion of a pre-tax payment that is eligible for direct rollover treatment, mandatory 20% withholding for federal income tax will be applied.

Tax-exempt Thrift Savings Plan (TSP) rollovers

If you have a traditional (non-Roth) balance that was rolled over from a TSP account into the Future Roast 401(k) and it contains tax-exempt money (i.e., tax-exempt contributions from pay earned in a combat zone), you may transfer or rollover the balance of such account into a traditional IRA, Roth IRA or an eligible employer plan, but only if the IRA or eligible employer plan accepts tax-exempt balances. (An IRA or employer plan is not legally required to accept the rollover or transfer.) If you choose to transfer a portion of the eligible rollover distribution, the taxable portion of your balance will be transferred first. Tax-exempt money will be transferred only if the taxable portion of your distribution does not satisfy your requested transfer amount. Any tax-exempt money in your distribution that cannot be transferred will be paid directly to you. If you transfer or roll over a tax-exempt balance into a traditional IRA, it is your responsibility to keep track of the amount of those contributions and report that amount to the IRS on the appropriate form so that the nontaxable amount of any future distribution(s) can be determined. You should consult a tax advisor to ensure that you understand the tax consequences of these transactions.

Pre-tax rollover to a Roth IRA

If you directly roll over a pre-tax distribution to a Roth IRA, the taxable portion of the distribution is subject to federal (and state, if applicable) income tax for the taxable year in which the distribution occurs.

GENERAL PROVISIONS

(ANY REFERENCE TO "STARBUCKS" IS INTENDED TO INCLUDE ANY RELATED COMPANY)

Loss or denial of benefits

Under the following circumstances, some or all of your benefits might not be payable to you:

- If a qualified domestic relations order applies to your interest under the Plan, all or a portion of your account balance may be payable to the alternate payee named in the order. See **Qualified domestic relations order on page 101** for more information on QDROs.
- Contributions may be reduced or frozen to comply with maximum limitations prescribed by federal law.
- Depending on the investment performance of the investment funds in which you elect to invest your account, the amount you ultimately receive could be more or less than your current vested account balance.

In addition, if your Plan benefits become payable after termination of employment and the Plan Administrator is unable to locate you at your last address of record, you may forfeit your benefits. Therefore, it is very important that you keep the Plan Administrator apprised of your mailing address even after you have terminated employment. (The amount forfeited, unadjusted for net income, gain or loss, will be restored if you later make a claim for your benefit before the Plan is terminated.)

Rights of participants

The adoption and maintenance of the Plan is not a contract of employment between Starbucks and any partner.

Nothing contained in the Plan documents, insurance contracts, trusts, this summary plan description or any other related documents gives any partner the right to remain employed by Starbucks or interferes with Starbucks right to discharge any partner at any time.

Similarly, nothing in the documents described above gives Starbucks the right to require any partner to remain employed by Starbucks or interferes with the partner's right to end employment with Starbucks at any time.

Plan amendment or termination

Starbucks, or any other authorized person, reserves the right to amend the Plan at any time and for any reason. In some cases, an amendment may be retroactive. Although Starbucks adopted the Plan with the intention that it is to be continued indefinitely, Starbucks also reserves the right to terminate the Plan at any time, and for any reason.

PBGC coverage

Benefits under the Plan are not insured by the Pension Benefit Guaranty Corporation (PBGC) because the Plan is a defined contribution plan. The PBGC only insures defined benefit plans.

Disclaimer

In exercising its responsibilities, the Plan Administrator or Trustee has sole and absolute discretion in determining whether, and to what extent, participants and beneficiaries are entitled to benefits — and to interpret Plan terms. Failure to enforce any provision of any Plan at any time does not mean that the right to enforce that provision at another time has been waived.

Assignments

As a general rule, the interest in your account cannot be sold, used as collateral for a loan, given away or otherwise transferred. In addition, any creditors you may have cannot attach, garnish or otherwise interfere with your account. However, a court order may require that part or all of your Future Roast 401(k) benefits be paid to an alternate payee, such as your former spouse under a qualified domestic relations order (see Qualified domestic relations order below), and the Plan Administrator must honor IRS levies against your account and orders to pay arising from judgments or convictions for crimes involving the Plan.

Qualified domestic relations order

A qualified domestic relations order (QDRO) is a court order that provides child support, alimony or marital property rights from your account to your spouse, former spouse or dependent (Alternate Payee).

The Plan Administrator will determine whether any domestic relations order the Plan receives is a "qualified" one that the Plan must honor. A copy of the procedures used by the Plan Administrator to make this determination is available without cost online through Fidelity at **qdro.fidelity.com**. You may also request a copy from the Plan Administrator. Participants may initiate a QDRO online through Fidelity at **qdro.fidelity.com**.

QDROs that are processed online and submitted to Fidelity for approval are subject to a fee that is payable by the participant and/or the Alternate Payee. The fee is communicated to participants who initiate and draft QDRO paperwork online, and generally only applies once the Order is submitted for approval. A fee of $300 applies for the review of Orders generated via Fidelity's QDRO website with no modifications. A fee of up to $1,800 applies for the review of certain complex Orders or custom Orders not generated via Fidelity's website, or for review of an Order that is generated via the website, but subsequently altered. These fees are subject to change and apply regardless of whether the Order is determined to be qualified or not.

If an approved QDRO awards your Alternate Payee a portion of your account, such portion will be transferred into an account in the name of your Alternate Payee and your Alternate Payee can then direct the investment of that account.

Responsibility for investment decisions

You choose how to invest your account in Future Roast 401(k). The Plan Trustee follows your investment directions without reviewing your investment decisions.

Starbucks, as the Plan Administrator, and Fidelity Management Trust Company as the Plan Trustee, are not responsible or liable for the investment choices that you make or for any investment losses that are the direct and necessary result of your investment choices. This is because the Plan is intended to satisfy the requirements of Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA) and Title 29 of the Code of Federal Regulations Section 2550.404c-1. ERISA Section 404(c) provides that if a Plan participant controls the investment of his or her account, then the participant is responsible for the investment results, including both earnings and losses.

Nothing contained in this summary plan description is intended to constitute investment advice. Please carefully review the information provided to you about the investment funds, including the prospectus for each fund, before deciding how you would like your account to be invested.

How 401(k) pre-tax contributions and/or Roth after-tax contributions affect other benefits

401(k) pre-tax contributions under Future Roast 401(k) reduce your current taxable income — that is, they are not reported as taxable income on your W-2 earnings statement. However, they are included in determining your Social Security taxes and benefits.

Roth after-tax contributions are deducted from your eligible pay after income taxes are withheld. Therefore, your take home pay will be less if you are making Roth after-tax contributions than it would be if you were contributing the same percentage in 401(k) pre-tax contributions.

Saving with 401(k) pre-tax dollars and/or Roth after-tax dollars does not reduce the eligible pay used to calculate pay-related benefits, such as life insurance and disability coverage.

Tax treatment

Starbucks intends to operate the Plan so that it qualifies under Sections 401(a) and 501(a) of the Internal Revenue Code. Accordingly, 401(k) pre-tax contributions, pre-tax rollovers, matching contributions, discretionary profit-sharing contributions, merged plan accounts and any earnings on these contributions should not be taxable to partners until distributed directly to them from the Plan.

Roth after-tax contributions are taxed at the time they are made to the Plan. However, such contributions, and in certain cases the earnings on those contributions, are not subject to income taxes when distributed to you. In order for the earnings to be tax-free, the distribution must be a qualified distribution. A qualified distribution is one that is taken after you have had a Roth 401(k) account in the Plan for at least five years and after you have (a) reached age 59½, (b) become disabled, or (c) died. In applying the five-year rule, you count from January 1 of the year your first Roth after-tax contribution was made to the Plan (or, if earlier, to another 401(k) plan if such amount was directly rolled over into this Plan). For example, if you make your first Roth after-tax contribution to the Plan on November 30, 2020, your five-year period will end on December 31, 2024. It is not necessary to make Roth after-tax contributions in each of the five years.

Correction of errors

You are responsible for identifying any discrepancies in the percentage of eligible pay you have elected to contribute to the Plan, in the allocation of your account among the various investment funds or in the amount of Plan loan payments withheld from your paychecks. You should review each quarterly account statement and paycheck carefully. You must notify the Plan Administrator in writing of any such discrepancies within 60 days after you receive notification from Fidelity that your statement is available online at **netbenefits.com** or within 60 days of receipt of a paper statement or confirmation notice that contains the discrepancy. Discrepancies reported after 60 days will not be corrected unless required by applicable law. If you discover a discrepancy, send your written notification to Starbucks Corporation, c/o Savings Department, 2401 Utah Avenue South, Mail Stop S-HR3, Seattle, WA 98134.

Top-heavy provisions

Certain plans that provide a significant percentage of their total benefits to employees who are defined as “key employees” by the Internal Revenue Code are known as “top-heavy” plans. If the Plan is deemed top-heavy, certain partners may be entitled to receive a top-heavy contribution. The Plan is currently not top-heavy and you will be notified in the event that the Plan ever becomes top-heavy.

YOUR ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that plan participants shall be entitled to:

Receive information about your Plan and benefits

- Examine, without charge, at the Plan Administrator's principal office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, if any, 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, if any, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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.

Prudent action 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 Plan. The people who operate Future Roast 401(k), called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

Discrimination

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a 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 the Plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory, or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR RIGHTS UNDER USERRA

The Plan provides for make-up contributions and service credits to partners returning to employment after military service, to the extent required by federal law. If you are rehired following a period of uniformed service that entitles you to rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be credited with such service for purposes of determining years of service for eligibility and any applicable vesting.

You will also be able to make up missed 401(k) pre-tax contributions and/or Roth after-tax contributions for the period while you were in qualified military service. For purposes of determining your make-up contributions, you generally will be treated as having earned eligible pay during your military leave at the rate you would have earned it had you been actively at work with Starbucks during your period of uniformed service, or if the determination of such rate is not reasonably certain, on the basis of your average rate of eligible pay during the 12-month period immediately preceding such period (or, if shorter, your actual period of employment with Starbucks immediately preceding such period). You have a limited time (three times your period of military service, but not more than five years) to make up your missed 401(k) pre-tax contributions and/or Roth after-tax contributions and qualify for Starbucks matching contributions.

You may be eligible for Starbucks matching contributions based on the make-up contributions you make. You will also be eligible for your share of any Starbucks discretionary profit-sharing contributions made during the period you were in qualified military service. You may also be able to suspend payments on any Plan loan during the period of your military leave and receive an extended period to repay the loan.

Because your rights under USERRA are subject to certain conditions and time restrictions, you should contact the Starbucks Savings team via email at **Savings@Starbucks.com** before commencing leave and as soon as you return to employment.

PLAN FUNDING AND EXPENSES

The Plan is funded through contributions by partners who designate a part of their eligible pay to be contributed on their behalf and by Starbucks through matching and discretionary profit-sharing contributions. All contributions to the Plan are placed in a trust fund. The Plan Trustee, Fidelity Management Trust Company, administers all funds under the Plan. The funds are invested for the exclusive benefit of partners and for defraying reasonable Plan administration expenses.

Starbucks generally pays the expenses of administering the Future Roast 401k) Plan, while investment fees are paid, directly and indirectly, by the investments in the respective investment funds and to the extent provided in the applicable prospectus or profile for each fund. The following exceptions apply:

- Separated partners with an account balance are assessed an annual administrative fee for account maintenance, which is deducted quarterly from their Future Roast 401(k) Savings Plan account. The annual administrative fee is generally $26 per year and may be adjusted periodically based on the actual per-participant fee assessed by Fidelity.
- The initial loan setup fee for all new loans is deducted from the partner's account balance when the loan is initially taken out. The loan setup fee is $35 but may be adjusted based on the actual loan fee assessed by Fidelity.
- The annual ongoing loan maintenance fee is deducted from the partner's account balance quarterly. The annual loan maintenance fee is $15 ($3.75 per quarter) but may be adjusted annually based on the actual loan maintenance fee assessed by Fidelity.
- The cost of overnighting a distribution check to a partner (upon their request) is $25 (subject to adjustment). This fee will be deducted from the partner's account balance.
- The cost for reviewing a Domestic Relations Order to determine whether it is qualified ranges from $300 to $1,800 depending on how the Order was generated or drafted (see the section titled **Qualified domestic relations order on page 101**). This fee will be deducted from the participant and/or the alternate payee accounts per applicable rules.

Fidelity® Personalized Planning & Advice

If you actively elect to utilize the fee-based professional management advisory service offered through Fidelity® Personalized Planning & Advice, the fees include the following: 0.35% annually for the first $50,000 in your Future Roast 401(k) account; 0.25% annually on the next $50,001 to $250,000; 0.20% annually for amounts over $250,000. These fees are calculated and deducted quarterly from your Future Roast 401(k) account. For additional information regarding this fee-based managed account advisory service, log on to **netbenefits.com/plan**. You may also call Fidelity at (866) 811-6041, Option 1.

CLAIMS

Claiming benefits

Distribution of your benefits will normally be made as described in **Total Distribution from Future Roast 401(k) on page 92**. However, if you do not receive a distribution to which you believe you are entitled, you may file a claim in writing with the Plan Administrator for any unpaid benefits.

If you believe you are entitled to, but have not received, a benefit from the Plan or if you disagree with the Plan Administrator's determination of the amount of your Plan benefit or any other decision regarding your interest in the Plan, you or your duly authorized representative may present a claim to the Plan Administrator.

Submit your claim in writing to the Plan Administrator at Starbucks Corporation, c/o Savings Department, 2401 Utah Avenue South, Mail Stop S-HR3, Seattle, WA 98134.

Procedures for benefit claims

NOTE: The procedures described on this page do not apply to claims and appeals for a benefit due to disability. The procedures for claims and appeals due to disability are set forth in a separate document, which you can request free of charge from the Plan Administrator.

If you or your representative submits a written claim for benefits (other than a benefit due to disability) and your claim is denied in whole or in part, the Plan Administrator will notify you in writing of such denial within 90 days after the claim is received, unless special circumstances require an extension of up to 90 more days, in which case, you will be notified in writing of the extension, the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision.

The denial notice will include all of the following:

- The specific reason(s) for the denial
- References to the specific Plan provision(s) on which the denial was based
- A description of any additional material or information that is necessary to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan's procedures for appealing the denial
- A statement regarding your right to bring an action under Section 502(a) of ERISA

Request for review

If you disagree with the Plan Administrator's decision, either you or your representative has 60 days from the receipt of the original denial notice to appeal the decision. This appeal must be in writing and sent to the Plan Administrator.

You or your representative have the right to review and receive copies of (upon request and at no charge) all documents and other information relevant to your claim and to submit written comments, documents and other information relating to your claim (whether or not such information was submitted or considered in the initial benefit determination). The Plan Administrator will notify you in writing of its decision within 60 days after it receives your appeal, unless special circumstances require an extension of up to 60 more days, in which case you will be notified in writing of the extension, the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision. If your appeal is denied, written notice will include all of the following:

- The specific reason(s) for the denial.
- References to the specific Plan provision(s) on which the denial was based.
- A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to your claim.
- A statement regarding your right to bring an action under Section 502(a) of ERISA.

Limitations on legal action

You may file a lawsuit regarding the denial of an appeal after following the claims and review procedures above. You must file any lawsuit within 12 months after the date the Plan Administrator issued its final decision on an appeal. If you do not file a claim or exhaust the claims review process for any reason, any lawsuit must be filed within 12 months of the date of the conduct at issue in the lawsuit (which includes, among other things, the date you became entitled to any Plan benefits at issue in the lawsuit). If you fail to file a lawsuit within these timeframes, you will lose your right to bring the lawsuit at any later time.

Future Roast 401(k) Savings Plan

Plan information for Starbucks Corporation 401(k) Plan (Informally known as Starbucks Future Roast 401(k) Savings Plan and Future Roast 401(k))	
EIN/Plan Number	91-1325671 / 001
Type of Plan	Section 401(k) Defined Contribution Plan Subject to Section 404(c) of ERISA Not subject to Pension Benefit Guarantee Corporation (PBGC) insurance
Plan Year	January 1 through December 31
Plan Sponsor	Starbucks Corporation, c/o Savings Department 2401 Utah Avenue South, Mail Stop S-HR3, Seattle, WA 98134 (888) SBUX-411
Plan Administrator	Administrative Committee, c/o Savings Department 2401 Utah Avenue South, Mail Stop S-HR3, Seattle, WA 98134 (888) SBUX-411
Plan Trustee	Fidelity Management Trust Company 53 State Street Boston, MA 02109
Type of Plan Administration	The Plan is administered by an internal Administrative Committee. The Plan Administrator has contracted with Fidelity Investments Institutional Services Company to assist with Plan administration.
Agent for Service of Legal Process	Starbucks Corporation, c/o General Counsel 2401 Utah Avenue South, Mail Stop S-LA1, Seattle, WA 98134 (888) SBUX-411 Service of legal process may also be made on the Plan Administrator or the Trustee.
Plan Funding	Starbucks Future Roast 401(k) Savings Plan benefits are paid from a trust fund. Contributions are made by partners and the Plan Sponsor and other participating companies, as applicable.
Participating Companies (as of October 1, 2020)	Starbucks Corporation Any other participating U.S. affiliates

Information provided by Starbucks. Fidelity is not responsible for contents.

Every effort has been made to communicate this benefit information clearly and in easily understandable terms. If there is any discrepancy between the information set out here and the legal Plan and trust documents, the terms of the legal Plan and trust documents always govern. Starbucks intends to continue the Future Roast 401(k) Savings Plan indefinitely but reserves the right to amend or terminate the Plan at any time and for any reason.

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan conforme al Plan de Ahorro 401(k) Starbucks Future Roast. Si tiene problemas para entender cualquier apartado de este folleto, envíe sus preguntas a **Savings@starbucks.com**. También puede escribirle a la Sra. Lisa Coutts, Savings and Retirement Plan Administrator, Starbucks Corporation, 2401 Utah Ave S. Ste 800, MS: HR-3, Seattle, WA 98134. Asimismo, puede llamar al despacho de la administradora del plan al +1 (888) 796-5282 opción 8, ext. 85653 u 83012 para solicitar ayuda. Horarios de atención: de lunes a viernes, de 7:30 a.m. a 4:30 p.m., hora del Pacífico.

STARBUCKS FINANCIAL WELLNESS@WORK

What is Financial Wellness?

Financial Wellness is feeling confidence in your financial situation and understanding how to better manage your money, your credit, your debt and your investments. For many of us, this is simply taking small, positive steps toward financial goals and avoiding costly mistakes. For others, it might include retirement and estate planning. Money plays a critical role in our lives and good money management can positively impact our physical and mental wellness.

Every individual's financial situation is unique and can be complex. There is no one-size-fits-all solution. Starbucks Financial Wellness@Work is a gathering of resources and tools offered by experts in money management, including Fidelity. These resources are available to all U.S. partners to use in whatever way works best for their needs.

Resources from Fidelity

Fidelity NetBenefits® (**netbenefits.com**) is your destination for broad financial help. It is a place to turn to for answers on everything from budgeting and debt management to Future Roast 401(k) and Bean Stock questions.

Financial Wellness Checkup

Start by taking the **Fidelity Financial Wellness Checkup** and get suggestions to help improve your financial health. This free and confidential tool will give you immediate feedback including a broad evaluation of your current financial situation and personalized financial content and direction. This checkup is entirely confidential, and none of your personal information or responses are shared with anyone. Find it by visiting **fidelity.com/mymoneycheckup** or by texting "Checkup" to 343898. After logging on to **netbenefits.com**, simply enter a few details about your financial situation such as annual income, spending and savings habits and goals. Upon completion of the assessment, you will receive evaluation scores for four categories:

- Budgeting
- Debt management
- Savings
- Protection

Based on your input and scores, Fidelity will recommend a specialized set of resources relevant to you. The customized tips will show you things you can do today to help improve your financial standing and give you direction on future goals.

For Everyday Money Matters

Explore Fidelity's full online financial library to help you make educated financial decisions. This is where you can find answers to common questions, (e.g. renting a home vs buying, how to consolidate credit card debt etc.). Resources are available in different formats, including articles, infographics, videos, and podcasts. You can browse any of these financial resources based on topic or format. Log on to netbenefits.com, click on the "Library" tab, and start exploring.

- Access **live and on-demand webinars** about managing your money – from paying down debt to budgeting and emergency funds
- **Learn the basics** to help improve your finances

Future Roast 401(k) Savings Plan

- Search for topics relevant to your major **life events** such as buying a home or getting married
- Help grow your savings and protect your lifestyle

For Retirement Readiness Help

- Retirement Analysis – Go to Fidelity's Planning and Guidance Center to get your personalized retirement score. Consider aggregating your account information using **Full View®** to get the most accurate picture of your projected retirement outcome.
- If you contribute to the Future Roast 401(k), look for an annual Personalized Retirement Assessment that will show how you are saving and investing, and what changes might help you improve your retirement outlook.

Fidelity® Personalized Planning & Advice

Managing your Future Roast 401(k) Savings Plan investment funds can be confusing, and yet neglecting to manage your investments can reduce your potential for growth over time.

For those who like to manage their investments themselves, the Future Roast 401(k) Savings Plan offers a variety of options including target date funds, foreign and U.S. equity investments, bond and stable value investments as well as a tier of ESG (Environmental, Social and Corporate Governance) sustainable investment options. More information about these options can be found in the Future Roast 401(k) Summary Plan Description "Investment Options Tiers" section or when you log in to netbenefits.com.

For those who want someone to manage their funds for them, Fidelity® **Personalized Planning & Advice** is a fee-based investment service that includes a dedicated team of professionals that will manage your Future Roast 401(k) account investments on your behalf. You provide information about your savings goals and preferences online, then Fidelity will create a personalized savings plan, put the plan into action and track your progress against your savings goals. As you notify Fidelity of changes in your life or as the investment environment changes, Fidelity will make adjustments to your investments. Fees associated with the Fidelity® Personalized Planning & Advice service are outlined online at netbenefits.com/plan. You can also learn more by calling Fidelity at (866) 811-6041, option 1.

Talk to an expert

Fidelity's registered phone representatives are only a call away and can help you with lots of everyday and long-term financial questions. Call (800) 603-4015 to utilize this complimentary resource.

Partner Hub Financial Wellness

Go to the Financial Wellness page on the Partner Hub to access links to the resources offered by Fidelity along with other free tools, services and content. The "My Money Matters" section of the Financial Wellness page on the Partner Hub focuses on a different financial topic every month or so. It contains links to online articles and videos that will help you learn more about that topic.

Stock Plans

STARBUCKS STOCK INVESTMENT PLAN (S.I.P.)

Through S.I.P. (Starbucks Corporation Employee Stock Purchase Plan — 1995), partners have an opportunity to buy company stock each quarter at a discounted price through regular payroll deductions.

When you participate in the Starbucks Stock Investment Plan (S.I.P.), you are investing in Starbucks stock. You can use your stock to help achieve short- or long-term goals. It's important to research your options before you invest.

Before you decide to enroll in S.I.P., and when determining the right amount to contribute to the plan, ask yourself:

- Is Starbucks stock the best investment for me?
- Do I understand the risks associated with investing in stock?
- How much can I afford to contribute to the plan each pay period?

Eligibility

You are eligible to participate if you have worked as a regular partner for Starbucks for at least 90 days.

How S.I.P. works

- You can contribute from 1% to 10% of your gross base pay to the plan, in whole percentage increments.
- Your contributions are automatically deducted from your paycheck, after taxes, each pay period.
- Each quarter, your contributions are used to purchase shares of Starbucks stock.
- Your contributions automatically continue into each quarterly offering unless you make a contribution change, withdraw from the plan, or end employment with Starbucks.

Your discounted purchase price

At the end of each quarter, your contributions are used to buy shares of Starbucks stock at a 5% discount, applied to the fair market value of Starbucks stock on the last business day of the quarterly offering.

Stock purchase example

Here is an example for a partner who is paid $1,000 biweekly and decides to contribute 10% of pay to S.I.P.:

Stock price on last business day of quarter	$55
Biweekly base pay	$1,000
Contribution percentage	10%
Biweekly contribution	$100
Pay periods per quarter	6
Total quarterly contribution	**$600**
Discounted stock purchase price (5% off of $55)	$52.25
Number of shares purchased ($600 ÷ $52.25)	**11**

($25.25 balance applied to next purchase)

Enrolling

It's easy to enroll in S.I.P.:

1. Decide how much you wish to contribute.
2. Enroll at **netbenefits.com**. New users: If you are logging in for the first time, you will need to create a PIN.
3. If you do not have online access, contact a Fidelity representative at (866) 697-1048, option 2, from 2 p.m. Sunday through 9 p.m. Friday, Pacific Time, excluding holidays observed by the New York Stock Exchange.
4. You must enroll by the 15th of each open enrollment period, as shown in the table below.
5. Your payroll deductions start with the first paycheck after the new quarterly offering begins.

Enroll, make changes, or withdraw during this open enrollment period…	… to be effective during this offering and subsequent offerings, until changed
December 1 – 15	January – March
March 1 – 15	April – June
June 1 – 15	July – September
September 1 – 15	October – December

During any open enrollment period, eligible partners can:

- Enroll in S.I.P. for the first time
- Change their contribution percentage
- Withdraw from the plan, or
- Re-enroll in the plan (if previously withdrawn).

Once enrolled, you can access plan documents on the Fidelity NetBenefits® site by clicking on the S.I.P. link and then on the Plan Documents section.

Tax information

For U.S. citizens, there are no income tax consequences related to your stock purchased under S.I.P. until you sell or transfer your shares. A key factor in determining the income tax consequences of a stock sale is how long you have held the shares.

If you hold the stock for a "qualified holding period," the law allows preferential tax treatment. Under S.I.P., you must hold your stock in your Fidelity account for at least 21 months from the date of purchase to meet this requirement. (This is a specific requirement for this type of stock purchase and is a different holding period than what is required for capital gains purposes.)

Generally, you will pay tax on a portion of this income at lower capital gains rates if you meet the holding-period requirement. After that 21-month period, you are free to transfer those shares to another brokerage account. If you sell your stock at a gain before holding it for 21 months, a portion of the gain will be reported as ordinary income.

Starbucks will report this income on your W-2 as compensation in the year you sell your stock. Currently, Starbucks does not withhold any taxes on this amount.

If you are no longer a Starbucks partner

If you are no longer employed by Starbucks for any reason, the balance of your S.I.P. contributions not used for purchase is refunded to you — or to your designated beneficiary if you die — on your next paycheck after your separation has been processed. You can continue to hold S.I.P. shares you have purchased after you leave Starbucks.

Your Fidelity account

When you purchase shares of Starbucks stock, they are held in a Fidelity account. Your Fidelity account statements available on **netbenefits.com** reflect the number of shares of Starbucks stock you own, the purchase price, and the market value of your shares.

How to sell your stock

If you sell your shares, the proceeds will be deposited into your Fidelity account. You can sell your S.I.P. shares by:

- Logging in to **netbenefits.com**, or
- Calling Fidelity at (866) 697-1048, option 2, where you can speak with a Fidelity representative, from 2 p.m. Sunday through 9 p.m. Friday, Pacific Time, excluding holidays observed by the New York Stock Exchange.

Managing your account

You can use your Fidelity account to manage a portion — or all — of your other investing activity. You always have access to your S.I.P. account by logging in to **netbenefits.com** or calling (866) 697-1048, option 2. When you log in, you can manage your account information, as well as sell shares.

For more information

For more information about S.I.P., call Fidelity at (866) 697-1048 or, for online information, visit **netbenefits.com.**

BEAN STOCK

Bean Stock granted under Starbucks Corporation 2005 Long-Term Equity Incentive Plan, gives a broad base of partners the opportunity to own Starbucks stock through a grant of restricted stock units (RSUs). With *Bean Stock,* partners have a personal connection to Starbucks growth and a means of sharing in the benefits of the company's success.

Eligibility

To be eligible for *Bean Stock*, partners must be:

- Employed by Starbucks as of May 1 of the fiscal year preceding the grant date and
- Are a store partner, or a non-retail partner in a position up to, but not including grade 25+ jobs, and
- Work in a company owned market (licensed/franchise stores are not eligible)

Bean Stock RSUs

Each year, our Board of Directors evaluates the company's performance, cost of the program and how many shares of Starbucks stock are available to grant to partners. Based on this information the Board decides whether to grant restricted stock units (RSUs) to eligible partners. The number of *Bean Stock* RSUs a partner may receive will vary from year to year based on their job (retail) and annualized salary (nonretail), and the fair market value of Starbucks stock on the grant date.

Bean Stock is generally granted to eligible partners each November, subject to approval by the Starbucks Board of Directors. Eligible partners will receive a *Bean Stock* grant in the form of restricted stock units (RSUs), which turn into shares of Starbucks stock after a specific period of time has passed. As long as you remain continuously employed during that waiting period (called vesting), you get one share of Starbucks stock for each RSU, less taxes. Once you own the shares, you can hold or sell them.

For more information

For more information about *Bean Stock*, call Fidelity at (866) 697-1048 or, visit **netbenefits.com** or **starbucksbeanstock.com**.

Short Term Disability

Starbucks provides you with pay for up to 26 weeks if you are sick or injured and cannot work. U.S. mainland partners eligible for Starbucks benefits are covered by the Short Term Disability (STD) plan. Hawaii partners meeting the eligibility requirements of the state of Hawaii are covered by Temporary Disability Insurance (TDI). Your STD and TDI coverage is automatic — you do not need to do anything to enroll.

SHORT TERM DISABILITY COVERAGE

U.S. mainland partners

If you have an illness or injury that prevents you from working, you may be eligible for Short Term Disability (STD) pay. To receive this benefit, you must meet certain eligibility requirements.

Any partner who meets the benefits eligibility requirements (see the **Eligibility and Enrollment** chapter) is automatically covered for STD.

Once covered, you must meet the following criteria in order to receive STD benefits for your disability:

- You are totally and medically disabled;
- You require the ongoing care of a healthcare provider; and
- You are actively working on the date your disability commences.

"Totally and medically disabled" means that you are not working in any other capacity or occupation, full-time or part-time, with another employer or self-employed.

"Healthcare provider" means any physician who is duly licensed and acting within the scope of his/her practice; a nurse practitioner or nurse midwife who is licensed to practice under state law and who is performing with the scope of his/her practice; or a psychologist licensed in the state of practice with a doctorate degree in psychology. A healthcare provider cannot be the partner, his/her spouse, daughter, son, mother, father, sister or brother by marriage, blood or adoption, or registered domestic partner.

"Actively working" means you are employed by Starbucks and not on a leave of absence for any reason other than your disability.

If you are disabled while not actively working (for example you become disabled during a planned Career Coffee Break), your eligibility for STD benefits will be delayed until you are scheduled to return to work. If you have a planned leave of absence and are unexpectedly disabled prior to beginning that leave of absence, your benefits will be delayed during that planned absence and may resume should you still be disabled upon your expected return to work.

Did You Know?

If you're unable to work due to pregnancy or recovery from childbirth exceeding the Parental Leave benefit, you are eligible for STD benefits. For information, call (866) 206-6769.

Hawaii partners

Partners working in Hawaii are eligible for Temporary Disability Insurance (TDI) instead of STD. Starbucks TDI coverage may provide you with pay for up to 26 weeks if you cannot work due to a non-occupational total medical disability. As long as you satisfy the State of Hawaii's eligibility requirements, you are automatically covered by TDI – you don't need to enroll.

If you cannot work because of a covered sickness or injury, the TDI plan will replace 66-2/3% of your average weekly earnings, up to $2,250 per week. The plan pays benefits starting on the fourth day of absence. TDI benefits are paid to you every two weeks.

TDI benefits are not considered earnings for *Bean Stock*, S.I.P. and Future Roast 401(k) plan purposes.

Refer to **page 120** for information on how to file a claim for Temporary Disability Insurance.

CALCULATING YOUR BENEFIT

If approved, the STD plan will replace 66-2/3% of your average weekly earnings, up to $2,250 per week. STD benefits are paid to you based on your pay cycle. Any STD benefits payable for less than a week will be paid to you at the rate of 1/7 of the STD weekly benefit for each day of your total disability.

STD benefits are not considered earnings for *Bean Stock*, S.I.P. and Future Roast 401(k) plan purposes.

Here is an example of how STD pay is calculated:

Your average weekly earnings are	$500
2/3 of this amount	x 0.666
Equals your weekly STD benefit of	$333

Average weekly earnings

Under the STD plan, your average weekly earnings are defined as the average weekly gross pay you received from Starbucks over the 26 weeks before the date you became disabled. If you have been employed for less than 26 weeks, gross pay will be averaged over your period of employment. Eligible performance-based bonuses paid over the 12 months immediately preceding your disability will be included when calculating your average weekly earnings (total eligible bonuses in the 12-month period divided by 52). Your earnings under the STD plan do not include any commissions, stipends, ineligible bonuses, overtime pay or other extra compensation or income from sources other than Starbucks. Imputed tips are included in average weekly earnings. For hourly non-exempt partners in Hawaii, average weekly earnings are defined as gross pay you receive from Starbucks over the eight weeks before you become disabled and for salaried partners the gross wages are reported for the week prior to your disability date.

If you are at a vice president job level or above, your average weekly earnings are defined as your weekly gross base salary in effect on the date you became disabled plus your average performance bonus over the 12 months immediately preceding the date you became disabled.

Periods of approved leaves of absence during the 26 weeks preceding your disability are excluded when determining your average weekly earnings. Periods of unapproved leaves of absence are included with weekly earnings of $0. If, due to an approved leave of absence, you were not receiving wages during any of the 26 weeks preceding your disability, your STD wages will be calculated using the 26 weeks preceding the start of that leave.

Other disability income benefits

Your STD pay will be reduced by most other disability income benefits you receive or are entitled to receive, even if you do not receive benefits because of your failure to initiate a claim. These include, but are not limited to, state disability programs and policies from other employers that cover the same disabilities as Starbucks STD plan. Your STD pay will not be offset by individual disability plans.

If you work in California, New Jersey, New York, Rhode Island, Washington D.C., or Washington State you may be eligible to receive state disability benefits. You must apply for those state benefits in addition to sending your claim to Starbucks Short Term Disability administrator (Sedgwick). Contact your state disability office to apply for state disability. Note that you will not be eligible for Short Term Disability or Starbucks paid leave benefits until you have applied for any applicable paid family and medical leaves available in your state and provided proof of your benefit amount.

If you work in New York, Unum is the administrator of your state disability claim. You can apply for New York state disability at the same time you are filing your STD claim; however, Unum will correspond with you and send you your disability payments.

Here is an example of how other disability income benefits affect your STD benefit.

Your average weekly earnings	$500
2/3 of this amount	x 0.666
Equals your STD benefit before reduction	$333
Subtract other sources of disability income (from your state, Social Security, etc.)	($275)
STD plan pays the difference	$58

What About Federal Income Withholdings?

If you are a U.S. mainland partner, your STD pay will be subject to the same tax withholding as your Starbucks pay. If you are a Hawaii partner, federal and state income tax will not be withheld from your TDI pay. If you wish to have income taxes withheld, you must include a W–4 with your application. Social Security and Medicare (FICA) taxes will be withheld from both STD and TDI pay, as required by law.

WHAT IS NOT COVERED

The STD and TDI plans do not cover any loss of income that results from the following:

- Illness or injury sustained while acting within the course of employment with Starbucks or another employer, unless your illness or injury has been denied by workers compensation as a non-covered condition
- Loss of a professional license, occupational license or certification not related to a covered illness or injury
- Treatment not medically necessary (except for disabilities due to organ donation, which are covered)
- Procedures under clinical investigation or considered experimental by health professionals
- Reversal of a sterilization procedure
- Plastic, reconstructive or cosmetic surgery or any other service intended to improve, alter or enhance appearance unless due to one of the following:

- Surgery or other service performed for breast reconstruction following mastectomy due to medical condition;
- Coverage under Starbucks Transgender Medical Benefits coverage;
- To improve the function of a body part (not teeth or supporting structures) malformed by a severe birth defect, disease, or surgery; or
- To repair an injury that occurred while employed by Starbucks.

- Disability arising out of war, any act of war (declared or undeclared) or from service in any of the regular U.S. armed forces
- Active participation in a riot, or committing or attempting to commit an assault or felony
- When you are being treated solely by a chiropractor

YOU MUST APPLY FOR A LEAVE OF ABSENCE

When you apply for STD or TDI benefits, you will be required to apply for a leave of absence. Reporting requirements may be different for leave of absence approval. See the **Time Off chapter** for information on Starbucks leave of absence programs. While on leave, you will also be billed for any amount you owe for benefit contributions. Please refer to **Paying for benefits while on leave on page 21** for more information.

WHEN YOUR STD BENEFITS BEGIN AND END

Once approved, your STD pay will begin on the earlier of the following:

- The eighth consecutive calendar day following the day you establish eligibility for STD
- The first full day of absence following hospitalization; or
- The first full day of absence following outpatient surgery if you are totally and medically disabled as a result of the surgery

If you became totally and medically disabled while not actively working (e.g. previously requested leave of absence), you are not eligible to receive Short Term Disability until the day you were scheduled to return.

Your STD benefits will end on the earliest of the following occurrences:

- You are no longer considered disabled under this plan
- You fail to provide adequate evidence of your disability as required
- You are gainfully employed in any capacity or occupation with any employer, including self-employment
- The end of the maximum benefit period
- Your death

USING VACATION PAY AND/OR SICK TIME

During the waiting period before your disability pay benefits begin, you may elect to use any available sick time or vacation pay. You may also use your available sick time or vacation pay in lieu of receiving STD pay. You are not required to exhaust available sick time or vacation pay prior to receiving STD pay. For more information regarding STD pay replacement, call (866) 206-6769.

Maximum benefit period

The STD plan may pay you for up to 26 weeks. This 26-week maximum benefit period only applies to one continuous period of a total disability.

If you have a recurrent disability

If you return to work from a disability for which you received STD pay and you become disabled again, your second absence may count against your previous 26-week maximum benefit period. Your subsequent disability will count against your previous maximum benefit period if:

- Your subsequent disability is the same medical condition and you return to work for less than 60 consecutive days, or,
- Your subsequent disability is unrelated to the first and you return to work for one full day or less.

If your second disability is treated as a continuation of the first, your pay will resume with no waiting period.

WHEN COVERAGE ENDS

Your participation in the STD plan and eligibility for STD benefits ends when you are separated from employment with Starbucks. Your coverage will end if you lose eligibility due to an ongoing eligibility audit. The eligibility requirements are covered in detail in the **Eligibility and Enrollment chapter.**

Any STD paperwork submitted prior to your separation from Starbucks will be reviewed for approval. If approved, you will continue to receive STD benefits for the maximum period of 26 weeks or less if any other occurrence applies (see **When Your STD Benefits Begin and End on page 119**). If you become disabled before you lose coverage due to an eligibility audit, you may still be eligible to receive STD pay for the maximum period of 26 weeks or less if any other occurrence applies.

HOW TO FILE A CLAIM

U.S. mainland partners

To receive STD benefits, you — or someone acting on your behalf — must file a claim. You must file your claim within 60 days from the date of disability. Take the steps outlined below. Claims will be processed by the Partner Care Team at Starbucks Short Term Disability administrator (Sedgwick); see the Time Off chapter for leave of absence reporting timelines, as they may differ from STD pay replacement timelines listed here.

1. Go to **claimlookup.com/starbucks** or call (866) 206-6769 to request a Short Term Disability claim form..
2. Complete your portion of the claim form and follow up to ensure completion.
3. Ask your doctor to complete the physician section of the claim form and follow up to ensure completion.
4. Make copies for your records.
5. Submit your completed documentation in one of the following ways:

Email: starbucksmail@sedgwickcms.com
Fax: (866) 315-0607
Mail: Sedgwick Claims Management Services, Inc.
PO BOX 14424
Lexington, KY 40512-4424

Note: Please allow 24 hours before calling to confirm the receipt of your email or fax.

If approved, you can expect a disability check within two to three weeks of submitting your complete claim documentation. Ongoing disability checks will mirror your normal Starbucks pay cycle.

You may be required to provide additional information from you or your doctor certifying your continued total disability. The Partner Care Team may require that you be independently examined by a physician, other health professional or vocational expert of their choice and interviewed by an authorized Sedgwick representative.

The Partner Care Team may require this independent examination as often as reasonably necessary. The independent examination will be paid for by Starbucks.

You will be notified in writing if a claim or any part of a claim is denied. The denial letter will state:

- The specific reason(s) for the denial with reference to the applicable plan provision(s)
- A description of any additional material or information that is necessary to complete the claim
- An explanation of why the additional material or information is necessary
- A statement describing your access to documents
- A statement describing your appeal rights

If you are not satisfied with the reason(s) for the denial, you or your representative may appeal the claim decision. Your appeal must be in writing and submitted within 90 days of your denial notice. Your appeal should include all supporting materials or information that will help review the claim. An appeals specialist will review your appeal and all new information submitted and notify you or your representative of its decision promptly. In some cases, you may need to provide additional information to assist in the review.

Hawaii partners

Hawaii state law requires that you file your claim 90 days from the date you were disabled. If you file your claim after 90 days, you may lose part of your benefits unless good cause can be shown. If you file your claim 26 or more weeks after your disability, you will not be entitled to any benefits. To avoid partial or complete loss of benefits, file your claim within 90 days.

To apply for Hawaii Temporary Disability Insurance (TDI) benefits, please follow the steps below:

1. Call (866) 206-6769 to request a TDI claim form.
2. Complete Part A — Claimant's Statement.
3. Ask your doctor to complete and sign Part C — Doctor's Statement.
4. Make copies for your records.
5. Submit your completed application in one of the following ways:

   Email: SRcrdsRm@starbucks.com
   Fax: (206) 594-6761
   Mail: Starbucks Coffee Company
   Attn: HR Operations
   P.O. Box 34067, Mail Stop S-SPSS
   Seattle, WA 98124-1067

QUESTIONS?

For general questions about the STD or TDI plans or how to file a claim, visit **claimlookup.com/starbucks** or call (866) 206-6769.

For the status of your ongoing claim payments, call (866) 206-6769. Phone lines are open weekdays from 5 a.m. to 6:30 p.m. Pacific Time.

For the status of your ongoing claim payments, visit **claimlookup.com/starbucks** or call (866) 206-6769. Phone lines are open weekdays from 5 a.m. to 6:30 p.m. Pacific Time.

For assistance with your TDI Disability claim, contact Pacific Guardian TDI Department at (800) 367-5354.

Long Term Disability

The Long Term Disability plan provides you with benefits that replace part of your income when you are completely or partially limited from working for more than 26 weeks due to a medical disability resulting from a sickness or injury.

HOW THE PLAN WORKS

Starbucks Long Term Disability (LTD) plan picks up where Short Term Disability (STD) leaves off after you have been disabled for a continuous 26-week period. It may replace part of your income if you are medically disabled and are limited from working. You must be eligible on the date your disability commences, as determined by Starbucks Long Term Disability administrator (Unum) in order to receive LTD benefits. If you are not actively working at Starbucks at the time you initially become benefits eligible — for example, if you are on a leave of absence or taking a sick day — your LTD coverage will go into effect once you return to work at least one full day (four hours or more).

Your eligibility for coverage under the Long Term Disability plan depends on your position at Starbucks:

- **If you are a retail hourly partner**, (excluding shift managers), you have the option to enroll in the LTD plan and pay for your coverage through automatic payroll deductions.
- **If you are a retail management, shift manager, or nonretail partner**, your enrollment in the LTD plan is automatic and your coverage is paid for by Starbucks.

During the first 26 weeks of disability, called the "elimination period," you will be considered medically disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury and are under the regular care of a physician. The STD plan may pay you benefits during the elimination period.

You will receive an LTD benefit from Unum as long as you provide proof that you are under the regular care of a doctor, medically disabled due to sickness or injury and have suffered a loss of income of 20% or more.

DEFINITION OF DISABILITY

Partners other than vice president job level and above

For the first 24 months of disability, you are disabled when:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and
- You have a 20% or more loss in your indexed basic monthly earnings due to the same sickness or injury.

You will continue to receive LTD benefits beyond 24 months if you are also:

- Working in any occupation and continue to have a 20% or more loss in your indexed monthly earnings due to your sickness or injury, or
- Not working and, due to the same sickness or injury, are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Vice president job level and above

You are disabled when:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and
- You have a 20% or more loss in your indexed basic monthly earnings due to the same sickness or injury.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

CALCULATING YOUR BENEFIT

If you are a retail hourly partner (excluding shift managers)

Your LTD plan replaces 60% of your average monthly earnings, up to a maximum benefit of $1,000 per month for claims with a first date of absence occurring October 1, 2019 or later. For claims with a first date of absence prior to October 1, 2019, or recurrent disabilities, the maximum benefit is $500 per month. See **if you have a recurrent disability on page 129**.

Your minimum monthly benefit is the greater of:

- $100, or
- 10% of your monthly benefit before reductions for other disability income benefits you may receive, such as workers compensation or Social Security

If you are medically disabled and receiving Short Term Disability pay, you will need to continue paying your LTD premiums, if enrolled. However, once you begin receiving LTD benefits (after 26 weeks of disability), you are no longer required to pay your LTD premiums. Call Unum at (800) 858-6843 for more information.

If you are a retail management, shift manager, or nonretail partner

Your LTD plan replaces 60% of your average monthly earnings, up to a maximum benefit of $10,000 per month. If you are in a vice president job level or above, the maximum benefit is $15,000 per month.

Your minimum monthly benefit is the greater of:

- $100, or
- 10% of your monthly benefit before reductions for other disability income benefits you may receive, such as workers compensation or Social Security

If your job level is vice president or above, the premium paid by Starbucks for your LTD coverage is included in your gross wages.

Average monthly earnings

Under the LTD plan, your *average monthly earnings* are defined as the average monthly gross pay you received from Starbucks over the 26 weeks before the date you became disabled. If, due to an approved leave of absence, you were not receiving wages during any of the 26 weeks preceding your disability, your LTD wages will be calculated using the 26 weeks preceding the start of that leave. Periods of approved leaves of absence during the 26 weeks preceding your disability are excluded when determining your average monthly earnings. Periods of unapproved leaves of absence are included with monthly earnings of $0. Your earnings under the

LTD plan do not include any commissions, tips, stipends, bonuses, overtime pay or other extra compensation or income from sources other than Starbucks.

If you are in a vice president job level or above, your average monthly earnings are defined as your monthly gross base salary in effect on the date you became disabled plus your average performance bonus over the 12 months immediately preceding the date you became disabled.

Partial disability benefits

Starbucks LTD plan encourages you to return to work as soon as you and your doctor determine you are able. During the time you are partially disabled, Unum may pay you a reduced benefit in addition to your regular earnings.

Once your doctor releases you to return to work part-time, your partial disability benefit will be determined as outlined below.

Unum will adjust your average monthly earnings to account for inflation. Adjustments will be made annually on the anniversary of your benefit payments and will be based on the lesser of 10% or the current annual percentage increase in the Consumer Price Index (CPI). Your adjusted average monthly earnings are called indexed pre-disability earnings. Indexing is only used to determine the percentage of lost earnings while you are disabled and not working.

If you are capable of earning at least 20% (but no more than 80%) of your indexed pre-disability earnings, then you become eligible for a partial disability benefit. Unum will calculate your benefit as follows:

During the first 12 months of your partial disability, if you work while partially disabled, you will receive your LTD benefit plus your disability earnings, up to 100% of your LTD indexed pre-disability earnings.

After the first 12 months of your partial disability, if you work while partially disabled, your LTD benefit will be reduced in proportion to your loss of earnings.

What Are Disability Earnings?

Disability earnings include the income you receive while you are disabled and working and earnings you did not receive but could have if you had been working to the full extent to which you were capable.

For example, if your doctor releases you to return to work 30 hours a week and you choose to work only 20 hours a week, the plan will consider your disability earnings to be equivalent to 30 hours a week.

Other income benefits

Your gross LTD benefits will be reduced by any other income benefits you receive or are entitled to receive due to your disability. Other income benefits include, but are not limited to:

- Benefits from state disability or workers compensation, unemployment, sick or vacation pay
- Benefits from any other group insurance coverage
- Social Security disability or retirement benefits for you or your dependents
- The amount you receive from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise

In calculating your monthly benefit from the LTD plan, Unum will estimate the amount of any other income benefits if they have not yet been determined or if a denial is being appealed. This estimate will be used to reduce the amount of your monthly LTD benefit payments.

If you do not want Unum to use an estimate, you must complete and return the *Benefit Payment Option* form to Unum. This agreement states that you promise to reimburse Unum for any overpayment caused by a later reward of other income benefits. For more information, call Unum at (800) 858-6843.

WHAT IS NOT COVERED

The LTD plan does not cover any loss of income that results from the following:

- Loss of a professional license, occupational license or certification
- Commission of a crime for which you have been convicted under state or federal law
- War or any act of war (declared or undeclared)
- Active participation in a riot
- Intentionally self-inflicted injuries, while sane or insane
- A pre-existing condition

Unum will not pay a benefit for any period of disability during which you are incarcerated.

Pre-existing conditions

The LTD plan will not cover any disability caused by, contributed to or resulting from a pre-existing condition and occurring in the first 12 months after your LTD coverage began. This 12-month period is called the pre-existing condition exclusion period.

If your coverage ends while you are on an approved leave of absence and if you were previously enrolled in LTD coverage for at least 12 consecutive months prior to the beginning of your approved leave, coverage will be reinstated when you return to active employment. You will not have a new waiting period, a new pre-existing conditions exclusion, or need to provide evidence of insurability.

If you terminate employment and are rehired, a new pre-existing condition exclusion period will apply.

Retail hourly partners:
You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a healthcare provider in the 12 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

Retail management and nonretail partners:
You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a healthcare provider in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

Self-reported symptoms and mental illness limitations

Payment of LTD benefits is limited to 24 months of disability when primarily based on self-reported symptoms or caused by or contributed to by a mental illness. However, if you are confined to a hospital or institution at the end of the 24 months, this limitation will not apply while you are continuously confined. If you are disabled when discharged, you will receive a monthly LTD benefit for a recovery period of up to 90 days.

If you are confined again at any time during the recovery period and remain confined for at least 14 days in a row, you will receive an LTD benefit for the additional admission and for one additional recovery period up to 90 days.

What Is Considered Mental Illness?

Mental illness is defined as a psychiatric or psychological condition regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment.

What Are Self-reported Symptoms?

Self-reported symptoms are the manifestations of your condition, which you tell your physician, that are not verifiable using tests, procedures or clinical examinations generally accepted in the practice of medicine. Examples include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in the ears, dizziness, numbness and loss of energy.

WHEN YOUR LTD BENEFITS BEGIN AND END

If eligible, you must meet the following criteria in order to receive LTD benefits for your disability:

- You have been totally and medically disabled for a period of 26 weeks;
- You require the ongoing care of a healthcare provider;
- You were actively working on the date your disability commences; and
- You are employed by Starbucks at the time the plan administrator determines your eligibility for LTD benefits.

"Totally and medically disabled" means that for a continuous period of at least 26 weeks:

- You have been limited from performing the material and substantial duties of your regular occupation; and
- Were not working in any other capacity or occupation, full time or part time, with another employer or self-employed, due to your sickness or injury.

Your disability will be treated as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period. Please see the section titled **Partial disability benefits on page 125** for details on partial LTD disability benefits.

"Healthcare provider" means any physician who is duly licensed and acting within the scope of his/her practice; a nurse practitioner or nurse midwife who is licensed to practice under state law and who is performing with the scope of his/her practice; or a psychologist licensed in the state of practice with a doctorate degree in

psychology. A healthcare provider cannot be the partner; his/her spouse, daughter, son, mother, father, sister or brother by marriage, blood or adoption, or registered domestic partner.

"Actively working" means you are employed by Starbucks and not on a leave of absence for any reason other than your disability.

If you are disabled while not actively working, your eligibility for LTD benefits will be delayed until you are scheduled to return to work. If you have a planned leave of absence and are unexpectedly disabled prior to beginning that leave of absence, your benefits will be delayed during that planned absence and may resume should you still be disabled upon your expected return to work.

Your LTD benefits will continue until one of the following occurs:

- You are no longer medically disabled under the terms of the plan.
- Your monthly disability earnings exceed 80% of your pre-disability earnings.
- You reach the end of the maximum benefit period.
- You fail to provide proof of your continued medical disability, as requested by Unum.
- You die.
- You are not in a vice president job level or above and you are able to work part-time in your regular occupation during the first 24 months of LTD payments, or any gainful occupation after 24 months but choose not to.
- You are in a vice president job level or above and you are able to work part-time in your regular occupation but choose not to.

Maximum benefit period

How long you can receive benefits from the LTD plan depends on your age when you become medically disabled. The following chart shows your maximum benefit periods:

Age at disability	Maximum benefit period
Under age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

When you reach the maximum benefit period, your LTD benefits will end.

If you are overpaid, Unum has the right to recover any overpayments resulting from errors Unum makes in processing a claim, your receipt of deductible sources of income and fraud. Unum will determine your repayment method.

If you have a recurrent disability

What happens if you try to return to work and become disabled again? A *recurrent disability* is a disability which is caused by a worsening in your condition and due to the same cause(s) as your prior disability for which you received a monthly LTD benefit.

If you are receiving LTD benefits, recover and return to active employment in your regular occupation, then suffer a relapse, certain provisions apply.

- If the relapse is a result of the same or related cause and occurs within 12 months of your return to work, and you were continuously enrolled in the LTD plan during this time, your disability is considered a continuation of your earlier disability. Benefit payments will resume with no waiting period.
- If the relapse occurs more than 12 months after your return to work, it is considered a new disability. You must be disabled for a new 26-week period before you are eligible to receive LTD benefit payments.

IF YOU TAKE A LEAVE OF ABSENCE

Your Long Term Disability coverage may continue during a leave of absence as outlined on page 25. Retail hourly partners who purchase LTD coverage will be required to continue to make their premium payments for LTD coverage during a leave of absence. Premiums for LTD coverage will be collected through direct billing from Starbucks Benefits Center. If the partner does not make premium payments while on leave of absence, coverage will be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

WHEN COVERAGE ENDS

If you are no longer a Starbucks partner, your LTD coverage ends on the last day you are actively at work.

If you lose benefits eligibility due to the ongoing benefits eligibility audit, your coverage ends as described in the Eligibility and Enrollment chapter.

If you are on a leave of absence and do not make payment by your deadline, your elected coverage will end at the end of the month in which you last made full payment. LTD coverage provided by Starbucks will continue.

HOW TO FILE A CLAIM

Starbucks Short Term Disability (STD) administrator (Sedgwick) will notify Unum when an STD claim has reached 18 weeks. Unum has access to view the STD claim information and paperwork as long as there is a signed waiver from the partner. If the signed waiver has been received, you will not need to file a claim for LTD benefits.

If you have purchased an LTD plan and have not received STD benefits through Starbucks, you will need to apply for LTD benefits before completing the 26-week waiting period. Partners can apply for LTD by calling Unum at (800) 858-6843.

Unum will notify you of its decision within 45 days after your claim is filed. If, because of matters beyond the control of Unum, a decision cannot be made within 45 days, then Unum has an additional 30 days to make its decision. If the matters preventing a decision have not been resolved after the 30-day extension, Unum may

extend its decision a final 30 days. If an extension is needed, Unum will send you a notice explaining why the extension is required and by what date it expects to make a decision regarding your claim.

If the extension is required because you fail to submit the information necessary to decide the claim, Unum will send you a notice describing the information it requires to decide your claim. You will then have at least 45 days from the date you receive the notice to provide the required information.

Unum's 30-day extension will begin after you have submitted the required information, provided you did so within the time frame specified by Unum. If you do not provide the required information within the time frame specified, Unum may decide your claim without that information.

If your claim for benefits is denied, either in whole or in part, you may appeal the claim denial by following the process described on **page 249**.

IF YOU DIE

A survivor benefit equal to three times your gross monthly LTD benefit is paid to your *eligible survivors* if all of the conditions below apply:

- You die while you are receiving or are entitled to receive a monthly LTD benefit.
- Your disability had continued for 180 or more consecutive days.
- Unum receives proof of your death.

Benefits will be paid to your eligible survivors, in this order:

1. Your spouse
2. Your children under age 25, in equal shares
3. Your estate

The survivor benefits are reduced by any overpayment that may exist on your claim.

Taxes

Your LTD payments may be subject to taxes, including federal and state income taxes, as well as unemployment taxes. You may want to talk to a tax advisor for more information. If your job level is vice president or above, your LTD benefit is not taxable because you paid taxes on the LTD premium paid by Starbucks. If you are a retail hourly partner, your LTD benefit is not taxable because your LTD premiums were paid for by after-tax payroll deductions.

QUESTIONS?

For general questions about the LTD plan and how to file a claim, call Unum at (800) 858-6843. For the status of your ongoing claim payments, call Unum directly at (800) 858-6843. Phone lines are open from 5 a.m. to 5 p.m. Pacific Time, Monday through Friday.

You can also visit Unum at **unum.com**. You can check on status of claims, as well as find other useful information.

Please note that the above is just a highlight of the Unum plans and plan provisions. Please refer to the formal document for all policy plans, exclusions, limitations and provisions.

Life Insurance & AD&D Insurance

LIFE INSURANCE

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life Insurance

Having financial protection in the event of death means more security for your family members. To help you prepare, Starbucks offers you three life insurance plans: partner life insurance, spouse or domestic partner life insurance, and child life insurance.

HOW THE PLANS WORK

Partner life insurance provides benefits to your designated beneficiary(ies) if you die. The more others depend on you and your income, the more partner life insurance you may need. Your coverage level is the amount that is paid to your beneficiary(ies) if you die.

Starbucks gives you the option to purchase life insurance coverage for your spouse or domestic partner. You may choose spouse or domestic partner life insurance only if you are covered by partner life insurance.

You have the option to purchase life insurance coverage for your child(ren) who are under the age of 26. You may choose child(ren) life insurance only if you are covered by partner life insurance.

All three Starbucks life plans — partner, spouse or domestic partner and child — are insured and administered by Hartford Life and Accident Insurance Company ("Hartford Life").

PARTNER LIFE INSURANCE

Your partner life insurance coverage depends on your position at Starbucks.

Retail hourly partners (excluding shift managers)

Basic life
Once you become benefits eligible, you are automatically covered for partner life insurance coverage in the amount of $10,000, fully paid by Starbucks.

Supplemental life
You can also purchase additional levels of coverage. Your payroll deductions for coverage are taken before taxes are withheld.

Your partner supplemental life insurance coverage options are:

- $5,000
- $10,000
- $25,000
- $40,000

Retail management, shift managers, or nonretail partners

Basic life
Once you become benefits eligible, you are automatically covered for partner life insurance coverage at one times your annualized base pay, paid for by Starbucks. If you are an executive at Starbucks (vice president job level and above), you are provided life insurance coverage at three times your annualized base pay, and the coverage begins at date of hire.

Supplemental life

You can also purchase additional levels of coverage. Your payroll deductions for coverage are taken before taxes are withheld.

Your partner supplemental life insurance coverage options are:

- One times base pay
- Two times base pay (maximum for executives)
- Three times base pay
- Four times base pay

The maximum total coverage (basic and supplemental) any partner may have is five times the partner's base pay.

Your life insurance cost and coverage amounts are calculated at the time you become eligible to participate and are shown online when you enroll in benefits. Your coverage amount is based on your annualized base pay at that time, rounded up to the next $1,000. The maximum amount of partner basic and supplemental life insurance coverage combined that you can carry through Starbucks plan is $750,000; executives may carry a maximum of $2,000,000.

Your cost will remain constant until the next annual benefits enrollment. During benefits enrollment, you may increase supplemental life insurance coverage for yourself by one level without providing evidence of insurability, up to each plan's guarantee issue maximum. If your base pay changes during the year, any benefit paid to your beneficiary(ies) will be based on your actual pay at the time life insurance benefits become payable. You need to be actively at work at the time a pay change goes into effect for your life insurance coverage to reflect that change. Otherwise, the change will take effect when you actively return to work.

What Is Annualized Base Pay?

Your *annualized base pay* is your gross earnings prior to any before-tax deductions. It does not include any commissions, tips, stipends, bonuses, overtime pay or other compensation.

Imputed income

You may be taxed on the value of partner life insurance coverage (basic and supplemental combined) that exceeds $50,000 and is paid for by Starbucks. The amount of imputed income is shown on your pay statement as "Taxable Life."

Beneficiary Designations

You are asked to designate beneficiaries on your life insurance coverage at the time you enroll in Starbucks benefits. You can change your beneficiary(ies) at any time by logging in to **mysbuxben.com** or by calling Starbucks Benefits Center at (877) SBUXBEN and speaking with a representative.

Reduction in benefits

The amount of your death benefit is reduced once you reach age 65, as shown below.

At ages	Your death benefit is reduced by	The percentage of life insurance benefit payable is
65 through 69	35%	65% (rounded to the next highest $500)
70 and over	55%	45% (rounded to the next highest $500)

Any reduction in your death benefit may also reduce your spouse or domestic partner amounts, if enrolled, in order to satisfy the rule that your dependent life insurance coverage cannot be more than 50% of your total partner life insurance coverage. (See **Spouse or Domestic Partner Life Insurance** below and **Child Life Insurance on page 135** for more information.)

Actively-at-Work Provision

If you are not actively working at Starbucks at the time you initially become eligible for benefits or when your coverage is reinstated following re-establishment of benefits eligibility (for example, when you are on a leave of absence or taking a sick day), your life insurance coverage will go into effect once you return to work at Starbucks at least one full day (four hours or more). You must return from a leave of absence before any change to your life insurance can take effect.

When coverage begins

Provided you meet the actively-at-work provision, your life insurance begins as outlined below:

- Starbucks-provided basic partner life insurance begins on your initial benefits eligibility date. If you transfer positions (from retail hourly to retail management/nonretail or vice versa), the applicable basic life insurance coverage is effective the date of your transfer.
- Supplemental partner life coverage that you elect and pay for begins on your initial benefits eligibility date or position transfer date, provided you enroll before that date , or on 10/1 for elections made during annual enrollment.

SPOUSE OR DOMESTIC PARTNER LIFE INSURANCE

You can elect spouse or domestic partner coverage of $5,000, $10,000, $25,000, $50,000, $100,000, $200,000 or $300,000 depending on your role and the amount of your partner life insurance coverage. The amount of life coverage you elect for your spouse or domestic partner cannot exceed 50% of your total partner life insurance coverage amount.

You pay the full cost of spouse or domestic partner life insurance through automatic payroll deductions taken after taxes are withheld. The cost will remain constant until the next annual benefits enrollment. You may increase supplemental life insurance coverage for your spouse/domestic partner by one level during benefits enrollment without providing evidence of insurability, up to each plan's guarantee issue maximum.

If your spouse or domestic partner is also a partner at Starbucks and is eligible for benefits coverage, you cannot cover him or her as a dependent under the life insurance plan.

What Is a Domestic Partner?

Your domestic partner is your unmarried same- or opposite-sex life partner with whom you have a committed relationship as outlined in the **Eligibility and Enrollment chapter**. If you enroll your domestic partner for life insurance coverage, you may be asked to provide additional information verifying your domestic partnership.

Deferred Effective Date for Dependents

If your spouse or domestic partner and/or child is confined at home, in a hospital or elsewhere because of a disability on the date coverage or a change in coverage would otherwise begin, spouse or domestic partner and/or child life coverage will not begin until your dependent is discharged and engages in normal activities for at least 15 consecutive days.

CHILD LIFE INSURANCE

You can elect child coverage of $5,000 or $10,000 depending on the amount of your partner life insurance coverage. The amount of child life insurance coverage you elect cannot exceed 50% of your total partner life insurance coverage amount. If you elect less than $10,000 of child life insurance, you can increase coverage each benefits enrollment by $5,000. The maximum child life insurance is $10,000. The cost for this coverage is the same regardless of the number of children you cover. You pay the full cost of child life insurance through automatic payroll deductions taken after taxes are withheld.

Children eligible to be covered under child life insurance include:

- Your unmarried children, stepchildren, stepchildren, children placed for adoption, legally adopted children, children for whom you have legal guardianship; or
- Any other children related to you by blood or marriage or domestic partnership who:
  - Live with you in a parent-child relationship for more than 50% of the year; and
  - You claim as a dependent on your federal income tax return; provided such children are primarily dependent upon you for financial support and maintenance and are:
    - Below the age of 26;
    - Age 26 or older and disabled. Such children must have become disabled before turning 26. You may be asked to submit proof of the child's disability.

EVIDENCE OF INSURABILITY

Evidence of Insurability (EOI) is proof of good health as certified by a licensed doctor and approved by Hartford Life. You or your covered spouse or domestic partner may be required to provide EOI in certain instances for coverage under the life insurance plans. When asked to provide EOI, you will need to complete a *Personal Health Statement* that gives information about your health and medical history, so that Hartford Life may determine whether you qualify for certain levels of coverage. You may also be asked to undergo a physical exam, which may be at your cost.

If you are ever required to provide EOI, you will complete this process online when you enroll in coverage.

Until you or your spouse or domestic partner's good health is confirmed by Hartford Life, coverage will be the highest level of life insurance coverage available that does not require EOI. If good health is confirmed, the additional coverage you have requested will go into effect the first of the month following the date of the

approval or eligibility date, whichever is later. Your payroll deductions will increase beginning the first paycheck received following your approval or eligibility date.

If you die within two years of the date you provided EOI, Hartford Life has the right to review and deny the claim if you failed to disclose important information about your health.

When you must provide evidence of insurability			
Event	**Partner supplemental life – retail management and nonretail (includes shift managers)**	**Partner supplemental life – retail hourly**	**Spouse or domestic partner life**
Upon initial eligibility	Elect four times your annual base pay	N/A	Elect coverage over $50,000
Benefits enrollment	Elect to increase coverage beyond one level or beyond the plan's guarantee-issue limit	Elect to increase coverage beyond one level	Elect to increase coverage beyond one level or beyond the plan's guarantee-issue limit
Qualified status change	Elect to increase any coverage, including new election	Elect to increase any coverage, including new election	Elect to increase any coverage, including new election
Other	You are a vice president or above and elect two times your annual base pay		

Enrolling in and increasing child life insurance does not require evidence of insurability.

When you do not need to provide evidence of insurability			
Event	**Partner supplemental life – retail management and nonretail (includes shift managers)**	**Partner supplemental life – retail hourly**	**Spouse or domestic partner life**
Upon initial eligibility	Elect one, two or three times your annualized base pay	Elect any amount	Elect $50,000 or less
Lose and re-establish eligibility in the same plan year	Prior coverage is reinstated at the level in effect immediately preceding your loss of eligibility	Prior coverage is reinstated at the level in effect immediately preceding your loss of eligibility	Prior coverage is reinstated at the level in effect immediately preceding your loss of eligibility
Re-establish eligibility in a new plan year following your loss of eligibility	Elect one, two or three times your annualized base pay	Elect any amount	Elect $50,000 or less
Benefits enrollment	You increase coverage by one level (up to overall guarantee limits) or reduce coverage	You increase coverage by one level (up to overall guarantee limits) or reduce coverage	You increase coverage by one level (up to overall guarantee limits) or reduce coverage
Other	N/A	N/A	You elect coverage within 45 days of your spouse or domestic partner's loss of life coverage with his or her employer, either through loss of employment or the employer's cancellation of group coverage*

* Hartford Life will require proof of your spouse or domestic partner's prior coverage, including the date of termination.

HOW BENEFITS ARE PAID

Benefits are paid to your designated beneficiary(ies) if you die. Benefits are paid to you if your covered dependent dies.

Partner life insurance

Naming your beneficiaries

When you enroll for partner life insurance, you will be asked to name your beneficiary(ies). You may designate your beneficiary(ies) online after enrollment at **mysbuxben.com.** You may change your life insurance beneficiary(ies) at any time at **mysbuxben.com** or by calling Starbucks Benefits Center at (877) SBUXBEN and speaking with a representative. Your beneficiary(ies) cannot be changed by power of attorney.

How beneficiaries are paid

When Hartford Life receives notice of your death, the amount of life insurance benefit is paid to your named beneficiary(ies). Hartford Life has the right to review and deny the claim if you fail to disclose important information about your health as described in **Evidence of Insurability on page 135** or if payment of the claim is forbidden by law.

Unless you have given different instructions, your insurance benefit is paid as listed below:

- If more than one beneficiary is named, each is paid equal shares.
- If any named beneficiary dies before you, that person's share is divided equally among the named beneficiaries who survive you.

If no beneficiary is named, or if no named beneficiary survives you, Hartford Life may pay:

- The executors or administrators of your estate
- Your surviving relatives in the following order:

    Your spouse or domestic partner

    Your children in equal shares

    Your parents in equal shares

Your domestic partner may be required to provide evidence of your domestic partner relationship prior to payment of benefits.

Spouse or domestic partner insurance

If your dependent dies while covered under Starbucks life insurance plan, you will receive his or her life insurance benefit. Hartford Life has the right to review and deny the claim if your spouse or domestic partner failed to disclose important information about his or her health as described in **Evidence of Insurability on page 135** or if payment of the claim is forbidden by law.

Name Your Beneficiary!

It is very important for you to name your life insurance beneficiary(ies) when you enroll in coverage. Be sure to keep your beneficiary designation current because it governs the distribution of benefits from Starbucks life insurance plans if you die. As a Starbucks partner, all Starbucks life insurance policies are made in *your name*, even the spouse or domestic partner or child life insurance policies covering your dependents.

Accelerated death benefit

Accelerated death benefits are available to you, your covered spouse or domestic partner and child(ren) who are covered under the Starbucks life insurance plan.

If you are under age 60 and diagnosed as being terminally ill with less than 24 months to live, you may request that a portion of your life insurance be paid as an *accelerated death benefit*. Accelerated death benefits are paid as a lump-sum amount that cannot exceed 80% of your total coverage amount.

The minimum accelerated death benefit amount is $3,000 and the maximum is $500,000. Only one lump-sum payment will be made. At the time of death, your beneficiary(ies) receive the remainder of the death benefit.

To apply for the accelerated death benefit, call the Partner Contact Center at (888) SBUX-411. Contact a tax attorney for information about tax implications of the accelerated death benefit.

Partners diagnosed with a terminal illness should refer to **Compassionate Benefits for Terminally Ill Partners on page 29**.

Your Hartford Life Insurance Booklet Has Details

Keep in mind this section only summarizes your Starbucks life insurance plan benefits. You can learn all the details – a complete description of the terms, conditions and limitations of your coverage – in the Hartford Life Insurance Booklet issued by Hartford Life and Accident Insurance Company. If there is a discrepancy between this document and the Hartford Life Insurance Booklet, the Hartford Life Insurance Booklet will govern. The Hartford booklet may be requested online at **mysbuxben.com**. Select Health & Insurance, then Forms & Materials under the Learn About drop-down menu. If you prefer, you may make your request by speaking with a Starbucks Benefits Center representative at (877) SBUXBEN.

IF YOU TAKE A LEAVE OF ABSENCE

Your partner life insurance, spouse or domestic partner life insurance and child life insurance may continue during a leave of absence as outlined in **Benefits Eligibility While on an Approved Leave of Absence.** You will be required to continue to make your premium payments for life insurance coverage during your leave of absence. Premiums for life insurance coverage will be collected through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make your premium payments while on leave of absence, your coverage will be cancelled. If you are disabled and on leave for longer than 6 months, you may also be eligible for continuation of coverage under **Waiver of Premium**. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

WHEN COVERAGE ENDS

If you are no longer a Starbucks partner, your Starbucks life insurance coverage ends on the last day of the month in which your separation is processed by payroll. You can elect to continue your life coverage through the portability option or you can convert 100% of your coverage into a personal policy with Hartford Life as outlined on the following page. The portability option allows you to continue your life insurance coverage and that of your dependents under a group term plan, while the conversion option allows you to convert your coverage to an individual policy.

If you lose benefits eligibility due to an ongoing benefits eligibility audit, your life insurance coverage ends as described in the **Eligibility and Enrollment chapter.** You can elect to continue your coverage through the portability option or you can convert 100% of your coverage into a personal policy with Hartford Life, as described in this section.

If you are on a leave of absence and do not make payment by your deadline, your elected supplemental coverage will end at the end of the month in which you last made full payment. Starbucks-provided basic life insurance will continue.

If you change positions from retail management/nonretail to retail hourly, your basic life insurance coverage will change from a multiple of your annualized base pay to $10,000. Any supplemental life insurance coverage will end as of your transfer date and you will have the opportunity to elect new supplemental options by enrolling online or by speaking with a Starbucks Benefits Center representative at (877) SBUXBEN within 45 days of your transfer date. Refer to **Partner Life Insurance on page 132** for more information.

If you change positions from retail hourly to retail management/nonretail, your basic life insurance coverage will change from $10,000 to one times your annualized pay. Any supplemental life insurance coverage will end as of your transfer date and you will have the opportunity to elect new supplemental partner life insurance options by enrolling online or by speaking with a Starbucks Benefits Center representative at (877) SBUXBEN within 45 days of your transfer date. Refer to **Partner Life Insurance on page 132** for more information.

Portability and conversion of coverage

When your life insurance coverage ends, you can continue coverage for you and your enrolled dependents through the portability option. Or you can choose to convert coverage to an individual policy. When you can elect portability or conversion, the amounts that can be continued or converted, the application process and application deadlines are outlined on the next page.

	Portability option for insurance previously enrolled in	Conversion option for insurance up to the amount previously enrolled in
Starbucks-paid basic life insurance ($10,000 for retail hourly partners, one times pay for retail management and nonretail partners, three times pay for executives)	Yes, up to $250,000 total coverage (basic and supplemental combined)	Yes
Partner-paid partner supplemental life insurance	Yes, up to $250,000 total coverage (basic and supplemental combined)	Yes
Spouse or domestic partner life insurance	Yes, up to $50,000 You must also port your partner life insurance Your dependent must continue to meet the definition of a dependent under Starbucks plans	Yes, when you lose coverage under Starbucks plan and/or when your dependent no longer meets the definition of a qualified dependent and loses coverage under Starbucks plan
Child life insurance	Yes You must also port your partner life insurance Your dependent must continue to meet the definition of a dependent under Starbucks plans	Yes, when you lose coverage under Starbucks plan and/or when your dependent no longer meets the definition of a qualified dependent and loses coverage under Starbucks plan
Type of coverage	Term life Rates similar to Starbucks group rates and may be modified from time to time	Individual policy Premium based on age and will remain the same until the policy expires or death
Deadline to apply	Must apply and pay the applicable quarterly premium within 31 days of when Starbucks group coverage ended	Must apply and pay the applicable premium within 31 days of when Starbucks group coverage ended
How to obtain a quote and apply	Call Hartford Life at (877) 320-0484	Call Hartford Life at (877) 320-0484
If you die during the conversion period	No benefit available	Hartford Life will pay, upon proof of death, the amount you or your dependent was entitled to convert when death occurs within the 31-day conversion period

In choosing whether or not the portability option is right for you, here are a few things to keep in mind.

- You can only elect the portability option if you are under age 65 and do not lose eligibility due to retirement as defined by the Social Security Act, as amended.
- Your coverage is reduced by 75% at age 65.
- Your coverage ends at age 75, when you can convert to an individual policy.

Waiver of premium

If you become medically disabled before age 60, your basic and supplemental coverage may continue after a six-month waiting period with all premiums waived (including dependent coverage premiums) until you are age 65. To receive a premium waiver, you must meet the definition of disabled as outlined in Hartford's Life Insurance Booklet and be approved for waiver of premium by Hartford Life.

During the first six months of your disability, you may continue paying premiums for your life insurance and apply for a waiver of premium. If your application is approved, you pay no more premiums (after the six-month waiting period) and you remain covered for the duration of your disability, until you reach age 65. If your application is denied, you will have the option to port or convert your coverage.

To apply for a waiver of premium, call Starbucks Benefits Center at (877) SBUXBEN.

If your application for waiver is denied and you had converted your coverage after you became ineligible for benefits, you can continue to pay premiums for your life insurance coverage under the conversion option.

If you did not elect to convert your coverage after becoming ineligible for benefits and continued to be disabled (as defined by Hartford Life) for six consecutive months, you can still apply for a waiver of premium. If your application is approved, your coverage will be reinstated and you will pay no premium for the period of time you are disabled. If your application is denied, your coverage remains cancelled.

For purposes of this plan, *disabled* means that you meet at least one of the following criteria:

- Approved for Long Term Disability benefits through Starbucks or
- Have a life expectancy of 24 months or less or
- Are prevented by disability for 24 months from doing the essential duties of your own work.

To receive a waiver of premium, proof of your total disability must be submitted to Hartford Life within one year of your last day of active full-time work. During the first two years of your disability, Hartford Life may request you have additional physical exams to verify your continued disability. After the first two years, you will be asked to have an annual physical exam to confirm your continued disability.

If you die while you are disabled and before you qualify for a waiver of premium, your life insurance will be paid to your beneficiary(ies) as long as you:

- Were continuously disabled from your last day of active full-time work until the time you died or the policy terminated, and
- Proof of your disability is given to Hartford Life within one year from your last day of active full-time work.

If you are no longer disabled or you reach age 65, your waiver of premium ends. You may elect the *conversion option* at that time.

HOW TO FILE A CLAIM

Starbucks Benefits must be notified immediately in the event of your or your covered dependent's death by calling the Partner Contact Center at (888) SBUX-411. A member of Starbucks Benefits Department will then contact you or your designated emergency contact with next steps to provide the necessary forms for completion.

If your claim for life insurance benefits is denied, in whole or in part, you or your beneficiary(ies) may appeal the claim decision by following the process described in **Appealing Denial of Claims on page 249**.

QUESTIONS?

If you have general questions about the life insurance plans or if you want to order a Hartford Life Insurance Booklet, call Starbucks Benefits Center at (877) SBUXBEN. You may also request a Hartford Life booklet online at **mysbuxben.com**. Select Health & Insurance, then Forms & Materials under the Learn About drop-down menu.

For information on how to file a life insurance claim, call the Partner Contact Center at (888) SBUX-411.

For help with the portability or conversion options, call Hartford Life directly at (877) 320-0484 between 6 a.m. and 2 p.m. Pacific Time, Monday through Friday.

Accidental Death & Dismemberment

Starbucks offers Accidental Death and Dismemberment (AD&D) insurance, which provides financial protection in the case of an accidental injury or death. Your participation in the plan is entirely voluntary and you pay the full cost of coverage through automatic payroll deductions.

If you are eligible for Starbucks benefits, you can enroll in AD&D insurance. AD&D is offered through Hartford Life and Accident Insurance Company ("Hartford Life").

HOW THE PLAN WORKS

If you are injured or die in a covered accident, your AD&D benefits will pay you or your beneficiary(ies) some or all of your AD&D coverage amount, depending on your loss.

YOUR COVERAGE OPTIONS

Your coverage options under the AD&D plan depend on your position at Starbucks.

If you are a retail hourly partner (excluding shift managers)

You can purchase AD&D coverage in one of these amounts:

- $10,000, $25,000, or $50,000

If you are a retail management, shift manager, or nonretail partner

You can purchase AD&D coverage in one of these amounts:

- One times base pay
- Two times base pay
- Three times base pay
- Four times base pay
- Five times base pay

What Is AD&D Based On?

If you are a retail salaried or nonretail partner, your AD&D coverage is based on your annualized base pay, rounded up to the next $1,000. Your *annualized base pay* is your gross earnings prior to any before-tax deductions. It does not include any commissions, tips, stipends, bonuses, overtime pay or other compensation.

Your AD&D cost and coverage amounts are calculated at the time you become eligible to participate and are shown online when you enroll in benefits. Your cost will remain constant until the next annual benefits enrollment. If your base pay changes during the year, any benefit you actually receive will be based on your actual pay at the time AD&D benefits become payable.

The maximum amount of AD&D coverage available to you through Starbucks is $750,000, except for vice president job level and above, in which case the maximum amount is $2,000,000.

HOW BENEFITS ARE PAID

Your AD&D insurance pays lump-sum benefits to you if you lose a limb, your hearing or your sight in a covered accident — or to your beneficiary(ies) if you die in a covered accident — if your loss occurs within 365 days after the date of the accident.

A written notice of claim must be submitted to Starbucks, within 20 days after the loss occurs (See **How to File a Claim AD&D on page 147**). If notice cannot be given within that time, it must be given as soon as reasonably possible.

If you die as the result of a covered accident, your beneficiary(ies) will receive your AD&D benefit *in addition* to any group life insurance benefits.

The following chart describes how some of the AD&D benefits are paid. The maximum benefit payable is 100% of your AD&D coverage for all losses combined due to the same accident.

AD&D benefits coverage overview

For your loss* of …	The AD&D plan will pay this percentage of your AD&D benefits to you or your beneficiary(ies) …
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing	100%
Either hand or foot and sight of one eye	100%
Movement of both upper and lower limbs – quadriplegia	100%
Movement of both lower limbs – paraplegia	75%
Movement of both upper and lower limbs of one side of the body – hemiplegia	50%
Either hand or foot	50%
Sight of one eye	50%
Speech or hearing	50%
Thumb and index finger of either hand	25%

* Loss means with regard to (a) hands and feet: actual severance through or above the wrist or ankle joints; (b) sight, speech or hearing: the entire and irrecoverable loss thereof; (c) thumb and index finger: actual severance through or above the metacarpophalangeal joints; and (d) movement of limbs: complete and irreversible paralysis of such limbs.

Exposure and disappearance

Should a vehicle, aircraft or boat you are traveling on disappear because of an accidental forced landing, stranding, sinking or wreck, and your body is not recovered within one year from the disappearance, you will be presumed to have died. Accidental death benefits will be payable provided you would have been covered for injury resulting from the accident. Benefits will also be payable if a covered injury results from exposure to the elements due to the same causes.

Seat belt coverage

If you die in an accident while riding or operating a registered automobile and while wearing a seat belt, the amount of the benefit payable for accidental death will be increased by 10% up to a maximum of $10,000. The accident must be unintentional and your use of a seat belt must be verified in the police report. *Automobile* includes a four-wheeled, private passenger car, station wagon, van, SUV or similar vehicle that is not being used as a common carrier for the transportation of passengers for hire.

The additional seat belt coverage will not apply if you were driving the vehicle while under the influence of drugs or alcohol.

Coma benefit

If, as the result of your accidental injury, you become comatose within 31 days of the accident and remain comatose for at least 30 days, you will be paid a monthly benefit. The monthly benefit will be 1% of your accidental death and dismemberment benefit remaining after other benefits have been paid. A coma is a complete and continuous state of unconsciousness and an inability to respond to external or internal stimuli.

The coma benefit will continue until the earlier of:

- The end of the month in which you die
- The end of the month in which you recover from the coma, or
- 100% of your coverage amount has been paid.

Adaptive home and vehicle benefit

If you suffer a loss, other than loss of life, you may be eligible for assistance with the cost of home and/or automobile alterations to make them accessible to you. For example, wheelchair ramps may be installed if you are confined to a wheelchair.

The alterations must be made within two years from the date of your accident, made to your principal residence and/or private automobile and be required to make your residence accessible to you and/or your private automobile drivable or ridable for you.

Home alterations must be made by someone with experience in such alterations and recommended by a recognized organization associated with your type of injury. Similarly, vehicle modifications must be carried out by someone with experience in such matters and approved by the Motor Vehicle Department.

The amount available under the adaptive home and vehicle benefit will be the lesser of:

- 2.5% of your accidental death and dismemberment coverage
- The actual cost
- $2,500

REDUCTION IN BENEFITS

The amount of AD&D benefits you are entitled to is reduced once you reach age 65, as shown below.

At ages	Your death benefit is reduced by	The percentage of life insurance benefit payable is
65 through 69	35%	65% (rounded to the next highest $500)
70 and over	55%	45% (rounded to the next highest $500)

BENEFICIARY DESIGNATION

When you enroll in AD&D insurance, you will need to designate one or more beneficiaries. To designate your AD&D beneficiary(ies), log in to **mysbuxben.com** or call Starbucks Benefits Center at (877) SBUXBEN and speak with a representative. Accidental *death* benefits are paid to your beneficiary(ies). Accidental *dismemberment* benefits are paid directly to you.

What Is the Difference?

What is the difference between AD&D and partner life insurance? AD&D pays benefits if you are injured or die in an accident, while partner life insurance pays benefits if you die, whatever the cause. If you die as a result of an accident, your beneficiary(ies) will receive benefits from both plans, if you were covered by both plans at the time of your death.

WHAT IS NOT COVERED

Starbucks AD&D plan does not cover losses resulting from:

- An intentionally self-inflicted injury, a suicide or attempted suicide, whether sane or insane
- War or an act of war (declared or undeclared)
- An injury sustained while full time in the armed forces of any country or international authority
- An injury sustained while riding on any aircraft, except a civil or public aircraft (with a current and valid airworthiness certificate and piloted by a person with a valid and current pilot's license for the aircraft) or a military transport aircraft
- An injury sustained while committing or attempting to commit a felony
- An injury sustained while riding on any aircraft if you are a:

  Pilot, crew member or student pilot

  Flight instructor or examiner

  If you are an active flight crew member employed by Starbucks and are enrolled in AD&D coverage, this exclusion will not apply to you while you are performing your job as a flight crew member.

IF YOU TAKE A LEAVE OF ABSENCE

Your AD&D coverage may continue during a leave of absence, as outlined on page 25. However, you will be required to continue to make your premium payments for AD&D coverage during your leave of absence. Premiums for AD&D coverage will be collected (depending on your length of leave) through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make your premium payments while on leave of absence, your coverage will be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

WHEN COVERAGE ENDS

If you change positions from retail management/nonretail to retail hourly, your AD&D coverage options change from a multiple of your annualized base pay to flat dollar amounts and you will need to make new AD&D elections by speaking with a Benefits Center representative at (877) SBUXBEN within 45 days from your change in position date to continue coverage. Refer to Your Coverage Options on page 143 for more information.

If you are no longer a Starbucks partner, your AD&D coverage ends on the last day of the month in which your separation is processed by payroll.

If you lose benefits eligibility due to an ongoing benefits eligibility audit, your AD&D coverage ends as described in the Eligibility and Enrollment chapter.

If you are on a leave of absence and do not make payment by your deadline, your AD&D coverage will end at the end of the month in which you last made full payment.

HOW TO FILE A CLAIM

Starbucks must be notified immediately in the event of an accidental injury or death. Call the Partner Contact Center at (888) SBUX-411, and Starbucks will send a claim form to you or your beneficiary(ies) to complete and return to Starbucks.

Claims for AD&D benefits are processed by Hartford Life. Hartford Life will distribute your AD&D benefits to you or your beneficiary(ies). If your claim for AD&D benefits is denied, you or your beneficiary(ies) may appeal the claim decision by following the process described in Appealing Denial of Claims on page 249.

QUESTIONS?

If you have general questions about the AD&D plan, call Starbucks Benefits Center at (877) SBUXBEN. To find out the status of an outstanding AD&D claim, call Hartford Life directly at (888) 563-1124.

Time Off

Time away from work gives us time to relax and recharge, returning to our jobs more productive. If you have to miss work because of an illness or injury that lasts more than three days, refer to the **Leaves of Absence** section and **Short Term Disability** chapter.

For purposes of this chapter, Retail Hourly includes the following roles unless otherwise noted:

- Café attendant
- Barista
- Shift supervisor
- Shift manager
- Team member
- Team lead
- Operations lead
- Princi savory and pastry chef
- Commessa
- Mixologist
- Porter
- Assembler

All other roles will be defined as Retail Management or Nonretail, unless otherwise noted.

RETAIL HOURLY VACATION PROGRAM

Retail hourly partners who have completed 12 months of consecutive service are eligible to begin accruing vacation hours.

You earn — or accrue — vacation hours based on the actual number of hours you work. You continue to accrue vacation as long as you are an active Starbucks partner, even while you are receiving holiday pay or taking sick time. However, you do not accrue additional vacation when taking vacation. The amount of time off you receive depends on your length of service with Starbucks. At all times, Starbucks will follow applicable law to the extent the law provides benefits more generous than those provided here.

Vacation may not be borrowed, advanced, donated or paid to you in cash in lieu of vacation.

Vacation hours are paid to you at your current rate of pay at the time you take your vacation and are paid on your normal paycheck. You can start using your accrued vacation immediately. Talk to your manager about any vacation you plan to take, so schedules can be adjusted, if necessary.

Retail hourly vacation accrual schedule

You accumulate vacation based on your actual hours worked. If you work less than 40 hours a week, you will accrue time on a prorated basis. You continue to accrue vacation each pay period until you reach the maximum accrual limit, as shown below. Once you reach your vacation accrual limit, you stop accruing additional time until you use some and your vacation accrual balance drops below the maximum accrual limit.

The vacation accrual schedule below outlines the maximum vacation accrual based on service, and the rate at which you accrue vacation per hour (based on a 40-hour work week).

Completed months of service from most recent hire date	Maximum vacation accrual	Accrual Rate Per Hour (based on 40 hours a week)
Less than 12	N/A	N/A
12 but less than 36	40 hours (64 in California)	.01961
36 but less than 60	80 hours (127 in California)	.0400
60 or more	120 hours (190 in California)	.06122

If you are on a leave of absence
You do not earn vacation time while you are on a leave of absence from Starbucks. If you are on a Career Coffee Break, you are required to use any available vacation time during your unpaid leave.

Refer to page 173 for additional information regarding pay while on a leave of absence.

If you change positions
The amount of vacation you are eligible to receive and how you earn vacation hours depends on your position and place of employment with Starbucks. If your position changes, your vacation will be adjusted accordingly. Refer to the Retail Management and Nonretail Vacation Program section below for more information.

If you are no longer a Starbucks partner
Your unused accrued vacation will generally be paid to you upon separation provided you have at least one hour of unused accrued time. Your unused vacation is included in your final paycheck. Your unused vacation may not be used to extend your separation date.

If you are later rehired at Starbucks, you will begin to accrue vacation after you complete 12 consecutive months of employment from your most recent date of hire. Your prior service will not count.

RETAIL MANAGEMENT AND NONRETAIL VACATION PROGRAM

Retail management and nonretail vacation

Starbucks has two retail management and nonretail vacation plans: the accrual program and the grant program. Which vacation plan you have depends on where you work at Starbucks. This is because there are different state laws in place that impact how your vacation plan is structured. At all times, Starbucks will follow applicable law to the extent the law provides benefits more generous than those provided here.

Vacation time may not be borrowed, advanced, donated or paid to you as cash in lieu of paid time off.

Accrual program

The accrual program is for retail management and nonretail partners working in California, Colorado, Illinois, Louisiana, Massachusetts, and certain nonretail part-time variable hour partners in Starbucks roasting plants, distribution centers or juiceries.

You earn — or accrue — vacation hours based on the actual number of hours you work. You continue to accrue vacation time as long as you are an active Starbucks partner, even while you are receiving holiday pay, taking sick time or a personal day. However, you do not accrue additional vacation time when taking vacation. The amount of vacation you receive depends on your position and length of service with Starbucks.

Vacation hours are paid to you at your current rate of pay at the time you take your vacation and are paid on your normal paycheck. You can start using your accrued vacation immediately. Talk to your manager about any vacation time you plan to take so schedules can be adjusted, if necessary.

Accrual schedule

You accumulate vacation time based on your actual hours worked. If you work less than 40 hours a week, you will accrue vacation time on a prorated basis. You continue to accrue vacation time each pay period until you reach the maximum accrual limit, as shown on the following page. Once you reach your vacation accrual limit, you stop accruing additional vacation time until you use some and your vacation accrual balance drops below the maximum accrual limit. You begin to accrue vacation time as of your hire date.

The vacation accrual below outlines the maximum vacation accrual based on service, and the rate at which you accrue vacation per hour (based on a 40-hour work week). If you are classified as working less than 40 hours a week, you will accrue vacation time on a prorated basis.

Retail management and nonretail partners below director level working in California, Colorado, Illinois, Louisiana or Massachusetts

Completed months of service from most recent hire date	Maximum accrual	Accrual Rate Per Hour (based on 40 hours a week)
Less than 60	120 hours (190 in California)	.06122
60 but less than 120	160 hours (253 in California)	.08333
120 or more	200 hours (316 in California)	.10638

Retail management and nonretail partners at director level or above working in California, Colorado, Illinois, Louisiana or Massachusetts

Completed months of service from most recent hire date	Maximum accrual	Accrual Rate Per Hour (based on 40 hours a week)
All levels of service	200 hours (316 in California)	.10638

If you are on a leave of absence

You do not earn vacation time while you are on a leave of absence from Starbucks. If you are on a Career Coffee Break, you are required to use any available vacation time during your unpaid leave. For all other approved leaves of absence, use of vacation time is optional.

Refer to page 173 for additional information regarding pay while on a leave of absence.

If you are no longer a Starbucks partner

Your unused accrued vacation time will generally be paid to you upon separation provided you have at least one hour of unused accrued vacation time. Your unused vacation time is included in your final paycheck. Your unused vacation time may not be used to extend your separation date.

If you are later rehired at Starbucks, you will begin to accrue vacation time again from your most recent date of hire. Your prior service will not count.

Grant program

This grant program is for retail management and nonretail partners working in states other than California, Colorado, Illinois, Louisiana and Massachusetts.

About the plan

Annually, on October 1, you are granted your full year's vacation to be used by the following September 30. Any unused granted vacation time remaining each September 30 is lost. You cannot carry over your unused vacation time from one year to the next. Vacation hours are paid to you at your current rate of pay at the time you take your vacation and are paid on your normal paycheck.

Granted vacation is available to use as soon as it has been granted. Talk to your manager about any vacation time you plan to take so schedules can be adjusted, if necessary.

Grant schedule

The following schedule applies to full-time partners who are classified as working 40 or more hours per week. Partners who are classified as working less than 40 hours a week receive a prorated grant based on their regular part-time schedule.

Completed months of service from most recent hire date	Annual vacation grant (below director level)	Annual vacation grant (director and above)
Less than 60	120 hours	200 hours
60 but less than 120	160 hours	200 hours
120 or more	200 hours	200 hours

Service anniversary and vacation grant

If, due to your length of service at Starbucks, you will pass from one service anniversary level to the next within the upcoming vacation year (October 1 through September 30), you will be awarded a "blended" grant. This means your vacation grant will be adjusted to reflect the number of days in the vacation year at one grant level and the remaining days in the vacation year at the next higher grant level.

Here is an example:

This partner will complete 60 months of service on April 1, 2021. On October 1, 2020, his vacation grant takes into account that in the next 12 months he will have 182 days at the 120-hour grant level and 181 days at the 160-hour grant level. The partner's October 2020 grant calculation is as follows:

Grant level	Grant hours
182 days at 120 hours a year	60
181 days at 160 hours a year	+ 80
Vacation grant on October 1, 2020	= 140

Vacation grants are rounded up to the next full hour for nonretail hourly partners and up to the next full eight-hour day for salaried partners.

Grant for new partners

- If your hire date falls on or after October 1, but before July 1, you will receive a prorated grant upon your date of hire.

  On the following October 1, you will receive your first full year's vacation grant.
- If your hire date falls on or after July 1, you will receive a full year's vacation grant on October 1.

If you are on a leave of absence

If you are on a leave of absence (other than a Career Coffee Break) from Starbucks, your vacation grant will not be adjusted for the time you are on leave. When you are on an approved leave of absence (other than a Career Coffee Break), you may choose to use any available vacation time to substitute for any or all of your unpaid leave (unless you are using sick time or receiving Short Term Disability or Parental Leave pay). If you are on a Career Coffee Break, you are required to use any available vacation time during your unpaid leave.

If your leave of absence is not a Career Coffee Break and crosses over a new fiscal year, you will receive a new grant on the normal schedule. You may choose to apply it to any unpaid leave taken in the new fiscal year. If you are on a Career Coffee Break and your leave crosses over a new fiscal year, you will receive a pro-rated vacation grant upon your return to work.

For example, if you begin your Career Coffee Break in June and return January 2, you would receive a pro-rated vacation grant in January equal to 9/12 of your annual grant. This new pro-rated vacation grant will be available upon your return from Career Coffee Break.

Refer to **page 173** for additional information regarding pay while on a leave of absence.

If you are no longer a Starbucks partner

Any unused granted vacation time is forfeited. Your unused vacation time may not be used to extend your separation date and may not be used in the final four weeks of employment.

If you are later rehired by Starbucks, your vacation grant will be based on your most recent date of hire. Your prior service will not count.

If you transition between full–time and part–time status

If you transition from a part-time to a full-time position during the plan year, your vacation grant will be adjusted to reflect the number of days in a full-time role and the remaining days in the part-time role. If you transition from a full-time to part-time position, your vacation grant will not be adjusted.

Transition between accrual and grant programs

If you move between states or have a job change resulting in a change in your vacation plan, your vacation will be affected as follows:

	Accrued vacation	Granted vacation
From accrual to grant program	Unused balance paid at time of transfer	Receive a prorated grant (if eligible) for remainder of vacation year (October – September) to be used by September 30
From grant to accrual program	Begin accruing vacation time October 1 following your transfer	Unused granted vacation reclassified as accrued vacation

PARTNER AND FAMILY SICK TIME

All U.S. partners are eligible to accrue Partner and Family Sick Time ("sick time"). Sick time is categorized in two ways:

- Protected Sick Time (PST) is job-protected and cannot be included for consideration in any absence policy.
- Extended Sick Time (EST) can be used for any reason outlined here but is only job-protected when used in conjunction with an approved, job-protected leave of absence.

All partners working in locations with legally mandated sick time requirements accrue and may use sick time in accordance with both Starbucks Partner and Family Sick Time and any local laws. Partner and Family Sick Time will apply in most locations, as it is often more generous than the local laws; see the chart at the end of this section for exceptions.

Accrual, carryover and pay

You accrue 1 hour of sick time for every 30 hours of paid hours worked, vacation, personal day, holiday and sick time. You begin to accrue sick time at date of hire and may use it as soon as it is accrued.

Throughout the year, all sick time will accrue as PST. There is no sick time accrual maximum; however, you may only carry over up to 520 total hours of sick time from year to year (January 1 – December 31), made up of no more than 80 hours of PST and 440 hours of EST. At the start of the calendar year, up to 80 hours will be carried over as PST. Any remaining sick time will be carried over as EST, up to a maximum of 440 hours. Sick time beyond the 520 total hours will be forfeited.

Example: If you have 540 hours of sick time on December 31, you will carry over 80 hours as PST, 440 hours as EST, and the remaining 20 hours are forfeited. Any new sick time accrued after January 1 will also be counted as PST.

Your sick time balance can be viewed in My Partner Info on the Partner Hub (select "Timecard"). Balances are updated each time you are paid.

Your sick time is paid to you at your current rate of pay at the time the sick time is used, or as required by applicable law (for instance, in Washington state, partners will be paid their normal hourly rate). To receive sick time, you will need to record the time and submit it to payroll, indicating the amount of sick time you wish to use. Hourly partners may record sick time in the smallest increments allowed by the payroll system. Salaried partners need only use sick time when absent for a full day but may opt to take sick time in one-hour increments, or a smaller increment if required by a local sick time law.

For planned absences in advance of the posted schedule, the partner may use up to 8 hours of sick time per day or 40 hours per week. For absences after the schedule is posted, the partner may submit sick time hours equivalent to missed scheduled shifts.

All paid hours for sick time will be included as BEN hours when determining benefits eligibility.

Allowed uses

Sick time is available to replace income when a scheduled shift is missed due to the following reasons:

- Your existing health condition including a mental or physical illness, injury, or health condition; to obtain medical diagnosis, care, or treatment (including home care) for the same; or for preventive medical care or routine medical appointments, including pregnancy, childbirth, pre-natal visits, postpartum care, and dental visits;

- To care for your eligible family member with an existing health condition including a mental or physical illness, injury, or health condition; for your family member to obtain medical diagnosis, care, or treatment (including home care) for the same; or for your family member who needs preventive medical care or routine medical appointments, including as described in the bullet above;
- Your Starbucks store or work location has been closed by order of a public official due to a public health emergency (including exposure to an infectious agent, biological toxin, or hazardous material); to care for a child whose school or childcare provider has been closed for any of those same reasons;
- To care for yourself or family member when it has been determined by the health authority or healthcare provider that the family member's presence in the community could jeopardize the health of others because of the family member's exposure to a communicable disease, whether or not the family member has contracted the disease; or if any law or regulation requires the employer to exclude the partner or family member from the workplace for health reasons;
- If you are a victim or have a family member who is a victim of domestic violence, harassment, sexual assault or violence, sex offense, family offense matter, human trafficking, abuse, or stalking, and needs time off to seek legal or law enforcement assistance for yourself or your family member, or to attend to the following: treatment by a healthcare provider, social services, victim services provider, counseling, safety planning, relocation, enrolling children in a new school, or other actions to increase safety for yourself or your family member or to maintain, improve, or restore the physical, psychological, or economic health or safety of you or your family or to protect those who associate or work with you;
- If you or your family member are undergoing bone marrow donation or an organ transplant;
- Aid or care for a guide, signal, or service dog belonging to you or a family member;
- For any unpaid time under Starbucks Parental Leave policy (retail hourly, shift managers and retail management partners); and
- Other reasons required under any jurisdiction with mandated sick time laws if you are scheduled to work in that jurisdiction (see chart at the end of the section for details).

A "family member" includes your:

- Spouse, domestic partner or equivalent designation
- Child of any age or dependent status
- Legal ward, or a child to whom you stand in loco parentis
- Parent
- Legal guardian, or a person who stood in loco parentis when you were a minor child
- Sibling
- Grandparent
- Grandchild
- Any individual related by blood or affinity whose close association with you is the equivalent of a family relationship
- Any other family member or designated person identified by local sick time laws (see chart at the end of the section for details).

These family relationships include not only biological relationship, but relationships resulting from adoption, marriage, step-relations, or foster care relationships.

Notice and verification

If the need for sick time is foreseeable, you must provide reasonable advance notice to your manager. If the need is not foreseeable, you must provide notice as soon as practicable. Notice may be given either verbally or in writing.

Starbucks may request verification or certification as permitted by federal, state or local law.

Leave of absence

If you are absent for more than three days due to your own, or family member's, serious health condition, you must request a leave of absence by going to **claimlookup.com/starbucks** or calling (866) 206-6769. You may continue to receive sick time while on applicable leave of absence, or you may be eligible to apply for Short Term Disability (STD) pay replacement. See the Leaves of Absence section and **Short Term Disability** chapter for more information.

Documentation submitted when applying for a leave of absence may count as verification or certification as noted above.

Other considerations

- You are not required to use sick time if you call out sick; however, if you do not use available Protected Sick Time and are not on an approved, job-protected leave of absence, you may be subject to existing absence policies.
- You are not required to find a replacement to cover shifts when using sick time.
- Sick time cannot be donated to another Starbucks partner.
- You can only use the sick time that you have already accrued. In other words, if you have accrued only four hours of sick time and miss an eight-hour shift due to illness, you will only be paid for the four hours.
- You may not request sick time for more hours than your missed shift. For example, if you call out for a scheduled four-hour shift, you may not use more than four hours of sick time.

If you are no longer a Starbucks partner

If you leave employment with Starbucks for any reason, you will not be paid for any accrued and unused sick time. If you are rehired by Starbucks within twelve months of separation, your prior sick time balance will be reinstated.

Questions?

Speak with your manager or call Starbucks Partner Contact Center at (888) SBUX-411.

Local Laws and Regulations (as of October 1, 2020)

For the most up-to-date information, visit the Partner Hub.

Starbucks Partner and Family Sick Time is intended to meet or exceed the requirements of all relevant federal, state, county and local laws and regulations.

When any provision of a local law or regulation is more generous than Partner and Family Sick Time, the local law or regulation will govern. Starbucks will not retaliate or tolerate retaliation against any partner who seeks or obtains leave under this policy, complains of a violation of any paid sick leave law or otherwise exercises their rights under a paid sick leave law.

Location	Local Sick Laws in Place?	Provisions More Generous Than Partner and Family Sick Time
Alabama	No	N/A
Alaska	No	N/A
Arizona	Yes	No. Partner and Family Sick Time will govern.
Arkansas	No	N/A
California (state)	Yes	No. Partner and Family Sick Time will govern.
Berkeley, CA	Yes	If the partner has no spouse or domestic partner, they may designate one person as to whom sick time may be used.
Emeryville, CA	Yes	If the partner has no spouse or domestic partner, they may designate one person as to whom sick time may be used.
Los Angeles, CA	Yes	No. Partner and Family Sick Time will govern.
Oakland, CA	Yes	If the partner has no spouse or domestic partner, they may designate one person as to whom sick time may be used.
San Diego, CA	Yes	No. Partner and Family Sick Time will govern.
San Francisco, CA	Yes	If the partner has no spouse or domestic partner, they may designate one person as to whom sick time may be used.
Santa Monica, CA	Yes	No. Partner and Family Sick Time will govern.
Colorado	No	N/A
Connecticut	Yes	No. Partner and Family Sick Time will govern.
Delaware	No	N/A
Florida	No	N/A
Georgia	No	N/A
Hawaii	No	N/A
Idaho	No	N/A
Illinois (state)	No	N/A
Chicago, IL	Yes	Sick time may be used by an FMLA-eligible partner for an FMLA-eligible reason, including baby bonding (even if the partner is not benefits eligible under Starbucks parental leave).
Cook County, IL	Yes	Sick time may be used by an FMLA-eligible partner for an FMLA-eligible reason, including baby bonding (even if the partner is not benefits eligible under Starbucks parental leave). Closure of a school for a public health emergency may include closure by a school district depending on how public official characterizes the school closure.
Indiana	No	N/A

Location	Local Sick Laws in Place?	Provisions More Generous Than Partner and Family Sick Time
Iowa	No	N/A
Kansas	No	N/A
Kentucky	No	N/A
Louisiana	No	N/A
Maine	No	N/A
Maryland (state)	Yes	Sick time may be used for maternity or paternity leave (even if the partner is not benefits eligible under Starbucks parental leave).
Montgomery County, MD	Yes	Sick time may be used for birth of a child, or the placement of a child with the partner for adoption or foster care, and care for a newborn, newly adopted, or newly placed child within 1 year of birth, adoption, or placement (even if the partner is not benefits eligible under Starbucks parental leave).
Massachusetts	Yes	No. Partner and Family Sick Time will govern.
Michigan	Yes	No. Partner and Family Sick Time will govern.
Minnesota (state)	No	N/A
Diluth, MN	Yes	No. Partner and Family Sick Time will govern.
Minneapolis, MN	Yes	Sick time may be used when dependent's school is closed by public official due to weather, loss of power, loss of heating, loss of water, or other unexpected closure. "Family member" also includes ward or guardian of partner, and any person who resides in the partner's home.
St. Paul, MN	Yes	Sick time may be used when family member's workplace is closed by order of public official to limit exposure to an infectious agent, biological toxin, or hazardous material; or to accommodate need to care for family member whose school or place of care is closed due to weather, loss of power, loss of heating, loss of water, or other unexpected closure.
Mississippi	No	N/A
Missouri	No	N/A
Montana	No	N/A
Nebraska	No	N/A
Nevada	Yes	Retail hourly partners: sick time may be used for any reason, including time away from work for vacation, illness, appointments, emergencies, or any other situation that requires time away from work. All other partners: standard sick and vacation policies apply.
New Hampshire	No	N/A
New Jersey (state)	Yes	Sick time may be used to attend child's school-related conference, meeting, function or other event requested or required by school officials or attend meeting regarding care provided to child in connection with child's health conditions or disability.

Location	Local Sick Laws in Place?	Provisions More Generous Than Partner and Family Sick Time
New Mexico	No	N/A
Bernalillo County, NM	Yes	Protected Sick Time (PST) may be used for any reason, including time away from work for vacation, illness, appointments, emergencies, or any other situation that requires time away from work.
New York (state)	No	N/A
New York City, NY	Yes	Starbucks will not require disclosure of details relating to a partner's or his or her family member's medical condition or require the disclosure of details relating to an partner's or his or her family member's status as a victim of family offenses, sexual offenses, stalking, or human trafficking as a condition of taking Partner and Family Sick Time.
Westchester County, NY	Yes	"Family member" includes: Persons related by consanguinity or affinity; Persons with a child in common, regardless of whether they have been married or domestic partners or have lived together at any time; Persons not related by consanguinity or affinity that are or have been in an intimate relationship, regardless of whether they have lived together at any time; current of former spouse or domestic partner regardless of whether they live in the same household. Beginning on October 30, 2019, in addition to paid sick time use, partners who are victims of domestic violence or human trafficking will have an additional forty (40) hours of paid safe time available each calendar year to attend or testify in criminal or civil court proceedings related to domestic violated or human trafficking or to move to a safe location.
North Carolina	No	N/A
North Dakota	No	N/A
Ohio	No	N/A
Oklahoma	No	N/A
Oregon	Yes	Sick time may be used for bereavement or for an Oregon Family Leave Act purpose (even if the partner is not benefits eligible under Starbucks parental leave or under OFLA).
Pennsylvania (state)	No	N/A
Pittsburgh, PA	Yes	"Family member" includes any individual for whom the partner has received oral permission from the employer to care for at the time of the partner's request to make use of sick time.
Philadelphia, PA	Yes	No. Partner and Family Sick Time will govern.
Rhode Island	Yes	"Family member" includes care recipients (any person for whom the partner is responsible for providing or arranging health and safety related care), and other members of the partner's household. Sick time accrues while partner is on a leave of absence.
South Carolina	No	N/A
South Dakota	No	N/A
Tennessee	No	N/A
Texas	No	N/A
Dallas, TX	Yes	No. Partner and Family Sick Time will govern.

Location	Local Sick Laws in Place?	Provisions More Generous Than Partner and Family Sick Time
Utah	No	N/A
Vermont	Yes	Sick time may be used where family member's school, business of place of care is closed for public health or safety reasons.
Virginia	No	N/A
Washington, DC	Yes	No. Partner and Family Sick Time will govern.
Washington (state)	Yes	"Family member" includes person with whom the partner has a dating relationship.
Seattle, WA	Yes	Starbucks is a Tier 3 employer for purposes of Seattle's law. "Family member" includes: • Person with whom the partner has a dating relationship • Persons who have a child in common regardless of whether they have been married or have lived together at any time • Adult persons related by blood or marriage • Adult persons who are presently residing together or who have resided together in the past • Persons 16 years of age or older who are presently residing together or who have resided together in the past and who have or have had a dating relationship • Persons 16 years of age or older with whom a person 16 years of age or older has or has had a dating relationship • Former domestic partners and former spouses Exempt partners will not have paid sick leave bank docked for absences of less than one hour.
Tacoma, WA	Yes	Sick time may be used for bereavement, or closure of a child's school or place of care by order of a public official.
West Virginia	No	N/A
Wisconsin	No	N/A
Wyoming	No	N/A

OTHER PAID TIME OFF PROGRAMS

Eligible partners can earn personal days. All partners are eligible from date of hire for bereavement and jury duty or witness duty time off pay with approval from your manager.

Personal days

Personal days are awarded to eligible retail management and nonretail partners on January 1 to be used by June 30, and July 1 to be used by December 31. A partner must be employed on or before the award date and be in an eligible position on the award date to receive a personal day. An unused personal day does not carry forward and is not paid upon separation (except where required by law), and no more than one personal day is available at any given time. Personal day hours cannot be split between days.

Personal days will expire on the standard schedule, regardless of your leave status.

A partner who transfers from an eligible to ineligible position with an unused personal day may still use the personal day by the end of the six-month period.

Retail hourly partners are not eligible for a personal day benefit but instead may use available vacation hours.

Military Service Pay

Military Service Pay is provided to partners who are active duty or reservist U.S. military service members and must be absent from work to fulfill their obligation of service. Starbucks provides eligible partners with up to 80 hours of pay each plan year (October 1- September 30) to replace lost income when service obligations require the partner to miss work for two weeks or less. Examples of service obligations would include reservist or National Guard training or duties, appearing for a Fitness for Duty exam, or funeral honors duties.

To receive the pay benefit, you must notify your manager at least 30 days in advance of the absence and provide your manager supporting documentation. If you will be away for more than two weeks, you may qualify for military leave of absence. See the **Military Leave** of absence section for details.

Military Service Pay is paid at your current rate of pay, and will be reflected in your paycheck for the payroll period in which the absence occurs. Any hours you are paid due to Military Service Pay will be included as BEN hours when determining benefits eligibility.

Military Allowance

When you are called to active military duty, Starbucks will pay the difference between your Starbucks pay and your military pay if your military pay is less than your Starbucks base pay. Starbucks base pay is defined as your current rate of pay, not including overtime hours or bonus pay. Information about applying for military allowance will be included in the paperwork when you request a Military Leave. Copies of your military earnings statements will be required in order to review your eligibility for this benefit.

For the purposes of this benefit, Starbucks defines active duty as receiving military orders requesting you to report for active duty. Eligibility and final approval for a military allowance is subject to review of your military deployment orders and supporting documentation. It is a partner's responsibility to ensure the necessary information is provided to Starbucks for review of eligibility and entitlement for military allowance

Bereavement

If you experience a death in your family as defined below, you will receive up to two consecutive days off scheduled work time for grieving. If overnight travel for a funeral is required, two additional consecutive days (for a total of four days) of time away from work will be provided. If you are notified of the family member's death while working, you may leave work immediately and you will be paid for the remainder of your shift.

A "family member" includes your spouse, domestic partner, parent, stepparent, grandparent, child, stepchild, foster child, grandchild, step-grandchild, sibling or your spouse's or domestic partner's parent, grandparent, sibling or child.

In order to receive time off for bereavement, you must submit a written request to, and receive approval from, your manager. Partners in nonexempt jobs will receive pay for any scheduled shift(s) missed because of bereavement time. Partners in exempt jobs will be paid their regular salary for the week in which bereavement time is taken.

Paid hours for bereavement will be included as BEN hours when determining benefits eligibility.

Partners in locations with specific bereavement ordinances will receive bereavement leave as required by law.

Jury and witness duty

Serving on a jury or being a witness is a fundamental responsibility of citizenship. If summoned to serve on a jury or if subpoenaed to testify as a witness, you should immediately provide your manager with a copy of the summons or subpoena and make arrangements for the time away from work.

Starbucks will pay you for any scheduled workdays or shifts missed for jury or witness duty. Paid hours for jury or witness duty will be included as BEN hours when determining benefits eligibility. If your jury or witness duty extends into time that is not yet on the schedule, you will be paid an average of your hours, calculated over the 26 weeks prior to the start of your jury or witness duty.

HOLIDAYS

Starbucks observes the following eight holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

How you receive pay for an observed holiday depends on your position at Starbucks.

If you are a retail hourly partner you are paid 1.5 times your base hourly rate of pay for any hours you work on a holiday.

Retail management and nonretail partners not working a holiday are paid straight time for the holiday. However, if you are an hourly partner working in a roasting plant, distribution center or juicery, the observed holiday must fall on a regularly scheduled workday and you must work the last scheduled shift before the holiday and the first scheduled shift after the holiday to receive pay for the holiday. If you obtain pre-approval to extend the holiday by one or more shifts, then you must work the last scheduled shift before your pre-approved time off and the first scheduled shift after your pre-approved time off to receive pay for the holiday.

If you must work the holiday, you may be paid overtime or have an opportunity to take an alternative day off as follows:

- If you are a nonretail hourly partner, you are paid 1.5 times your base hourly rate for hours worked on the holiday. In addition, you receive straight time pay for the holiday. You cannot take a paid day off in lieu of the holiday.
- If you are a salaried exempt or salaried non-exempt partner and you work on a holiday, you receive regular pay for the holiday and can take a paid day off within the 60 days following the holiday. When you take the holiday, submit your holiday pay via My Partner Info (or enter information into the POS system if you work in a store).

Unpaid time off before or after a holiday must be approved in advance.

Partners on a leave of absence do not receive holiday pay, including a holiday that coincides with the partner's return-to-work date. In those circumstances, the return-to-work date will be adjusted to the first work day following the holiday.

LEAVES OF ABSENCE (UNPAID TIME OFF)

Starbucks offers leaves of absence to all partners for extended periods of time, depending on the reason why you need time off. All leave types except Parental Leave are unpaid. The types of leaves are:

- Family Medical Leave
- Parental Leave
- State Leave (as required by state law)
- Medical Leave
- Pregnancy Disability Leave
- Caregiver Leave
- Accommodation Leave
- Military Leave
- Personal Leave
- Career Coffee Break (sabbatical leave)

To request a leave of absence, go to **claimlookup.com/starbucks** or call (866) 206-6769.

It is your responsibility to ensure that all paperwork is completed and returned within the time frame provided. Failure to complete and return the necessary paperwork may delay the start of your leave or, if your absence has already begun, may result in some or all of your absence being unapproved. An unapproved absence may result in corrective action, up to and including separation from employment, and may also have an impact on your continued benefits eligibility.

Any approved leave begins on the approved leave start date regardless of any sick, vacation or Short Term Disability pay you are receiving while on leave.

Call (866) 206-6769 for more information on leaves of absence.

Family Medical Leave

Starbucks intends for its Family Medical Leave to provide benefits consistent with the federal Family Medical Leave Act of 1993. At all times, Starbucks will follow applicable state law to the extent state law provides benefits more generous than those provided here.

Family Medical Leave is available if you are absent more than three days:

- Due to a serious health condition that prevents you from working, including an on-the-job injury
- Due to pregnancy or childbirth
- To care for a family member with a serious health condition
- To stay home to care for a newborn child, newly adopted child or newly placed foster child
- Due to any qualifying exigency arising out of the fact that the partner's spouse, son, daughter, or parent is a covered military member on active duty or has been called to active duty in support of a contingency operation
- To care for a covered service member with a serious injury or illness (if the partner is the spouse, son, daughter, parent or next of kin)

For purposes of this policy, unless specified, a "family member" is considered your spouse, domestic partner, parent, child or domestic partner's child. A child is defined as a biological, adopted, foster or stepchild under

age 18, or as otherwise defined by state and federal law, or a child over age 18 who is incapable of self-care because of a mental or physical disability.

Eligibility
To be eligible for Family Medical Leave, you must have been employed by Starbucks for at least a total of 12 months and must have worked at least 1,250 hours over the 12-month period immediately preceding the leave. If eligible, you have up to 12 weeks of Family Medical Leave every 12 months or up to 26 weeks to care for a covered service member with a serious illness or injury (Military Caregiver leave). For Family Medical Leave, Starbucks calculates the amount of time you have available by reviewing the 12-month period preceding your first day of leave. The amount of Family Medical Leave taken in the prior 12 months will be subtracted from the 12 weeks of Family Medical Leave otherwise available to you. For Military Caregiver leave, you have 26 weeks available in the 12 months following the first date of leave.

Requesting Family Medical Leave
A request or application for Family Medical Leave must be made at least 30 days in advance of your first day off work. If 30 days advance notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

Duration of leave
Family Medical Leave is limited to 12 weeks in a rolling 12-month period (or 26 weeks in a rolling 12-month period for Military Caregiver leave). If you exhaust your Family Medical Leave entitlement, you may still be eligible for leave under Starbucks policies. Refer to **Medical Leave on page 169** and **Accommodation Leave on page 170.** For leave to care for a family member refer to **Caregiver Leave on page 169.**

Reinstatement
When Family Medical Leave ends, you will be returned to work in the same position held when leave began or to a similar position with similar pay, benefits, and other terms and conditions of employment. You are required to contact your manager at least two weeks in advance of your return to work, or as soon as reasonably possible, to ensure that you are scheduled for work. Additionally, if you have been unable to work due to your own serious health condition, you may be required to provide medical documentation of your fitness to return to work.

See **Employee Rights and Responsibilities Under the Family and Medical Leave Act on page 175** for more information.

Parental Leave for Retail Hourly, Shift Managers, and Retail Management Partners

Starbucks provides time off and pay replacement to eligible partners who welcome a new child. This benefit is intended to supplement any benefit already available to a partner under state or federal law. Parental leave is intended for the purpose of recovery from childbirth and/or bonding with the new child.

Eligibility
To be eligible for Parental Leave, the partner must be benefits eligible.

A partner who is not otherwise benefits eligible may still be eligible for time off under applicable federal or state law (e.g., Family Medical Leave), Pregnancy Disability Leave, and/or Personal Leave.

Pay Replacement and Time Off

- All parents welcoming a new child, either by birth, foster placement, or adoption, will receive 6 weeks of paid leave, paid at 100% of the partner's average pay. All parents will also be entitled to up to 12 weeks of unpaid leave. Parental Leave is to be taken within the first year after birth, placement, or adoption.
- Birth parents may begin their leave up to two weeks prior to their due date without being required to provide supporting medical documentation. This portion of leave will be unpaid, and the partner may choose to use available sick time or vacation pay.
- Birth parents recovering from a C-section or a medically supported disability following a vaginal delivery are eligible for an additional 2 weeks of leave, paid at 100% of the partner's average pay.
- Any medically supported disability due to pregnancy or childbirth extending beyond 8 weeks will be evaluated under the Short Term Disability plan, paid at 66-2/3% of the partner's average pay.
- Partners may elect to use available sick or vacation for any unpaid portion of approved Parental Leave.

How your pay benefit is calculated

Your average weekly earnings are defined as the average weekly gross pay you received from Starbucks over the 26 weeks before your first date of absence. If you have been employed for less than 26 weeks, gross pay will be averaged over your period of employment. Eligible performance-based bonuses paid over the 12 months immediately preceding your first date of absence will be included when calculating your average weekly earnings (total eligible bonuses in the 12-month period divided by 52). Your earnings do not include any commissions, stipends, ineligible bonuses, overtime pay or other extra compensation or income from sources other than Starbucks. Imputed tips are included in average weekly earnings. For hourly non-exempt partners in Hawaii, average weekly earnings are defined as gross pay you receive from Starbucks over the 8 weeks your first date of absence and for salaried partners the gross wages are reported for the week and month prior to your first date of absence.

Periods of approved leaves of absence during the 26 weeks preceding your first date of absence are excluded when determining your average weekly earnings. Periods of unapproved leaves of absence are included with weekly earnings of $0. If, due to an approved leave of absence, you were not receiving wages during any of the 26 weeks preceding your first date of absence, your Parental Leave pay replacement will be calculated using the 26 weeks preceding the start of that leave.

Parental Leave pay replacement will be reduced by most other income benefits or pay you receive or are entitled to receive for the same qualifying reason, even if you do not receive benefits because of your failure to initiate a claim. These include, but are not limited to:

- State disability or parental leave programs
- Policies from other employers covering the same leave reason
- Short Term Disability pay replacement
- Any other form of pay replacement from Starbucks (sick, vacation, etc.)

Conditions and Limitations

- One continuous period of Parental Leave will be available per birth event. The time taken for Parental Leave may not be split between different time periods.
- Family Medical Leave will run concurrent with Parental Leave if the partner is also eligible for Family Medical Leave.
- If the partner and spouse or domestic partner are both employed by Starbucks and eligible for Parental Leave, each partner is eligible for their own Parental Leave.

- A partner on Parental Leave is not eligible for holiday pay.
- If you become benefits eligible while out on another approved leave type, you will transition onto Parental Leave for the remainder of your available time upon your first date of eligibility. Any leave previously taken for the same leave reason will be subtracted from your available Parental Leave entitlement.
- The Parental Leave benefit is available to eligible partners upon the long-term or permanent placement of a foster or adopted child. Parental Leave is not available for short-term or temporary placements, adopting a child of a spouse or domestic partner, or adopting a child who already lives with the partner (e.g., grandchild, niece or nephew).
- The birth, adoption, or placement of multiple children at the same time shall be considered a single event. Parental Leave may begin prior to placement if travel is needed to pick up the child. Parental Leave must be used within the first year following the child's placement, must be used in one continuous period, and is not contingent on Family Expansion Reimbursement benefits.
- For multiple birth events, adoptions, or foster placements in the same rolling 12-month period, Parental Leave is limited to two per partner per rolling 12-month period.
- You will be notified in writing if a claim or any part of a claim is denied. If you are not satisfied with the reason(s) for the denial, you may provide supporting materials or information and ask to have the claim reviewed within 90 days of the denial.

Requesting Parental Leave

A request or application for Parental Leave must be made at least 30 days in advance of your first date of absence. If 30 days of notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

When Parental Leave Pay ends

Your eligibility for Parental Leave Pay ends when you are separated from employment with Starbucks.

Birth parents who have been approved for Parental Leave pay prior to separation will continue to receive pay through the recovery portion of their leave, up to the maximum period of 6-8 weeks.

Reinstatement

Starbucks will make reasonable efforts to reinstate the partner returning from Parental Leave to the same or similar position.

Parental Leave for Nonretail Partners

Starbucks provides time off and pay replacement to eligible partners who welcome a new child. This benefit is intended to supplement any benefit already available to a partner under state or federal law. Parental leave is intended for the purpose of recovery from childbirth and/or bonding with the new child.

Eligibility

To be eligible for Parental Leave, the partner must be benefits eligible.

A partner who is not otherwise benefits eligible may still be eligible for time off under applicable federal or state law (e.g., Family Medical Leave), Pregnancy Disability Leave, and/or Personal Leave.

Time Off and Pay Replacement

- All parents welcoming a new child, either by birth, foster placement, or adoption, will receive up to 12 weeks of leave paid at 100% of the partner's average pay to be taken within the first year after birth, placement, or adoption.

- Birth parents may begin their leave up to two weeks prior to their due date without being required to provide supporting medical documentation. This portion of leave will be unpaid, and the partner may choose to use available sick time or vacation pay.
- Birth parents will receive an additional 6 weeks of leave immediately following the birth of the child, paid at 100% of the partner's average pay.
- Birth parents recovering from a C-section or a medically supported disability following a vaginal delivery are eligible for an additional 2 weeks of leave, paid at 100% of the partner's average pay.
- Any medically supported disability due to pregnancy or childbirth extending beyond 8 weeks will be evaluated under the Short Term Disability plan, paid at 66-2/3% of the partner's average pay.

How your pay benefit is calculated

Your average weekly earnings are defined as the average weekly gross pay you received from Starbucks over the 26 weeks before your first date of absence. If you have been employed for less than 26 weeks, gross pay will be averaged over your period of employment. Eligible performance-based bonuses paid over the 12 months immediately preceding your first date of absence will be included when calculating your average weekly earnings (total eligible bonuses in the 12-month period divided by 52). Your earnings do not include any commissions, stipends, ineligible bonuses, overtime pay or other extra compensation or income from sources other than Starbucks. Imputed tips are included in average weekly earnings. For hourly non-exempt partners in Hawaii, average weekly earnings are defined as gross pay you receive from Starbucks over the 8 weeks before your first date of absence and for salaried partners the gross wages are reported for the week and month prior to your first date of absence.

If you are at a vice president job level or above, your average weekly earnings are defined as your weekly gross base salary in effect on your first date of absence plus your average performance bonus over the 12 months immediately preceding your first date of absence.

Periods of approved leaves of absence during the 26 weeks preceding your first date of absence are excluded when determining your average weekly earnings. Periods of unapproved leaves of absence are included with weekly earnings of $0. If, due to an approved leave of absence, you were not receiving wages during any of the 26 weeks preceding your first date of absence, your Parental Leave pay replacement will be calculated using the 26 weeks preceding the start of that leave.

Parental Leave pay replacement will be reduced by most other income benefits or pay you receive or are entitled to receive for the same qualifying reason, even if you do not receive benefits because of your failure to initiate a claim. These include, but are not limited to:

- State disability or parental leave programs
- Policies from other employers covering the same leave reason
- Short Term Disability pay replacement
- Any other form of pay replacement from Starbucks (sick, vacation, etc.)

Conditions and Limitations

- One continuous period of Parental Leave will be available per birth event. The time taken for Parental Leave may not be split between different time periods.
- Family Medical Leave will run concurrent with Parental Leave if the partner is also eligible for Family Medical Leave.
- If the partner and spouse or domestic partner are both employed by Starbucks and eligible for Parental Leave, each partner is eligible for their own Parental Leave.

- A partner on Parental Leave is not eligible for holiday pay.
- If you become benefits eligible while out on another approved leave type, you will transition onto Parental Leave for the remainder of your available time upon your first date of eligibility. Any leave previously taken for the same leave reason will be subtracted from your available Parental Leave entitlement.
- The Parental Leave benefit is available to eligible partners upon the long-term or permanent placement of a foster or adopted child. Parental Leave is not available for short-term or temporary placements, adopting a child of a spouse or domestic partner, or adopting a child who already lives with the partner (e.g., grandchild, niece or nephew).
- The birth, adoption, or placement of multiple children at the same time shall be considered a single event. Parental Leave may begin prior to placement if travel is needed to pick up the child. Parental Leave must be used within the first year following the child's placement, must be used in one continuous period, and is not contingent on Family Expansion Reimbursement benefits.
- For multiple birth events, adoptions, or foster placements in the same rolling 12-month period, Parental Leave is limited to two per partner per rolling 12-month period.
- You will be notified in writing if a claim or any part of a claim is denied. If you are not satisfied with the reason(s) for the denial, you may provide supporting materials or information and ask to have the claim reviewed within 90 days of the denial.

Requesting Parental Leave

A request or application for Parental Leave must be made at least 30 days in advance of your first date of absence. If 30 days of notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

When Parental Leave Pay ends

Your eligibility for Parental Leave Pay ends when you are separated from employment with Starbucks.

Birth parents who have been approved for Parental Leave pay prior to separation will continue to receive pay through the recovery portion of their leave, up to the maximum period of 6-8 weeks.

Reinstatement

Starbucks will make reasonable efforts to reinstate the partner returning from Parental Leave to the same or similar position.

State Leave

As of October 1, 2020, the following states have established paid family and medical leave of absence laws: California, Hawaii, New Jersey, New York, Washington D.C., and Washington State. Eligibility and requirements vary by location. If you live in a state with a state-specific leave of absence, you will be provided information when you request a leave. Call (866) 206-6769 for more information.

Note that you will not be eligible for Short Term Disability or Starbucks paid leave benefits until you have applied for any applicable paid family and medical leaves available in your state and provided proof of your benefit amount.

Additional unpaid leaves of absence may also be available depending on your location. Your eligibility for these leaves will be automatically reviewed when you initiate your leave of absence request.

Medical Leave

Partners who are disabled and unable to work may be eligible for a Medical leave of absence.

Eligibility

Partners approved for and receiving Starbucks Short Term Disability pay may be eligible for a Medical leave of absence. The maximum duration of a continuous Medical Leave is 26 weeks. A Medical Leave may run concurrent with Family Medical Leave under Starbucks policy or State leave if available.

Requesting a Medical Leave

Medical Leave approval is contingent upon approval for Starbucks Short Term Disability pay. You must apply and be approved for Short Term Disability pay in order to be approved for a Medical leave of absence.

A request or application for Medical Leave must be made at least 30 days in advance of your first day off work. If 30 days advance notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

Duration of leave

The length of time you can take under a Medical leave of absence will be based on the amount of time you are approved for Starbucks Short Term Disability pay. However, a partner's total duration of absence cannot exceed 26 weeks. If you are medically unable to return to work after Medical Leave is exhausted, you may be eligible for additional leave as accommodation of a disability. Please refer to **Accommodation Leave on page 170** for more information.

Reinstatement

Starbucks will make reasonable efforts to reinstate the partner returning from Medical Leave to the same or similar position.

Pregnancy Disability Leave

Pregnancy Disability Leave is provided to you if you are unable to work due to pregnancy or childbirth. Pregnancy Disability Leave will be administered in accordance with applicable law. No eligibility restrictions apply. Unless otherwise prohibited by law and upon satisfaction of eligibility requirements, Pregnancy Disability Leave will also be counted as Family Medical Leave under Starbucks policy.

Requesting a Pregnancy Disability Leave

A request or application for Pregnancy Disability Leave must be made at least 30 days in advance of your first day off work. If 30 days advance notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

Reinstatement

Starbucks will make reasonable efforts to reinstate the partner returning from Pregnancy Disability Leave to the same or similar position.

Caregiver Leave

A leave of absence may be granted to care for a family member with a serious health condition.

Eligibility

To be eligible for Caregiver Leave, you must be benefits eligible and not otherwise eligible for Starbucks Family Medical Leave or comparable local, state or federal leaves. If your request also qualifies under the

Family Medical Leave or comparable local, state or federal leaves and you meet the eligibility requirements, Caregiver Leave will run concurrently.

Length of leave
If eligible, you may qualify for up to 12 weeks of Caregiver Leave every 12 months. To qualify for a leave, you must be absent a minimum of three consecutive days. No more than two separate blocks of Caregiver Leave may be taken in a rolling 12 months, even if the full 12 weeks has not been used. Starbucks calculates the amount of leave you have available by reviewing the 12-month period preceding your first day of leave. The amount of Caregiver Leave taken in the prior 12 months will be subtracted from the 12 weeks of Caregiver Leave otherwise available to you.

Family Member
For purposes of this policy, a "family member" is considered your spouse, domestic partner, parent, child or domestic partner's child. A child is a biological, adopted, foster or stepchild under age 18, or a child over age 18 who is incapable of self-care because of a mental or physical disability. A serious health condition is an illness, injury, impairment or physical or mental condition that requires a hospital stay or continuing treatment for a condition that prevents the family member from participating in school or other daily activities.

Limitations:

- Caregiver Leave is not available on a reduced schedule or intermittent basis.
- Caregiver Leave is unpaid. You may substitute any available sick time or vacation pay while on Caregiver Leave.

Requesting Caregiver Leave
A request or application for Caregiver Leave must be made at least 30 days in advance of your first day off work. If 30 days advanced notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

Reinstatement
Starbucks will make reasonable efforts to reinstate the partner returning from Caregiver leave to the same or similar position.

Accommodation Leave

A leave of absence may be granted to accommodate a disability, provided the leave is reasonable and does not impose an undue hardship on Starbucks operations. If your medical condition also qualifies as a serious health condition under Starbucks Family Medical Leave policy and you meet the eligibility requirements for Family Medical Leave, your request for Accommodation Leave will be treated as a request for Family Medical Leave. You may be eligible for Accommodation Leave if Family Medical Leave is not available.

Starbucks will require medical documentation to review in response to a request for leave as an accommodation of a disability. Your failure to submit medical documentation may result in denial of leave and/or separation from employment if you are unable to immediately return to work. Upon receipt of the required medical documentation, Starbucks will conduct a review to determine whether the leave may be reasonably accommodated.

Requesting an Accommodation Leave
A request or application for Accommodation Leave must be made at least 30 days in advance of your first day off work. If 30 days advance notice cannot be provided because the reason for leave is sudden and unexpected, notice should be provided as soon as possible. Leave may be denied or delayed if timely application is not made.

Reinstatement
Starbucks will make reasonable efforts to reinstate the partner returning from Accommodation Leave to the same or similar position.

Military Leave

Starbucks abides by all applicable federal and state laws in providing members of our military services with an unpaid leave of absence to attend to military duties. If you are a member of the military and receive notice of annual reserve training or active duty, you must immediately notify your manager to arrange for the time away from work.

Eligibility
You are immediately eligible for Military Leave upon hire.

Requesting a Military Leave
When you request a Military Leave, you will be asked to provide a copy of your military orders along with required documentation to prior to your leave start date. Should you need to extend your leave, you must request an extension as soon as you are made aware. If possible, provide advance notice for your need for Military Leave.

A stateside contact and mailing address will be requested in order for Starbucks to send various communications during your leave. In your application, you may also elect to have no additional communications sent to your stateside contact.

Reinstatement
When your military service ends and your combined periods of Military Leave from Starbucks have not exceeded five years, you may be reinstated in the same or similar position. You should contact your manager and/or Partner Resources generalist at the end of your Military Leave to make arrangements for your return to work. You may be asked to provide a copy of your discharge documentation to allow for coordination of your return to work.

The timeframe you have to notify your manager or Partner Resources generalist to make arrangements for your return to work depends on the length of your most recent military service. In any case, if notification is not possible within the given timeframe through no fault of your own, you must notify your manager as soon as possible after the timeframe has passed.

- Periods of service of up to 30 consecutive days: the first full calendar day following the completion of the period of service and safe transportation home, plus an 8-hour period for rest.
- Periods of service of 31-180 days: no later than 14 days after the completion of the period of service.
- Periods of service 181 days or more: no later than 90 days after completion of the period of service. These deadlines to report to work or apply for reemployment can be extended up to two years to accommodate a period during which you were hospitalized for or convalescing from an injury or illness that occurred or was aggravated during a period of military service. In either case, you do not automatically forfeit the right to reemployment, but will be "subject to the conduct rules, established policy, and general practices of the employer pertaining to explanations and discipline with respect to absence from scheduled work."

Pay while on a Military Leave
Military Leave is unpaid. However, you may be eligible for a military allowance. See the **Military Allowance section** for details. You may also choose to receive vacation hours during your Military Leave.

The military allowance will be paid for the duration of the Military Leave, not to exceed 78 weeks for a partner with at least six months of continuous service with Starbucks or 52 weeks for a partner with less than six months of continuous service.

A partner participating in annual reserve training or a partner whose military pay exceeds his or her regular pay with Starbucks will not be eligible for the allowance.

Personal Leave

An unpaid leave of absence for personal reasons is available in certain circumstances with manager approval. To be eligible, you must have been continuously employed with Starbucks for at least 90 days. Personal Leave is limited to 30 days and only one Personal leave will be granted every three years. When combined with vacation pay, the total duration of the absence may not exceed 30 days. A Personal leave of absence must be approved by your manager and Partner Resources generalist or district manager (for retail partners). A partner on Personal Leave may choose to use available vacation pay during the unpaid Personal Leave.

If you are requesting a Personal Leave for the purpose of military relocation for yourself or your spouse/domestic partner and you have already taken one Personal Leave in the last three years, you may be eligible for an additional Personal leave of absence.

Personal Leave is not available to obtain or work at another job, or to extend a Career Coffee Break.

Reinstatement

Starbucks will make reasonable efforts to reinstate the partner returning from Personal Leave to the same or similar position.

Career Coffee Break (sabbatical leave)

A Career Coffee Break leave is available to a partner with an interest in taking a break to travel, spend extended time with family and friends or pursue volunteer interests or additional education.

Eligibility

You are eligible for a Career Coffee Break after completing 10 years of continuous service and meeting the expectations of your position with Starbucks. A second Career Coffee Break may be available to you after working at least seven consecutive years after the end of the previous Career Coffee Break. No more than two Career Coffee Breaks will be granted to the same partner.

Requesting a Career Coffee Break

You should request a Career Coffee Break at least six months prior to the requested leave commencement date. The request should be submitted in writing to your manager, with a copy to your Partner Resources generalist.

The decision to grant the leave will depend on various factors, including your position, the timing and length of leave requested and current and future business needs. At all times, Starbucks retains sole discretion in determining whether a Career Coffee Break will be permitted. Employment with another company is not an appropriate use of the Career Coffee Break and generally will result in separation from employment with Starbucks. “Employment” does not include a volunteer assignment where you receive a daily stipend or paid housing.

Duration

The maximum duration for any approved Career Coffee Break leave is 12 consecutive months. Career Coffee Break will be reduced by any leave of absence taken during the 12 months preceding your Career Coffee Break. You will be required to use all vacation pay available while on leave. Sick pay and holiday pay are not available while on a Career Coffee Break.

You may apply for a Career Coffee Break leave to follow any other leave. However, you should apply for the Career Coffee Break at least six months prior to the first day of absence from work. When combined with any other type of leave, the total duration of the absence may not exceed 12 consecutive months.

Reinstatement

While on leave, you are encouraged to stay in contact with your manager and Partner Resources generalist to ensure a smooth transition back to work.

If you take a Career Coffee Break of six months or less, you will be reinstated into the same position you held before your absence began. When your Career Coffee Break is combined with any other job-protected leave of absence (i.e., Family Medical Leave), the six months or less includes your total duration from all leaves combined. For example, if you are on a Family Medical Leave for 3 months and then move to Career Coffee Break, you may only take 3 months for your Career Coffee Break if you wish to be reinstated into the same position.

If your position is eliminated due to company reorganization or downsizing while you are absent, you may be offered a comparable position, or you may be eligible for severance benefits when your leave ends.

If your Career Coffee Break is longer than six months, Starbucks will make reasonable efforts to reinstate you into the same or comparable position upon your return to work. However, reinstatement cannot be promised due to business needs or changes in the business that may occur over the duration of your leave. You are encouraged to contact your manager well in advance of the end of your Career Coffee Break to determine whether your position will still be available at the end of the approved Career Coffee Break, and, if not, to explore employment opportunities or apply for any other available position. If for any reason you have not secured a position upon the end of your Career Coffee Break, you will be separated from employment. An exception may be made, in rare circumstances, to reinstate a partner into a specific position following Career Coffee Break longer than six months. See your Partner Resources generalist for more information.

Pay while on a leave of absence

All leaves of absence are unpaid; however, certain pay replacement options may be available or required depending on the type of leave you are on.

Sick Time while on leave

You may substitute any available sick time when not receiving Short Term Disability pay. Sick time is not available when taking Military, Personal, or Career Coffee Break (sabbatical) leave and as detailed below on the chart. A partner eligible for Short Term Disability pay may be eligible to receive partial reimbursement of lost wages if taking leave due to his or her own serious health condition. See the **Short Term Disability** chapter for more information, and refer to the chart below. If you are receiving Short Term Disability pay, you are not eligible to use available sick time or vacation pay.

Vacation Pay while on leave

You are only required to substitute available vacation if you are on Career Coffee Break leave. You may choose to use available vacation pay during any other leave when not receiving Short Term Disability (STD), Parental Leave Pay, or sick time.

Period	Eligible pay replacement				
	Vacation	Personal Day	Sick	STD	Other
Short Term Disability waiting period	x	x	x		Holidays are not available during a leave of absence until you return and work your first shift.
Leave for your own serious health condition	x	x	x	x	
Leave to care for an ill family member	x	x	x		
Unpaid leave to bond with a newborn child or newly placed foster/ adopted child	x	x	x		
Career Coffee Break	x	x			
Personal Leave	x	x			

A partner who is unable to work because of an on-the-job injury or illness may be eligible for time-loss compensation through workers compensation insurance.

Benefits continuation while on a leave of absence

Refer to the **Eligibility and Enrollment** chapter for information about benefits continuation, including health coverage, while on a leave of absence.

QUESTIONS?

For more information about what happens to your benefits coverage and eligibility while on a leave of absence, refer to the **Eligibility and Enrollment** chapter. If you have questions about time off benefits, speak with your manager, Partner Resources generalist or Starbucks Partner Contact Center at (888) SBUX-411. To apply for a leave of absence or to obtain more information, go to **claimlookup.com/starbucks** or call (866) 206-6769.

Employee Rights and Responsibilities Under the Family and Medical Leave Act

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth
- To care for the employee's child after birth, or placement for adoption or foster care
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition, or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA.
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

Employee Assistance Programs (EAP)

Lyra Mental Health and Work–Life Services

Care@Work by Care.com

Headspace

Lyra Mental Health and Work-Life Services

MENTAL HEALTH SERVICES

Lyra is a Starbucks-sponsored benefit that can help you and your eligible family members with confidential mental and emotional health care. Lyra mental health therapists and coaches can help when you are feeling stressed, anxious, depressed, or experiencing other stress-related emotional difficulties such as alcohol and drug abuse, sleep issues, concerns at work or home, family relationship issues, and parent/child concerns.

Lyra Mental Health services are typically initiated via the online platform at **lyrahealth.com/starbucks**, where you will be able to find coaches and therapists matched to your needs, and access other resources to support your emotional wellbeing. You may also contact a Lyra care specialist by phone at 844-643-1263 if you wish to speak with someone directly.

Benefits include:

- Up to 20 sessions per eligible person per fiscal year with a mental health therapist or coach at no cost
- Appointments with therapists available by video or in-person, and mental health coaches via video

WORK–LIFE SERVICES

Lyra also provides support for legal services, identity theft support, and financial coaching.

- Free initial consultation for all work-life services
- Connect with someone via phone for legal, financial, and identity theft support
- Intake support 24-7 for urgent legal issues
- Elect ongoing services offered at a discounted fee

WHO IS ELIGIBLE

Lyra is available to all U.S. Starbucks partners from their date of hire, as well as their eligible family members. Eligible family members are defined as your spouse/domestic partner and your tax dependent children.

Proof of Family Member Eligibility

If your eligible family member is using services from Lyra, we may ask you or your family member at any time for proof that your family member meets the definition of an eligible participant. Examples of acceptable documentation to establish your family member's eligibility include, but are not limited to:

- Marriage certificate
- Domestic partner certification
- Birth certificate
- Adoption certification

If it is determined that the individual(s) using the Lyra benefit does not qualify as an eligible family member, you may be responsible for the cost of services used by the ineligible participant. Starbucks may also take corrective action, which may include separation from employment.

HOW THE PLAN WORKS

Lyra will provide confidential mental health counseling and coaching at no cost to you. You and your eligible family members are each eligible for up to 20 sessions with a Lyra mental health therapist or coach each fiscal year (October 1-September 30), including the partial first year April 6, 2020 through September 30, 2020. To find coaches and therapists matched to your needs and access other self-care resources, you must create an account at **lyrahealth.com/starbucks** or call 844-643-1263.

Lyra Mental Health and Work-Life Services

To create an account, you will need to provide your name, a personal email address, birthday, and partner number. Your eligible family members will also need to provide your partner number in order to access the benefit. Lyra will send you an email asking you to verify your email address. You will need to follow the steps in the confirmation email in order to complete your account set up. You may also call and speak with a Lyra care specialist who will work with you to identify your needs and determine the course of action best suited to your situation, or direct you to services that may help you.

What to expect

When you use Lyra mental health counseling and coaching services, here is what you can expect:

- You will need to create an account by providing your name, personal email address, birthday and partner number.
- For privacy reasons, each adult user (age 18+) will register for their own Lyra account.
- If you are a Starbucks partner under the age of 18, you may be prompted to call or email Lyra in order to find providers matched to your needs.
- Dependent children under the age of 18 will seek services under the partner's account.
- You will answer some questions about how you are feeling to assess your needs and concerns.
- You will be asked to indicate your preferences on connecting with support in-person or via video.
- You will receive personalized recommendations for mental health therapists and coaches specializing in your needs and concerns.
- You will have visibility to calendars for some therapists and coaches to schedule appointments online or you may need to call/email your preferred provider for an appointment.
- Most often you will be able to book an appointment and see a therapist or coach within 2 weeks from the date you search for care.
- Typically, you will have the option to meet with coaches and therapists via live video or choose in-person care.
- You and your eligible family members can each access up to 20 sessions each fiscal year at no cost.
- You may receive a recommendation to utilize free self-guided online programs.

When you use Lyra work-life services, here is what you can expect:

- Free initial consultation for all work-life services
- Connect with someone via phone for legal, financial, and identity theft support
- Elect ongoing services offered at a discounted fee
- Free access to online resources

Tax Treatment

For tax purposes, the value of mental health counseling and coaching sessions used by a domestic partner who is not your tax dependent will be treated as a taxable fringe benefit. This amount will appear on your paycheck as imputed income under "EAP Taxable". The imputed income is considered wages subject to withholding and payroll taxes and will be reported as income on your year-end earnings statement.

Confidentiality

.Lyra is a confidential benefit. When you create an account or call, your contact or usage will not be revealed to anyone — including Starbucks — without your permission, except as required by law and within Lyra's HIPAA guidelines and privacy policy which can be found at **lyrahealth.com/starbucks**.

The value of mental health counseling and coaching sessions used by a non-tax dependent domestic partner will appear as imputed income on the Starbucks partner's paycheck for tax purposes, no additional information regarding services used by the domestic partner will be included.

WHAT THE PLAN COVERS

The Lyra benefit provides access to up to 20 sessions for each eligible person each fiscal year at no cost for short-term therapy with the Lyra network of mental health therapists and coaches.

Short–term therapy and coaching

Visits 1–20

You and your eligible family members are each eligible for up to 20 sessions at no cost with a Lyra mental health therapist or coach per fiscal year. To access the no cost sessions, you must visit a Lyra provider, otherwise your treatment will not be included under this benefit. Start by creating an account at lyrahealth.com/starbucks or by calling 844-643-1263 to find Lyra providers.

Starbucks will cover the cost of up to 2 last-minute cancellations or no-shows and these will count toward your 20 session limit. For cancellation or no-show fees beyond 2, you will be responsible for any fees charged by your provider.

More than 20 visits

If you need more than 20 visits for mental health care or if you need a type of care outside of Lyra services and are enrolled in Starbucks medical coverage, you may have access to coverage within the medical plan. Refer to your medical insurance carrier's Certificate of Coverage (see Appendix A) for information regarding mental health/chemical dependency benefits.

You may also choose to pay your provider out of pocket, either directly or through your out-of-network benefits if available. Refer to your medical insurance carrier for additional details.

Work–Life services

Lyra provides work-life services that can connect you to the information and services that may help support additional needs.

You may receive free and confidential services throughout the United States 24 hours per day, 7 days a week, including holidays. Specific services offered to help support additional needs include:

Financial consultation

Your Lyra benefit includes one free 30-minute initial consultation per issue and a discounted rate for any additional services you elect. Lyra can connect you with a financial counselor for a variety of needs, such as:

- General budget assistance
- Buying or leasing a car
- Rebuilding Credit
- Buying a home
- Student loans
- Planning for college or retirement
- Debt consolidation
- Savings and investments
- Divorce planning
- Tax assistance

Legal consultation

Your Lyra benefit includes one free 30-minute initial consultation per issue and a discounted rate for any additional services you elect. Lyra can connect you with an attorney for a variety of needs, such as:

- Real estate matters
- Estate planning
- Family/divorce law
- Car accidents
- Criminal and government matters

The legal consultation services do not include advice on issues regarding the Lyra benefit, its employees, providers or attorneys. It does not cover matters relating to your job or business concerns. This program does not provide advice on any matter that is frivolous, harassing or would otherwise be a violation of ethical rules.

Identity Theft Services

Lyra offers identity theft services in the event that you, or an eligible family member, experience fraud related to your credit or personal identity. Your benefits include:

- Free 60-minute consultation with fraud resolution specialists
- Assistance with identity and credit restoration
- Free ID theft emergency response kit

Visit **lyrahealth.com/starbucks** for additional details on these benefits

IF YOU TAKE A LEAVE OF ABSENCE

Your Lyra benefit will continue during a leave of absence as long as you continue to meet the eligibility guidelines above.

WHEN COVERAGE ENDS

Lyra benefits are available to you and your eligible family members for 18 months after your separation.

VISITS OUTSIDE OF LYRA BENEFIT

There are no claims associated with the Lyra services offered through the Starbucks benefit. However, there may be claims associated with treatment outside the scope of services obtained through Lyra. Any costs incurred outside the Lyra benefit are not covered, and you are responsible for paying the provider directly. These costs may be covered by your mental health/ chemical dependency benefits, if you are enrolled in Starbucks medical coverage. Refer to your medical insurance carrier's Certificates of Coverage (see **Appendix A**) for information regarding mental health/chemical dependency benefits.

To meet Lyra's commitment of using evidence-based treatment, only providers in the Lyra network are included in the Lyra benefit. If you are currently seeing a provider and are interested in learning if your sessions could be covered under the Lyra benefit, you or your provider can contact Lyra at lyrahealth.com/apply-now. If your provider is approved, you will be able to begin using the Starbucks benefit for your sessions beginning on the date the provider joins the Lyra network.

QUESTIONS?

Additional program information is available on the Starbucks Partner Hub or by calling Lyra, 24 hours a day, seven days a week, at (844) 643-1263.

SUPPORT FOR YOUR WHOLE FAMILY

Care@Work, administered by Care.com, is available to all U.S. partners. Activate your account at **care.com/starbucks** to take advantage of the benefit. You may also call Care@Work at (866) 500-5170 at any time.

SERVICES AVAILABLE THROUGH CARE@WORK BY CARE.COM

At **care.com/starbucks**, partners have access to:

- Up to 10 total backup care days per partner per fiscal year for children or adults for a small cost
- Senior care planning services (offered as part of Starbucks Employee Assistance Program)
- A free premium membership to Care.com

Any instance of backup care for children or adults will apply toward the 10 total backup care days per partner per fiscal year (October 1 – September 30). You pay the full cost for any services beyond the 10 days of backup care and senior care planning.

When you use the backup care service, all of the in-home backup caregivers are thoroughly vetted and background-checked employees of either Care.com or of an agency that has met the rigorous standards to be included in the Care@Work backup care network. All of the childcare centers in the Care@Work backup care network are licensed in accordance with applicable law.

In–home backup childcare

In-home backup childcare is available 24 hours a day, seven days a week for any of your children from birth to age 17.

You pay $1.00 per hour for in-home backup childcare, for up to four children. If you need care for more than four children, you will be assigned a second caregiver, be charged a second day of backup care, and pay $2.00 per hour. Requests for in-home backup childcare must be for a minimum of four hours and a maximum of 10 hours. You will be charged a second day of care for requests over 10 hours.

If you cancel after a caregiver has already been assigned to the job, you will be charged $30.00. If a caregiver is already en route to the job when you cancel, you will be charged $60.00.

Visit **care.com/starbucks** or call (866) 500-5170 to request in-home backup childcare.

In–center backup childcare

In-center backup childcare is available Monday through Friday, during childcare center hours. Some childcare centers may provide weekend availability. Age restrictions can vary by center, but care is generally available for children between six weeks and 12 years. If your child is sick, they are not eligible for in-center backup care.

You pay $5.00 per child per day for in-center backup childcare. If you have multiple children who need in-center care on the same day, it will count as multiple days of use. Requests for in-center backup childcare must be a minimum of one day, within the center's hours of operations.

If you cancel within 24 hours of the date of care, you will be charged $5.00 and the day will be counted toward your allotted days of backup care.

Visit **care.com/starbucks** or call (866) 500-5170 to request in-center backup childcare.

In-home backup adult care

In-home backup adult care is available to every adult in your family and extended family – even if they live in another city. "Extended family" includes (but is not limited to): your spouse, domestic partner, adult children, siblings, and grandparents. Backup adult care is available 24 hours a day, 7 days a week at your home, or the home of the family member needing care.

Care@Work will work with their network of adult care agencies to select and confirm a caregiver. For new adult care requests, the adult care agency will conduct an initial assessment of the home in which care will be provided. While Care@Work cannot guarantee an adult care network agency in all locations throughout the country, every effort will be made to meet the needs of your family member.

You will pay $1.00 per hour for in-home backup adult care. If two caregivers are required to care for more than one adult, you will be charged a second day of backup care and pay $2.00 per hour. Requests for in-home backup adult care must be for a minimum of four hours and a maximum of 10 hours. Requests for more than 10 hours of in-home backup adult care will count as a second day of care, and requests for 24 hours of in-home backup adult care will count as three days of care.

Your cost may increase as a result of local overtime requirements. If a caregiver is expected to reach an overtime threshold (which may vary depending on where you live), the caregiver or Care@Work will do its best to notify you in advance. Additionally, while transportation is a part of in-home backup adult care, mileage fees, parking and tools are not included in the cost and will be charged when services are billed if applicable.

If you cancel after a caregiver has already been reserved for the job, you will be charged $30.00. If a caregiver is already en route to the job when you cancel, you will be charged $60.00.

Call (866) 500-5170 to request in-home backup adult care.

Senior care planning

You have unlimited access to senior care planning services through a dedicated Senior Care Advisor. Senior care planning can help create a personalized action plan, and help you find assisted living and nursing care centers, in-home care, aging life care professionals, elder law attorneys, transportation companies and more.

Call (866) 500-5170 to request senior care planning services.

Premium Care.com membership

Starbucks provides a premium Care.com membership to all partners. If you need services beyond adult or child backup care, you can find caregivers near you.

Use your premium membership to find child caregivers, senior caregivers, dog walkers, pet sitters and groomers, personal assistants, summer or vacation camps, special needs caregivers, house cleaners, tutors, transportation assistance, childcare centers, and more.

For any services outside of the 10 total backup care days and senior care planning, you pay for the full cost of services.

TAXATION

The IRS requires employers to treat certain benefits as taxable income, also known as imputed income. Care@Work identifies the market rate for services provided by region. The imputed income for the Care@Work benefit is calculated by subtracting your out-of-pocket cost for backup care from the market rate. This is the fair market value for the benefit and may be considered taxable.

Annual membership and backup childcare

Starbucks provides the annual Care.com premium membership and use of backup childcare as part of our Dependent Care Reimbursement Account (DCRA). The fair market value of your annual membership and backup childcare utilized may be added to your paycheck as imputed income. Refer to the DCRA chapter for additional details.

Backup adult care

The fair market value of backup adult care utilized will be added to your paycheck as imputed income. This information is reported by Starbucks monthly—if you use multiple days of backup adult care within the month, it may appear combined on one paycheck.

Senior care planning

Senior care planning services are offered as part of Starbucks Employee Assistance Program. There is no tax impact for using senior care planning services.

IF YOU TAKE A LEAVE OF ABSENCE

Your Care@Work benefit may continue during a leave of absence as long as you continue to be employed by Starbucks.

WHEN COVERAGE ENDS

Your eligibility for Care@Work will end on the last day of employment. Your Care.com premium membership will be updated to reflect a free basic membership. If you have backup care days scheduled for dates after your separation, you will be responsible for the full cost of care. You may also cancel the reservation (applicable cancellation fees may apply).

QUESTIONS?

For answers to your questions about the Care@Work benefit, call (866) 500-5170. Representatives are available 24 hours a day, seven days a week.

HEADSPACE

Headspace is a Starbucks-sponsored benefit that teaches you how to meditate and supports your ongoing meditation journey. Headspace offers meditation and sleep content, including hundreds of easy-to-follow guided meditations on topics ranging from managing stress and anxiety, personal growth and productivity to life challenges, kids and parenting, and physical health.

WHO IS ELIGIBLE

Headspace is available at no cost to all U.S. Starbucks partners from their date of hire.

HOW THE PLAN WORKS

Starbucks partners will receive free access to Headspace, including short meditations to stay on track throughout the day, longer sessions to deepen your practice, and tools to help you sleep—including sleep meditations, music, wind-downs and specially-designed sleepcasts.

To receive your free membership, you will need to visit **headspace.com/starbucks** to create an account and provide your Starbucks partner number, an email address, and your first and last name as they appear on your Starbucks paycheck. You may email **teamsupport@headspace.com** if you are having trouble registering or using the Headspace app/site.

What to expect

When you use the Headspace benefit, here is what you can expect:

- You will need to create an account at **headspace.com/starbucks** by providing your Starbucks partner number, an email address, and your first and last name as they appear on your Starbucks paycheck
- After creating your account, you can use the benefit on the Headspace app or access Headspace on a computer
- You can link an existing account by visiting **headspace.com/starbucks**, selecting LOG IN, and following the instructions to verify your account
- If you are currently the owner of a Family Plan, you will need to close your Family Plan or turn off auto-renew to access the Starbucks Headspace benefit

Tax Treatment

There are no tax impacts with the Headspace benefit.

IF YOU TAKE A LEAVE OF ABSENCE

Your Headspace benefit will continue during a leave of absence as long as you continue to meet the eligibility guidelines above.

WHEN COVERAGE ENDS

Your eligibility for the Headspace benefit will end at the end of the month in which your separation is processed. If you leave Starbucks, you will automatically move to the free version of Headspace and will then have the option to purchase a Headspace Plus subscription.

QUESTIONS?

Additional program information is available on the Starbucks Partner Hub.

Family Expansion Reimbursement

Starbucks Family Expansion Reimbursement Program is designed to assist you with the costs of growing your family through adoption, surrogacy, or Intrauterine Insemination. For information on time off after the birth or adoption of your child, see the **Parental Leave** information in the Time Off chapter.

FAMILY EXPANSION REIMBURSEMENT

How the plan works

Family Expansion Reimbursement is available to eligible partners who choose to build their families through adoption, surrogacy, or Intrauterine Insemination (IUI). This benefit will reimburse you up to $10,000 per qualifying event, up to a lifetime maximum of $30,000 per partner.

Qualifying events are defined as attempted or successful:

- Adoption of an eligible child (see eligibility details below)
- Surrogacy
- IUI procedure

Partners may request reimbursement for both adoption and surrogacy expenses for the same child, but the amount reimbursed may not exceed a combined total of $10,000 per attempt. If you and your spouse or domestic partner are both employed by Starbucks, only one of you is eligible for reimbursement for the same incurred expenses under this program up to $10,000 per adoption, surrogacy or IUI procedure, and up to a lifetime maximum of $30,000 per couple.

You must submit eligible expenses for reimbursement within one year of the date the expenses were paid or, for eligible medical expenses, the date the expense was incurred.

Eligibility

All benefits eligible partners are eligible to apply for reimbursement of eligible adoption expenses and eligible, non-medical surrogacy expenses. To be eligible to apply for reimbursement of eligible medical expenses for surrogacy and IUI, you and your spouse/domestic partner must be enrolled in a Starbucks medical plan. To be reimbursed for eligible expenses, you must be benefits eligible at the time your adoption, surrogacy, or IUI expense is incurred, enrolled in Starbucks medical coverage at the time eligible medical expenses are incurred, and also employed by Starbucks at the time your reimbursement is processed by payroll. For more information about benefits eligibility, see the **Eligibility and Enrollment chapter** of the *U.S. Benefits Plan Description*.

The program is designed to support a partner who is the intended parent. Partners who are surrogates are not eligible to submit expenses for reimbursement. The intended parent is defined as an individual who intends to become the legal parents of a child(ren) born through the surrogacy or IUI process or adopted through the adoption process. In order to be eligible for reimbursement of IUI expenses under the program, the partner or partner's spouse/domestic partner must either be ineligible for a diagnosis of infertility on the Starbucks medical plan, or unsuccessful in obtaining a diagnosis of infertility after having exhausted all available options on the Starbucks medical plan.

There are various types of surrogacy arrangements, each dependent on the source of genetic material involved, and who provides the material (the surrogate, the intended parent(s), or a donor(s)). This benefit is available to eligible partners regardless of the method through which the legal surrogacy occurs. Starbucks accepts no liability arising out of or in connection with the adoption or surrogacy agreement or process entered into by the partner.

ELIGIBLE AND INELIGIBLE EXPENSES

Eligible expenses may be submitted for reimbursement only if they have not been covered by another source, such as a medical plan or public program. Note that if you are reimbursed for medical expenses through Family Expansion Reimbursement, you may not also be reimbursed for the same expenses through another source, such as a medical plan, a Health Savings Account (HSA) or Health Care Reimbursement Account (HCRA), if eligible.

Adoption

Eligible adoption expenses:	Ineligible adoption expenses include but are not limited to:
• Court costs, legal costs, and attorney's fees (includes a "foster to adopt" program) associated with the adoption process • Adoption agency fees • Travel expenses for the intended parents or adoption child specifically related to the adoption process • Psychological or mental health counseling expenses for the adopted child and/or intended parents, if not covered by another source • Immigration fees associated with the adoption process • Immunization fees associated with the adoption process, if not covered by another source	• Childcare costs, whether before or after child placed in the home • Any expenses tied to the living costs of the birth parents • Any adoption that is not legally valid and recognized in the United States • Any adoption expenses incurred if you are adopting a child of your spouse or domestic partner • Any expenses incurred as part of fostering a child, unless it is a "foster-to-adopt" program or if you are adopting the foster child • Any expenses that violate a state or federal law • Pregnancy medical expenses associated with the adoption process • Unreimbursed medical expenses of the child(ren) and/or birth mother • Voluntary or charitable donations or contributions to the adoption agency • Guardianship or custody costs that are not associated with the legal adoption of the child(ren) • Cost of personal items such as: transportation to doctor's appointments, special food, over-the-counter supplements, maternity clothing, etc. • Loss of income for reasons including, but not limited to, complications of pregnancy such as bed rest for birth mother • Costs paid using funds from any other program providing monetary support for adoption • Expenses reimbursed by another source (such as an employer, public program, or health plan)

Surrogacy

Eligible surrogacy expenses*:	Ineligible surrogacy expenses include but are not limited to:
• Court costs, legal costs, and attorney's fees associated with the surrogacy process • Surrogacy agency fees • Travel expenses for the intended parents, donor, or gestational carrier specifically related to the surrogacy process • Fees charged by the agency to administer the surrogacy occurrence • Screening costs for gestational carrier and egg or sperm donor associated with the surrogacy process, if not covered by another source* • Egg or sperm retrieval fees, IVF, and certain eligible medical costs associated with the surrogacy process, if not covered by another source* • The cost of transfer of the embryo to the gestational carrier, if not covered by another source* • Immigration fees associated with the surrogacy process • Immunization fees associated with the surrogacy process, if not covered by another source*	• Any surrogacy arrangement that is not legally valid and recognized in the United States • Any expenses tied to the living costs of the surrogate • Any expenses that violate a state or federal law • Compensation to gestational carrier • Compensation to egg or sperm donor • Any medical expense considered experimental or investigational • Any cost-sharing expenses such as copays, deductibles, coinsurance, or any amount over the maximum the insurance company will pay for a procedure • Any medical expense from an out-of-network provider • Egg/sperm donation agency fees, including the cost to purchase biological material • Egg or sperm shipping and transport fees • Any medical expenses for partners and their spouse/domestic partner who are not covered under a Starbucks medical plan at the time the expense is incurred. • Fertility treatment costs and fees for a potential donor who has fertility issues that prevent pregnancy • Pregnancy medical expenses associated with the surrogacy process • Unreimbursed medical expenses of the child(ren) and/or surrogate, other than those defined as eligible expenses above • Voluntary or charitable donations or contributions to the surrogacy agency • Storage of blood, umbilical cord, reproductive materials or other material (e.g. cryopreservation of tissue, blood and blood products) • Guardianship or custody costs that are not associated with the legal surrogacy of the child(ren) • Cost of personal items such as: transportation to doctor's appointments, special food, over-the-counter supplements, maternity clothing, etc. • Loss of income for reasons including, but not limited to, complications of pregnancy such as bed rest for surrogate • Costs paid using funds from any other program providing monetary support for surrogacy • Expenses reimbursed by another source (such as an employer, public program, or medical plan)

*Medical expenses associated with surrogacy are only covered if the partner/spouse/DP are covered by the Starbucks medical plan.

IUI

Reminder: In order to be eligible for reimbursement of IUI expenses under the program, the partner or partner's spouse/domestic partner must either be ineligible for a diagnosis of infertility on the Starbucks medical plan, or unsuccessful in obtaining a diagnosis of infertility after having exhausted all available options on the Starbucks medical plan.

Eligible IUI expenses*:	Ineligible IUI expenses include but are not limited to:
• Medical expenses for the IUI procedure for partners or the partner's spouse/domestic partner that meets the criteria as stated above, if not covered by another source*	• Any medical expense incurred by the partner or partner's spouse/domestic partner that doesn't meet the criteria for IUI as stated above • Egg/sperm donation agency fees, including the cost to purchase biological material • Egg or sperm shipping or transport fees • Screening costs associated with the IUI process • Any expenses that violate a state or federal law • Compensation to or sperm donor • Any medical expense considered experimental or investigational • Any cost-sharing expenses such as copays, deductibles, coinsurance, or any amount over the maximum the insurance company will pay for a procedure • Any medical expense associated with Starbucks fertility coverage after the lifetime maximums have been reached • Any expense for fertility procedures other than IUI, such as IVF • Any medical expense from an out-of-network provider • Any medical expenses for partners and their spouse/domestic partner who are not covered under a Starbucks medical plan at the time the expense is incurred. • Storage of blood, umbilical cord, reproductive materials or other material (e.g. cryopreservation of tissue, blood and blood products) • Expenses reimbursed by another source (such as an employer, public program, or health plan)

*Medical expenses associated with surrogacy are only covered if the partner/spouse/DP are covered by the Starbucks medical plan.

TAXATION

Under Sections 137 and 105 of the Internal Revenue Code, certain reimbursements may be excludable from your gross income and may not be subject to federal income taxes. No federal income taxes will be withheld from reimbursements deemed excludable for federal income tax purposes; however, Social Security and Medicare (FICA) taxes will be withheld from reimbursements where appropriate.

Any expenses deemed excludable for federal income tax purposes will be treated consistently for state income tax purposes; however, depending on your state's tax law, state income taxes may be owed. Unreimbursed adoption expenses may also be eligible for a tax credit up to IRS defined limits. Because any excludable reimbursements or tax credits will depend on your personal situation, please consult with a tax advisor on these provisions.

Excludable reimbursements will be reported on your W-2 in Boxes 3 and 5 (Social Security, Medicare), where applicable, and Box 12 with the code "T" or "DD," depending on the applicable tax code exclusion. Non-excludable reimbursements will be included in your regular wages.

HOW TO FILE A CLAIM

You must submit expenses for reimbursement within one year of the date the expenses were paid or, for eligible medical expenses, the date the expense was incurred. Complete a Family Expansion Reimbursement request form, attach copies of receipts, Explanation of Benefits from the Starbucks medical plan showing any out-of-pocket balance owed, or other documentation and submit via one of the following methods:

Email: **benefitsadmin@starbucks.com**
Fax: (206) 594-6752
Mail: Starbucks Coffee Company
Attn: Benefits Department, S-HR3
P.O. Box 34067
Seattle WA 98124-1067

Family Expansion Reimbursement request forms are available on the Partner Hub (Benefits – Partner and Family Support – Family Expansion Reimbursement) or upon request from the Starbucks Benefits Department via email at **benefitsadmin@starbucks.com**.

QUESTIONS?

For more information about Family Expansion Reimbursement, email Starbucks Benefits Department at **benefitsadmin@starbucks.com**, or call the Partner Contact Center at (888) SBUX-411.

Deferred Action for Childhood Arrivals (DACA) Fee Reimbursement

Deferred Action for Childhood Arrivals (DACA) Fee Reimbursement

A partner who has obtained employment eligibility under DACA will be required to renew his or her status with the United States Citizenship and Immigration Services (USCIS) every two years.

HOW THE PLAN WORKS

Starbucks will reimburse a partner for the (current) $495 filing fee required by USCIS to renew DACA status. Only the filing fee for renewal qualifies for reimbursement.

Eligibility

To be eligible for the DACA Fee Reimbursement, the partner must be:

- employed by Starbucks when the fee was paid,
- have 90 days of consecutive employment before submitting their application for reimbursement, and
- employed by Starbucks when the reimbursement is processed by payroll.

Taxation

The DACA Fee Reimbursement will be taxed as regular income.

How to file for reimbursement

Eligible partners must submit a completed DACA Fee Reimbursement form (found under Benefits – Partner and Family Support on the Partner Hub) and copy of their Form I-797C (Notice of Action) as a receipt to Starbucks Benefits Department in one of the following ways:

Email: **benefitsadmin@starbucks.com**
Fax: (206) 594-6752
Mail: Starbucks Coffee Company
Attn: Benefits Department, S-HR3
P.O. Box 34067
Seattle WA 98124-1067

When to file for reimbursement

You must submit for reimbursement within one year of the date of renewal. Reimbursement will be included on the partner's paycheck within 1-2 pay periods of submitting the completed application and receipt. You must be employed at the time your reimbursement is processed by payroll to be eligible to receive reimbursement.

QUESTIONS?

For more information about the DACA Fee Reimbursement call the Partner Contact Center at (888) SBUX-411.

Starbucks College Achievement Plan

Earn your bachelor's degree with 100% tuition coverage through Arizona State University's (ASU) top-ranked degree programs, delivered online.

STARBUCKS COLLEGE ACHIEVEMENT PLAN ELIGIBILITY

To participate in the Starbucks College Achievement Plan (SCAP), you must:

1. Be employed within the U.S. by Starbucks or one of its U.S. Subsidiaries, including (but not limited to) Evolution Fresh, Siren Retail Corporation, and Starbucks Manufacturing (collectively, "Starbucks" unless the context clearly indicates otherwise);
2. Have established eligibility for Starbucks benefits on or before the final day of the enrolled term;
3. Not be a recipient of a prior bachelor's degree from a nationally-accredited or regionally-accredited college or university;
4. Have completed the required Program Application Process; and
5. Satisfy ASU's requirement of a student in "academic good standing" (as defined by ASU at **catalog.asu.edu/retention_standing**).

THE FINANCIAL BENEFIT

All eligible Starbucks Scholars

- Will receive a College Achievement Plan (CAP) Scholarship of 42% of the partner's net tuition balance incurred at the time of enrollment.
- Will receive the CAP Reimbursement which covers the expense of Tuition, ASU's Financial Aid Trust Fee and reimbursable college fees net of the CAP Scholarship received at time of enrollment, any federal or military student aid, and any need-based aid from ASU. Merit-based academic scholarships and private scholarships applied to tuition and fees do not reduce the reimbursement Eligible Expenses.

HOW IT WORKS

If you participate in the Starbucks College Achievement Plan, here are some key steps you must take:

1. Speak with an enrollment coach and start your application	• Visit **starbucks.asu.edu** to learn more about the program or start an application • Speak with an enrollment coach at (844) ASU-SBUX (278-7289) for help with the application process • Be sure to request your official transcripts from your high school and all colleges and/or universities you have attended to send to ASU.
2. Activate your MyASU Account	• You will receive an email from ASU with your username and instructions after you apply. • Activate your account so you can track your application progress and get access to other ASU services.

3. Submit your Free Application for Federal Student Aid (FAFSA)	• Submit your Free Application for Federal Student Aid (FAFSA), which is required to participate in the program. • Visit **fsaid.ed.gov/npas** to register for your FSA ID, and **fafsa.ed.gov** to complete your FAFSA. • Remember to request that a copy be sent to ASU (School Code: 001081). • Speak with your financial aid counselor to explore the SCAP benefit and help you understand how the financial part of the program works. They can also help explore other need-based financial aid you may qualify for such as University grants or Federal Pell Grants. • SCAP Financial Aid counselors are available at (844) ASU-6693.
4. Speak with an Academic Advisor	• Schedule an appointment with your Academic Advisor on the Academic Support Team section of your MyASU homepage to help you identify your major and the courses you should take for the year. Your enrollment coach can also help to schedule your academic advising appointment.
5. Register for classes	• With the assistance of your academic advisor, select your classes. • Before classes start, complete ASU 10:– ASU Orientation. This brief orientation to ASU and online learning gives you the tools to succeed in achieving your academic goals.
6. Start classes and connect with your peers	• Now that you're set up for success, it's time to focus on the rigorous and rewarding classes you are taking with ASU's award-winning faculty. • Join the Workplace platform to connect with your Starbucks partner peers in the program.
7. Get reimbursed	• At the end of each semester, you will be reimbursed for the amount you paid out of pocket for tuition and mandatory fees. • Your Reimbursement Grant will be paid prior to the start of the next semester, provided you are employed with Starbucks on the date payment is made. You don't need to fill out any additional forms or take extra steps to make it happen. **Still need assistance in understanding your finances?** ASU is here to help – call financial aid at (844) ASU-6693. A few words of friendly advice: • We encourage you to apply each Reimbursement Grant toward the next semester's tuition. • Be smart with your money. Remember that your Reimbursement Grant covers the portion of your tuition and mandatory fees after receiving financial aid. You can take out student loans to cover other expenses, like textbooks, class fees, laptops, and living expenses, but you won't be reimbursed for those and the loan will be your responsibility.

CREDIT MAXIMUM

Eligible Partners may receive the CAP Scholarship and CAP Reimbursement Grant for up to 135 credits within the Program. The 135 credit maximum will not include credits transferred to ASU earned prior to being admitted to the Program, regardless of when they are transferred.

TUITION REIMBURSEMENT TAXATION

To the extent required by applicable law, the amount of any tuition reimbursement will be included in an eligible partner's ordinary income and subject to all applicable withholding taxes.

Each tuition reimbursement paid to an eligible partner must be evaluated to determine the amount that can be excluded from the eligible partner's ordinary taxable income as a payment under the Starbucks Education Assistance Plan (described below). Starbucks may include the amount of any tuition reimbursement in an eligible partner's ordinary income if Starbucks reasonably determines that it is required by applicable law.

Education Assistance Plan overview

In conjunction with this Program, Starbucks has developed an Education Assistance Plan ("The Plan") pursuant to Section 127(b) of the Internal Revenue Code of 1986, as amended. Partners may request a copy of The Plan by sending a request to **starbuckscollegeplan@starbucks.com**. In the event of a conflict between this overview and The Plan, the written terms of The Plan will govern.

Under Code Section 127, an eligible partner may receive educational assistance on a tax-free basis, for federal payroll tax purposes, provided that the aggregate payments or reimbursements do not exceed $5,250 per calendar year. Applicable state law may or may not be consistent with the exclusion provided under federal law. Highlights of The Plan are listed below.

Eligibility: The eligibility requirements under The Plan are consistent with eligibility requirements of this Program, including the Reimbursement Payment Conditions of the College Achievement Plan Reimbursement.

Benefits: The benefit covered by the Education Assistance Plan is consistent with all Program rules related to the tuition reimbursement with the following exceptions:

- The Education Assistance Plan benefit is limited to $5,250 per calendar year. If the tuition reimbursement payment(s) in a calendar year exceed $5,250, only the amount above the $5,250 limitation will be excluded from the Education Assistance Plan benefit (see Taxable Reimbursements below).
- The Education Assistance Plan benefit does not include any tuition reimbursement payment which includes a reimbursement for merit-based academic scholarships and private scholarships.
- Starbucks may include the amount of any tuition reimbursement in an eligible partner's ordinary income if necessary in the discretion of Starbucks to assure that the Program meets the requirements of Code Section 127.

Limitations: Limitations under the Education Assistance Plan are consistent with Reimbursement Limitations associated with the College Achievement Plan Reimbursement.

Funding: Starbucks shall contribute the amount required to pay Benefits under The Plan out of the general assets of the Employer at the time such Benefits are to be paid.

Administration and Claims Procedure: The Administration and Claims Procedure of The Plan are consistent with this Program.

Taxable reimbursements

The eligible partner shall be responsible for any income tax liability arising from any tuition reimbursement payment received under this Plan, whether or not Starbucks withheld tax on those benefits.

With respect to any benefit provided by Starbucks that does not qualify for exclusion under section 127 of the Code (or under applicable state law), Starbucks will include the value of the benefit in the partner's wages, apply the appropriate payroll taxes (e.g., federal and state income tax withholding, and FICA taxation), and report it as additional income on Form W-2 and the relevant state employee wage statement.

For example, an eligible partner reaches a credit milestone at the completion of the 2020 Spring Semester and has reimbursement-eligible expenses of $6,250. The eligible partner will receive a tuition reimbursement of $6,250, consisting of $5,250 that is not subject to Federal Income Tax, Social Security Tax, or Medicare Tax and $1,000 that is subject to those taxes. The eligible partner will receive a payment of $6,073.50 in his or her paycheck determined as follows:

Non-taxable tuition reimbursement:	$5,250.00
Taxable tuition reimbursement:	$1,000.00
	less
Federal income tax withholding (10% in this example)	($100.00)
Social security tax (6.2%)	($62.00)
Medicare tax (1.45%)	($14.50)
Net payment:	**$6,073.50**

This example is based on current income tax withholding, Social Security Tax, and Medicare Tax rates and certain assumptions about the eligible partner's income. The tuition reimbursement payment received by an eligible partner may vary from the example based on the eligible partner's Form W-4 Employee's Withholding Allowance Certificate. State taxes may apply depending upon the eligible partner's state of residence.

SEPARATION AND REHIRE

If you separate from employment with Starbucks while you are participating in the Starbucks College Achievement Plan:

- Your tuition scholarship will apply to any classes in which you are enrolled as of your separation date – but it will not apply to any subsequent courses.
- You are not required to repay any previously paid tuition reimbursements from the Starbucks College Achievement Plan. If your separation occurs after a reimbursement has been approved but prior to payment, the payment will not be made.
- If you are rehired by Starbucks, you must reestablish program eligibility. Any credit hours previously completed prior to separation and rehire may be considered for tuition reimbursement provided all other requirements of tuition reimbursement are satisfied.

LEAVE OF ABSENCE

If you take a leave of absence, you may continue to participate in the Starbucks College Achievement Plan provided you maintain Starbucks benefits eligibility. See the **Eligibility and Enrollment** chapter for more information.

SEPARATION DUE TO DISABILITY

If your employment ends due to total and permanent disability, the tuition reimbursement payment conditions are waived for the final tuition reimbursement payment. For the purposes of this program, you are "totally and permanently disabled" if:

- You have a medically determinable physical or mental impairment that can be expected to result in death within 24 months or last for 24 continuous months or more;
- You are incapable of continuing your usual and customary employment with Starbucks; and
- You are receiving income replacement benefits for a period of not less than three months from Starbucks or a participating company's Long Term Disability plan (or if you are not eligible to participate in such plan, you are unable to engage in any substantial gainful activity by reason of such impairment).

The program administrator will determine, at its discretion, whether a partner is totally and permanently disabled under the terms of the program.

PATHWAY TO ADMISSION

Pathway to Admission provides an individualized "pathway" of coursework through which a partner may become eligible for coursework through the Starbucks College Achievement Plan. Eligible partners may take up to 10 courses for college credit within the Pathway to Admission program with credit conversion costs fully covered by Starbucks and ASU.

Once a partner has been admitted to ASU, the partner may transfer credits earned through the Pathway to Admission into ASU and may join SCAP, subject to eligibility. Credits earned through Pathway to Admission and transferred to SCAP will not reduce the total credits paid for by Starbucks within SCAP. Participation in Pathway to Admission ends after the partner becomes eligible for admission into ASU.

With Pathway to Admission, there's help at every step:

Personalized support: Every partner's path is unique and ASU will work with them to craft a personalized admission plan, including a "pathway" of course recommendations and GPA requirements.

Preparation orientation course: ASU offers a free orientation course to help partners prepare for online learning.

College courses that count toward a degree at ASU: Partners can take courses — and retake them as many times as needed — to earn a "C" grade or better. Plus, to receive college credit, the partner is only responsible for a $25 fee per course, paid up front. This means partners can immediately take ASU classes that, once admitted, count toward an ASU degree.

An accredited university experience, delivered online: Partners receive the same caliber of coursework and learn from the same world-class ASU faculty as partners participating in the Starbucks College Achievement Plan.

Flexibility: Take one course or several courses at a time — it's up to the partner and what fits best into their schedule.

No strings attached: Wherever they aspire to go, they're not obligated to stay at Starbucks. Once a partner earns their degree at ASU, it's their degree to keep, whether they advance at Starbucks or elsewhere.

Pathway to Admission eligibility and participation

Eligible participants include partners as identified by their application for admission to ASU under the Starbucks College Achievement Plan.

For purposes of Pathway to Admission, a participant ("Eligible Partner") must meet the following criteria:

1. Is employed within the U.S. by Starbucks or one of its U.S. subsidiaries, including (but not limited to) Evolution Fresh, Siren Retail Corporation, and Starbucks Manufacturing (collectively, "Starbucks");
2. Is not a recipient of a prior bachelor's degree from a nationally accredited or regionally accredited college or university;
3. Has completed the required program application process; and
4. Has established eligibility for Starbucks benefits on or before the final day of the enrolled session.

Leave of absence

An Eligible Partner on a leave of absence may continue to participate in the Program so long as he or she meets all eligibility criteria.

Loss of benefits eligibility

If an Eligible Partner loses benefits eligibility before the academic course ends, Starbucks will pay the credit conversion fee if the partner elects course credit within up to 12 months following the end of the course. A partner may regain eligibility for the Program upon subsequent satisfaction of all eligibility requirements.

Separation from employment

If the Eligible Partner separates from employment before the course is converted for academic credit, the partner will not receive credit conversion assistance. Participation in the plan ends upon separation from employment. A separated partner will not be required to reimburse Starbucks for any previous benefit received.

Pathway to Admission application process

Entrance into the Pathway to Admission program requires completing an ASU application and any additional paperwork requested by Starbucks and ASU. If ASU determines that the partner is not yet academically eligible for admission, ASU will offer the opportunity to join Pathway to Admission Prior to starting classes, the partner will complete an online orientation course.

Credit conversion assistance

Starbucks will pay to ASU, on behalf of the partner, the cost of credit conversion for up to ten (10) ASU courses offered through Earned Admission. A partner may retake classes as many times as desired until the partner receives a grade of 2.0 ("C") or better and elects course credit. The Eligible Partner will have up to 12 months following the end of the course to elect course credit. If course credit is elected within the 12 month timeframe, credit conversion will be paid (subject to the partner's eligibility), and the course will count toward the cap of ten (10) classes eligible for credit conversion assistance.

Dropped, withdrawn or failed courses

Any course the partner drops, withdraws from, fails to achieve a minimum 2.0 ("C") grade, or does not elect course credit is not recorded on the partner's transcript and does not incur a cost to the partner beyond the credit eligible fee. Since there are no credit conversion costs for courses dropped, withdrawn, completed with a grade below 2.0 ("C") or where course credit is not elected, no tuition costs will be paid by Starbucks.

Payment limitations

The Pathway to Admission credit conversion payment program is limited to no more than ten (10) classes per Eligible Partner, each completed with a grade of 2.0 ("C") or higher. This is a lifetime maximum.

FOR MORE INFORMATION

For more information about the Starbucks College Achievement Plan, visit **starbucks.asu.edu** or contact **starbuckscollegeplan@starbucks.com**.

Commuter Benefit Program

Do something good for the environment and your budget by signing up for Starbucks Commuter Benefit Program. Whether you take the bus, the subway or park your car, you can save money on most work-related commuting expenses with before-tax dollars.

PLAN OVERVIEW

Starbucks provides eligible partners an easy way to pay for work-related commuter expenses through before-tax payroll deductions. Deductions that are made on a before-tax basis do not have federal income or FICA taxes withheld (and in most cases, state taxes). Taxes not taken out of your paycheck offset the commuter expense, which, over a year, could cover one or more months of commuting expenses.

Below is an example of how the savings works:

Transaction	Amount
Partner purchases a $100 monthly transit pass (deducted from paychecks)	$100.00
Tax savings (tax NOT withheld) • 10% federal income tax1 ($100 x 10%) • 7.65% FICA tax1 ($100 x 7.65%) Net tax savings	 ($10.00) ($7.65) ($17.65)
Net expense to partner	$87.35

In this example, one year's worth of tax savings would cover more than two months of commuting expenses ($17.65 x 12 = $211.80).

1 The tax rates are for illustration purposes only. Your federal tax rate is determined by your annual income and deductions. The higher the federal tax rate, the greater the tax savings will be. The FICA (Social Security and Medicare taxes) tax rate is determined by the IRS and varies from year to year.

HOW TO PARTICIPATE

Go to **mysbuxben.com**, click on the Other Benefits tab and select the 'Save on Commuter Expenses' tile. You will then be directed to make your monthly commuter and/or parking selections. The site will display the options available to you.

ELIGIBLE TRANSPORTATION EXPENSES

IRS regulations allow the following work-related transportation expenses to be covered:

- Bus, train, subway, ferry, transit vehicle and street car fares
- Vanpool fees
- Monthly parking fees at a garage or lot
- Parking meter, parking lot cash box, and park-and-ride fees

Examples of transportation expenses that are NOT eligible include:

- Taxi fare
- Bridge tolls

- Mileage reimbursement costs (see Starbucks travel policy for mileage reimbursement rules)
- Expenses related to maintenance of a personal vehicle, including fuel costs
- Costs associated with bicycling
- Valet parking fees
- Work-related commuter expenses incurred by your spouse, dependents or friends

Commuter options

You can select weekly or monthly transit passes or parking options, based on what is offered in your area. Don't need a weekly or monthly option? Sign up for the Commuter Check Card. These pre-loaded cards can be used at your convenience at most transit agency ticket vending machines and ticket windows.

You may make a selection every month or select the "Recurring" option, which will automatically re-load your commuter transit card or commuter parking card on the 20th of each month until you cancel or change your ongoing "Recurring" order. Any unused amount will remain on your card for use in the following month.

Log in to **mysbuxben.com** for full details on the options available in your area.

ELIGIBILITY

All active U.S. partners on the U.S. payroll, excluding SSC and Kent Roasting Plant partners, are eligible to participate (different transportation options are available for SSC and Kent Roasting Plant partners). There is no length of service or minimum hours requirement.

You lose eligibility if you:

- Separate from the company
- Are on a leave of absence

You regain eligibility after you:

- Come back to work for Starbucks as a partner on the U.S. payroll
- Return from a leave of absence
- Pay what you owe, through payroll deductions, if your monthly pay was not enough to cover your deductions

If you regain eligibility, you will need to re-enroll.

MAKE, CHANGE OR CANCEL YOUR SELECTIONS

You can make, change or cancel your transportation and/or parking selections by going to **mysbuxben.com**.

Order deadline, deduction and receipt of pass timeline

The deadline to make, change or cancel your selections is 8:59 p.m. Pacific Time on the 25th, two months prior, for the following month's benefit. For example, if you won't need an October pass, you must cancel your selection on or before August 25. If you cancel after August 25, you will receive the October pass and deductions will continue until your October pass is paid for.

Following the successful completion of your selection, deductions will start coming out of your paycheck after the first of the month.

Your pass will generally be mailed about 10 days before the start of the month. For example, if you make your selection by August 25 for the purchase of an October pass, your October pass will be mailed to your home by September 20.

Below is a sample timeline:

Monthly enrollment period	Payroll deductions	Pass mailed by	Benefit month
July 26 – August 25	September paychecks	September 20	October pass

Payroll deductions

Your monthly deductions are taken out of your paycheck. Based on the timing of the administration process, there may be months when no deduction is taken from your first paycheck of the month. In these cases, a double deduction will be taken on your second paycheck of the month. If you have both before-tax and after-tax deductions, all before-tax deductions will be taken first.

Monthly deduction limits

Each year, the IRS sets monthly before-tax limits for eligible transportation and parking expenses. For more information on this year's limits, please contact Starbucks Benefits Center.

You can choose deductions up to $1,000 per month for eligible transportation expenses and $1,000 per month for eligible parking expenses (a separate monthly benefit of $1,000 each). Deduction amounts above the IRS monthly before-tax limit (currently $265) are taken out of your paycheck on an after-tax basis.

If your commuting expenses exceed $1,000 per month for transportation and $1,000 for parking, you must pay for the excess expense out of pocket.

If you do not receive your pass

If you do not receive your pass in the mail by the first day of the month, you can either contact Starbucks Benefits Center or submit a "Never Received Pass" claim form on mysbuxben.com (select "Save On Commuter Expenses" under the Other Benefits tab) by the tenth business day of the month in order to qualify to have a replacement pass sent to you at no additional cost. If you do not submit the claim form by the deadline, you will be responsible for paying for the pass you did not receive.

Replacement passes are NOT available if:

- Your pass is delivered to a post office box
- You have a forwarding address
- Your address is updated after the monthly enrollment/selection deadline
- You call after the third business day of the month

Not all commuter products are eligible for the "Never Received Pass claim," and limits may apply regarding how many claims you may submit. Contact Starbucks Benefits Center at (877) SBUXBEN for details.

Important:

You are responsible for making sure your address is correct and secure for delivery and receipt of your pass via U.S. mail.

Lost or stolen pass

In the event your pass is lost or stolen, in general, the policies of the transit agency that issued the pass will apply. Contact Starbucks Benefits Center about a replacement pass, and they will be able to advise if the agency has a lost-pass policy. Typically, you must register your pass with the transit agency to qualify for a replacement pass. It is highly recommended that you register your pass with the appropriate transit agency. This registration must be completed by you; it is not completed by Starbucks Benefits Center or by Starbucks.

Pre-loaded options such as Commuter Check Card, Commuter Check Voucher or Fare Media may not be eligible for replacement if lost or stolen; please contact Starbucks Benefits Center directly for details.

The IRS does NOT allow, under any circumstances, refunds of pre-tax deductions including situations where a pass was lost or stolen.

IF YOU LEAVE STARBUCKS

You lose eligibility to participate in the program and your selections are cancelled when you leave Starbucks. Outstanding deductions, if any, will be taken from your last paycheck. If you are re-hired and there is an outstanding deduction on record upon re-hire, the amount owed will be deducted from your first paycheck.

If you take a leave of absence

You are not eligible to participate in the Commuter Benefit Program while on a leave of absence (approved or unapproved). You are not considered “active” while on leave and therefore are not eligible for before-tax commuter benefits deductions per IRS regulations since you are not commuting to work.

While on leave, your account is suspended, new commuter benefit orders cannot be processed and any recurring commuter benefit orders will be cancelled. When you return from leave, you will have to re-elect any recurring orders, and any existing Commuter Check Card would then become effective again.

MANAGING YOUR ACCOUNT

Go to **mysbuxben.com**, click on the Other Benefits tab and select the ‘Save on Commuter Expenses’ tile to take you to the Commuter Benefits page, then click ‘Manage Your Account.’

- Make, change or cancel your selections
- View information about commuting and/or parking benefits

QUESTIONS?

Contact Starbucks Benefits Center at (877) SBUXBEN, available weekdays, 7:30 a.m. to 4 p.m. Pacific Time, for the following inquiries:

- Partner elections
- Parking and transportation options
- Transit locations
- Non-delivered passes

Aflac Voluntary Benefits

PLAN OVERVIEW

Aflac is a supplemental benefit offering that can be used to complement your current medical coverage by paying you cash benefits directly (unless otherwise assigned) to help cover unexpected costs that arise with accidents, illnesses and hospitalizations. Your participation in the plan is entirely voluntary and you pay the full cost of coverage through automatic payroll deductions.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

YOUR COVERAGE OPTIONS

Starbucks offers the following Aflac insurance plans:

- Aflac Partner Critical Illness
- Aflac Spouse/Domestic Partner Critical Illness
- Aflac Additional Hospital
- Aflac Accident

AFLAC PARTNER AND SPOUSE/DOMESTIC PARTNER CRITICAL ILLNESS

Aflac Critical Illness coverage can help with treatment costs of covered critical illness, such as cancer, a heart attack, or stroke. You receive cash benefits directly (unless otherwise assigned) to help pay bills related to treatment, or to help with everyday living expenses. Coverage is available for partners and their Spouses/Domestic Partners who are below the age of 70 when they enroll in coverage.

The Aflac Critical Illness plan benefits include:

- Critical Illness Benefit payable for
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Major Organ Transplant
  - End-Stage Renal Failure
  - Coronary Artery Bypass Surgery
  - Carcinoma In Situ
- Health Screening Benefit

Features:

- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse/domestic partner, and dependent children. Each dependent child is covered at 50% of the primary insured's benefit amount at no additional cost.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.

Aflac Critical Illness Plan benefits overview

Covered Critical Illnesses:	Plan Covers:
Cancer (Internal or Invasive)	100%
Heart Attack (Myocardial Infarction)	100%
Stroke (Apoplexy or Cerebral Vascular Accident)	100%
Major Organ Transplant	100%
End-Stage Renal Failure	100%
Carcinoma In Situ (Payment of this benefit will reduce your benefit for cancer by 25%.)	25%
Coronary Artery Bypass Surgery	25%

First occurrence benefit

A lump sum benefit is payable upon initial diagnosis of a covered critical illness. Benefit amounts available are $15,000 for partner coverage and $7,500 for spouse/domestic partner coverage. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

Additional occurrence benefit

If you collect full benefits for a critical illness under the plan and later are diagnosed with one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months or for cancer at least six months treatment free.

Reoccurrence benefit

If you collect full benefits for a covered condition and are later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer at least 12 months treatment-free. Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have gone treatment-free for 12 months.

Child coverage at no additional cost

Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge.

Health Screening Benefit (partner and spouse/domestic partner only)

You may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under the plan. There is no limit to the number of years you can receive the Health Screening Benefit; it will be payable as long as coverage remains in force. This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse/domestic partner. This benefit is not paid for dependent children.

Covered health screening tests include:

- Mammography
- Colonoscopy
- Pap smear
- Breast ultrasound
- Chest X-Ray
- PSA (blood test for prostate cancer)
- Stress test on a bicycle or treadmill
- Bone marrow testing
- CA 15-3 (blood test for breast cancer)
- CEA (blood test for colon cancer)
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- Fasting blood glucose test
- Serum cholesterol test to determine level of HDL and LDL
- Blood test for triglycerides

The plan has limitations and exclusions that may affect benefits payable. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Limitations and Exclusions

If the coverage outlined in this summary will replace any existing coverage, please be aware that it may be in your best interest to maintain that existing coverage.

The applicable benefit amount will be paid if the date of diagnosis occurs while the certificate is in force and the cause of the illness is not excluded by name or specific description.

Exclusions

Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action
- Suicide or attempted suicide while sane or insane
- Illegal activities or participation in an illegal occupation
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence
- Substance abuse

No benefits will be paid for loss which occurred prior to the effective date of coverage.

No benefits will be paid if your spouse or domestic partner is hospitalized or unable to perform his or her normal duties or activities on the election and the effective date of coverage.

No benefits will be paid for diagnosis made or treatment received outside of the United States.

Terms you need to know – Partner and Spouse/Domestic Partner Critical Illness

The **Effective Date** of your insurance will typically be the same date as your other elected benefits, refer to the effective date on the Aflac certificate schedule sent to you after enrollment.

Employee/partner means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband. Spouse also includes individuals in state-registered domestic partnerships.

Dependent Children means your dependent children as defined in the **Eligibility and Enrollment chapter.**

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines.

Treatment Free means a period of time without the consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition treatment does not include maintenance drug therapy or routine follow-up visits to verify if cancer or carcinoma in situ has returned.

Maintenance Drug Therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria: 1. New and serial eletrocardiographic (EKG) findings consistent with myocardial infarction; 2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used; and 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Termination

Coverage will terminate on the earliest of: (1) The date the plan is terminated, for class I insureds; (2) The 31st day after the premium due date if the required premium has not been paid; (3) The date the insured ceases to meet the definition of an employee as defined in the plan, for class I insureds; or (4) The date the employee is no longer a member of the class eligible.

Coverage for an insured spouse/domestic partner or dependent child will terminate the earliest of: (1) the date the plan is terminated, for dependents of class I insureds; the 31st day after the premium due date, if the required premium has not been paid; (2) the date the spouse or dependent child ceases to be a dependent; (3) the premium due date following the date we receive your written request to terminate coverage for his or her spouse and/or all dependent children. Termination of the insurance on any insured will not prejudice his rights regarding any claim arising prior to termination.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

AFLAC ADDITIONAL HOSPITAL

Aflac Additional Hospital plan provides cash benefits (unless otherwise assigned) during a covered hospitalization for you, your spouse or domestic partner, and dependent children.

The Aflac Additional Hospital Plan benefits include:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit

Features:

- Benefits are paid directly to you, unless you choose otherwise.
- Coverage is available for you, your spouse or domestic partner, and dependent children.
- Coverage is portable. This means you can take it with you when you leave Starbucks (with certain stipulations).
- Fast claims payment. Most claims are processed in about four days.

Aflac Additional Hospital Plan benefits overview

Nature of service	
Hospital Admission The benefit is paid when an insured is admitted to a hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. In order to receive this benefit for Accidental Injuries resulting from a Covered Accident, an insured must be admitted to a Hospital within one year of the date of the Covered Accident. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. We will pay this benefit once per period of Hospital Confinement. We will only pay this benefit once for each Covered Accident or Covered Sickness. If an insured is confined to the Hospital because of the same or related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year. Residents of Massachusetts are not eligible for Hospital Admission Benefit amounts in excess of $500.	$1,000 per admission

Nature of service	
Hospital Confinement (up to 30 days per confinement) This benefit is paid when an insured is confined to a hospital as an in-patient as the result of a Covered Accidental Injury or because of a Covered Sickness. In order to receive this benefit for Accidental Injuries received in a Covered Accident, the insured must be confined to a Hospital within one year of the date of the Covered Accident. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one Hospital Confinement at a time even if caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.	$150 per day
Hospital Intensive Care (10 day maximum for any one period of confinement) This benefit is paid when an insured is confined in a hospital intensive care unit because of a Covered Accidental Injury or because of a Covered Sickness. In order to receive this benefit for Accidental Injuries received in a Covered Accident, an insured must be admitted to a Hospital Intensive Care Unit within one year of the date of the Covered Accident. We will pay this amount for each day of such confinement, but not to exceed ten days during any one period of confinement. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness or a Covered Accidental Injury and a Covered Sickness. If we pay benefits for confinement in a Hospital's Intensive Care Unit and an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement benefit.	$150 per day

Limitations and Exclusions

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain the existing policy.

Exclusions

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision).

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.

- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
    - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
    - Congenital defects in newborns.
- Mental or emotional disorders without demonstrable organic disease.

Pre-Existing Condition Limitation

Pre-Existing Condition is a sickness, an accidental injury, or a physical condition that existed within the 12-month period before the insured's effective date. For the condition to be considered pre-existing, it must have resulted in the insured's receiving advice, diagnosis, or treatment from a medical professional during this preceding time period.

We will not pay benefits for any loss resulting from or affected by a pre-existing condition if the loss occurs within the 12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any loss that occurred more than 12 months after the insured's effective date on the grounds that it is caused by a pre-existing condition.

Terms you need to know – Aflac Additional Hospital

The **Effective Date** of your insurance will typically be the same date as your other elected benefits, refer to the effective date on the Aflac certificate schedule sent to you after enrollment.

Accidental Injury means accidental bodily damage to an insured. This must be the direct result of an accident and not the result of disease or bodily infirmity. A Covered Accidental Injury is an Accidental Injury that occurs while coverage is in force. A Covered Accident is an accident that occurs on or after an insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your Employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

Calendar Year means the period beginning on the policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Dependent means your spouse/domestic partner or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Dependent Children means your dependent children as defined in the **Eligibility and Enrollment chapter.** However, the age-26 limit will not apply to any dependent child who is incapable of self-sustaining employment due to developmental disability or physical handicap and is chiefly dependent on a parent for support and maintenance. You or your spouse/domestic partner must furnish proof of this incapacity and dependency to us within 31 days following the dependent child's 26th birthday.

Children Placed for Adoption are children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Your **natural dependent children** born after the effective date of the dependent child rider will be covered from the moment of live birth. No notice or additional premium is required.

If the **dependent child rider** coverage is not already in force, newborn children are automatically covered from the moment of birth for 60 days.

Newly adopted children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the employee must contact us within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and

- Licensed to practice medicine and prescribe and administer drugs or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor does not include you or any of your Family Members.

For the purposes of this definition, **Family Member** includes your spouse/domestic partner as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets eligibility requirements and who is covered under this Plan. The employee is the primary insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has Full-Time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit twenty-four hours a day; and
- Has a Doctor assigned to the Hospital Intensive care Unit on a full-time basis.

The term Hospital Intensive Care Unit specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step–Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A Pre- or Post-Intensive Care Unit.

An Intermediate Intensive Care Step-Down Unit is not a Hospital Intensive Care Unit as defined in this Plan.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit or facility specifically designated for this service. This is not a facility for the treatment of alcoholism or drug addiction.

A **Related Accidental Injury or Sickness** is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition, or pregnancy, which is not caused solely by, or the result of, any Injury. A Covered Sickness is one which is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while coverage is in force.

Spouse is your legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication in order to assist with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Telemedicine Services.

Termination

An employee's insurance will terminate on the earliest of:

- The date the plan is terminated, for Class I insureds;
- The 31st day after the premium due date, if the required premium has not been paid;
- The date you cease to meet the definition of an Employee as defined in the Plan, for Class I insureds;
- The date an employee no longer belongs to an eligible class.

Insurance for an insured spouse/domestic partner or dependent child will terminate the earliest of:

- The date the plan is terminated, for dependents of class I insureds;
- The 31st day after the premium due date, if the required premium has not been paid;
- The date the spouse/domestic partner or dependent child ceases to be a dependent; or
- The premium due date following the date we receive written request to terminate coverage for an insured's spouse/domestic partner and/or all dependent children. If the group master policy and/or certificate terminates, we will provide coverage for claims arising from covered accidents or sickness that occurred while the plan was in force.

AFLAC ACCIDENT

In the event of a covered accident, Aflac Accident pays for cash benefits to help with the costs associated with out-of-pocket expenses and bills – expenses your medical coverage may not take care of, including:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches and casts.

The Aflac Accident plan benefits:

- Transportation and Lodging benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental Death Benefit
- A Dismemberment Benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse/domestic partner, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

Aflac Accident Plan benefits overview

Hospital Benefits	Employee	Spouse/ Domestic Partner	Child
Hospital Admission We will pay the amount shown, when because of a covered accident, you are injured, require hospital confinement, and are confined to a hospital for at least 24 hours within one year after the accident date. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$1,000	$1,000	$1,000

Hospital Benefits	Employee	Spouse/ Domestic Partner	Child
Hospital Confinement (per day) We will pay the amount shown when, because of a covered accident, you are injured and those injuries cause confinement to a hospital for at least 24 hours within one year after the accident date. The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$200	$200	$200
Hospital Intensive Care (per day) We will pay the amount shown when, because of a covered accident, you are injured, and those injuries cause confinement to a hospital intensive care unit. This benefit is paid up to 30 days per covered accident. Benefits are paid in addition to the Hospital Confinement Benefit.	$400	$400	$400
Medical Fees (for each accident) We will pay up to the amount shown for X-rays and doctor services when, because of a covered accident, you are injured and those injuries cause you to receive initial treatment from a doctor within one year after the accident. If you do not exhaust the maximum benefit paid during the initial treatment, we will pay the remainder of this benefit for treatment received due to injuries from a covered accident and for each covered accident up to one year after the accident date.	$125	$125	$75
Paralysis **(lasting 90 days or more and diagnosed by a physician within one year)** **Quadriplegia** **Paraplegia** Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident, you are injured, the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within one year after the accident. The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.	 $10,000 $5,000	 $10,000 $5,000	 $10,000 $5,000

Accidental Death and Dismemberment (within one year)	Employee	Spouse/ Domestic Partner	Dependent
Accidental Death	$50,000	$25,000	$5,000
Accidental Common-Carrier Death (plane, train, boat, or ship)	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers or Toes	$1,250	$500	$250
Partial Amputation of Fingers or Toes (including at least one joint)	$100	$100	$100

If the Accidental Common-Carrier Death Benefit is paid, we will pay the Accidental Death Benefit.

Accidental Death Benefit

We will pay the amount shown if, because of a covered accident, you are injured, and the injury causes you to die within one year after the accident.

Accidental Common–Carrier Death Benefit

We will pay the amount shown if you are a fare-paying passenger on a common carrier, as defined below, are injured in a covered accident, and die within one year after the covered accident. We will pay the Accidental Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

Dismemberment Benefit

We will pay the appropriate amount shown if, because of a covered accident, you are injured and lose a hand, a foot, or sight within one year after the accident as a result of the injury. If you lose one hand, one foot, or the sight of one eye in a covered accident, we will pay the single dismemberment benefit shown. If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double dismemberment benefit shown. If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.

If the Dismemberment Benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Major Injuries (diagnosis and treatment within one year)	Employee/ Spouse/ Children	Definition
Fractures (closed reduction)		
Hip/Thigh	$4,000	**Fracture*** is a break in the bone that can be seen by X-ray. If a bone is fractured in a covered accident, we will pay the appropriate benefit shown. **Multiple fractures*** means having more than one fracture requiring open or closed reduction. If these fractures occur in any one covered accident, we will pay the appropriate benefits shown for each fracture, but no more than double the amount for the bone fractured that has the highest benefit amount. **Chip fracture*** means a piece of bone that is completely broken off near a joint. If a doctor diagnoses a chip fracture, we will pay 25% of the appropriate benefit shown. *If a fracture requires open reduction, we will pay double the amount shown.
Vertebrae (except processes)	$3,600	
Pelvis	$3,200	
Skull (depressed)	$3,000	
Leg	$2,400	
Forearm/Hand/Wrist	$2,000	
Foot/Ankle/Kneecap	$2,000	
Shoulder Blade/Collar Bone	$1,600	
Lower Jaw (mandible)	$1,600	
Skull (simple)	$1,400	
Upper Arm/Upper Jaw	$1,400	
Facial Bones (except teeth)	$1,200	
Vertebral Processes	$800	
Coccyx/Rib/Finger/Toe	$320	
Dislocations (closed reduction)		
Hip	$3,000	**Multiple Dislocations*** means having more than one dislocation requiring either open or closed reduction. For each dislocation, we will pay the amounts shown. We will not pay more than 200% of the benefit amount for the dislocated joint that has the highest benefit amount. **Partial dislocation*** means the joint is not completely separated. If a doctor diagnoses and treats the partial dislocation, we will pay 25% of the amount shown for the affected joint. * If a dislocation requires open reduction, we will pay double the amount shown.
Knee (not kneecap)	$1,950	
Shoulder	$1,500	
Foot/Ankle	$1,200	
Hand	$1,050	
Lower Jaw	$900	
Wrist	$750	
Elbow	$600	
Finger/Toe	$240	

Specific Injuries	Employee/ Spouse/Children
Ruptured Disc (treatment within one year; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
Tendons/Ligaments (treatment within one year; surgical repair within one year)	
If you tear, sever, or rupture a tendon or ligament in a covered accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for tendons and ligaments repaired.	$600 (multiple) $400 (single)
Torn Knee Cartilage (treatment within one year; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
Eye Injuries	
Treatment and surgical repair within one year	$250
Removal of foreign body nonsurgically, with or without anesthesia	$50
Concussion	
A concussion or mild traumatic brain injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head.	$200
Coma	
Coma means a state of profound unconsciousness caused by a covered accident. If you are in a coma lasting 30 days or more as the result of a covered accident, we will pay the benefit shown.	$10,000
Emergency Dental Work (per accident; injury to sound, natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50
Burns (treatment within one year and based on percentage of body surface burned)	
Second-Degree Burns	
Less than 10%	$100
At least 10%, but less than 25%	$200
At least 25%, but less than 35%	$500
35% or more	$1,000

Burns (treatment within one year and based on percentage of body surface burned)	
Third-Degree Burns	
Less than 10%	$1,000
At least 10%, but less than 25%	$5,000
At least 25%, but less than 35%	$10,000
35% or more	$20,000
(First-degree burns are not covered.)	
Lacerations (treatment and repair within one year)	
Under 2″ long	$50
2″ to 6″ long	$200
Over 6″ long	$400
Lacerations not requiring stitches	$25
Multiple lacerations: we will pay for the largest single laceration requiring stitches	

Additional Benefits	Employee/ Spouse/Children
Emergency Room Treatment We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room and receive initial treatment within one year after the covered accident. This benefit is payable only once per 24-hour period and only once per covered accident. We will not pay the Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.	$200
Emergency Room Observation We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room, and are held in a hospital for observation for at least 24 hours. This benefit is payable only once per 24-hour period and only once per covered accident. This benefit is payable in addition to Emergency Room Treatment Benefit.	$100
Major Diagnostic Testing We will pay the amount shown if, because of injuries sustained in a covered accident, you require one of the following exams, and a charge is incurred: computerized tomography (CT scan); computerized axial tomography (CAT); magnetic resonance imaging (MRI); electroencephalography (EEG). These exams must be performed in a hospital or a doctor's office. This benefit is limited to one payment per covered accident.	$200

Post-Traumatic Stress Disorder Diagnosis (PTSD) *Post-traumatic Stress Disorder* is a mental health condition triggered by a covered accident. We will pay the amount shown if you are diagnosed with post-traumatic stress disorder. You must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist. This benefit is payable only once per covered accident.	$200
Ambulance/Air Ambulance If you require transportation to a hospital by a professional ambulance or air ambulance service within one year after a covered accident, we will pay the amount shown.	Ambulance $200 Air Ambulance $1,000
Blood/Plasma If you are injured, and receive blood or plasma within one year after the covered accident, we will pay the benefit shown.	$100
Appliances If a doctor advises you to use a medical appliance, we will pay the benefit shown. *Medical appliance* means crutches, wheelchairs, leg braces, back braces, and walkers.	$100
Internal Injuries (resulting in open abdominal or thoracic surgery) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.	$1,000
Accident Follow-Up Treatment We will pay this benefit for up to six treatments (one per day) per covered accident, per insured for follow-up treatment. You must have received initial treatment within one year of the accident, and the follow-up treatment must begin within one year of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.	$30
Exploratory Surgery Without Repair (i.e., arthroscopy) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.	$250
Prosthesis We will pay this benefit if you require the use of a prosthetic device due to injuries received in a covered accident. We will pay this benefit for **each** prosthetic device you use. Hearing aids, wigs, dental aids, and false teeth are not covered.	$500

Physical Therapy We will pay this benefit for up to six doctor-prescribed physical therapy treatments per covered accident. You must have received initial treatment within one year of the covered accident. The physical therapy treatment must begin within one year after the covered accident or discharge from the hospital and must take place within one year of the covered accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.	$30
Transportation We will pay this benefit if a doctor-recommended hospital treatment or diagnostic study is not available in your resident city. Transportation must begin within one year from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.	$300 (train/plane) $150 (bus)
Family Lodging Benefit (per night) We will pay this benefit for each night's lodging, up to 30 days, for an adult immediate family member's lodging if you are required to travel more than 100 miles from your resident home due to confinement in a hospital for treatment of an injury from a covered accident. This benefit is only payable while you remain confined to the hospital, and treatment must be prescribed by your local doctor.	$100
Rehabilitation Unit Benefit (per 12-month period) We will pay the amount shown for injuries received in a covered accident if you are admitted for a hospital confinement, are transferred to a bed in a rehabilitation unit of a hospital, and incur a charge. This benefit is limited to 30 days per period of hospital confinement. This benefit is also limited to a calendar year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.	$75

Limitations and Exclusions

If the coverage outlined in this summary will replace any existing coverage, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

We will not pay benefits for injury, total disability, or death contributed to, caused by, or resulting from:

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport—professional or semi-professional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
- An injury arising from any employment.
- An injury or sickness covered by Workers' Compensation.

Terms You Need to Know – Aflac Accident

The **Effective Date** of your insurance will typically be the same date as your other elected benefits, refer to the effective date on the Aflac certificate schedule sent to you after enrollment.

Accidental injury or **injuries** means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of covered accident.

Common carrier means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Covered accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan's effective date, occurs while coverage is in force, and is not specifically excluded.

Dependent children means your dependent children as defined in the **Eligibility and Enrollment** chapter.

Dismemberment means: loss of a hand – The hand is removed at or above the wrist joint; loss of a foot – The foot is removed at or above the ankle; or loss of sight – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

Doctor is defined as a person who is a legally qualified to practice medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

Employee means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of employees eligible for coverage.

Family member includes your spouse/domestic partner as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother. This includes step-family members and family-members-in-law.

Hospital refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or prearranged use of X-ray equipment, laboratory, and surgical facilities; and maintains permanent medical history records. A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

Rehabilitation Unit is a unit of a hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

You and Your refer to an employee as defined in the plan. We refers to Continental American Insurance Company.

Spouse means your legal wife or husband or state registered Domestic Employee pursuant to RCW 48.21.900. Coverage may only be issued to your spouse if your spouse is over 18.

PORTABLE COVERAGE FOR ALL AFLAC PLANS

Under the Portability Privilege provision, when coverage would otherwise terminate because an employee ends his employment, coverage may be continued. The employee may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- The date the employee fails to pay the required premium; or
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the employee fails to pay any required premium; or
- If the Company receives notice of Class I plan termination.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan. As a result, please check the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

Class I

All full-time and part-time benefit-eligible employees are eligible for class I coverage. That eligibility extends to their spouses/domestic partners and children.

Class II

A class I primary insured is eligible for class II coverage if he or she:

- was previously insured under class I; and
- is no longer employed by the policyholder.

The employee must elect class II coverage under the portability privilege within 31 days after the date for which his class I eligibility would otherwise terminate.

Only dependents covered under class I coverage are eligible for continued coverage under class II.

Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

IF YOU LEAVE STARBUCKS

Coverage ends on the last day you are actively at work at Starbucks.

If you take a leave of absence

If you are enrolled in an Aflac plan at the start of your leave, your coverage will continue provided you pay your required contributions and remain eligible. See 'Paying for benefits while on leave' on page 21 for more information.

QUESTIONS?

Contact Starbucks Benefits Center at (877) SBUXBEN. You may also contact Aflac at (800) 433-3036 or Aflac.com/starbucks.

Partner Discount and Markout

All Starbucks partners may purchase Starbucks beverages, food and merchandise at a discounted price at company-operated Starbucks retail stores. Additionally, the "markout" benefit is available at Starbucks company-operated retail stores as a means for you to sample and enjoy Starbucks coffee and tea.

ELIGIBILITY

All active U.S. partners are eligible to participate. There is no length of service or minimum hours requirement.

You lose eligibility if you:

- Separate from the company

You regain eligibility after you:

- Come back to work for Starbucks as a partner on the U.S. payroll

PARTNER DISCOUNT AND MARKOUT BENEFIT

All Starbucks partners may purchase Starbucks® food, beverage and merchandise at a 30% discount at any U.S. and Canada company-owned and operated Starbucks stores.

Partners may purchase items for personal use or to give as gifts. Partners may not use the partner discount to purchase items for others — such as family members, friends or acquaintances — and then receive reimbursement for the cost.

Purchasing items with the partner discount and reselling the merchandise — on the Internet, for example, or in a side business — is strictly forbidden. Partners may not use the partner discount in any manner that would result in a profit to the partner.

"Markout" is the term used for coffee and tea that partners may receive each week at any U.S. and Canada Starbucks Coffee company-owned location (excluding both stores located in the Seattle Support Center in Seattle). The purpose of this benefit is to provide partners with the opportunity to explore the many coffees and teas offered as well as introduce these products to friends and family. For the purpose of the markout a week is Monday through Sunday. If a week is missed, there is no opportunity to make up for it in future weeks. For a list of current products available for markout, visit the Partner Hub (Benefits – Perks & Other Benefits – Discounts) or email partnercard@starbucks.com.

OBTAINING THE PARTNER DISCOUNT AND MARKOUT

To obtain the merchandise discount and markout, you must tell the barista that you are a partner, then present your partner card at POS in one of the following versions:

- Show your temporary paper partner card with photo ID. The barista will enter your partner number to validate for discount.
- Present your plastic partner card. The barista will swipe it to validate for discount.
- Scan your partner card image on the Starbucks App. Scanning the barcode on your app will validate for discount.

IF YOU LEAVE STARBUCKS

Your Partner Discount and Markout will end in conjunction with your separation from the company. If you retire from Starbucks at a minimum age of 55 with at least 10 years of continuous service or at least 25 years of continuous service, you will receive the Partner Discount and Markout benefit for life.

IF YOU TAKE A LEAVE OF ABSENCE

Your Partner Discount and Markout are still available to you while you are on a leave of absence, as long as you remain an active partner.

QUESTIONS?

Contact the Partner Contact Center at (888) SBUX-411.

Partner Connection, Fitness Event Reimbursement & Elite Athlete Programs

The Partner Connection Program encourages partners who share a common interest to participate in activities together outside of work, helping to create a work environment that supports teamwork, fun and a well-balanced life. You just need a minimum of three partners participating together. In some cases, funding may be available.

ELIGIBILITY

All active U.S. partners are eligible to participate. There is no length of service or minimum hours requirement.

PARTNER CONNECTION GUIDELINES

- A minimum of 3 active partners must be participating together in the activity.
- Excluded activities are walks/runs – see the Fitness Event Reimbursement section.
- Partner Connection may fund up to a 50% subsidy for fees related to the nature of the activity (i.e., league fees) with a max of $50 per partner, per quarter.
- Supplies, equipment or uniform costs may also be considered upon request. Please list any additional items that the group may need on the application. Items such as food, transportation, lodging and tickets are not eligible for funding.
- Partners must submit the Partner Connection application at least 1-2 months in advance to the activity start date and/or before fees are due. Failure to submit requests in a timely manner will result in denial of funds.
- Partner Connection requests must first be approved before any funds are dispersed, meaning that there is no reimbursement for funds that are paid out of pocket prior to approval.
- Once your application is submitted, the Partner Connection Program administrator will contact you within 2-3 weeks to discuss your budget and next steps.

HOW TO APPLY FOR PARTNER CONNECTION

If you have met all of the guidelines and have not yet paid for any expenses out of pocket, complete the Partner Connection application found on the **Partner Hub.**

IF YOU LEAVE STARBUCKS

You may continue to participate in a Partner Connection group; however, the subsidy for your portion of the fees will end after your separation of employment.

You regain eligibility to receive funding if you come back to work for Starbucks as a partner on the U.S. payroll.

QUESTIONS?

Contact **perksforpartners@starbucks.com**

Partners participating in a run, walk or cycling event who register and pay in full with out-of-pocket expenses are eligible to submit a registration fee reimbursement of up to $240 per plan year.

ELIGIBILITY

All active U.S. partners are eligible to participate. There is no length of service or minimum hours requirement.

FITNESS EVENT REIMBURSEMENT GUIDELINES

- Race event fees (registration/entry fees for partners participating in running, walking, cycling activities) are eligible for reimbursement. Examples include 5k, 10k, half marathons, full marathons, triathlons, fun runs/walks, mud runs, and century rides
- Ineligible fees include, but are not limited to: Partner Connection program sports teams, sport and recreation lesson fees, sports equipment, weight management program membership fees, exercise equipment and apparel, transportation to events, health clubs, and gym memberships.

Events must occur during the plan year (October 1 – September 30) to be eligible for reimbursement. You have until December 31 to submit a reimbursement for an event that occurred in the plan year.

- The event has to occur before a reimbursement can be submitted.
- Any unused portion of the annual $240 maximum that is left over will not be rolled over to the next year.
- You must be actively employed (includes being on Leave of Absence) to submit a reimbursement, and will only receive reimbursement if you are an active partner when your reimbursement is processed by payroll.

HOW TO REQUEST A FITNESS EVENT REIMBURSEMENT

Go to **mysbuxben.com**, click on the Other Benefits tab and select the Fitness Event Reimbursement tile to create a request. You will need to upload, fax or mail your itemized receipt(s) or other documentation that shows you registered and paid for an event. Receipts must contain information such as your name, the name and date of the event, description of event and total purchase amount. Requests are typically processed within 10 business days. Once approved, it will be submitted to payroll which will take 1-2 pay cycles before you will see your reimbursement on your paycheck

IF YOU LEAVE STARBUCKS

Your eligibility to submit for reimbursement ends in conjunction with your separation from Starbucks. You must be an active partner when your previously-submitted reimbursement is processed by payroll to receive reimbursement. If you separate from the company and lose eligibility, you may regain eligibility if you come back to work for Starbucks as a partner on the U.S. payroll.

QUESTIONS?

Contact Starbucks Benefits Center at (877) SBUXBEN.

The Elite Athlete Program provides support to partners who are participating in athletics at a world-class level. The majority of partners that have participated in the program are nationally or internationally ranked in their sport.

ELIGIBILITY

To be eligible for consideration in this program, you must:

- Have been employed by Starbucks Coffee Company in the U.S. or Canada for at least six months of the beginning of the Sponsorship Date.
- Be in good standing with the company, and
- Have amateur athletic status as defined by the governing authority of your sport.

You lose eligibility if you separate from the company.

ELITE ATHLETE ASSISTANCE

Upon selection, you will receive financial assistance through a monthly stipend (minus payroll taxes) through your regular paycheck. These funds will assist partners to cover the cost of competition, and may be used toward such expenses as entry fees, travel, accommodations and equipment.

HOW TO SUBMIT AN APPLICATION

To apply to be considered for the Elite Athlete Program, complete the application found on the **Partner Hub**. Applications for the upcoming fiscal year are due by June 30.

IF YOU LEAVE STARBUCKS

Your eligibility for financial assistance ends in conjunction with your separation of employment.

QUESTIONS?

Contact **thrive@starbucks.com**.

Matching Gifts

Starbucks recognizes and supports partners' individual contributions of financial gifts or volunteer time to qualified organizations. Review the guidelines below for both aspects of the program, Financial Gifts and Volunteer Time.

ELIGIBILITY CRITERIA

Partners

All active partners of Starbucks Coffee Company in the U.S. and Canada are eligible. An applicant must be an active partner at the time they contribute time or financial gifts through the time a request is processed and paid.

Organizations

Grants can be made only to 501(c)(3) public charities in the United States and Registered Charities in Canada. If you have questions about whether an organization qualifies, contact CyberGrants at **starbucks@cybergrants.com** or (866) 763-1815.

Organizations not eligible to receive grants include:

- Political organizations
- Religious organizations benefiting only those with like beliefs
- Private foundations
- Professional organizations

FINANCIAL GIFTS

Any active partner may request that Starbucks match a financial contribution to an eligible organization. Partners may request up to $1,500 in grants per fiscal year (October 1- September 30) in support of such contributions. Requests will be processed in the order of contribution date, up to the maximum fiscal year limit.

Eligible Contributions

- Must be a personal financial donation, from the partner's personal funds, which has been paid and not simply pledged. The minimum gift eligible for matching is $20. For gifts of installments, each installment must be submitted separately and meet the $20 minimum gift requirement.
- Gifts must be personal contributions made directly to approved organizations.
- Gifts must be in the form of cash, check, credit card or marketable securities with a quoted market value. Gifts of securities are valued based on the average of the high and low on the date of the gift. No other form of personal or real property will be matched.

Ineligible Contributions

Such exclusions include, but are not limited to:

- Cumulative gifts from several individuals reported as one contribution
- Membership fees for which benefits are received
- Dues to alumni(ae) or similar groups
- Gifts from spouses or surviving spouses
- Gifts made in lieu of tuition payment for services

- Fees for service or tuition payments
- Gifts or payments for primarily political purposes
- Subscription fees for publications
- Insurance premiums
- Bequests or life income trust arrangements
- Gifts of real or personal property

Request Considerations

- Within 12 months of making your contribution, go to Matching Gifts on the Benefits page on the Partner Hub to request a match.
- Important: You must then send a notification to the organization and instruct them to confirm your donation. From there, it is the organization's responsibility to complete the process. This can be done as part of the Match request process.
- The organization has 12 months from the gift date to confirm your donation, otherwise the donation will not be matched.
- If the amount that is donated is different than the organization verifies, the lower of the two amounts will be matched.
- Once the organization confirms your donation, your gift will be processed and paid on the following quarterly schedule:

Partner completes request form and organization confirms gift by:	Matching donation to be issued on/around:
November 25	December 15
February 25	March 15
May 25	June 15
August 25*	September 15

*Please note that gifts confirmed by the organization before August 25 are part of the current fiscal year's $1,500 allotment. Any gifts confirmed after August 25 will count towards the next fiscal year.

VOLUNTEER TIME

Any active partner may request that Starbucks support their community service efforts with a grant to an eligible organization. If partners volunteer as a group, each partner must submit their own grant request separately if the 25-hour volunteer time minimum is met.

Number of Hours Volunteered	Grant Amount
25 to 49	$250
50 to 74	$500
75 to 99	$750
100 to 149	$1,000
150 or more	$1,500

Ineligible Projects

Such exclusions include, but are not limited to:

- Projects that do not directly involve a non-profit organization
- Any project involving brewing or serving coffee
- Time spent training for an event, such as a marathon. (Note: time spent fundraising and participating in these events does qualify. Similarly, for multi-day events, only time spent walking or riding qualifies.)
- Blood donation or other medical procedures
- Foster parenting children
- Registration fees, fees for tables at fundraising events, board dues and membership fees
- Internships

Request Considerations

- There is a minimum of 25 hours of volunteer time with one non-profit organization before a grant will be processed.
- Within 12 months of volunteering, go to the Matching Gifts on the Benefits page on the Partner Hub to request a grant. You may let the organization know that you will be applying for a grant on behalf of your efforts, but you must not guarantee that they will receive financial support.
- Partners must then send a notification to the organization and instruct them to confirm your hours. From there, it is the organization's responsibility to complete the process.
- The organization has 12 months from the volunteer date to confirm your hours, otherwise the grant will not be processed.
- If the number of hours that is submitted is different than what the organization confirms, the lower of the amounts will be processed.
- Once the organization confirms your hours, your grant will be processed and paid on the following quarterly schedule:

Partner completes request and organization confirms hours by deadline:	Grant issued on/around:
November 25	December 15
February 25	March 15
May 25	June 15
August 25*	September 15

*Please note that hours confirmed by the organization before August 25 are part of the current fiscal year's $1,000 allotment. Any hours confirmed after August 25 will count towards the next fiscal year.

QUESTIONS?

Call (866) 763-1815, email **starbucks@cybergrants.com** or visit the Matching Gifts page on the Partner Hub (Benefits - Perks - Matching Gifts).

Starbucks Coffee Company reserves the right to suspend, change, revoke or terminate the program at any time. Additionally, Starbucks shall be the sole judge as to the eligibility of projects and potential grantee organizations including whether their missions support Starbucks Guiding Principles. In all of the foregoing matters, the decisions of Starbucks Coffee Company shall be final.

Your Rights and Responsibilities

In this chapter, you can see at a glance who serves as the administrator of each benefit, how the coverages are financially structured and your rights and responsibilities as a plan member under ERISA, COBRA and other laws that apply to health and welfare plans. See the **Stock Plans** and **Future Roast 401(k) Savings Plan** chapters for similar information on those plans.

Effective March 1, 1987, Starbucks adopted the Starbucks Corporation Group Health and Welfare Plan, which included medical, dental, and vision coverage. Effective October 1, 1994, Starbucks adopted the Starbucks Corporation Dependent Care Reimbursement Account as part of the Starbucks Corporation Group Health and Welfare Plan. Effective October 1, 1997, the Group Health and Welfare Plan provided the following types of insured and self-insured benefits: medical benefits, including mental health, chemical dependency, and employee assistance benefits; dental benefits; vision benefits; a Health Care Reimbursement Account; a Dependent Care Reimbursement Account; optional Long Term Disability coverage; and optional accidental death and dismemberment coverage. For purposes of the annual report filed pursuant to ERISA, this plan is assigned plan number 501.

Effective June 1, 1987, Starbucks adopted the Starbucks Corporation Group-term Life and Disability Plan. This Plan provided the following types of insured benefits: Long Term Disability benefits; group-term life insurance benefits, including optional coverage for partners, spouses and domestic partners, and children. For purposes of the annual report filed pursuant to ERISA, this Plan is assigned plan number 503.

Effective July 1, 1990, Starbucks adopted the Starbucks Corporation Premium Plus Plan. This Plan was a cafeteria plan that permitted partners to elect before-tax salary reduction contributions to the benefit programs included in the Group Health and Welfare Plan and the Group Term Life and Disability Plan. For purposes of the annual report filed pursuant to ERISA, this Plan is assigned plan number 506.

Effective October 1, 1999, Starbucks merged the Starbucks Corporation Group Term Life and Disability Plan and the Starbucks Corporation Group Health and Welfare Plan into the Starbucks Corporation Premium Plus Plan and renamed the merged plans as the Starbucks Corporation Welfare Benefits Plan (the "Plan"). The Plan continues to use plan number 506 for purposes of the annual report filed pursuant to ERISA.

Effective January 1, 1988, Starbucks adopted the Starbucks Corporation 401(k) Plan and Trust. This plan provides a cash or deferred arrangement that is intended to be qualified under ERISA. For purposes of the annual report filed pursuant to ERISA, the Plan uses plan number 001. See the **Future Roast 401(k) Savings Plan chapter** for specific Plan information.

The compensation and benefits arrangements described in this book are generally referred to as Starbucks benefits, each of which is governed by the terms and conditions of a formal plan, program or policy document. This book is intended as a single resource for communicating all Starbucks benefits. This book serves as the formal plan document or includes a summary of a plan documents that are set forth separately from this book, as follows:

- **Starbucks Corporation Welfare Benefits Plan** (including health care, life and disability coverages and reimbursement accounts): This book is the formal document for the plan, as required by Section 402 of the Employee Retirement Income Security Act, or ERISA. In addition, this book also serves as the plan's "summary plan description" within the meaning of ERISA Section 102.
- **Starbucks Corporation 401(k) Plan**: This book includes the plan's "summary plan description" within the meaning of ERISA Section 102. The plan document is set forth in a separate document.

- **Starbucks Stock Investment Plan and *Bean Stock*:** This book summarizes these compensation plans. The plan documents for these plans are set forth in separate documents.
- **Other Starbucks Benefits** (including Lyra, Care@Work by Care.com, Headspace, time off, Family Expansion Reimbursement, Starbucks College Achievement Plan and commuter benefits): This book summarizes these benefit plans, programs and policies.
- **These benefits and plans may be referred to collectively as the "plan" throughout this booklet**.

PLAN ADMINISTRATOR

Starbucks may appoint a person or committee to serve as the plan administrator. If no person or committee is appointed, then Starbucks shall serve as the plan administrator.

The principal duty of the plan administrator is to see that the plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the plan. The administrative duties of the plan administrator include, but are not limited to, interpreting the plan, prescribing applicable forms and procedures, determining eligibility for and the amount of benefits, authorizing benefit payments and gathering information necessary for administering the plan. The plan administrator may delegate any of these administrative duties to one or more persons or entities, provided that such delegation is in writing, identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The plan administrator may also employ and engage such persons, counsel and agents and obtain administrative, clerical, medical, legal, audit and actuarial services as it may deem necessary in carrying out the provisions of the plan.

Each participant must provide the plan administrator with information the plan administrator may require in connection with the administration of the plan. All forms and other communications from any participant or other person to the plan administrator required or permitted under the plan must be in the form and manner prescribed from time to time by the plan administrator, and will be deemed to have been given and delivered only upon actual receipt by the plan administrator.

Starbucks bears the incidental costs of administering the plans, to the extent they are not paid from partner contributions.

RIGHTS OF PARTICIPANTS

The adoption and maintenance of Starbucks benefits plans is not a contract of employment between Starbucks and any partner.

Nothing contained in the plan documents, Insurance Contracts, trusts, summary plan descriptions or any other related documents gives any partner the right to remain employed by Starbucks or interferes with Starbucks right to discharge any partner at any time.

Similarly, nothing in the documents described above gives Starbucks the right to require any partner to remain employed by the company or interferes with the partner's right to end employment with Starbucks at any time.

PLAN AMENDMENT OR TERMINATION

Starbucks or any other authorized person reserves the right to amend the plan at any time and for any reason. In some cases, an amendment may be retroactive. Although Starbucks adopted the plan with the intention that it is to be continued, the company also reserves the right to terminate the plan at any time, and for any reason.

DISCLAIMER

Except where such power and authority is given to an insurance company or third party administrator, the plan administrator has the power and discretionary authority to carry out its duties under the plan, including, without limitation, the discretionary authority to construe and interpret the terms and provisions of the plan, to decide all questions of eligibility for and the amount of benefits under the plan, to decide all issues of fact or law, to prescribe such forms as it deems necessary or appropriate for the proper administration of the plan, and to appoint such other persons as it deems necessary or appropriate to act on its behalf or to assist it in carrying out its duties. Any interpretation or construction of or action by the plan administrator with respect to the plan and its administration shall be conclusive and binding on any and all affected parties and persons.

With respect to coverage that is self-insured, Starbucks or its delegate has the discretionary authority to determine entitlement to benefits for claims and to construe the terms of the plan. With respect to coverages that are insured, the insurance company has the discretionary authority to determine entitlement to benefits for claims and to construe the terms of the Insurance Contract.

The provisions of the plan shall not be construed to limit a participant's choice of treatment or services. Each participant shall be solely responsible for deciding the care that he or she receives and shall make such decision independent of any determination by the plan.

Failure to enforce any provision of the plan or group contract at any time does not mean that the right to enforce that provision at another time has been waived. The plan shall be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the State of Washington, except to the extent provided otherwise in the governing documents for the fully-insured coverages. If any provision of the plan is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of the plan which shall be construed as if the illegal or invalid provision had never been included.

Starbucks does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in the plan. A participant should consult with professional tax advisors to determine the tax consequences of participation.

In the event any benefit under the plan is payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the plan administrator may direct payment of such benefit to such person or to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge Starbucks and the plan of any liability to the extent of such payment. In the event an incorrect amount is paid to or on behalf of a participant or beneficiary, any remaining payments may be adjusted to correct the error. The plan administrator may take such other action it deems necessary and equitable to correct any such error.

Plan funding	Nature of service
Paid through Insurance Contracts with premiums paid partially from Starbucks general assets and partially from partner contributions: • Medical • Prescription drugs • Dental • Vision • Mental health/chemical dependency • Long Term Disability claims are paid under an Insurance Contract with Unum Corporation • Partner group term life claims are paid under an Insurance Contract with Hartford Life and Accident Company	• Aetna, Cigna, Dean Health, Geisinger, Health Net, HMSA, Kaiser Permanente, Premera Blue Cross, UnitedHealthcare National, UnitedHealthcare California, UPMC Health Plan: Provides insurance and processes claims for medical, prescription drugs, mental health/ chemical dependency • EyeMed, MetLife, UnitedHealthcare, VSP: Provides insurance and processes claims for vision • Aetna, Cigna, DeltaCare USA, Delta Dental of WA, MetLife, UnitedHealthcare: Provides insurance and processes claims for dental • Cigna International: Provides insurance and processes medical claims for expatriates and international travelers
Paid through contributions made by partners: • Health Care and Dependent Care Reimbursement Accounts	• Your Spending Account (YSA) processes claims for reimbursement and health savings accounts
Paid through Insurance Contracts with premiums paid from partner contributions: • Voluntary partner group term life insurance • Voluntary spouse or domestic partner group term life insurance • Voluntary child group term life insurance • Voluntary Long Term Disability	• Unum Corporation: Provides insurance and processes claims for Long Term Disability • Hartford Life and Accident Company: Provides insurance and processes claims for partner, spouse or domestic partner and child group term life insurance and AD&D
Paid through contract with Lyra Clinical Associates: • Employee Assistance Program	• Lyra: Provides and administers the Employee Assistance Program
Paid through contract with Care.com • Care@Work by Care.com	• Care.com: Provides and administers Care@Work by Care.com
Paid through contract with Headspace • Headspace benefit	• Headspace: Provides and administers Headspace benefit
Paid through Starbucks general assets: • Certain transgender medical benefits not covered by insurance	• Aetna: Processes claims for certain transgender medical benefits
	For addresses and phone numbers of these providers, see Appendix B.

COORDINATING YOUR BENEFITS

Your Starbucks benefits plans, like many other plans, have a coordination of benefits (COB) provision. Under this provision, the amount normally reimbursed under your Starbucks plan may be reduced to reflect payments made by any other plan under which you're covered. If you or your dependents are covered under more than one plan, the COB rules determine which plan pays first (primary) and which plan pays second (secondary).

Primary vs. Secondary Plan

Primary plan is a plan that provides benefits as if you had no other coverage.

Secondary plan is a plan that is allowed to reduce its benefits in accordance with coordination of benefits rules. When this plan is secondary, it will provide benefits as explained later in this section.

When Starbucks plan is primary

As a general rule, if the COB rules of both plans agree that Starbucks plan is primary and the other plan is secondary, Starbucks plan will pay benefits first. After Starbucks plan has paid benefits, you must submit the claim to your secondary plan(s) to receive any additional benefits.

When Starbucks plan is secondary

As a general rule, if the COB rules determine that Starbucks plan is secondary, the benefits paid under Starbucks plan are reduced by the amount paid by the primary plan. In this case, you'll want to send your claim to your primary plan first. After your primary plan has paid benefits, you must submit your claim to Starbucks plan, and it will pay any additional benefits to bring the total benefit paid to the amount Starbucks plan would have paid if it were the primary plan. (Check your benefits booklet for further information.)

In many cases, this means that Starbucks plan will pay nothing. Here are two examples:

Example #1:
Your spouse or domestic partner has a cavity filled for a fee of $60. Your spouse has dental coverage through his employer. Therefore that plan is primary. Your spouse is also covered as your dependent through Starbucks dental plan. So Starbucks is secondary coverage.

Plan coverage	Coordination-of-benefit order	Plan payable
Coverage under Starbucks plan: 80% of $60 = $48	Secondary	$48
Less coverage by spouse's plan: 80% of $60 = $48	Primary	($48)
Payable by Starbucks plan		$0

Example #2:
Your dependent child has a root canal for a fee of $650. Your child has dental coverage through your spouse's plan (primary) and Starbucks plan (secondary).

Plan coverage	Coordination-of-benefit order	Plan payable
Coverage under Starbucks plan: 80% of $650 = $520	Secondary	$520
Less coverage by spouse's plan: 50% of $650 = $325	Primary	($325)
Payable by Starbucks plan		$195

How to determine which plan is primary

Let's say you are covered by a Starbucks benefits plan and another group plan, such as your spouse's or domestic partner's medical plan. The COB rules listed below apply.

1. The other plan is primary if it has no coordination of benefits provision.
2. The Starbucks plan covering you as a Starbucks partner is primary and pays benefits before the other plan covering you as a dependent.
3. The plan covering your spouse or domestic partner as an employee is primary and pays benefits for your spouse first if the Starbucks plan covers your spouse as a dependent.
4. Coverage for dependent children is determined as follows, unless a court decree states otherwise. For the purpose of these rules, the custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the plan year, excluding any temporary visitation.
    - The plan of the parent whose birthday falls earlier in the year — regardless of the birth year — is primary and pays benefits first.
    - If both parents have the same birthday, the plan covering one parent for a longer period of time is primary and pays benefits first.
    - If the other plan does not have the parents' birthday rule described above but instead has a rule based on parental gender, that gender rule will determine the order of benefits.
5. Coverage for dependent children of parents who are separated or divorced is determined as listed below:
    - If there is a court decree that gives both parents joint custody of the child without stating which parent is responsible for the child's healthcare expenses, the parents' birthday rules, specified in (4) above, will determine the order of benefits.
    - If there is a court decree making one parent financially responsible for the medical, dental or other healthcare expenses of the child, that parent's plan will be primary and pay benefits first. This rule supersedes the birthday rule (4) above.
    - If there is no court decree and the parent with custody of the child has not remarried, that parent's plan is primary and pays benefits before the plan of the parent without custody.
    - If there is no court decree and the parent with custody of the child has remarried, that parent's plan is primary and pays benefits first. The stepparent's plan is secondary and pays benefits second, if that stepparent's plan covers the child as a dependent. The plan of the parent without custody will pay last.

6. If rules (1) through (5) above do not establish any order of payment, the plan that covers you under a right of continuation pursuant to federal or state law — such as COBRA — is secondary and pays benefits after the plan that doesn't cover you under this kind of continuation. If the other plan doesn't have a continuation provision, then this exception does not apply.
7. If rules (1) through (6) above do not establish any order of payment, the plan that covers you as an active employee, or as a dependent of an active employee, is primary and pays benefits first. The plan that covers you as a laid-off or retired employee, or as a dependent of such a person, is secondary and pays benefits second. If the other plan doesn't have a provision about laid-off or retired employees, then this exception doesn't apply.
8. If rules (1) through (7) above do not establish any order of payment, the plan that covers you the longest is primary and will pay benefits first.

Effect of Medicare

Coverage will not be coordinated with Medicare when Starbucks compliance with federal law requires your Starbucks benefits for you or your dependents to be primary to Medicare.

For example, if you are actively working and enrolled in a Starbucks benefits plan but eligible for Medicare because of age alone, the Starbucks plan will remain primary.

Your coverage under Starbucks plans may be coordinated with Medicare, however, if you or a covered dependent becomes eligible for Medicare under other circumstances.

A partner or dependent is eligible for Medicare if he or she:

- Is covered under Medicare
- Is not covered under Medicare because of having refused or dropped Medicare or failed to properly enroll in Medicare.

If Medicare is primary:

- The total amount of "regular benefits" under all Starbucks plans will be calculated. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare covers for the expenses involved, the Starbucks plan will pay the difference. Otherwise, the Starbucks plan will pay no benefits. This will be done separately for each claim.
- Charges used to satisfy a partner's or a dependent's Medicare Part B deductible will be applied under the Starbucks plan in the order received. Two or more charges received at the same time will be applied starting with the largest first.

Submitting claims

If your dependent is covered under another benefits plan and your Starbucks plan is secondary, you must submit your claim to the other plan first. Certain information may be requested from you in order to apply the COB rules. Usually, your Starbucks benefits will not be paid until proof of payment, such as an Explanation of Benefits (EOB), is received from the primary plan.

End Stage Renal Disease (ESRD) and Medicare elections

When you have been diagnosed with ESRD, you become eligible for Medicare Part A and B. To enroll in Medicare, you should contact the Social Security Administration office. They will assist and guide you in the enrollment. Medicare Part A will be provided at no cost. However, Medicare Part B has a separate monthly premium. It is very important for you to enroll in Medicare Part B for coverage of dialysis and any other covered outpatient services. Failure to enroll in Part B when you initially become eligible may result in a higher Medicare premium and higher out-of-pocket costs.

If you remain an active partner with Starbucks, or are a dependent of an active partner, and are continually covered under the Starbucks benefit plan, Starbucks medical plan pays benefits as primary insurer, with Medicare secondary, for covered services you receive during a 30-month "coordination period." This 30-month period begins when you become eligible for Medicare due to ESRD regardless of when Medicare coverage actually starts. Following completion of the 30-month period, Starbucks' medical plan pay benefits secondary and Medicare will become primary.

The rules about coordination with Medicare are set by federal law and regulation. If the law or regulation changes, this plan will comply with those changes, even though they are not addressed in this booklet.

ELIGIBILITY REQUEST FOR REVIEW

If you believe that an incorrect decision has been made regarding your eligibility to maintain, enroll in, change or terminate any of Starbucks benefits available to you (including COBRA), you may ask the plan administrator to review the decision.

You have 60 days in which to submit a request for review. Your appeal must:

- Be in writing
- Provide specific information regarding the basis for your appeal, and
- Include all supporting documentation.

Your written request for review must be received no later than 60 days after the date on which your benefits were affected. For example, if your benefits terminate on March 31 because you did not meet the ongoing eligibility requirements, you will have until May 30 (60 days) to submit your request for review. If you miss a deadline and your benefits are affected or enrollment denied, you will have 60 days after the deadline in which to submit your request for review. Requests that are received late may not be eligible for review.

The plan administrator will provide you with written notice of its decision within 60 days of the date it receives your appeal. If special circumstances require an extension of time to review your appeal, you'll be notified of the extension within the initial 60-day review period. An extension will provide the plan administrator 60 additional days in which to respond.

If, upon review, the determination you are requesting be reviewed is upheld, you'll be provided an explanation of the reason(s), as well as references to the plan provisions on which the decision is based. The decision of the plan administrator is final and is not subject to further review or appeal.

BENEFITS CLAIMS

How to request a review of a benefit claim

A "claim" is a request for a benefit under a benefit plan that is made by a claimant or the claimant's authorized representative in accordance with the benefit plan's procedure for filing benefit claims. For information on how to file a claim under a particular benefit plan, please see the related benefit plan material listed in Appendix A. A participant must follow the benefit plan's procedures in order to designate an authorized representative. An assignment of benefits by a participant to a healthcare provider does not constitute a designation of an authorized representative for purposes of the plan and does not give a provider standing to represent the participant in the plan's claim and appeal process or file a lawsuit in court.

Fully Insured Benefit Plans

For purposes of determining the amount of, and entitlement to, any covered benefits under any fully insured benefit plan provided under an Insurance Contract, the respective Insurance Carrier listed in Appendix B is the named fiduciary under such plan, with the full power to make factual determinations and to interpret and apply the terms of the fully insured benefit plan as they relate to the benefits provided under that Insurance Contract.

To obtain a covered benefit under a fully insured benefit plan, you must follow the claims procedures under the related Insurance Contract, which may require you to complete, sign, and submit a written claim on the Insurance Carrier's claim form. In that case, the form is available from the Insurance Carrier. The Insurance Carrier will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. The claims procedures under any fully insured benefit plan are set forth in the benefit plan materials for that plan. The Insurance Carrier has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Insurance Carrier denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA and other applicable law.

You may appeal any adverse benefit decision to the Insurance Carrier, as applicable, for a review of the denied claim. You must follow the claim appeal procedures under the applicable Insurance Contract, including any filing deadlines, which are set forth in the related benefit plan materials. The Insurance Carrier will decide your appeal in accordance with its reasonable appeals procedures, as required by ERISA and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, a review outside of the benefit plan). If the Insurance Carrier denies your appeal, then you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA and other applicable law.

VERY IMPORTANT: For details about the claims and/or appeal procedures that you must follow in order to file a benefit claim under a fully insured benefit plan and/or appeal any denial of such claim, you must read the related benefit plan materials and follow the procedures set forth in such materials. See Appendix A and B for more information.

Self-Insured Benefit Plans, including certain Transgender Medical Benefits

For purposes of determining the amount of, and entitlement to, any covered benefits under any self-insured benefit plan, the respective Claims Administrator listed in Appendix B is the named fiduciary under such plan, with the full power to make factual determinations and to interpret and apply the terms of the benefit plan as they relate to the benefits provided under such plan.

To obtain a covered benefit under a self-insured benefit plan, you must follow the claims procedures under such plan, which may require you to complete, sign, and submit to the applicable Claims Administrator a written claim on the form available from the Claims Administrator. The Claims Administrator will decide your claim in accordance with the benefit plan's reasonable claims procedures, as required by ERISA. The claims procedures under any self-insured benefit plan are set forth in the benefit plan materials for that plan.

The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Claims Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA.

You may appeal any adverse benefit decision to the Claims Administrator for a review of the denied claim. You must follow the claim appeal procedures under the applicable self-insured benefit plan, including any filing deadlines, which are set forth in the related benefit plan materials. The Claims Administrator will decide your appeal in accordance with such plan's reasonable appeals procedures, as required by ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). If the Claims Administrator denies your appeal, then you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA.

VERY IMPORTANT: For details about the claims and/or appeal procedures that you must follow in order to file a benefit claim under a self-insured benefit plan and/or appeal any denial of such claim, you must read the related benefit plan materials and follow the procedures set forth in such materials. See Appendix A and B for more information.

Claims Related to Rescissions

Any rescission of coverage under the Health Plan will be considered an adverse benefit determination. You will then have the opportunity to appeal the rescission, as described above. (For more information about rescissions, see Termination of Coverage for Misrepresentations.)

APPEALING DENIAL OF CLAIMS

When a claim is denied in whole or in part

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the partner, or in the case of partner life insurance or Long Term Disability survivor benefits, to the beneficiary. Notice of determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

This written decision will:

- Give the specific reason or reasons for the claim determination
- Make specific reference to plan or policy provisions on which the determination is based
- Provide a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary
- Provide an explanation of the review procedure including time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court, and
- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the claim determination (or state that such information will be provided free of charge upon request).

You have the right to file a written appeal of an "adverse benefit determination." An adverse benefit determination is a denial, reduction or termination of a benefit, or a failure to provide or pay a benefit, in whole or in part. This includes:

- A denial, reduction, termination, or failure to provide or pay benefits that is based on a determination that a partner or dependent is not eligible to participate in this plan
- A rescission of coverage

- A denial, reduction, or termination of a benefit, or a failure to provide or pay a benefit that results from a clinical review of your case
- A failure to cover an item or service because it is determined to be experimental or investigational or not medically necessary or appropriate as defined in the plan.

During the appeal process, you will have the opportunity to submit written comments, documents or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the initial claim determination will consider all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

If your appeal is denied

If, upon appeal, your request is denied, the denial will contain the following information:

- The specific reason(s) for the appeal determination
- A reference to the specific plan provision(s) on which the determination is based
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- A statement describing your right to bring a civil suit under federal law, and
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Your denial may also contain a statement that, "You or 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."

Time frames for submitting your appeal

The time frames for filing your written appeal and for the plans', insurance carriers' or claims administrators' consideration and response are outlined on the following page by benefit.

Who Is Your Authorized Representative?

An authorized representative means a person you authorize, in writing, to act on your behalf or a person given authority by court order to submit claims on your behalf. In the case of a claim involving urgent care, a healthcare professional with knowledge of your condition may always act as your authorized representative. A participant must follow the Plan's procedures in order to designate an authorized representative. An assignment of benefits by a participant to a health care provider does not constitute a designation of an authorized representative for purposes of the plan.

Filing a health claim appeal

You (or your authorized representative acting on your behalf) have 180 days following receipt of an adverse benefit determination to file a written appeal.

Claims appeals for…	Should be sent to…
Medical claims, mental health and chemical dependency claims Prescription drug claims	Insurance Carrier for your medical plan identified in Appendix A.
Dental claims	Insurance Carrier for your dental plan identified in Appendix A.
Vision claims	Insurance Carrier for your vision plan identified in Appendix A.
Health Care Reimbursement Account Claims and certain transgender medical benefit claims	Claims Administrator identified in Appendix A.

If the claim involves urgent care, you or your authorized representative may request an expedited review of the claim denial by calling the member services number shown in your benefits booklet set forth in Appendix A.

All necessary information, including the appeal decisions, will be communicated between you and your authorized representative and the plan by telephone, facsimile or other similar method. You or your authorized representative may appeal urgent care claim denials either orally or in writing. You will be notified of the decision not later than 72 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you can file a second level appeal in accordance with the procedures set forth in your benefits booklet in Appendix A. You will be notified of the decision not later than 72 hours after the appeal is received. An urgent appeal is when your physician or other provider advises your insurance carrier that a delay will harm your health.

What Is Urgent Care?

Urgent care is defined as a sudden illness, injury, or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health
- Includes a condition that would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment
- Does not require the level of care provided in the emergency room of a hospital, and
- Requires immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available.

For all other denials, you will be notified of the appeal decision not later than 30 days after the request for review is received for services already delivered to the patient (post-service claims).

Appeals about ongoing care

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, the plan's denial of benefits will be suspended during the internal appeal period. The plan's provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse the

plan's denial. If the decision is upheld, you must repay all amounts the plan paid for such services. You will also be responsible for any difference between the allowable charge and the provider's billed charge if the provider is out of network.

Second level claims appeal

If you are not satisfied with an appeal decision, under some plans you may be able to file a second level appeal in accordance with the appeal procedures set forth in your benefits booklet identified in Appendix A. Second level appeals must be received in writing within 60 days after you receive the determination from the first appeal. Your appeal will be reviewed by a panel that includes healthcare providers who did not participate in the first level of review. You or your authorized representative may meet with the panel in person or, if you prefer, you may participate by telephone. Written notice to you regarding the date and time of the panel's meeting will be sent within 5 days of receiving the request. You will be notified of the decision no later than 15 days for pre-service claims (claims for which prior authorization was denied) or 30 days for post-service claims after the appeal is received. If your second level appeal is denied, the notice of the panel's decision will include the same information as was included in the response to your initial appeal.

Independent review

You can, at your option, obtain an independent review of certain medical claims:

- You have exhausted either one or both levels of the appeal process for denied claims as outlined above, and you have received a final denial
- The final decision was based upon the carrier's determination that the proposed or rendered service or supply, healthcare setting or level of care is not medically necessary or is experimental or investigational or is not effective for your condition or is not justified under medical standards that are based on evidence.

> **What Is Independent Review?**
>
> An independent review is a review by a neutral independent physician with the appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, justification or effectiveness of the service, supply, healthcare setting or level of care, or the experimental or investigational nature of a proposed service or treatment.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an independent review at the time the final decision on your appeal has been rendered. Either you or your authorized representative will be required to submit to the insurance carrier the request for independent review, subject to verification procedures that the Insurance Carrier or Claims Administrator may establish.

Claims and Appeals for Certain Transgender Medical Benefits

Claims for transgender medical benefits should first be filed with the applicable insurance carrier of the Insurance Contract in which you are enrolled. If all or a portion of your transgender medical benefit claims are not covered by your Insurance Contract, you may file a claim for transgender medical benefits with Aetna Life Insurance Company. You will need to work with a Starbucks Advocate to file a claim for transgender medical benefits.

If your claim for transgender medical benefits is denied, you have the right to appeal an adverse benefit determination within 180 days of receipt of such determination. Your appeal should be submitted to Aetna Life Insurance Company in writing (see Appendix A). If the appeal relates to a claim for payment, your request should include: the patient's name and plan identification number; the date(s) of healthcare service(s); the

Provider's name; the reason(s) you believe the claim should be paid; and any documentation or other written information to support your request for claim payment.

Your appeal will be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with a healthcare professional who has appropriate training and experience in the particular field of medicine in order to make a healthcare judgment and who was not involved in the prior determination, and the Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. Upon request and free of charge, the claimant has the right to reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits.

The Claims Administrator will have 60 days, upon receiving notice of appeal of the denial of benefits under a post-service claim, to notify you electronically or in writing of the appeal determination. The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan, and its decisions with respect to claims are conclusive and binding.

If your appeal is denied

If, upon appeal, your request is denied, the denial will contain the following information:

- The specific reason(s) for the appeal determination
- A reference to the specific plan provision(s) on which the determination is based
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- A statement describing your right to bring a civil suit under federal law, and
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Filing a Life or Accidental Death and Dismemberment Insurance claim appeal

You, your authorized representative or your beneficiary may request an appeal for a full and fair review. Your appeal should be sent to Hartford Life at the address provided in Hartford Life's notice. To appeal, you, your authorized representative or your beneficiary:

- Must request a review upon written application within:
  - 180 days of receipt of claim denial if the claim requires The Hartford to make a determination of disability; or
  - 60 days of receipt of claim denial if the claim does not require The Hartford to make a determination of disability; and
- May request copies of all documents, record, and other information relevant to the claim; and
- May submit written comments, documentations, records and other information relating to the claim.

The Hartford will respond in writing with their final decision on the claim.

Filing a Long Term Disability claim appeal

You or your beneficiary (in the case of a survivor benefit) has 180 days from your receipt of Unum's notice of adverse benefit determination to file a written appeal. Your appeal request should be sent to the address provided in Unum's notice.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a healthcare professional with appropriate training and experience. The healthcare professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, Unum will provide you with the name of such expert, regardless of whether the advice was relied upon.

A decision will be made by Unum no more than 45 days after receipt of your request for review, except in special circumstances. If special circumstances require an extension of time to decide your appeal, Unum may extend the review period by an additional 45 days (90 days in total). Unum will notify you in writing before the end of the initial 45-day period if an additional 45-day extension is needed.

If an extension is needed because you failed to submit the information necessary to decide the appeal, the extension notice will specifically describe the required information and you will have at least 45 days from receipt of the notice to provide it. If you submit the required information within the extension period, Unum will have 45 days from receipt of your information to decide your appeal. If you do not provide the information requested by Unum within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U. S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

A notice that your request on appeal is denied will contain the following information:

(a) The specific reason(s) for the appeal determination

(b) A reference to the specific Plan provision(s) on which the determination is based

(c) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)

(d) A statement describing your right to bring a civil suit under federal law

(e) A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination, and

(f) A statement that "You or 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."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Requesting a Reconsideration of a Dependent Care Reimbursement Claim

You have 180 days from receipt of Your Spending Account's benefit determination to request a reconsideration of a reimbursement claim. Your request should be submitted in one of the following ways:

Email: benefitappeals@starbucks.com

Fax: (206) 594-6752 (Attn: Appeals)

Mail: Starbucks Coffee Company
2401 Utah Ave S.
Suite 800, S-HR3
Seattle, WA 98134

Starbucks will make a decision within 60 days after receipt of your request for review.

Filing a Short Term Disability Claim Appeal

Although Starbucks Short Term Disability plan is not covered by ERISA, you still have the right to appeal an adverse benefits determination. You or your authorized representative may submit a written request for review of your denied claim within 90 days after your receipt of the denial letter. When requesting the review of your claim denial, please state the reason you believe your claim was improperly denied. You may also submit additional medical or vocational information and any facts, data, or comments you deem appropriate for us to give your appeal proper consideration. Requests for review and supporting documentations should be sent to the address provided on the Sedgwick notice.

Exhaustion of Administrative Remedies

The exhaustion of the applicable claims and appeal procedures (with the exception of any external claim review process) is mandatory for resolving every claim and dispute under the Plan before initiating any legal action. In any legal or other action brought after you have exhausted the applicable claims and appeal procedures under a benefit plan, all determinations made by any benefit plan fiduciary will be afforded the maximum possible deference permitted by law.

Notwithstanding any contrary provision in any benefit plan materials, no lawsuit or other legal action may be brought by or on behalf of any claimant with respect to any claim for any benefits under any benefit plan unless and until the claims and appeal procedures under the applicable benefit plan have been exhausted for every issue that the claimant deems relevant with respect to the claim. That is, each and every issue that supports the claimant's position or argument with respect to his or her claim under a benefit plan must be raised during the benefit plan's claims and appeal process in order for this exhaustion requirement to be satisfied and later pursue any such issue in court.

Limitation on Legal Actions

Any such lawsuit or other legal action under the Plan may not be brought if more than 365 days has passed since the date the Claims Administrator or Insurance Carrier, as applicable, has rendered its final decision upon appeal or as otherwise provided in the applicable Insurance Contract or Benefit Plan document.

Any lawsuits or other legal action involving the plan must be brought in the United States District Court for the Western District of Washington or, for fully-insured plans, the venue listed in the applicable benefit plan materials.

RECOVERY OF OVERPAYMENT

If a benefit payment exceeds the amount you are entitled to receive, the plan has the right to require the return of the overpayment on request. Or, the plan may reduce any future benefit payments by the amount of the overpayment.

ASSIGNMENTS

No benefit, right or interest of any participant, dependent or beneficiary under the plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; except as (i) required under a Qualified Medical Child Support Order as described in Section 609 of ERISA, or (ii) where required under a state Medicaid law. Medical coverage benefits under the plan may not be assigned, transferred or in any way made over to another party by a participant. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder, shall be void. A direction to pay a provider does not cause the provider to be a plan beneficiary and does not constitute not an assignment of any right under the plan or of any legal or equitable right to institute any court proceeding or to request or receive plan documents under ERISA. The plan prohibits any participant, dependent or beneficiary from assigning his or her right to bring a suit under ERISA to a physician or other health care providers who accept assignments of claims. Nothing contained in the plan shall be construed to make the plan or the Company liable to any third-party to whom a participant, dependent or beneficiary may be liable for medical care, treatment, or services.

NO RIGHT TO ASSETS

No participant, dependent, or beneficiary shall have any right to, interests in or claim for any particular assets of the Company, the Plan, any benefit plan or any underlying contract, trust or other funding vehicle.

COMPANY'S USE OF FUNDS

To the maximum extent permitted by applicable law, the Company shall be entitled to retain any policy dividend or refund, or portion thereof, it receives from any Insurance Carrier, administrative services organization, HMO, service program or any other organizations or individuals.

PLAN'S USE OF FUNDS

Any amounts paid to and held by the Plan (or any trust established in connection with the Plan), as well as any policy dividends and/or refunds not belonging to the Company (as described above), shall be available to fund the benefits provided by any benefit plan under the Plan and to pay the benefit plan's administrative expenses. To the maximum extent permitted by applicable law, the Plan Administrator, in its sole and unfettered discretion, may use any funds accumulated under this Plan for any benefit plan (whether they are funds accumulated from Insurance Contract reserves, Insurance Carrier refunds or dividends, participant or Company contributions, administrative fees or any other source) to reduce the level of contributions that the Company would otherwise make under the Plan for any benefit plan or to pay reasonable administrative expenses of any benefit plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about Health Plan coverage and services are needed to apply the Coordination of Benefits (COB) rules and to determine benefits under the Health Plan and other benefit plans. The Plan Administrator, Claims Administrators or Insurance Carriers, as applicable, have the right to release or obtain any information and make or recover any payments they consider necessary in order to administer this provision.

Mandatory Medicare Secondary Payer Program Reporting Requirements

Under the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), the Health Plan is required to report specified information about Plan participants and their covered dependents, including (for example) Social Security numbers, to the Centers for Medicare and Medicaid Services ("CMS"), the federal agency that oversees the Medicare program, to enable CMS to properly coordinate any Medicare payments with other employer-sponsored health care benefits. The Plan Administrator, Claims Administrators, or Insurance Carriers, as applicable, have the right to release or obtain any information about participants and their covered dependents they consider necessary in order to satisfy mandatory reporting requirements under MMSEA.

TERMINATION OF COVERAGE FOR MISREPRESENTATION

If you make a misrepresentation under the Plan, the Plan Administrator has the right to permanently terminate coverage for you and all of your otherwise eligible dependents. The Plan Administrator also has the right to seek reimbursement from you for any claims and expenses paid pursuant to the Plan as a result of the misrepresentation, and may pursue legal action against you. Misrepresentations include, but are not limited to, submitting falsified claims and obtaining coverage or services for an individual who is ineligible.

Please note that health plan coverage generally cannot be rescinded (that is, canceled or discontinued retroactively) for any individual (including any group classification in which the individual is included) once he or she becomes covered, unless the Plan Administrator (or its delegate) determines that the individual (or a person seeking coverage on behalf of the individual) has performed an act, practice or omission that constitutes fraud with respect to the health plan, or unless the individual makes an intentional misrepresentation of a material fact with respect to the health plan. For example, if you fail to timely advise the Health Plan that your covered dependent no longer satisfies the eligibility rules for dependent coverage or if you fail to timely respond to the Plan Administrator's (or its delegate's) request for proof of dependent eligibility, as required under the health plan.

A cancellation or discontinuance of health plan coverage is not a rescission if: (1) the cancellation or discontinuance of coverage has only a prospective effect; (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required contributions or premiums toward the cost of coverage; or (3) the cancellation or discontinuance is effective retroactively for COBRA continuation coverage for which a qualified beneficiary did not make a timely election or timely payment of the applicable COBRA contribution amount (see Continuing Coverage Under COBRA for more information).

If your health plan coverage is going to be rescinded, you generally will receive 30 calendar days' advance written notice. As noted earlier, any rescission of coverage under the health plan will be considered an adverse benefit determination. You will then have the opportunity to appeal the rescission as described in Claims and Benefit Payment

.

EXCLUSIONS AND LIMITATIONS ON BENEFITS

Benefits under the benefit plans may be limited or reduced under certain circumstances. For information on a benefit plan's provisions regarding any exclusions, limitations and/or reductions of benefits that otherwise may be payable, you must read the related benefit plan materials listed in Appendix A.

NO GUARANTEE OF EMPLOYMENT

By adopting and maintaining the Plan, Starbucks has not entered into any employment contract with any individual. Nothing in the Official Plan Documents, this summary, the benefit plan materials or any designated SPD materials, gives any individual the right to be employed by Starbucks or any of its affiliates or to interfere with Starbucks or its affiliate's right to discharge any partner at any time. Similarly, the Plan does not give Starbucks or its affiliates the right to require any partner to remain employed by Starbucks or any affiliate, or to interfere with the partner's right to separate from employment with Starbucks or its affiliates at any time. Your employment is always on an at-will basis.

OFFICIAL PLAN DOCUMENTS CONTROL

As noted earlier, the SPD was written to give you a summary of the key features of the Plan in effect as of October 1, 2020. As a summary, however, the SPD does not contain all of the terms and conditions of the Official Plan Documents. Accordingly, if there is any discrepancy between the SPD and the provisions of the Official Plan document, the Official Plan Documents will control.

Any statement or representation, whether oral, written, electronic, or otherwise, made by the Plan Administrator, a service provider, or any other person or entity that alters, modifies, amends, or is inconsistent with the written terms of the SPD or Official Plan Documents will be invalid and unenforceable, and may not be relied upon by any person or entity.

AMENDMENT AND TERMINATION

Starbucks reserves the right, in its absolute and unlimited discretion, to amend or terminate its benefit plans, including the Plan or any of the benefit plans under the Plan, at any time and for any reason, without advance notice. For example, Starbucks may, among other things, reduce the level of benefits provided under any plan, increase the amount you must pay for coverage under any plan, and/or change any plan's eligibility provisions so that you, your spouse or domestic partner, or your other dependents or family members are no longer eligible for coverage under the Plan.

NO VESTED RIGHTS TO ANY PLAN BENEFITS

You have no vested rights to any benefits under the Plan.

SUBROGATION

If you or your enrolled dependents have healthcare expenses or disability income due to an injury or sickness caused by a third party, your Starbucks benefits plans have certain rights for the recovery of benefits from you or that third party. In this way, the Starbucks plan is protected from paying benefits for a sickness or injury caused by another person or persons. Starbucks may authorize the claims administrator or another third party to protect the plan's subrogation and reimbursement rights, and to negotiate and compromise the plan's subrogation and reimbursement claims.

Starbucks plan has the right of subrogation to all rights of recovery by you or your enrolled dependents against:

- A third party
- Your insurance carrier if there's a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy

The plan has the right to be reimbursed for the amounts it has paid for healthcare expenses or disability income due to an injury or sickness caused by another party or persons from any amounts you receive by judgment, settlement or otherwise from:

- A third party
- Your insurance carrier
- Any other person or entity, including the auto insurance carrier who provides your uninsured or underinsured auto insurance coverage

You or your enrolled dependents — or a person authorized by law to represent you if you are not legally capable — must sign and deliver any documents that are required, and do whatever else is necessary or reasonably requested by Starbucks to follow through on the plan's rights of subrogation as described above. The Plan's right to recover from you any amounts received by judgment, settlement or otherwise means that the Plan has a first priority lien to recover from the judgment, settlement or otherwise and all such amounts shall be presumed to be for the recovery of past or future medical expenses for the sickness or injury. The plan has the right to recover from you, your estate or to recover on your behalf if you are incapacitated. The Plan's first priority lien will apply regardless of whether you or your enrolled dependents are or were made whole from the judgment, settlement or otherwise, whether before or after the Plan's subrogation recovery. The plan's first priority lien will not be reduced due to your negligence or due to attorney fees and costs. The Plan precludes the operation of the "made-whole" and "common fund" doctrines.

If you or your legal representative make a recovery and fail to reimburse the plan as described above, then the plan may reduce future benefits payable for the sickness or injury accordingly. Notwithstanding the foregoing, the provisions regarding subrogation and third party reimbursement under fully–insured plans are set forth in the benefit plan materials identified on Appendix A.

PLAN LIABILITY

Your Starbucks benefits plans will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for expenses incurred before your coverage has started or after your coverage has ended — even if the expenses were incurred as a result of an accident, injury or death that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

YOUR ERISA RIGHTS

As a participant in certain benefits plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that plan participants shall be entitled to:

Receive information about your plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations — such as worksites and union halls — 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.
- Upon written request to the plan administrator, obtain copies of all documents governing the operation of the plan, including Insurance Contracts and collective bargaining agreements, and other plan information. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial reports. The plan administrator is required by law to provide each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the plan for determining a Qualified Medical Child Support Order (QMCSO).

Continue group health plan coverage

- Continue health coverage for yourself, spouse, domestic partner 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.

Prudent action by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of your benefits plans. The people who operate your plans, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Discrimination

No one, including Starbucks or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining any plan benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a 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 example, if you request materials 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 $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the plan administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the status of a Qualified Medical Child Support Order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds that your claim is frivolous.

Questions?

If you have any questions about your plans, you should contact the appropriate plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact:

- The Employee Benefits Security Administration, U.S. Department of Labor, toll-free at (866) 444-EBSA (3272), or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You can also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration toll-free at (866) 444-EBSA (3272).

You can also find additional information about your rights under ERISA and other important information by visiting the Employee Benefits Security Administration website at **dol.gov/ebsa**.

YOUR COBRA RIGHTS

If you or your enrolled dependents are no longer eligible for Starbucks group health plan coverage (including your medical, dental, vision, mental health, chemical dependency or Health Care Reimbursement Account benefits), you may be eligible to continue your group health plan coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You pay for the cost of COBRA coverage entirely, plus a small administrative fee. You can receive group health plan benefits for up to 18 or 29 months after you lose coverage, and your enrolled dependents can receive benefits for up to 18, 29 or 36 months. This information provides you with a general notice of your rights under COBRA. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Eligibility

You and your enrolled dependents may choose to continue your Starbucks group health plan coverage under COBRA, depending on the circumstances under which you lose coverage. To be eligible for COBRA coverage, you or your dependents must be covered under Starbucks group health plans on the date you lose eligibility for that coverage. You don't need to provide evidence of good health to elect COBRA coverage.

You and your spouse or domestic partner

As a Starbucks partner covered by the group health plans, you have a right to elect COBRA coverage if you lose your coverage due to one of the reasons, called qualifying events, listed below:

- You separate from employment with Starbucks.
- Your work hours are reduced.

- You were contributing to a Health Care Reimbursement Account and move to a position that is not eligible for reimbursement accounts. In this case, you will be able to continue participation in a Health Care Reimbursement Account through COBRA for the remainder of the plan year.

COBRA coverage may not be available if your separation from employment is due to gross misconduct, including theft.

Military Leave

If you take military leave, you may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Generally, the procedures for electing, paying for and receiving continuation coverage under USERRA are similar to continuation coverage under COBRA. For more information on military leave and how it may affect your benefit coverage, refer to the **Eligibility and Enrollment chapter**.

Your spouse or domestic partner is eligible to continue health coverage under COBRA if he or she loses coverage due to any of the qualifying events listed below:

- You separate from employment with Starbucks.
- Your work hours are reduced.
- You are divorced or legally separated, or you end a domestic partner relationship.
- You become entitled to Medicare benefits.
- You die.

COBRA coverage is not available to your spouse or domestic partner if your separation from employment is due to gross misconduct, including theft.

If you and your spouse or domestic partner both work for Starbucks, and one of you loses group health plan coverage, only the partner who loses group health plan coverage — along with any dependent children who lose coverage because of the event — is eligible for COBRA coverage.

Your dependent children

Your children may be eligible for COBRA coverage if they lose group health plan coverage due to any of the qualifying events listed below:

- You separate from employment with Starbucks.
- Your work hours are reduced.
- You are divorced or legally separated, or you end a domestic partner relationship.
- You become entitled to Medicare benefits.
- You die.

Your children may also be eligible for COBRA coverage if they no longer qualify as a "dependent child" under Starbucks group health plans due to any of the circumstances listed below:

- They reach age 26.
- They are under the custody of your spouse or domestic partner after a divorce or legal separation, unless you are ordered by a court to continue coverage.

COBRA coverage is not available to your dependent children if your separation from employment is due to gross misconduct, including theft.

If your child's group health plan coverage was provided because of a Qualified Medical Child Support Order (QMCSO), and coverage ends because it is no longer required under the order, contact Starbucks Benefits Center at (877) SBUXBEN to find out whether your child is eligible for COBRA coverage.

Are Addresses Up to Date?

Make sure Starbucks has your current address on file, as well as the addresses of your covered dependents if different from yours. If your covered dependent loses eligibility, we need to know where to send a COBRA documents so your dependent knows his or her available options. It is your responsibility to ensure current addresses are on file for you and your covered dependents. Contact Starbucks Partner Contact Center at (888) SBUX–411 with any address change information.

COBRA notification and enrollment

By law, Starbucks is responsible for notifying you or your dependents if you or they lose group health plan coverage due to any of the reasons listed below:

- You separate from employment with Starbucks.
- Your work hours are reduced.
- You become entitled to Medicare benefits.
- You die.

However, you, your spouse or domestic partner, or your dependent child must provide notice to Starbucks Benefits Center at (877) SBUXBEN within 60 days after the qualifying event when your enrolled dependents have lost group health plan coverage due to any of the qualifying events listed below:

- You divorce or legally separate or you end a domestic partner relationship.
- Your child no longer qualifies as a "dependent child" under Starbucks health coverage.

If you or your dependent fails to notify Starbucks within 60 days after the qualifying event or, if later, within 60 days after the date coverage is lost, COBRA continuation coverage is not available.

If you cancel your spouse or domestic partner's coverage in anticipation of a divorce or end of a domestic partnership, your spouse or domestic partner will still be eligible for continuation coverage, provided you or your spouse or domestic partner notifies Starbucks Benefits Center within 60 days of the date of divorce or end of a domestic partnership.

After you or Starbucks receive notification of the loss of health coverage, you'll receive a COBRA Enrollment Notice with instructions on how to elect to continue your group health plan coverage.

Enrollment

If you choose to enroll for COBRA, you or your dependents have 60 days to call Starbucks Benefits Center to make your COBRA elections. The 60-day time frame begins on the day that you receive the COBRA notification letter or the date on which coverage is lost, whichever is later.

If you do not enroll in COBRA coverage within the 60-day time frame, Starbucks group health plan coverage for you and/or your dependents will end — and COBRA coverage will not be available.

What Is a COBRA Date?

Your COBRA date is the last day of the month in which you qualify for regular Starbucks group health plan coverage. After this date, you'll stop receiving Starbucks coverage and may elect to continue coverage through COBRA, where you pay the entire cost of coverage, plus a 2% administrative fee. A COBRA date may be the last day of the month:

- In which your separation from employment with Starbucks is recorded
- Following the period in which your paid hours are reduced to below eligibility levels for Starbucks benefits coverage
- In which you and your spouse or domestic partner divorce or legally separate
- Before you become entitled to Medicare benefits
- In which you die
- In which your child no longer qualifies as a "dependent child" under Starbucks group health plan

For example, if your separation is entered into Starbucks payroll system in September, your COBRA date is September 30.

Coverage you may continue under COBRA

If you or your dependents lose group health plan coverage and want to continue it under COBRA, you may elect coverage that is equal to or less than the coverage you had before you became eligible for COBRA coverage.

You have three choices to continue group health plan coverage:

- You may elect to continue the same group health plan coverage you are currently enrolled in.
- You may elect to continue some, but not all, of the group health plan coverage you are currently enrolled in. For example, you may elect to continue only the medical portion of your group health plan coverage. Or, if you have other medical coverage, you may only want to continue your dental coverage.
- You may elect a lower plan option (call Starbucks Benefits Center to make this election).

Each person eligible for COBRA coverage — you, your spouse or domestic partner or child — may make a separate election to continue coverage or not. Each person chooses which coverage to continue and for how long. Covered parents may elect COBRA continuation coverage on behalf of their children.

Health Care Reimbursement Account continuation under COBRA

With the Health Care Reimbursement Account (HCRA), you elect to pay for your non-covered eligible healthcare expenses for you and your eligible dependents (if any) with before-tax dollars. You and your enrolled dependents may continue HCRA participation with after-tax dollars until the end of the plan year (September 30) in which your COBRA qualifying event occurs. However, COBRA continuation of HCRA is not available if, as of the date of your COBRA qualifying event, you have been reimbursed from your HCRA more than you have contributed. For example, let's say you elected $2,000 for your HCRA for the year. If, as of your qualifying event you had received reimbursements totaling $1,000, but you had contributed only $450, then COBRA continuation is not available. This is because you would owe $1,550 in COBRA premiums to maintain your remaining $1,000 benefit.

Dual coverage

If you or your enrolled dependents have coverage under another group health plan on the COBRA date, you may still elect COBRA.

Impact of electing COBRA on other rights

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health plan coverage will affect your future rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health plan coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you receive continuation coverage for the maximum time available to you.

When COBRA coverage begins

COBRA coverage starts on the day after the COBRA date. If you receive your COBRA Enrollment Notice after the COBRA date, your COBRA coverage will be retroactive to the day after the COBRA date — provided Starbucks Benefits Center receives your enrollment and payment by the deadlines outlined in this section. Starbucks Benefits Center administers COBRA enrollment and premium collection for all Starbucks health plans, including Aetna, Cigna, Dean Health, Geisinger, Health Net, HMSA, Kaiser Permanente, Premera Blue Cross, UnitedHealthcare, UPMC Health Plan, DeltaCare USA, Delta Dental of WA, MetLife, EyeMed, and Vision Service Plan.

Enrollment Deadline

If you need group health plan coverage after losing your Starbucks coverage, make sure you enroll within 60 days of either the COBRA date or when you receive your COBRA enrollment information from Starbucks, whichever is later.

Duration of COBRA coverage

You may enroll in COBRA coverage for up to 18 or 29 months depending on your situation. Your enrolled dependents — spouse, domestic partner or children — may enroll for up to 18, 29 or 36 months, depending on your situation. Your COBRA coverage may end however, prior to 18, 29 or 36 months.

18 months

You and your enrolled dependents may continue group health plan coverage under COBRA for up to 18 months if you lose Starbucks group health plan coverage for one of the reasons listed below:

- You separate from employment with Starbucks.
- Your working hours are reduced.

29 months

You and your enrolled dependents may continue COBRA coverage for up to 29 months — 11 months beyond the initial 18-month coverage period — if any covered family member electing COBRA is disabled on the COBRA date, or becomes disabled during the 60 days following the COBRA date.

The disabled person must meet the Social Security definition of disability as described under Title II or XVI of the Social Security Act. You must provide proof of the disability to Starbucks Benefits Center within 60 days of obtaining Social Security's verification and before the end of the initial 18-month COBRA period.

You must pay higher rates for the additional 11 months of COBRA coverage — 150% of the total cost of coverage. COBRA coverage will end on the earlier of these two dates:

- The end of the month in which you are no longer disabled (beyond the 18-month coverage period)
- The end of the 11-month additional COBRA period (29-month total COBRA period)

36 months

Your enrolled dependents may receive up to 36 months of COBRA coverage if one of the following situations occurs during their initial 18 months of COBRA coverage, or if you lost Starbucks benefits eligibility due to one of the situations listed below:

- You divorce, legally separate or end your domestic partner relationship.
- You become entitled to Medicare benefits.
- You die.
- Your child no longer qualifies as a "dependent child" under Starbucks group health plans.

Only your affected dependents may elect to extend their COBRA coverage, after the original COBRA date, up to 36 months due to a second qualifying event. Please contact Starbucks Benefits Center at (877) SBUXBEN within 60 days of the second event if it is a legal divorce or a child no longer qualifying as a dependent.

Cost of COBRA coverage

If you or your enrolled dependents elect COBRA coverage, you must pay the full cost of the group health plan coverage, including what Starbucks paid while you were eligible for benefits or actively employed. Your cost for COBRA is 102% of the total cost. The additional 2% covers the cost to administer COBRA coverage.

If you are disabled and elect to continue COBRA for 29 months, you'll pay an increased premium after the 18th month of coverage. This increased premium is 150% of the total cost. For more information on COBRA coverage during a disability, refer to "29 months" above.

A new COBRA premium rate is determined each October 1 and will be included in your COBRA Notification Letter. Or, you can call Starbucks Benefits Center at (877) SBUXBEN to find out the current COBRA premium rates.

You pay your COBRA premiums on a monthly basis. The monthly premiums start on the first day of the month in which COBRA coverage starts.

When COBRA premiums are due

After you or your enrolled dependents have enrolled in COBRA coverage, you have 45 days to send in your first COBRA premium. This payment must include any COBRA premiums retroactive to your COBRA date — the date you lost Starbucks health coverage. Partial payments will be accepted if received before 45 days, but the remaining amount must be received by the 45-day deadline to secure elections.

Here's an example of how it works:

- Your COBRA date was January 31.
- You enrolled in COBRA continuation of coverage by March 12.
- You must pay your COBRA premium by April 27, or 45 days after you enrolled.
- Your first payment must include premiums for both February and March — the retroactive months — and April, the current month.
- COBRA coverage will not begin until Starbucks Benefits Center receives your premiums.

Once Starbucks Benefits Center has received your enrollment information, they'll bill you on a monthly basis for future COBRA premiums.

Your premium payments are due by the first day of each coverage month. You are granted a 30-day grace period. If you fail to submit monthly payments within 30 days of the due date, your coverage will end

retroactive to the last day of the month for which a payment was received. Payments made after coverage is dropped will be refunded and will not extend coverage.

Here's an example of how it works:

- Your premium for the month of April is due by April 1.
- Your 30-day grace period extends through April 30.
- Starbucks Benefits Center will not accept payments postmarked after April 30.
- Your COBRA coverage ends retroactively on March 31.

What if I Get Sick Before I Receive a COBRA Enrollment Form?

If you receive your COBRA Enrollment Form after the COBRA date, but you or your dependents need to see a doctor before then, go ahead. Your COBRA coverage is retroactive to the day after the COBRA date, provided that Starbucks Benefits Center receives your enrollment form and payment by the deadlines outlined in this section.

When COBRA coverage ends

If you or your enrolled dependents elect COBRA coverage, your group health plan coverage will continue for the 18-month, 29-month or 36-month period described previously.

However, COBRA coverage will end for you or your enrolled dependents — even before the full COBRA coverage period — as soon as any circumstance listed below occurs:

- You resume coverage under Starbucks benefits plans because you re-establish eligibility under the plans.
- You stop making timely payments of your monthly COBRA premiums.
- You or your dependents obtain coverage under another group health plan that doesn't have any pre-existing condition limitations affecting you or your enrolled dependents.
- You or your dependents become entitled to Medicare benefits.
- Starbucks no longer offers group health plan coverage.

For example, if you separate from employment with Starbucks, start working for another company and become covered under that company's group health plan, your COBRA coverage under the Starbucks plan will end on the first day of the month following the date your group health plan coverage starts with the other company.

You must inform us if you or your dependents obtain coverage under another group health plan.

Conversion option

When COBRA coverage ends, you and your enrolled dependents may convert your medical coverage to an individual medical policy, if the policy in which you are enrolled permits conversion of coverage.

You should know that the coverage and rates of an individual medical policy are significantly different than what may be available through Starbucks plans and COBRA coverage. Dental and vision conversion is not available.

If you've participated in COBRA for the 18-month or 36-month maximum, you'll receive a notification of your conversion rights, if any. You must apply for the medical conversion policy in writing in accordance with the procedures set forth in your benefit plan materials.

Changes in COBRA coverage

If Starbucks changes its group health plan coverage — for example, by increasing deductibles or no longer reimbursing a certain type of expense — COBRA coverage will also change at the same time. In some cases,

if you are receiving COBRA coverage, you may be required to switch to another form of group health plan coverage. And, as your COBRA coverage changes, your COBRA premiums may change to reflect the cost of your group health plan coverage.

Starbucks reserves the right to change the terms and conditions of its group health plans and COBRA coverage at any time, subject to applicable legal requirements. Starbucks also reserves the right to terminate COBRA coverage at any time and for any reason, to the extent permitted by law.

Annual benefits enrollment

At each annual benefits enrollment for active partners, each person receiving COBRA coverage may elect to change coverage. In addition, each dependent whose coverage started on the COBRA date has the same change options at benefits enrollment as active partners. Your enrolled dependents can make different coverage choices from you and your other enrolled dependents, subject to insurance company rules.

All changes at benefits enrollment are subject to the same terms and conditions that apply for active partners. If Starbucks changes the options available at benefits enrollment, the new options will be explained in the benefits enrollment materials.

If you or your covered dependent marries, enters into a domestic partner relationship or has a child while covered under COBRA, the new dependent may enroll as a spouse, domestic partner or child under the same special enrollment terms and conditions as active partners eligible for Starbucks benefits.

Coverage for newly acquired dependents continues under the same terms and conditions as the covered person. However, the maximum COBRA coverage period for such new enrollees may not extend beyond the end of the original covered person's maximum COBRA period. Additionally, the newly added dependent will not be able to make a separate election in a subsequent annual benefits enrollment.

In the case of a new COBRA enrollee who is either a newborn or newly adopted child, the COBRA coverage period will be 18 months, or 36 months if a second qualifying event occurs within their first 18 months of COBRA coverage.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Important Note: In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage

ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **medicare.gov/medicare-and-you**.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **HealthCare.gov**.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The COBRA Administrator is the Starbucks Benefits Center which can be reached at (877) SBUXBEN.

YOUR HEALTH PRIVACY RIGHTS — NOTICE OF PRIVACY PRACTICES

Effective October 1, 2020

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.

Introduction

The Health Insurance Portability and Accountability Act (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires a health plan to notify plan participants and beneficiaries of its practices to protect the confidentiality of their health information. This notice describes the ways self-insured health benefits, health care spending account plan and Employee Assistance Plan benefits within the Starbucks Corporation Welfare Benefits Plan (the "Health Plan") may use and disclose health information about you and your rights to review and control disclosure of this information. If you are enrolled in a fully-insured medical, dental or vision plan, you will receive the Insurance Carrier's Notice of Privacy Practices. You may also receive a HIPAA Notice of Privacy Practices directly from your health care providers.

The Health Plan needs to create, receive, maintain and disclose records that contain health information about you and your enrolled family members to administer its plan and provide you with health coverage.

To help protect the privacy of your health information, Starbucks, as the sponsor of the Health Plan, has appointed a Health Privacy Official and developed privacy policies and procedures. Our Health Privacy Official has authority to enforce the health privacy policy at Starbucks.

The Health Plan is required by law to:

- Protect and maintain the privacy of certain health information referred to as "protected health information"
- Provide you with this notice describing its legal duties, your legal rights and its privacy practices with respect to your protected health information
- Follow the terms of this notice currently in effect, and
- Notify you if your protected health information has been the subject of a Breach of Unsecured Protected Health Information, as defined under HIPAA, HITECH and the final regulations issued thereunder.

This notice is intended to satisfy the notice requirements under HIPAA and HITECH with respect to health information created, transmitted, received, or maintained by or on behalf of the Health Plan.

Effective date

This notice is effective as of October 1, 2020.

Genetic medical information

In addition to the above and in accordance with the Genetic Information Nondiscrimination Act of 2008, the Health Plan will not use, disclose, request, require or purchase your genetic medical information (1) prior to or in connection with the enrollment of you or your family member; (2) for purposes of establishing underwriting, enrollment eligibility criteria or premium rates; or (3) in connection with the creation, renewal or replacement of health benefits.

What's included in this notice

The notice outlines how the Health Plan may use or disclose your health information and your rights with respect to your health information. For example, the Health Plan uses your information to facilitate payment

of health services. You have certain rights, such as the right to review your health information and suggest correction of any errors.

Use and disclosure

The following are the different ways the Health Plan may use and disclose your health information. Most of these disclosures are not made to or from Starbucks, but to and from your healthcare providers and the Health Plan's third-party administrators who facilitate payment and other health care operations. Not every use or disclosure in a category is listed, but the ways in which the Health Plan is permitted to use and disclose information falls within one of the categories.

- **For treatment.** Your health information may be disclosed to healthcare providers including doctors, nurses, laboratory technicians, therapists, medical students and other healthcare personnel involved in your treatment. For example, the Health Plan may disclose your prescription medication information to a pharmacy to identify potential adverse drug reactions.
- **For payment.** Your health information may be disclosed so claims for healthcare treatment, services and supplies you receive from healthcare providers may be paid according to the Health Plan's terms. For example, the Health Plan may receive and maintain information about surgery you received to allow the Health Plan to process a hospital's claim for reimbursement of surgical expenses resulting from your surgery.
- **For healthcare operations.** The Health Plan may use and disclose your health information to enable it to operate more efficiently or verify that all of the Health Plan's participants receive their health benefits. For example, the Health Plan may use your health information for patient care management or to perform population-based studies designed to manage healthcare costs. In addition, the Health Plan may use or disclose your health information to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection. The Health Plan may also combine health information about many Health Plan participants and disclose it to Starbucks in summary fashion so that it can decide what coverages the Health Plan should provide.
- **To Starbucks as plan sponsor.** The Health Plan may disclose your health information to designated Starbucks partners so they can carry out their Health Plan-related administrative functions, including the uses and disclosures described in this notice, unless you have authorized further disclosure. Such disclosures are to designated members of the Health Privacy Office, who are required to safeguard your health information. Your protected health information cannot be used for employment purposes without your specific authorization.
- **To a business associate.** Certain services are provided to the Health Plan by third party administrators and other third parties known as "business associates." For example, the Health Plan may enter information about your healthcare treatment into an electronic claims processing system maintained by the Health Plan's business associate so your claim may be paid. In doing so, the Health Plan will disclose your health information to its business associate so it can perform its claims payment function. However, the Health Plan will require its business associates, through contract, to appropriately safeguard your health information.
- **As required by law.** The Health Plan will disclose your health information when required to do so by federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.
- **To avert a serious threat to health or safety.** The Health Plan may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your protected health information in a proceeding regarding the licensure of a physician.
- **Treatment alternatives and health-related benefits and services.** The Health Plan may use and disclose your health information to tell you about possible treatment options or alternatives and health-related benefits and services that may be of interest to you.

- **Individuals involved in your care or payment of your care.** The Health Plan may disclose your health information to a close friend or family member involved in or who helps pay for your health care. The Health Plan may also advise a family member or close friend about your condition, your location (for example, that you are in a hospital) or your death.

Special situations

The Health Plan may also use or disclose your health information in accordance with the law:

- To facilitate organ or tissue donation or transplantation, if you are an organ or tissue donor
- To the military command authorities if you are a member of the armed forces and the information is deemed necessary
- To workers compensation carriers to the extent necessary to comply with workers compensation laws
- To public health agencies for public health activities (for example, to avert a serious threat to health or safety; to prevent or control disease, injury or disability; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and to report reactions to medications or problems with products)
- For law enforcement purposes (for example, to identify or locate a suspect, material witness or missing person)
- To coroners, medical examiners or funeral directors (for example, to identify a person or cause of death)
- For national security and intelligence agencies (for example, for intelligence, counterintelligence and other national security activities authorized by law, and to enable them to provide protection to certain individuals or conduct special investigations)
- To correctional institutions or law enforcement officials if the person is in custody
- To a health oversight agency for audits, investigations, inspections and licensure needed for the government to monitor the healthcare system
- To law enforcement officials about victims of abuse, neglect or domestic violence
- For judicial and administrative proceedings (such as to respond to court orders or subpoenas)
- For research purposes in limited circumstances
- For other uses and disclosures that are outside of the categories described in this notice, but only with your written authorization. Generally, if you authorize the plan to use or disclose your health information, you may revoke the authorization, in writing, at any time.

Required disclosures

The following is a description of disclosures of your protected health information we are required to make.

- **Government audits.** We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to you.** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health coverage. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or healthcare operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other disclosures

- **Personal representatives**. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

  (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person, or

  (2) treating such person as your personal representative could endanger you, and

  (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- **Spouses and other family members.** With only limited exceptions, we will send all mail to the partner. This includes mail relating to the partner's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the partner's spouse and other family members and information on the denial of any Plan benefits to the partner's spouse and other family members. If a person covered under the Plan has requested restrictions or confidential communications (see **Your rights**), and if we have agreed to the request, we will send mail as provided by the request for restrictions or confidential communications.
- **Authorizations**. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your rights

You have rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Starbucks Benefits Department and Health Privacy Office through the Partner Contact Center at (888) SBUX-411. Specifically, you have the right to:

- **Inspect and copy your health information.** To review your health information that is in the possession or under the control of the Health Plan, and to obtain a copy of such information, you must make your request in writing and pay a reasonable fee for the copies. In certain circumstances, the Health Plan may deny your request to review your health information. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.
- **Request to amend your health information.** If you believe your health information is incorrect or incomplete, you may ask the Health Plan to amend the information if it is information that is kept by or for the Health Plan. In certain situations, the Health Plan may deny your request to amend your health information. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.
- **Receive a record of disclosures of your health information.** You have the right to request an accounting of certain disclosures of your health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or healthcare operations; (2) disclosures made to you; (3) disclosures

made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; (6) disclosures incidental to otherwise permissible disclosures; and (7) disclosures made more than six years prior to the date on which you make your request.

- **Restrict disclosure of your health information.** You have the right to request a restriction or limitation on how the Health Plan uses or discloses your health information for treatment, payment, healthcare operations or to those involved in your care or payment for your care. For example, you could ask that the Health Plan not use or disclose information about a specific surgery that you had. The Health Plan is not required to agree to your request. We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or healthcare operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a healthcare item or service for which the healthcare provider involved has been paid in full by you or another person.
- **Request confidential communications.** You have the right to request that the Health Plan communicate with you about health matters in a certain way or at a certain location. For example, you can request that the Health Plan only contact you by mail. The Health Plan will accommodate your reasonable requests.
- **Right to be notified of a breach.** You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured protected health information.
- **Obtain a copy of this notice.** You have the right to obtain a paper copy of this notice upon request.
- **File a complaint.** If you believe your privacy rights have been violated, you may complain to Starbucks by contacting the Starbucks Benefits Department and Health Privacy Office through the Partner Contact Center at (888) SBUX-411, or by writing to Starbucks Health Privacy Office, Starbucks Corporation, Mailstop S-HR3, P.O. Box 34067, Seattle, WA 98124-1067. You may also file a complaint with the Federal Department of Health and Human Services. The Health Privacy Official will assist you. We will not retaliate against you for filing such a complaint.

Changes to this notice

The Health Plan reserves the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised notice mailed to your home address. Until such time, the Health Plan will comply with this notice.

Specially protected health information

Federal and state law may impose additional privacy and confidentiality restrictions on the use and disclosure of mental health, AIDS/HIV, drug addiction, alcoholism, and other chemical dependency treatment, developmental disabilities and/or genetic information and records.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan you may contact us using the information below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Contact information

If you have questions, please contact the Starbucks Benefits Department and Health Privacy Office through the Partner Contact Center at (888) SBUX-411, via email at **benefitsadmin@starbucks.com**, or write the Benefits Department at Starbucks Corporation, Attn: Health Privacy Office, Mailstop S-HR3, P.O. Box 34067, Seattle, WA 98124-1067.

Representations

Starbucks will not use or further disclose protected health information (PHI) received from the Health Plan other than as permitted or required by the above notice. Further, Starbucks will:

- Ensure that any agent, including a business associate or subcontractor to whom it provides PHI received from the Health Plan, agrees to the same restrictions and conditions that apply to Starbucks with respect to such PHI.
- Not use or disclose PHI received from the Health Plan for employment-related actions and decisions or in connection with any other benefit or benefits plan of Starbucks (or its affiliates).
- Report to the Health Privacy Office any use or disclosure of PHI received from the Health Plan that is inconsistent with the permitted uses or disclosures of which it becomes aware.
- To the extent required by HIPAA, allow Health Plan participants to access their own PHI received from the Health Plan, consider (and incorporate, where appropriate) participant-requested amendments to such PHI and, upon request, provide Health Plan participants with an accounting of the disclosures of their PHI.
- Make Starbucks internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the U.S. Department of Health and Human Services for purposes of determining the Health Plan's compliance with HIPAA.
- Comply with breach notice obligations as necessary.
- If feasible, return or destroy all PHI received from the Health Plan that Starbucks still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Starbucks will provide adequate firewalls, in accordance with HIPAA, between the Health Plan and the components comprised of the remaining benefits provided under the Plan (i.e., group health plan benefits and non-group health plan benefits).

In addition, Starbucks will ensure that it is adequately separated from the Health Plan. Accordingly, Starbucks will restrict access to PHI to partners who (1) perform functions directly on behalf of the Health Plan or (2) have access to PHI on behalf of Starbucks for its use in Health Plan administrative functions. Such partners may use and disclose PHI for Health Plan administrative functions, and they may disclose PHI to other such partners for Health Plan administrative functions (but the PHI disclosed must be limited to the minimum amount necessary to perform the Health Plan administrative function). Such partners may not disclose PHI to partners other than those described in the foregoing sentence except as permitted by HIPAA. Sanctions for using or disclosing PHI in violation of these provisions may be imposed in accordance with Starbucks discipline policy, up to and including separation from employment.

To the extent required by HIPAA, Starbucks will implement steps to reasonably and appropriately safeguard electronic protected health information ("ePHI") created, received or maintained on behalf of the Health Plan, as well as policies and procedures to ensure that its creation, receipt, maintenance, or transmission of ePHI complies with the applicable administrative, physical, and technical safeguards required to protect the confidentiality and integrity of ePHI.

Starbucks will ensure that adequate separation between the Health Plan and the components comprised of the remaining benefits provided under the Plan and between the Health Plan and Starbucks be maintained and supported by reasonable and appropriate security measures. Starbucks will ensure that any agent, including a business associate or subcontractor, to whom Starbucks provides ePHI received from the Health Plan agrees to the same restrictions and conditions that apply to Starbucks with respect to such ePHI. Starbucks will further require any agents, including a business associate or subcontractor, to whom Starbucks provides ePHI received from the Health Plan, to notify Starbucks of any security incident as defined under HIPAA.

Health information not covered by this notice

The notice does not apply to certain activities listed below, although other protections may apply:

- Any health information you or your healthcare provider submits to Starbucks for workers compensation claims, leave of absence eligibility and Short and Long Term Disability benefits
- Employment-related activities, such as drug testing and fitness-for-duty physicals

Please recognize that health information you voluntarily disclose to your coworkers, supervisor or manager, Partner Resources generalist or Starbucks Business Conduct Helpline is not protected by the nature of your volunteering this information.

You should receive a separate notice of privacy practices from your healthcare providers, such as your physician, that will describe their privacy practices.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a court order compelling a parent to enroll a child in the employer's group health plan. A QMCSO may be issued as part of a divorce proceeding or court-ordered child support. A state child support enforcement agency may obtain health coverage for a child by issuing a National Medical Support Notice (NMSN).

A QMCSO must include:

- Your name and last known mailing address, as well as the name and address of each child covered by the QMCSO (except the name and mailing address of the appropriate government agency may be substituted for the address of the child)
- A reasonable description of the type of coverage to be provided by the plan for each child, or the manner in which the type of coverage is determined
- The period to which the QMCSO applies.

When Starbucks Benefits Center receives a medical child support order, it will promptly notify you and each child named in the order. Starbucks Benefits Center will inform all parties what Starbucks procedures are for determining whether the order is a QMCSO. If it's determined that the court order is a QMCSO, and the child is enrolled, you may incur additional payroll deductions.

Starbucks Benefits Center will also review NMSNs to make sure they have been completed appropriately. If so, they will be treated the same as QMCSOs.

The child named in the QMCSO or NMSN will be treated as a covered dependent under the plan. Any benefit paid under a QMCSO to reimburse a child or the custodial parent or legal guardian will be made to the child or to that custodial parent or legal guardian.

Participants and beneficiaries can obtain, without charge, a copy of the procedures governing qualified medical child support order determinations by contacting Starbucks Benefits Center at (877) SBUXBEN.

HEALTH PLAN DISCLOSURES

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits 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, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, precertification may be required for a hospital stay of more than 48 (or 96 hours, as applicable) in connection with childbirth. The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. Consult the applicable benefit plan materials for more information.

Special Rights under MHPA and MHPAEA

The Mental Health Parity Act ("MHPA") and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") contain certain requirements for group health plans and health insurance issuers concerning certain mental health and substance use disorder benefits. Any benefit plan that is subject to these requirements will provide for applicable parity of any aggregate lifetime dollar limits and annual dollar limits with respect to any mental health and substance use disorder benefits that may be provided. In addition, each such benefit plan will provide for applicable parity between any medical and surgical benefits offered by the benefit plan, on the one hand, and any mental health and substance use disorder benefits, on the other, as to any financial requirements (such as deductibles, co-payments, co-insurance and out-of-pocket maximums) and quantitative treatment limitations (such as the number of treatments, visits or days of coverage). Such benefit plan also will comply with other applicable parity-related requirements for any non-quantitative treatment limitations (such as medical management standards). However, this should not be construed to require Starbucks to provide any coverage for any mental health or substance use disorder benefits under any benefit plan, except as required by applicable law. Please refer to the applicable benefit plan materials or designated SPD materials, if any, for additional information.

Special Rights under GINA

The Genetic Information Nondiscrimination Act of 2008, as amended ("GINA"), contains certain requirements for group health plans and health insurance issuers prohibiting genetic discrimination, required genetic testing, purchasing or collecting genetic information and disclosure of genetic information except in limited circumstances. In the unlikely event that any genetic information is received by the Company, it will be maintained confidentially.

Physician Designation Notice

The Health Plan option in which you are enrolled may require or allow for the designation of a primary care provider for you and your enrolled dependents. You have the right to designate any primary care provider who participates in the plan option's network and who is available to accept you or your family members, including a pediatrician (in the case of children), as the primary care provider. Until you make this designation, the Health Plan option may designate a primary care provider for you or your covered dependents.

You do not need prior authorization from the Health Plan option or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in

the plan option's network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

To determine if these rules apply to your Health Plan option or to a Health Plan option that you are considering, or for information on how to select a primary care provider, or for a list of participating primary care providers or healthcare professionals who specialize in obstetrics or gynecology, contact the applicable Claims Administrator or Insurance Carrier directly at the address or phone number listed in Appendix B.

Non–Grandfathered Health Plan Status

The Health Plan is not a grandfathered health plan under the Affordable Care Act.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Preventive Care Disclosure

Preventive care is provided under the Health Plan without any deductibles, coinsurance, or copayments.

Emergency Services Disclosure

The Health Plan may not require preauthorization for emergency care and must provide coverage regardless of whether an emergency care provider is in or out-of-network. The Health Plan may not impose administrative requirements or coverage limitations on out-of-network emergency services that are more restrictive than those imposed on in-network emergency services. When providing emergency services out-of-network, the Health Plan complies with the applicable cost-sharing requirements. The Health Plan provides coverage of emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, a permissible affiliation or waiting period, or applicable cost-sharing requirements.

QUESTIONS?

To find out more about your rights and responsibilities under Starbucks benefits plans, call Starbucks Benefits Center at (877) SBUXBEN.

APPENDIX A: BENEFIT PLAN MATERIALS

The benefit plans and related benefit plan materials listed below are in effect as of October 1, 2020, and may change from time to time. The applicable benefit plan materials will be provided to you free of charge electronically or by mail, in some cases. If you don't receive these materials or need duplicate copies, please contact Starbucks Benefits Center at (877) SBUXBEN.

Find the group numbers for medical, dental and vision coverage below. To see complete details and contact information of the plans, including Certificates of Coverage, go to mysbuxben.com and follow the instructions given (look for the link labeled "Health Coverage Contacts" on the login page).

Important: The benefit plan materials, together with this handbook and any designated SPD materials, collectively constitute the summary plan description (SPD) for the Plan, as required by ERISA.

INSURANCE CARRIER	COVERAGE LEVEL	GROUP NUMBER
MEDICAL		
Aetna	(all coverage levels)	868241
Cigna	(all coverage levels)	3339768
Dean Health	(all coverage levels)	172555M
Dean Health / Prevea360 Health Plan	(all coverage levels)	1725561
Geisinger	Bronze	117740-0001
Geisinger	Bronze (COBRA)	117740-0002
Geisinger	Bronze Plus (individual)	117740-0003
Geisinger	Bronze Plus (individual) (COBRA)	117740-0005
Geisinger	Bronze Plus (family)	117740-0004
Geisinger	Bronze Plus (family) (COBRA)	117740-0006
Geisinger	Silver	117740-0007
Geisinger	Silver (COBRA)	117740-0008
Geisinger	Gold	117740-0009
Geisinger	Gold (COBRA)	117740-0010
Geisinger	Platinum	117740-0011
Geisinger	Platinum (COBRA)	117740-0012
Health Net (North California)	Bronze (partner + children)	PC163B
Health Net (North California)	Bronze (all other tiers)	PC163A
Health Net (North California)	Bronze Plus (partner + children)	PC164B
Health Net (North California)	Bronze Plus (all other tiers)	PC164A
Health Net (North California)	Silver (partner + children)	PC258B
Health Net (North California)	Silver (all other tiers)	PC258A
Health Net (North California)	Gold (partner + children)	PC166B

INSURANCE CARRIER	COVERAGE LEVEL	GROUP NUMBER
Health Net (North California)	Gold (all other tiers)	PC166A
Health Net (North California)	Platinum (partner + children)	PC167B
Health Net (North California)	Platinum (all other tiers)	PC167A
Health Net (South California)	Bronze (partner + children)	N6845B
Health Net (South California)	Bronze (all other tiers)	N6845A
Health Net (South California)	Bronze Plus (partner + children)	N6846B
Health Net (South California)	Bronze Plus (all other tiers)	N6846A
Health Net (South California)	Silver (partner + children)	N6848B
Health Net (South California)	Silver (all other tiers)	N6848A
Health Net (South California)	Gold (partner + children)	G0317B
Health Net (South California)	Gold (all other tiers)	G0317A
Health Net (South California)	Platinum (partner + children)	G0325B
Health Net (South California)	Platinum (all other tiers)	G0325A
Health Net (Oregon)	Bronze (individual)	VG050A
Health Net (Oregon)	Bronze (partner + spouse / family)	VG050B
Health Net (Oregon)	Bronze (partner + children)	VG050C
Health Net (Oregon)	Bronze (individual) (COBRA)	VG050D
Health Net (Oregon)	Bronze (partner + spouse / family) (COBRA)	VG050E
Health Net (Oregon)	Bronze (partner + children) (COBRA)	VG050F
Health Net (Oregon)	Bronze Plus (individual)	VG051A
Health Net (Oregon)	Bronze Plus (partner + spouse / family)	VG051B
Health Net (Oregon)	Bronze Plus (partner + children)	VG051C
Health Net (Oregon)	Bronze Plus (individual) (COBRA)	VG051D
Health Net (Oregon)	Bronze Plus (partner + spouse / family) (COBRA)	VG051E
Health Net (Oregon)	Bronze Plus (partner + children) (COBRA)	VG051F
Health Net (Oregon)	Silver (partner + children)	VG819B
Health Net (Oregon)	Silver (all other tiers)	VG819A
Health Net (Oregon)	Silver (partner + children) (COBRA)	VG819D
Health Net (Oregon)	Silver (all other tiers) (COBRA)	VG819C
Health Net (Oregon)	Gold (partner + children)	VG053B
Health Net (Oregon)	Gold (all other tiers)	VG053A
Health Net (Oregon)	Gold (partner + children) (COBRA)	VG053D
Health Net (Oregon)	Gold (all other tiers) (COBRA)	VG053C
Health Net (Oregon)	Platinum (partner + children)	VG054B

INSURANCE CARRIER	COVERAGE LEVEL	GROUP NUMBER
Health Net (Oregon)	Platinum (all other tiers)	VG054A
Health Net (Oregon)	Platinum (all other tiers) (COBRA)	VG054D
Health Net (Oregon)	Platinum (all other tiers) (COBRA)	VG054C
HMSA	(all coverage levels)	24514
Kaiser (California - North)	(all coverage levels)	602511
Kaiser (California - South)	(all coverage levels)	228863
Kaiser (Colorado – Denver/Boulder)	Bronze	35822-001
Kaiser (Colorado – Denver/Boulder)	Bronze (COBRA)	35822-C01
Kaiser (Colorado – Denver/Boulder)	Bronze Plus	35822-007
Kaiser (Colorado – Denver/Boulder)	Bronze Plus (COBRA)	35822-C07
Kaiser (Colorado – Denver/Boulder)	Silver	35822-019
Kaiser (Colorado – Denver/Boulder)	Silver (COBRA)	35822-C19
Kaiser (Colorado – Denver/Boulder)	Gold	35822-027
Kaiser (Colorado – Denver/Boulder)	Gold (COBRA)	35822-C27
Kaiser (Colorado – Denver/Boulder)	Platinum	35822-031
Kaiser (Colorado – Denver/Boulder)	Platinum (COBRA)	35822-C31
Kaiser (Colorado – Colorado Springs) So. Colorado	Bronze	35822-002
Kaiser (Colorado – Colorado Springs) So. Colorado	Bronze (COBRA)	35822-C02
Kaiser (Colorado – Colorado Springs) So. Colorado	Bronze Plus	35822-008
Kaiser (Colorado – Colorado Springs) So. Colorado	Bronze Plus (COBRA)	35822-C08
Kaiser (Colorado – Colorado Springs) So. Colorado	Silver	35822-020
Kaiser (Colorado – Colorado Springs) So. Colorado	Silver (COBRA)	35822-C20
Kaiser (Colorado – Colorado Springs) So. Colorado	Gold	35822-028
Kaiser (Colorado – Colorado Springs) So. Colorado	Gold (COBRA)	35822-C28
Kaiser (Colorado – Colorado Springs) So. Colorado	Platinum	35822-032
Kaiser (Colorado – Colorado Springs) So. Colorado	Platinum (COBRA)	35822-C32
Kaiser (Colorado – Pueblo) So. Colorado	Bronze	35822-004
Kaiser (Colorado – Pueblo) So. Colorado	Bronze (COBRA)	35822-C04
Kaiser (Colorado – Pueblo) So. Colorado	Bronze Plus	35822-010
Kaiser (Colorado – Pueblo) So. Colorado	Bronze Plus (COBRA)	35822-C10
Kaiser (Colorado – Pueblo) So. Colorado	Silver	35822-021
Kaiser (Colorado – Pueblo) So. Colorado	Silver (COBRA)	35822-C21
Kaiser (Colorado – Pueblo) So. Colorado	Gold	35822-029
Kaiser (Colorado – Pueblo) So. Colorado	Gold (COBRA)	35822-C29

INSURANCE CARRIER	COVERAGE LEVEL	GROUP NUMBER
Kaiser (Colorado – Pueblo) So. Colorado	Platinum	35822-033
Kaiser (Colorado – Pueblo) So. Colorado	Platinum (COBRA)	35822-C33
Kaiser (Colorado – Mountain Colorado)	Bronze	35822-090
Kaiser (Colorado – Mountain Colorado)	Bronze (COBRA)	35822-C90
Kaiser (Colorado – Mountain Colorado)	Bronze Plus	35822-091
Kaiser (Colorado – Mountain Colorado)	Bronze Plus (COBRA)	35822-C91
Kaiser (Colorado – Mountain Colorado)	Silver	35822-095
Kaiser (Colorado – Mountain Colorado)	Silver (COBRA)	35822-C95
Kaiser (Colorado – Mountain Colorado)	Gold	35822-093
Kaiser (Colorado – Mountain Colorado)	Gold (COBRA)	35822-C93
Kaiser (Colorado – Mountain Colorado)	Platinum	35822-094
Kaiser (Colorado – Mountain Colorado)	Platinum (COBRA)	35822-C94
Kaiser (Colorado – No. Colorado)	Bronze	35822-006
Kaiser (Colorado – No. Colorado)	Bronze (COBRA)	35822-C06
Kaiser (Colorado – No. Colorado)	Bronze Plus	35822-012
Kaiser (Colorado – No. Colorado)	Bronze Plus (COBRA)	35822-C12
Kaiser (Colorado – No. Colorado)	Silver	35822-022
Kaiser (Colorado – No. Colorado)	Silver (COBRA)	35822-C22
Kaiser (Colorado – No. Colorado)	Gold	35822-030
Kaiser (Colorado – No. Colorado)	Gold (COBRA)	35822-C30
Kaiser (Colorado – No. Colorado)	Platinum	35822-034
Kaiser (Colorado – No. Colorado)	Platinum (COBRA)	35822-C34
Kaiser (Georgia)	Bronze (individual)	10262-S40
Kaiser (Georgia)	Bronze (individual) (COBRA)	10262-S50
Kaiser (Georgia)	Bronze (family)	10262-F40
Kaiser (Georgia)	Bronze (family) (COBRA)	10262-F50
Kaiser (Georgia)	Bronze Plus (individual)	10262-S41
Kaiser (Georgia)	Bronze Plus (individual) (COBRA)	10262-S51
Kaiser (Georgia)	Bronze Plus (family)	10262-F41
Kaiser (Georgia)	Bronze Plus (family) (COBRA)	10262-F51
Kaiser (Georgia)	Silver	10262-400
Kaiser (Georgia)	Silver (COBRA)	10262-500
Kaiser (Georgia)	Gold	10262-402
Kaiser (Georgia)	Gold (COBRA)	10262-502

INSURANCE CARRIER	COVERAGE LEVEL	GROUP NUMBER
Kaiser (Georgia)	Platinum	10262-403
Kaiser (Georgia)	Platinum (COBRA)	10262-503
Kaiser (Hawaii)	(all coverage levels)	50028
Kaiser (Mid-Atlantic States)	(all coverage levels)	24293
Kaiser (Oregon)	(all coverage levels)	20493
Kaiser (Washington)	Bronze (individual)	6743600
Kaiser (Washington)	Bronze (family)	6743700
Kaiser (Washington)	Bronze Plus (individual)	6743800
Kaiser (Washington)	Bronze Plus (family)	6743900
Kaiser (Washington)	Silver	6744000
Kaiser (Washington)	Gold	6744100
Kaiser (Washington)	Platinum	6744200
Premera Blue Cross	(all coverage levels)	1037844
UnitedHealthcare	(all coverage levels)	908168
UPMC Health Plan	(all coverage levels)	21435
DENTAL		
Aetna	(all coverage levels)	868242
Cigna	(all coverage levels)	2500073
Delta Dental (California) Carrier for Platinum	(all coverage levels) Platinum	78703
Delta Dental	Bronze	3890
Delta Dental	Silver	3891
Delta Dental	Gold	3892
MetLife	(all coverage levels)	0165250
UnitedHealthcare	(all coverage levels)	1070520
VISION		
EyeMed	Bronze	1006826
EyeMed	Silver	1006825
EyeMed	Gold	1006824
EyeMed	COBRA	1006827
UnitedHealthcare	(all coverage levels)	1070520
VSP	(all coverage levels)	30066510
MetLife	All coverage levels	165250-4-G

OTHER BENEFITS	APPEAL SUBMISSION
Health Care Reimbursement Account	**Starbucks Benefits Department** PO Box 34067 Seattle, WA 98124-1067 benefitappeals@starbucks.com Fax: (206) 594-6752
Life Insurance	**Hartford** Claim Appeal Unit Hartford Life Insurance Company PO Box 14087 Lexington, KY 40512-4087
Long Term Disability	**Unum** The Benefits Center P.O. Box 9548 Portland, ME 04104-5058 Fax: (207)-575-2354
Employee Assistance Programs	**Lyra** Lyra Health 287 Lorton Avenue, Burlingame, CA 94010 Phone: (800) 505-5972
Self-insured Transgender Medical Benefits	**Aetna Life Insurance Company** Appeals Resolution Team PO Box 14464 Lexington, KY 40512

APPENDIX B: PLAN CONTACT AND FUNDING INFORMATION

Please direct all claims and appeals of any denied claims to the Claims Administrator or Insurance Carrier for the benefit plan in which you are enrolled.

BENEFIT PLAN	CLAIMS ADMINISTRATOR OR INSURANCE CARRIER	FUNDING
MEDICAL / DENTAL / VISION		
Aetna	Aetna 151 Farmington Avenue Hartford, CT 06156 (855) 496-6289	Fully Insured
Cigna	Cigna 900 Cottage Grove Road Hartford, CT 06152 (855) 694-9638	Fully insured
Dean Health Plan / Prevea360	Dean / Prevea360 1277 Deming Way Madison, WI 53717 (877) 232-9375	Fully insured
DeltaCare USA	DeltaCare USA 100 First Street San Francisco, CA 94105 (800) 471-8073	Fully insured
Delta Dental of Washington	Delta Dental 9706 4th Avenue NE Seattle, WA 98115 (800) 427-3370	Fully insured
EyeMed Vision Care, LLC	EyeMed 4000 Luxottica Place Mason, OH 45040 (844) 739-9837	Fully insured
Geisinger Quality Options, Inc.	Geisinger 100 N. Academy Avenue Danville, PA 17822 (844) 390-8332	Fully insured
Health Net of California, Inc.	Health Net 21281 Burbank Boulevard B3 Woodland Hills, CA 91367 (888) 926-1692	Fully insured
Health Net of Oregon, Inc.	Health Net 13221 SW 68th Parkway Tigard, OR 97223	Fully insured
Health Net Life Insurance Company, Inc.	Health Net 21281 Burbank Boulevard B3 Woodland Hills, CA 91367 (888) 926-1692	Fully insured

BENEFIT PLAN	CLAIMS ADMINISTRATOR OR INSURANCE CARRIER	FUNDING
Hawaii Medical Service Association (HMSA)	HMSA P.O. Box 860 Honolulu, HI 96808 (800) 651-4672 or (808) 948-6121	Fully insured
Kaiser Foundation Health Plan, Inc. (CA)	Kaiser One Kaiser Plaza Oakland, CA 94612 (800) 464-4000	Fully insured
Kaiser Foundation Health Plan of Colorado	Kaiser 10350 E. Dakota Avenue Denver, CO 80247 (303) 338-3800	Fully insured
Kaiser Foundation Health Plan of Georgia, Inc.	Kaiser Nine Piedmont Center 3495 Piedmont 3495 Piedmont Road NE Atlanta, GA 30305 (404) 504-5712	Fully insured
Kaiser Foundation Health Plan, Inc. (HI)	Kaiser 711 Kapiolani Boulevard Honolulu, HI 96813 (808) 432-5955	Fully insured
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Kaiser 2101 E. Jefferson Street Rockville, MD 20852 (800) 777-7902	Fully insured
Kaiser Foundation Health Plan, Inc. (WA)	Kaiser P.O. Box 34593 Seattle, WA 98124-1593 (855) 407-0900	Fully insured
Metropolitan Life Insurance Company	MetLife 200 Park Avenue New York, NY 10166-0188 (888) 309-5526	Fully insured
Premera Blue Cross	Premera Blue Cross 7001 220th Street SW Mountlake Terrace, WA 98043 (855) 430-5823	Fully insured
UnitedHealthcare Insurance Company (Medical)	UnitedHealthcare 185 Asylum Street Hartford, CT 06103-0450 (888) 297-0878	Fully insured
UnitedHealthcare Insurance Company (Dental and Vision)	UnitedHealthcare 9900 Bren Road E. Minnetonka, MN 55343 (888) 571-5218	Fully insured

BENEFIT PLAN	CLAIMS ADMINISTRATOR OR INSURANCE CARRIER	FUNDING
UnitedHealthcare of California	UnitedHealthcare 5701 Katella Avenue Cypress, CA 90630 (877) 365-4198	Fully insured
UPMC Health Plan, Inc.	UPMC Health Plan 600 Grant Street Pittsburgh, PA 15219 (844) 252-0690	Fully insured
Vision Service Plan	VSP 3333 Quality Drive Rancho Cordova, CA 95670 (877) 478-7559	Fully insured
Self-insured Transgender Medical Benefits (Please work with a Starbucks Advocate by calling Starbucks Benefits Center to submit claims)	Aetna Life Insurance Company Aetna 151 Farmington Avenue Hartford, CT 06156 (855) 496-6289	Self-insured
OTHER BENEFITS		
Hartford (Life Insurance)	Hartford Group Benefit Claims Sacramento Life Claims Office The Hartford P.O. Box 14298 Lexington, KY 40512-4298 Phone: (888)-563-1124 Fax: (877)-447-9370	Fully insured
Lyra (Employee Assistance Programs)	Lyra Health 287 Lorton Avenue, Burlingame, CA 94010 Phone: (800) 505-5972	Self-insured
Unum (Long Term Disability)	Unum PO Box 100158 Columbia, SC 29202-3158 Phone: (207)-858-9843 Fax: (207)-447-2498	Fully insured

OTHER RESOURCES

Benefits Website:
mysbuxben.com

Benefits Service Center:
Starbucks Benefits Center (877–SBUXBEN)

COBRA Administrator:
Starbucks Benefits Center (877–SBUXBEN)

APPENDIX C: PLAN ADMINISTRATION INFORMATION

Please direct all claims and appeals of any denied claims to the Claims Administrator or Insurance Carrier for the benefit plan in which you are enrolled.

Plan Names/Plan Numbers	Starbucks Corporation Welfare Benefits Plan / 506
Plan Administrator and Sponsor	Starbucks Corporation, c/o Benefits Department 2401 Utah Avenue South, Mail Stop S-HR3 Seattle, WA 98134 (206) 447-1575
Plan Sponsor's Federal Employer Identification Number	91-1325671
Types of Plans	The Welfare Benefits Plan provides certain welfare benefits including medical, dental, vision, Health Care Reimbursement Account, Employee Assistance Program, group Long Term Disability, Accidental Death and Dismemberment (AD&D), life, and business travel accident. The STD Plan provides Short Term Disability benefits and is not governed by ERISA. The benefits offered under the Welfare Plan are subject to change.
Type of Administration/ Insurance Carriers	As noted earlier, the benefit plans are provided under both self-insured and fully insured arrangements. The fully insured benefit plans (which include HMOs) are provided under group Insurance Contracts between the Company and the Insurance Carriers (including HMOs). The Insurance Carriers – not the Company – are responsible for determining eligibility for benefits, the amount of any benefits payable and for prescribing the claims and appeal procedures for the fully insured benefit plans. The self-insured benefit plans are administered on behalf of the Plan Administrator by Claims Administrators pursuant to administrative services agreements between the Plan Sponsor and Claims Administrators.
Insurance Carriers/Claims Administrators	See Appendix B
Agent for Service of Legal Process	Starbucks Corporation, c/o General Counsel 2401 Utah Avenue South, Mail Stop S-LA1 Seattle, WA 98134 (206) 447-1575
Plan Year	October 1 to September 30