

# 2022 Summary Plan Description



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# Welcome

Your good health and well-being are important to Costco. That’s why we are pleased to offer the Costco Employee Benefits Program, designed to promote your health and personal welfare, protect your income and help provide peace of mind.

Some benefits are provided to all benefit-eligible enrolled [employees](#) at no cost, including Basic Life Insurance, Basic AD&D Insurance and Long-Term Disability Insurance. Other benefits are optional – you choose the coverage you want and pay a share of the cost through payroll deductions.

Resources for Living is available to all employees, members of their households and their adult children up to age 26, whether or not they are eligible for Costco benefits.

This booklet is your guide to Costco benefits and is designed to help you find the information you need quickly and easily.

To understand your benefits and how the plans work, you’ll need to know what the terms used in this booklet mean. See the [Glossary](#) for definitions of important words and phrases.

The first instance of a glossary term on each page is [blue](#). Click on a term and it will take you to the definition in the glossary. References to other pages within this booklet are also [blue](#) and linked.

## HAVE QUESTIONS OR NEED HELP?

Call the [Costco Employee Benefits Department](#) at **800-284-4882** weekdays from 7:00 a.m. to 5:00 p.m. Pacific Time.

Visit [Costcobenefits.com](#) for detailed information on all your benefits and to enroll in coverage.

This Summary Plan Description contains a summary in English of your plan rights and benefits under the Costco Employee Benefits Program. If you have difficulty understanding any part of this Summary Plan Description, contact the Costco Employee Benefits Department at **800-284-4882** weekdays from 7:00 a.m. to 5:00 p.m. Pacific Time (select option 1).

Esta descripción resumida del plan contiene un resumen en inglés de sus derechos y beneficios bajo el Programa de Beneficios para Empleados de Costco. Si tiene dificultades para entender cualquier parte de esta descripción resumida del plan, póngase en contacto con el Departamento de Beneficios para Empleados de Costco llamando al **800-284-4882** los días laborables, de 7:00 a.m. a 5:00 p.m., Hora del Pacífico (seleccione la opción 1).

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OFFICIAL PLAN DOCUMENTS

This booklet, the Costco Wholesale Corporation [Cafeteria Plan](#), and various insurance contracts are the ERISA plan documents for the Costco Employee Benefits Program. You may request copies of any of these documents from the [Costco Employee Benefits Department](#).

- This booklet is the plan document for Costco health care plans, including the medical, vision care, prescription drug and dental plans, Resources for Living, and special health care programs such as Omada and 98point6.
- The Costco Wholesale Corporation Cafeteria Plan is the plan document for the Cafeteria Plan under which you may make pre-tax contributions to the Health Care Reimbursement Account and Dependent Care Assistance Plan and pay pre-tax for health care premiums.
- Insurance contracts are the plan documents for the Life, AD&D, Business Travel Accident, Aetna WorldTraveler, International SOS, Voluntary Short-Term Disability and Long-Term Disability Insurance plans. The plans and the benefits they pay are limited by all the terms, exclusions, and limitations of those contracts in force at the time of the covered incident. Costco Wholesale Corporation, as [plan sponsor](#), reserves the right to change insurance carriers and contracts. If Costco or an insurer makes any changes, the benefits coverage described in this booklet may not be accurate.

Employees in Hawaii are covered by an HMSA medical plan instead of an Aetna Select plan. The medical benefits for Hawaii employees are described in a separate booklet. All other terms and benefits are the same as for mainland employees, and are described in this booklet.

In the event of conflict or ambiguity between this booklet and the Cafeteria Plan document or insurance contracts, the plan document or contracts will control unless otherwise noted in this book. Also, the Program, Costco, its employees, Program fiduciaries, and administrators are not bound by any oral or written communication that conflicts with plan documents.

Officers and employees of Costco at the various Costco locations and other third parties are not authorized to represent or speak on behalf of the Costco Employee Benefits Program, the [plan administrator](#), the [Benefits Committee](#), the [claims administrator](#) or [claims fiduciary](#) for any Plan. Costco may amend, change or discontinue Program benefits at any time. Benefits are not vested or guaranteed. This booklet supersedes prior booklets, documents and summaries, except for the Cafeteria Plan and existing insurance contracts. This booklet is effective January 1, 2022. To understand benefits for claims incurred before then, see prior SPDs.

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# Eligibility and Enrollment

## Eligibility

### INITIAL ELIGIBILITY

The Costco Employee Benefits Program is available to those U.S. employees classified by Costco and on Costco's payroll system as a regular salaried, full-time hourly or part-time hourly employee, and who are employed by and receive a Form W-2 from a participating employer: Costco Wholesale Corporation, CWC Travel, Inc. and CWC WDC LLC. Employee classifications are defined in the Costco [Employee Agreement](#).

You are **not** an employee eligible for benefits if you are:

- Working in Puerto Rico (there is a different benefits program in Puerto Rico)
- Classified by Costco as a seasonal or utility employee (except in Hawaii)
- Classified by Costco as a temporary or limited part-time employee
- Classified by Costco as an independent contractor or a leased employee, or in any other non-employee capacity
- Living or working outside the United States, unless you are on the U.S. Costco payroll
- An illegal immigrant or non-resident alien (or otherwise not a citizen or legal resident of the United States)
- Classified by Costco as an intern or working in connection with your training or education, except in the case of an otherwise eligible Costco employee transferring to a temporary intern position in the Home Office
- Enrolled in Costco's college student retention program
- A union employee, unless your collective bargaining agreement expressly requires coverage under the Program

- A Northwest Atlantic Partners (NWP) employee
- A Lincoln Premium Poultry (LPP) employee
- Classified by Costco as working in a position that is not a regular salaried, full-time hourly, or part-time hourly employee

If an individual excluded from coverage is subsequently determined by a court, government agency or settlement agreement to be a common law employee of Costco, that determination does not alter the individual's classification as a non-employee for purposes of the Program. Similarly, if an individual excluded from coverage is subsequently determined by a court, government agency or settlement agreement to have been improperly excluded, that does not alter the individual's eligibility for benefits under the Program.

If Costco acquires a business, pre-acquisition employment with the business does not count toward your service, [continuous service](#) or employment with Costco for purposes of the Costco Employee Benefits Program. Similarly, if your employer isn't a participating employer in the Program, your work does not count toward your service, continuous service or employment for purposes of the Program.

In case of significant corporate transactions, exceptions are sometimes made in a nondiscriminatory and uniform manner. You will be notified if an exception applies to you.



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BENEFIT EFFECTIVE DATE

You must satisfy a waiting period before you are eligible for Costco employee benefits. Health care and most other coverage will begin on your **benefit effective date**, which depends on your employee classification, as shown below. For information on how to enroll in coverage and your enrollment deadline, see [Enrollment on page 16](#).

Employee classification	Benefit effective date
Salaried employee, full-time hourly pharmacist or full-time hourly senior hearing aid specialist	First day of the month after date of hire
Full-time hourly employee (other than those listed above)	First day of the second month after 250 <b>eligible paid hours</b> *
Part-time hourly employee	First day of the second month after 450 eligible paid hours*
Hourly Hawaii employee	First day of the month after four weeks of <b>service</b> , during which you worked a minimum of 20 hours per week
Employee in a college student retention program who accepts a regular position	Day of your <b>change in status</b> , as long as you have met the eligibility requirements for your new classification
Employee working for Costco in another country who transfers to the United States	Day of the transfer (if you transfer without a break in employment )

\* Eligible paid hours are calculated only after the end of each pay period.

In case of significant corporate transactions, exceptions are sometimes made in a nondiscriminatory and uniform manner. You will be notified if an exception applies to you.

If your employee classification changes before your benefit effective date

Your benefits will take effect on the effective date for your new classification. If you have already passed the benefit effective date for your new classification, you will be immediately eligible for benefits.

ONGOING ELIGIBILITY

Once you are eligible for benefits, you must meet the minimum eligible paid hours requirements described below to maintain eligibility.

You can view your average hours anytime by logging onto the Enrollment Website from [Costcobenefits.com](#) and clicking on *Dashboard*.

BENEFIT MEASUREMENT PERIODS

Costco's fiscal year is divided into two benefit **measurement periods**. The eligible paid hours you work each measurement period determine your ongoing eligibility for benefits. For each measurement period ending after you become eligible, you must average at least 23 eligible paid hours per week (20 in Hawaii) to maintain eligibility and continue coverage for most benefit options.

If you are a full-time employee, benefit measurement periods are also used to determine your status for "full-time" versus "part-time" health care, Basic Life and Basic AD&D Insurance options. You must average at least 36 eligible paid hours per week to continue coverage in full-time benefit programs.

Benefit measurement periods are based on payroll dates:

- One measurement period is the first 13 biweekly pay periods of the fiscal year, generally from early September through the end of February.
- The other measurement period is the second 13 biweekly pay periods of the fiscal year, generally from early March through the end of August.
- At the end of each measurement period, all of your eligible paid hours are added up and then divided by 26 (the number of weeks in the measurement period). The number of weeks is reduced by the following:
  - » The number of weeks you were on a continuous **Leave of Absence** or transitional duty following a continuous Leave of Absence



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- » The number of weeks in the [measurement period](#) prior to your initial [benefit effective date](#)
- » The number of weeks in the measurement period prior to your hire date
- » The number of weeks your [location](#) was closed due to a natural disaster
- » The number of weeks prior to a [change in status](#) from part-time employee to full-time employee

**Note:** Every five years Costco has a 53-week fiscal year, in which case the measurement period will still consist of the typical 13 biweekly pay periods.

Your eligibility for most benefits will:	This will happen:
<b>End</b> after any measurement period in which you work an average of less than 23 <a href="#">eligible paid hours</a> per week (20 in Hawaii)	March 31 or September 30 immediately following the end of that measurement period
<b>Resume</b> after any measurement period during which you work an average of 23 eligible paid hours or more per week (20 in Hawaii)	April 1 or October 1 immediately following the end of that measurement period

If you lose eligibility and then regain it, you will be treated as a newly eligible employee and have an opportunity to make benefit elections. If you do not make new benefit elections by your deadline, you will be automatically enrolled in [default coverage](#). Your prior elections do not carry forward, even if you elected [COBRA](#). See [Enrollment on page 16](#) for details.

**Determining “full-time” versus “part-time” benefit status for full-time employees**

Your status for benefits may be different than Costco’s payroll classification of your employment status. If you are classified as a full-time employee, each measurement period you must average at least 36 eligible paid hours per week to be considered “full-time” for benefit

purposes. Only eligible full-time employees classified as “full-time” for benefits purposes may enroll in the Aetna Select Plan. Eligible full-time and part-time employees who are classified as “part-time” for benefits purposes may enroll in the Aetna Part-Time Select Plan.

If payroll classifies you as a part-time employee, you are not eligible for “full-time” benefits regardless of your average paid hours.

Your status for benefit purposes will:	This will happen:
<b>Change to “part-time”</b> after any measurement period in which you average at least 23 (20 in Hawaii) but less than 36 eligible paid hours per week	March 31 or September 30 immediately following the end of that measurement period
<b>Return to “full-time”</b> after any measurement period during which you work an average of 36 eligible paid hours or more per week	April 1 or October 1 immediately following the end of that measurement period

Full-time employees may change their benefits within 30 days of a status change. For those who don’t change elections within 30 days, certain automatic changes apply. For example, if you are currently enrolled in health care coverage and your status changes:

- *From “full-time” to “part-time,”* your medical plan will switch to Aetna Select for Part-Time Employees or HMSA HMO in Hawaii. If you’re currently in the Premium Dental Plan, you will switch to the Core Dental Plan.
- *From “part-time” to “full-time,”* your medical plan will switch to Aetna Select for Full-Time Employees but you will continue to be covered by Core Dental.

Your Life and AD&D Insurance coverage will automatically change to the level available to other employees with the same benefit status and years of [continuous service](#).

For more information, see [Life Events on page 103](#).



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# TEMPORARY CORONAVIRUS BENEFITS ELIGIBILITY PROVISION

For the first [measurement period](#) in 2021 (ending February 28, 2021), you will not lose your eligibility because you did not work enough [eligible paid hours](#). The second measurement period in 2021 was June 7 through August 29, reducing the normal 26-week measurement period to a 12-week measurement period. All other rules continue to apply, such as those that apply to benefit continuation while on a [Leave of Absence](#).

# ELIGIBLE FAMILY MEMBERS

If you are eligible and enrolled for Costco benefit coverage, you may also enroll your eligible family members for the same health care plans in which you are enrolled, and in other benefits available to eligible family members. Eligible family members may only be added or removed from coverage during your initial enrollment period, [Annual Enrollment](#), or when you experience a qualifying change in your work, family or personal status.

As described in this section, eligible family members may include your spouse, your children, your domestic partner, and your domestic partner's children.

Individuals who are not specifically described in this section cannot be covered under the Costco Employee Benefits Program.

**Ineligible** persons include, for example:

- Your parents
- Your grandparents
- Your foster children
- Your child's spouse and children or their domestic partner and the domestic partner's children

Your family members cannot be enrolled until their eligibility for coverage is approved. To help prove an individual is an eligible family member, you will be required to submit certain documentation. See [Providing Proof of Your Family's Eligibility on page 10](#).

# Your spouse

For purposes of the Costco Employee Benefits Program, your spouse means the person to whom you are legally married, as determined for federal income tax purposes – that is, the person with whom you are eligible to file a joint federal income tax return. However, a spouse by common-law marriage is not an eligible family member under the Program.

# Your domestic partner

Your domestic partner is eligible if your relationship meets certain requirements as detailed in the Declaration of Domestic Partnership and as determined and approved by the [Costco Employee Benefits Department](#).

To be in a qualified domestic partnership, you and your domestic partner must:

1. Have shared the same household for at least six consecutive months and intend to continue to do so indefinitely,
2. Be engaged in a committed relationship of mutual caring and support and intend to remain so indefinitely,
3. Share responsibility for each other's common welfare and living expenses,
4. Share financial interdependence,
5. Consider yourselves to be life partners,
6. Not be married (as defined by federal tax law) to, in a committed relationship with, or legally separated without a dissolution of marriage from, anyone else,
7. Not have had another domestic partner or spouse enrolled in the plan within the prior six months,
8. Both be age 18 or older and mentally competent to consent to a contract,
9. Not be related by blood to a degree of closeness that would prohibit legal marriage,

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- 10. Not be in the relationship solely for the purpose of obtaining benefits coverage, and
- 11. Not have been previously legally married to each other.

Supporting documentation will be required, which includes a recorded deed and mortgage proving joint home ownership or a joint lease, plus wills naming each other as more than 50% heirs, joint bank accounts and credit cards, documentation that you and your domestic partner are beneficiaries for each other’s life insurance and retirement plans, proof of joint auto ownership, etc.

For details and supporting documentation requirements, see the *Declaration of Domestic Partnership with Overview*, available at [Costcobenefits.com](#) or from your Payroll Clerk.

Your children

Your children, and the children of your spouse or domestic partner, are eligible for coverage through age 25 (or older if they are disabled) as described below, whether or not they are married, eligible for other coverage or full-time students.

- Biological children, adopted children and children legally placed for adoption.** If you are divorced, you may enroll these eligible children even if you are not the custodial parent.
- Stepchildren**, including your spouse’s biological children, adopted children and children legally placed with them for adoption.

- If your spouse dies while your stepchildren are enrolled in a Costco health care plan, you may continue their coverage as long as:
- » You have been granted custody of them by court order,
  - » They are your dependents under the [Tax Code](#), and
  - » They continue to live with you and rely on you for principal support.

If you drop coverage for these stepchildren, you cannot re-enroll them. These children become ineligible for coverage when you are no longer married to their parent.

- Children for whom you are the legal guardian or custodian.** If a court has appointed you, your spouse or your enrolled domestic partner as the guardian or custodian of a sibling, grandchild, great-grandchild, niece or nephew, great-niece or great-nephew, that child may be eligible for health plan coverage.

There are three qualifying types of guardianship/custody:

- You (or your spouse or enrolled domestic partner) are the unrestricted full legal guardian of the child’s person and estate,
- If the child has no estate, you (or your spouse or enrolled domestic partner) are the unrestricted full legal guardian of the child’s person, or
- If guardianship is not available for children in your state, you (or your spouse or enrolled domestic partner) are the child’s permanent custodian.

The guardianship/custody order must be permanent, unrestricted and unshared, and must give you (or your spouse or enrolled domestic partner) full legal responsibility for making both financial and care decisions for the child. The court order must be entered before the child turns age 18, and the child must live with you 100% of the time until age 18. The child must be your tax dependent, and you must submit a copy of your tax return and other documents. Each year you must submit a completed IRS Form 8821, which will allow the IRS to share your filed tax returns with Costco.

If you (or your spouse or enrolled domestic partner) remain the legal guardian or custodian until the child reaches age 18, eligibility for coverage may continue through age 25, so long as the child continues to be your tax dependent.

For details and supporting documentation requirements, see the *Declaration of Legal Guardianship*, available at [Costcobenefits.com](#) or from your Payroll Clerk.



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4. Mentally or physically disabled children past the normal age limit, provided they:

- » Became disabled before age 26,
- » Were enrolled for Costco health care coverage before age 26 and have remained continuously enrolled since,
- » Are incapable of self-sustaining employment due to their disability,
- » Are chiefly dependent on you for support and maintenance,
- » Permanently reside with you,
- » Are eligible to be claimed as your dependents for federal income tax purposes, and
- » Are unmarried.

To continue a disabled child’s coverage past the normal age limit, you must apply to Aetna or HMSA within 31 days after their 26th birthday. As part of the application process, you must provide medical documentation substantiating the child’s disability.

If the disabled child is approved for continued coverage, Aetna or HMSA will send you an approval letter. At reasonable intervals after that, you may be required to provide proof that the child continues to be disabled and meet the requirements listed above. It is your responsibility to make sure that you re-apply within 31 days after the expiration dated noted on Aetna’s or HMSA’s approval letter. The Program reserves the right to have the child examined by a doctor of the Program’s choice at the Program’s expense to determine the existence and duration of their disability.

If there is an interruption in the child’s coverage, their coverage will not be reinstated regardless of subsequent disability. The exception is if you and your family lose eligibility because you are on a **Leave of Absence** or you fail to average the required number of **eligible paid hours** during a **measurement period**. In either case, once you resume eligibility you may re-enroll the child, provided they continue to meet the criteria listed above and are still disabled as determined by Aetna or HMSA.

DUPLICATE COVERAGE RULES FOR HEALTH CARE

If you have a spouse, domestic partner, child or parent who is also a benefits-eligible employee, the following rules apply to your Costco health care coverage:

- You cannot be covered as both an employee and as a family member of another employee. If an individual is enrolled as a family member of two employees or as an employee (including automatic enrollment in **default coverage**) and a family member of another employee, the employee will have to choose one coverage. Costco will notify affected employees when this applies, and which coverage will be dropped if they do not respond or agree on coverage.
- No individual may be covered as a family member of more than one employee, which means only one of you may enroll your eligible children. If both parents of a child are Costco employees, only one parent can enroll the child for Costco health coverage. If your child is enrolled at the same time by another Costco employee, Costco will notify both employees and will let you know which coverage will be dropped if you do not respond or agree on coverage. If your child is already enrolled as a dependent of one parent then the other parent will not be allowed to enroll the child, except as required by law.
- Your family member who is also an eligible Costco employee may either enroll independently for employee coverage or be enrolled as an eligible family member.
- If your family member enrolls separately for employee coverage, you can each elect a different medical plan available to you. You may also each elect or decline available dental options, no matter what the other chooses.
- An employee enrolled as an eligible family member must have the same medical and dental coverage as their spouse, domestic partner, or parent enrolled as an employee.
- If an employee loses healthcare coverage while on FMLA leave and is enrolled as the family member of another employee, Costco will re-enroll the employee in the lost coverage when they return



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to work from leave, to the extent required by law. If this results in duplicate coverage, Costco will notify affected employees and let them know which coverage will be dropped if they do not respond or agree on coverage.

PROVIDING PROOF OF YOUR FAMILY’S ELIGIBILITY

Your family members cannot be enrolled in the plans unless their eligibility for coverage has been reviewed and approved. As described in this section, the first time you enroll family members, you must submit certain documents to prove their relationship to you. Each year after that, you will be required to re-verify eligibility to continue coverage.

1. Enrolling a family member for the first time

You can enroll your family member on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**. You will be required to provide the Social Security Number or Individual Taxpayer Identification Number for each family member you are requesting to enroll. The system will confirm your request to enroll that person. If there is an additional cost for the coverage, your payroll deductions to pay those costs will begin while eligibility is being determined.

2. Required documents

Your confirmation notice will specify the documents you must submit and the deadline for submission. Examples of required documents include:

- A state-certified marriage certificate
- A state-certified birth certificate
- Proof of adoption or placement for adoption orders
- A Costco declaration form listed below, available at [Costcobenefits.com](#) or from your Payroll Clerk.

Costco declaration form	What it’s for
Declaration of Legal Guardianship	To enroll your niece, nephew, grandchild, or sibling for whom you, your spouse, or your domestic partner serve as legal guardian or custodian
Declaration of Domestic Partnership	To enroll your domestic partner and their eligible children

3. Submitting documentation

You may submit the required documentation in one of three ways:

- Log in to the Enrollment Website, available at [Costcobenefits.com](#) and select “My Alerts”, then navigate to the Dependent Approval page. Follow the instructions to upload documents for each dependent.
- Mail the required documents to:  
Costco Wholesale  
DPT: COS  
P.O. Box 981903  
El Paso, TX 79998
- Fax the documents to 844-832-0954 (Attn: Enrollment Center)

4. Notification of eligibility

After your documentation has been reviewed, you will be notified of your family member’s eligibility status:

- If eligible, their coverage will be effective on the enrollment start date. Payroll contributions for your family member will start once eligibility is approved. Enrollment will be effective back to the enrollment start date, which could result in back charges.
- If the person is not eligible (or if you did not submit required proof by the deadline), they will not be enrolled.





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5. Annual verification

Each year during the [Annual Enrollment](#) period, you'll be notified that you must verify eligibility for enrolled family members by a certain deadline. To verify eligibility:

- Go to "Dependent Verification" on the Enrollment Website, available at [Costcobenefits.com](#), or
- Call the Enrollment Center at **800-541-6205**.

If you do not verify a family member's eligibility by the deadline, coverage for that person will end as of December 31.

In addition to the requirements noted above, after you initially enroll a family member you may be required to provide proof of their continuing eligibility from time to time. For example, if you have enrolled a child for whom you are the legal guardian or custodian, each year you must submit a completed IRS Form 8821. Costco will then be able to confirm the child continues to be your tax dependent by viewing your filed tax returns. Costco may ask for proof that a family member was eligible for benefits when an expense was incurred. If you do not provide proof, that person's eligibility for coverage will end.

**It is considered falsification of company records if you verify eligibility for someone who is not eligible.** For example, after you get a divorce your former spouse is no longer eligible for coverage. If you verify eligibility anyway, you may be subject to disciplinary proceedings or termination, as described in the Costco [Employee Agreement](#) and applicable collective bargaining agreements. Also, program coverage for you and your family members may be retroactively terminated, without opportunity to elect [COBRA](#).



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ELIGIBILITY WHILE ON A LEAVE OF ABSENCE

Costco offers various [Leaves of Absence](#) (LOA) to eligible employees, as explained in the Costco [Employee Agreement](#). This section describes how your eligibility for benefits may be affected when you go on and return from an approved leave.

**If you are not benefits-eligible when you go on a Leave of Absence**

If you are not benefits-eligible when you go on leave, the time you are on an approved leave will count toward completing your initial eligibility waiting period before your [benefit effective date](#). Each calendar year, Costco calculates the average hours worked by all full-time employees and the average hours worked by all part-time employees. The hours you are credited each pay period you are on leave are based on the prior year's average for your job status, minus any hours you are paid in that pay period.

If your benefit effective date occurs while you are on an approved leave, you will become eligible for coverage. Costco will send you a Benefits Enrollment Notice with an explanation of your coverage, election options and enrollment deadlines.

- You may enroll from 30 days before your benefit effective date until 30 days after that date (a 60-day window). You can enroll on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.
- If you do not make elections by your enrollment deadline, you will receive [default coverage](#) through the end of that calendar year.

Your health care coverage will begin as of your benefit effective date. Your participation in other plans for which you are eligible, such as Life, AD&D and disability insurance, will not start until you return to [active employment](#).

If you are benefits-eligible when you go on a Family/Medical Leave of Absence

If you were eligible at the beginning of your Family/Medical Leave of Absence (defined in the Employee Agreement) or become eligible during your Family/Medical Leave of Absence, you are eligible to continue most benefits up to the maximum period of coverage shown in the table below. Once you reach the maximum period, except as required by law you will no longer be eligible and your coverage will end.

Length of continuous service at time of Family/Medical Leave of Absence	Maximum period benefits continue (counted from first day of Family/Medical Leave of Absence)
Less than 90 days	30 days
At least 90 days but less than 12 months	90 days
12 months or more	180 days

The maximum periods above apply to all plans in the Costco Employee Benefits Program.

In addition:

- If you become disabled while covered by Voluntary STD Insurance or Long-Term Disability Insurance, you will receive disability benefits as long as you qualify under that insurance policy.
- Certain states require that employers offer extended benefit coverage during medical leaves due to pregnancy. If you go on maternity leave, please contact the [Costco Employee Benefits Department](#) to find out whether this applies in your state.
- If Unum certifies you are [terminally ill](#), special provisions will apply to your continued coverage. See [COBRA Subsidy if You Are Terminally Ill on page 125](#) and [Costco Life Insurance If You Are Terminally Ill on page 79](#).

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Paying for coverage when benefits are continued during a Family/Medical Leave of Absence

- For the first 90 days of leave Costco pays the full cost of your health care benefits (medical, dental, prescription drug, vision) during your Family/Medical **Leave of Absence** up to your maximum benefits continuation period as shown above or 90 days, whichever is less.
- If you are eligible for more than 90 days of continued benefits (if you have 12 months or more of **continuous service** at the time your Family/Medical Leave of Absence begins) and your leave exceeds 90 days, you must pay your regular benefit-related paycheck deductions to continue your health care coverage, whether you are on a personal medical leave (including pregnancy) or workers' compensation leave. As long as you pay for Costco health care coverage, Costco will pay the required premiums for life and AD&D insurance up to the maximum benefit period noted above.

A notice and payment coupons will be sent to your mailing address when your Leave of Absence begins. If you do not receive your coupons, call Benefit Strategies at **855-729-2367**. Your check should be made payable to Costco Wholesale. Send your payments to Benefit Strategies, LLC, P.O. Box 3938, Manchester, NH 03105-3938. If you do not pay your premiums by the due date, your coverage will end.

Once your coverage ends you may be eligible to continue coverage under **COBRA** if you have experienced a COBRA-qualifying event. See **Continuation of Health Care Coverage (COBRA) on page 119**.

COBRA premium subsidy

If you are on a Family/Medical Leave of Absence that extends beyond the maximum period benefits continue listed above, and you elect to continue health care coverage under COBRA, Costco will assist you with the cost of monthly COBRA payments for a maximum of six months as follows:

Length of continuous service	Costco COBRA premium subsidy
Less than 12 months	None
At least 12 months but less than 5 years	25% premium subsidy for up to six months
5 years or more	50% premium subsidy for up to six months

You are not eligible for this COBRA subsidy if your benefits have terminated for non-payment of premium.

See **Continuation of Health Care Coverage (COBRA) on page 119** for more information.

**Note:** If you return from leave and then go back out on leave for any reason 90 calendar days or less after your return:

- Your original leave is considered continuous and unbroken
- Your benefits eligibility will continue for the balance of any remaining maximum period of continued coverage to which you are entitled
- If you are not entitled to any remaining period of continued coverage, your benefits will end on the date you go back out on leave

If you return from leave after eligibility ends

If you have not been terminated but your benefits ended while you were on a Leave of Absence, your eligibility for benefits will resume on the date you return to a benefits-eligible position.

All of your benefits that were in effect when your eligibility ended will be reinstated and your contributions to pay for those elections will also resume, except in the situations outlined below. You will be given a 30-day window to make changes to your benefit elections.

- Your Dependent Care Assistance Plan account will not be reinstated. You must re-enroll for the Dependent Care Assistance Plan within 30 days after you return if you want to participate.

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You can make this election on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.

- Your Health Care Reimbursement Account will not be reinstated if you return after the start of a new calendar year. In this case, you must wait until the next **Annual Enrollment** period to re-elect the Health Care Reimbursement Account.
- Your Supplemental Life Insurance and Supplemental AD&D Insurance will not be reinstated. You must re-enroll within 30 days after you return if you want coverage. You can make these elections on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**. Elections are subject to **Evidence of Insurability (EOI)** requirements and approval from Unum, as described in [Life and Accident Insurance on page 77](#).

ELIGIBILITY WHILE ON USERRA MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives you the right to continue your and your family's eligibility for coverage if:

- You are eligible for and enrolled in the Costco Employee Benefits Program,
- You leave your employment to perform certain United States uniformed military service, and
- You notify Costco before taking **military leave** unless precluded by military necessity or other reasonable cause.

The Costco *Military Leave Notification Form* includes a detailed description of Costco's policy regarding military leaves under USERRA. The form is available from your Payroll Clerk. For more information about continuing eligibility for benefits under USERRA, contact the [Costco Employee Benefits Department](#).

Continuing health care coverage while on a Military Leave of Absence

If you are benefits-eligible when your Military Leave of Absence begins, your eligibility and that of your enrolled family members will continue as long as you are on an approved Military Leave of Absence; you will not be required to make your regularly scheduled benefit contributions.

Returning from a Military Leave of Absence

When you return from your Military Leave of Absence, your contributions to pay for your coverage will resume.

You will have a 30-day window to enroll in or make changes to your benefits on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.



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A Benefits Enrollment Notice will be mailed to you, with election options and deadlines for making changes, at certain times. For example, you will get a notice:

- During your initial eligibility waiting period, as notification that you are eligible to enroll for coverage
- Before [Annual Enrollment](#)
- Following a change in your work status or hours or any other work event that will affect your current coverage or allow you to change your elections

INITIAL ENROLLMENT

When you are first eligible for benefits, during your initial enrollment period, you can enroll in or decline benefits. During your initial enrollment period, you can:

- Choose health care coverage from available options
- Enroll eligible family members
- Add Supplemental Life and Supplemental AD&D Insurance
- Elect to participate in the Dependent Care Assistance Plan (but not the Health Care Reimbursement Account, for which mid-year enrollment is not allowed)
- Decline health care and other coverage

A Benefits Enrollment Notice will be mailed to you, outlining your benefit options. Make your elections on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.

The first time you visit [Costcobenefits.com](#), you will need to register by verifying your employee number and personal information. Once you are registered and logged in, click the link to the Enrollment Website on the home page.

Special initial enrollment rules apply to the Voluntary Short-Term Disability (STD) Insurance Plan (see [Special Initial Enrollment for Voluntary STD on page 17](#)).

If You Don't Enroll

If you do not enter elections by your initial enrollment deadline, you will automatically receive [default coverage](#). This is the following coverage for yourself only, not your family:

- Medical – Aetna Select, Aetna Select for Part-Time Employees, or HMSA HMO in Hawaii
- Prescription Drug – Costco Health Solutions
- Dental – Core Exclusive Provider Plan (EPP)
- Vision – eye exams and hardware
- Basic Life and AD&D Insurance
- Long-Term Disability Insurance
- Business Travel Accident Insurance (salaried employees only)

By enrolling in or accepting default coverage, you agree to pay your share of the cost of coverage through payroll deductions. After initial enrollment, you may only change your coverage during Annual Enrollment or following certain changes in your job, personal or family status.

Confirming Your Coverage

After your coverage begins, Costco will mail you a confirmation of your elected or default coverage. Your online pay stub will also reflect these options along with any payroll deductions to pay for that coverage.

Be sure to carefully review any paperwork you receive from Costco regarding your benefit coverage, such as your pay stubs,





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work schedules, and Benefits Confirmation Statements. It’s your responsibility to make sure these include accurate, up-to-date eligibility and enrollment information about you and your family.

Any errors must be promptly reported to the [Costco Employee Benefits Department](#). Your failure to do so could affect your coverage and your financial responsibilities. Regardless of what the paperwork shows, the Costco plans only pay benefits according to the rules, requirements and restrictions described in this booklet.

When Coverage Begins

Any initial elections you make – or, if you do not make elections, [default coverage](#) – will apply starting on your [benefit effective date](#). These elections remain in effect and cannot be changed for the rest of the calendar year, unless you experience a qualifying job, personal or family change. Your next opportunity to change your benefit elections will be the following [Annual Enrollment](#) period.

Initial Enrollment Deadlines

You can complete your initial enrollment anytime from 30 days before your benefit effective date until 30 days after that date (a 60-day window).

- If you complete your initial enrollment during the 30-day period before your benefit effective date, your elected coverage and payroll deductions to pay for that coverage will start as of that date.
- If you do not complete your initial enrollment during this 30-day period, you will automatically have default coverage (as described under [If You Don’t Enroll on page 16](#)) starting on your benefit effective date. You will pay for your share of the cost through payroll deductions.
- If you complete your initial enrollment within 30 days after your benefit effective date, your elections will be effective on that date. Your cost for any retroactive coverage will be withheld from your first paycheck after you complete enrollment. All retroactive coverage costs are withheld on an after-tax basis.

KEEP YOUR ADDRESS UP TO DATE

The Benefits Program uses the most recent mailing address that you have provided in Costco’s Employee Self-Service (ESS) – not your Permanent Residence address. Be sure to update your mailing address promptly by logging on to Employee Self-Service (ESS) from the Costco Employee Website.

Special Initial Enrollment for Voluntary STD

Except in California, Hawaii, New Jersey and New York, the Voluntary Short-Term Disability Insurance plan is automatic for eligible hourly employees. If this includes you, your coverage (and payroll deductions to pay for that coverage) will begin automatically as of:

- The first day of the month after 90 days of [continuous service](#) (most hourly employees), or
- The first day of the month after 30 days of continuous service (full-time hourly pharmacists and senior hearing aid specialists).

If your employee status changes from salaried to hourly, or you transfer from a state with mandated disability coverage to one without, coverage will begin on the date of your status change, as long as the status change date is after the applicable time frame listed above.

Costco will send you a special Benefits Enrollment Notice notifying you of your opportunity to decline enrollment in the Voluntary Short-Term Disability Insurance plan. The Benefits Enrollment Notice will include your deadline for declining coverage. To be eligible to receive benefits under this plan, you must work at least 10 hours a week. If you are not working at least 10 hours a week, you may wish to decline this coverage. If Unum denies your claim for benefits because you have not worked at least 10 hours per week, you may decline ongoing

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coverage at that time. However, you will not receive a refund of premiums paid prior to that date.

Other than the situations described above, you can only drop or add this coverage during [Annual Enrollment](#). However, if you decline Voluntary STD Insurance then elect to participate during a subsequent Annual Enrollment, you will have a six-month benefit waiting period. Counted from the next January 1, that means your coverage will not start until July 1. If you are on a [Leave of Absence](#) on your first date of coverage, coverage will not take effect until you return to [active employment](#).

ANNUAL ENROLLMENT

Annual Enrollment is typically held in the fall of each year. This is your once-a-year chance to make changes to your current benefit elections, for example, to:

- Add or drop coverage for yourself or family members
- Switch health care options (if available)
- Change Life and AD&D Insurance coverage amounts
- Enroll in or decline Voluntary Short-Term Disability
- Enroll in the Dependent Care Assistance Plan or Health Care Reimbursement Account
- Decline coverage (there are several options for declining coverage, as described in [If You Decline Coverage on page 19](#))

Make your elections on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.

If you don't make changes during the Annual Enrollment period, you won't be able to make changes until the following Annual Enrollment period, unless you experience a qualifying change in your work, family or personal status. For more information, see [Life Events on page 103](#).

Keeping Your Current Elections

A “rolling election” applies to your medical, dental, Supplemental Life and AD&D Insurance, and Disability Insurance elections. This means if you do not submit election changes for these plans by the end of the Annual Enrollment period, most elections will continue “as is” for the following year and you will pay your share of those costs through payroll deductions.

The rolling election does not apply to the Health Care Reimbursement Account or Dependent Care Assistance Plan. To participate in either of these plans for the coming year, you must re-enroll each Annual Enrollment period.

You must verify eligibility for your enrolled family members each year in order to continue their coverage, as described under “Annual verification” in [Providing Proof of Your Family’s Eligibility on page 10](#).

Confirming Your Coverage

After your coverage begins, Costco will send you a written confirmation of your elected or [default coverage](#). Your pay stub will also show your coverage elections along with any payroll deductions to pay for that coverage.

Be sure to carefully review any paperwork you receive from Costco regarding your benefit coverage, such as your pay stubs, work schedules, and Benefits Confirmation Statements. It’s your responsibility to make sure these include accurate, up-to-date eligibility and enrollment information about you and your family.

Any errors must be promptly reported to the [Costco Employee Benefits Department](#). Your failure to do so could affect your coverage and your financial responsibilities. Regardless of what the paperwork shows, the Costco plans only pay benefits according to the rules, requirements and restrictions described in this booklet.



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**When Election Changes Go Into Effect**

If you make changes during [Annual Enrollment](#), your elections will go into effect January 1 of the coming calendar year, with the following exceptions:

- **If you add or increase Supplemental Life Insurance** and [Evidence of Insurability \(EOI\)](#) is required, the change will go into effect only after Unum approves your application. It’s your responsibility to be sure you have received Unum’s written approval. Otherwise, you will not be covered by your elected amount, even if your pay stubs or Benefits Confirmation Statements show you are enrolled, and even if you have begun to pay for coverage. If you are on a [Leave of Absence](#), the additional coverage will not go into effect and will not increase until you return to [active employment](#).
- **If you add Voluntary Short-Term Disability Insurance** (after declining during initial enrollment) coverage will begin July 1 of the coming year, after a six-month waiting period, provided you are actively at work. If you are on a Leave of Absence on the effective date, your coverage will not begin until you return to active employment.

**IF YOU DECLINE COVERAGE**

You can decline health care coverage and elect one of the following options instead. To do so, you must enter your elections on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.

If you fail to enroll or elect a decline option when you first become benefits-eligible, you will automatically receive the [default coverage](#) described in [Initial Enrollment on page 16](#).

- 1. Decline health coverage – covered as the dependent of another Costco employee**  
 With this package, your health care benefits, including medical and dental, can only be provided through family coverage under your spouse’s, domestic partner’s or parent’s plans. You will have automatic coverage, paid in full by Costco, under:
  - Resources for Living
  - Basic Life and Basic AD&D Insurance
  - Business Travel Accident Insurance, if you are a salaried employee
  - Long-Term Disability Insurance
 Your health care coverage will be limited to that provided to family members of employees.  
  
 In addition, you will have the same options as any other Costco employee who is eligible for benefits. This includes elective coverage under the following plans:
  - Supplemental Life Insurance
  - Supplemental AD&D Insurance
  - Dependent Care Assistance Plan (DCAP)
  - Health Care Reimbursement Account (HCRA), election allowed only during Annual Enrollment
  - Commuter Benefits Plan
 You will also be automatically enrolled in the Voluntary Short-Term Disability Insurance Plan if it is available at your [location](#) and you are an hourly employee. If you prefer, you may decline this coverage as described in [Initial Enrollment on page 16](#).
- 2. Decline with ancillary coverage**  
 If you choose this package, Costco will not provide you with medical, prescription drug, dental, vision or hearing aid coverage. However, Costco will provide LTD coverage at no cost to you. The following



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benefits are automatically included as part of your benefit package and you will be required to contribute toward the cost of these benefits:

- Resources for Living
- Basic Life Insurance
- Basic AD&D Insurance
- Business Travel Accident Insurance, if you are a salaried employee

Also, you may elect coverage under these plans:

- Supplemental Life Insurance
- Supplemental AD&D Insurance
- Dependent Care Assistance Plan (DCAP)
- Health Care Reimbursement Account (HCRA), election allowed only during [Annual Enrollment](#)
- Commuter Benefits Plan

In addition, you will be automatically enrolled in the Voluntary Short-Term Disability Insurance Plan if it is available at your [location](#) and you are an hourly employee. You may decline this coverage as described in [Initial Enrollment on page 16](#).

3. Decline all coverage

If you decline coverage, you will not be able to participate in the Costco medical, prescription drug, vision, hearing and dental plans, Life or AD&D Insurance, Long-Term Disability Insurance, Dependent Care Assistance Plan, or Health Care Reimbursement Account.

However, you will be eligible for:

- Resources for Living
- Commuter Benefits Plan

- Voluntary Short-Term Disability Insurance. If this is available at your location and you are an hourly employee, enrollment is automatic. You may decline this coverage as described in [Special Initial Enrollment for Voluntary STD on page 17](#).
- Business Travel Accident Insurance, if you are a salaried employee

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If Costco receives a medical child support order or medical support notice for your child, the Enrollment Center will, in accordance with the Program's [Qualified Medical Child Support Order \(QMCSO\)](#) Procedures, notify you and determine whether you and/or your child must be enrolled in coverage. You may obtain, without charge, a copy of the program's QMCSO Procedures by contacting the Enrollment Center at **800-541-6205** or sending a written request to:

Costco Wholesale  
DPT: COS  
P.O. Box 981903  
El Paso, TX 79998

If your child must be enrolled and you and your child are otherwise benefits-eligible, you'll pay the cost of coverage through payroll deduction. For any child enrolled in the plan pursuant to a QMCSO, you may disenroll such child as permitted by the plan, the QMCSO Procedures, and applicable law.

Costco does not honor QMCSOs for stepchildren or the children of domestic partners. However, if these children otherwise meet the requirements for eligible family members, you may be able to enroll them as described above.

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### ADDITIONAL ENROLLMENT FORMS AND DOCUMENTS

After entering your elections online or via the Enrollment Center, you may be required to submit certain forms or other documents to complete your enrollment as shown below. If documentation is required, Costco will send you a notification that specifies the required documents and the deadline for submitting those documents.

Form or Document	What It's For
Proof of Family Relationship	<p>To enroll a family member for the first time. As described in <a href="#">Providing Proof of Your Family's Eligibility on page 10</a>, this might include, for example:</p> <ul style="list-style-type: none"> <li>A state-certified marriage certificate</li> <li>A state-certified birth certificate for all children</li> <li>Proof of adoption or placement for adoption orders</li> <li>Costco <i>Declaration of Domestic Partnership</i> (available at <a href="#">Costcobenefits.com</a> or from your Payroll Clerk)</li> <li>Costco <i>Declaration of Legal Guardianship</i> and IRS Form 8821 (available at <a href="#">Costcobenefits.com</a> or from your Payroll Clerk)</li> </ul>
Evidence of Insurability Form	<p>To be approved for Supplemental Life Insurance that exceeds certain limits, as described in <a href="#">Supplemental Life Insurance on page 81</a>.</p> <p>If you're required to provide <a href="#">Evidence of Insurability (EOI)</a>, Unum will notify you and provide instructions on completing EOI through <a href="#">secure.unum.com</a>. You may request a paper form from Unum if you prefer. Your elected coverage won't be effective unless Unum notifies you in writing that your application has been approved based on your Evidence of Insurability.</p>



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## Costs for Coverage

You and Costco share in the cost of health care coverage for yourself and your other enrolled family members. Costco pays for some coverage in full, for example, your Long-Term Disability (LTD) Insurance.

You pay the full cost of coverage if you elect any of the following:

- Voluntary Short-Term Disability for hourly employees
- Supplemental Life Insurance
- Supplemental AD&D Insurance
- Dependent Care Assistance Plan
- Health Care Reimbursement Account
- Commuter Benefits Plan

### HOW YOU PAY

When you enroll for benefits (or if you do not enroll and receive [default coverage](#)), you agree to have your wages reduced to pay for the benefits you have chosen. Your pay stub will show the deduction for each plan.

Your contributions will start when you become eligible and your coverage goes into effect. Throughout the rest of the year, your contributions will be withheld from each paycheck as long as you are eligible for benefits through the last day of the pay period. Depending on the coverage start date, this may also include retroactive contributions for coverage that started before that pay period. If any paycheck does not cover your required contributions for benefits, subsequent paychecks may have additional deductions to cover the missed payment.

### WHAT YOU PAY

Current bi-weekly contributions are shown in the [Rate Booklet](#) provided to you during initial enrollment. Your contributions toward the cost of your coverage may change from one year to the next. After initial enrollment, updated Rate Booklets are available at [Costcobenefits.com](#) or from your Payroll Clerk.

If your share of costs for coverage decreases or increases during the year, your payroll deduction will be decreased or increased automatically to reflect that change.

### PRE-TAX VERSUS AFTER-TAX PAYMENTS FOR COVERAGE

You pay for Supplemental Life, Supplemental AD&D, and Voluntary Short-Term Disability coverage with after-tax wages.

You pay your share of the cost of the following coverage on a pre-tax basis. In other words, your payments for these benefits are not considered part of your wages and therefore not subject to federal income tax or FICA (Social Security/[Medicare](#)) taxes. This could potentially – but not necessarily – result in reduced future Social Security retirement payments to you.

- Medical
- Dental
- Health Care Reimbursement Account
- Dependent Care Assistance Plan
- Commuter Benefits Plan

### TAX IMPLICATIONS FOR DOMESTIC PARTNERS

If you enroll your domestic partner and their children, under federal [Tax Code](#) regulations:

- Your share of the cost of their health care coverage cannot be paid on a pre-tax basis. Costs will be deducted from your earnings after income and FICA taxes have been withheld.
- You cannot use the Health Care Reimbursement Account or the Dependent Care Assistance Plan to pay for their out-of-pocket expenses on a pre-tax basis.

In addition, the “imputed value” of their health care coverage (as determined by the IRS) will be reported as taxable wages. For more information, including an example of how “imputed value” is determined, please refer to the *Overview of Domestic Partnership*, available at [Costcobenefits.com](#).



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When Coverage Ends

Coverage under the Costco Employee Benefits Program ends at midnight on the date an employee or family member no longer meets the eligibility requirements, as described below. Benefits are not payable for expenses incurred after that date.

WHEN EMPLOYEE COVERAGE ENDS

Coverage ends on midnight of any of the following dates, whichever comes first:

- The date your employment ends for any reason including termination, voluntary resignation, retirement or [layoff](#).
- March 31 or September 30 after any benefit [measurement period](#) during which you averaged less than 23 [eligible paid hours](#) per week (20 in Hawaii).
- The date your employee classification changes if you have not completed the eligibility waiting period for your new classification.
- The last day of your maximum continuation period for coverage if you are on a [Leave of Absence](#).
- The day you begin a leave that is not a Leave of Absence.
- The last day of a Leave of Absence if you do not return to work.
- The date you fail to make any required contributions.
- The first day of an unauthorized work stoppage, as determined by Costco.
- The first day of a strike after your collective bargaining agreement expires.
- The last day of the calendar year if, during [Annual Enrollment](#), you decline to participate for the following year.
- The effective date of your mid-year election to decline participation, as permitted by the Program.
- The date the Program or an applicable plan is terminated.
- The date you no longer meet the Program's eligibility requirements.

- The date you change to an employee classification that is not benefits-eligible.

WHEN COVERAGE FOR FAMILY MEMBERS ENDS

Your family's coverage under the Program ends when your coverage ends. For individual family members, coverage also ends when they no longer meet Program eligibility requirements. This will apply, for example, to:

- Your spouse and stepchildren, if you get divorced or have your marriage annulled (regardless of any requirements specified in the divorce decree).
- Your domestic partner and your domestic partner's children, if your domestic partnership ends. This would happen, for example, if you and your partner no longer live together, or if your domestic partner dies.
- Children when they are no longer eligible as defined in [Eligible Family Members on page 7](#). For children losing eligibility due to reaching age 26, coverage ends on the last day of the month in which the eligible child turns 26.
- All family members, if you die.
- Any family members for whom you do not complete the annual dependent verification or for whom you do not, when asked, provide proof of continuing eligibility.

If a family member loses eligibility, you must notify Costco within 60 days after the event. You are responsible to repay any health care or other benefits they receive from the Program after they lose eligibility. If you do not notify Costco within 60 days, the family member will not be eligible for [COBRA](#).

To notify Costco, you must make changes on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**.



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COVERAGE OPTIONS AFTER ELIGIBILITY FOR BENEFITS ENDS

When eligibility under the Costco Employee Benefits Program ends:

- You may be able to purchase continued health care coverage for yourself and your family as described in [Continuation of Health Care Coverage \(COBRA\) on page 119](#),
- Resources for Living services will continue to be available to you and your family for up to 90 days, and
- Costco Life and AD&D Insurance plans are “portable.” This means that, in most cases, you can continue the same coverage on an individual basis. More information is included in the sections on those plans.

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- How the Plan Works
- Tobacco Quit Line
- myStrength

# Resources for Living

Resources for Living is our Employee Assistance Program (EAP), designed to help with a variety of personal, family and everyday needs. The program is available to all employees, members of their households and their adult children up to age 26. If you leave Costco, you can continue to use Resources for Living services for up to 90 days after your employment ends.

Resources for Living provides up to six no-cost counseling sessions per year. You choose how you access your counseling sessions – in person or as telehealth visits (by phone or virtually through your computer or mobile device). The program also offers tobacco cessation support through the Tobacco Quit Line, and digital and virtual care options through Talkspace and myStrength.

All information provided to Resources for Living is kept strictly confidential based on federal guidelines and the provisions described in [Confidentiality of Health Information on page 115](#).

## How the Plan Works

When you call Resources for Living, a Care Partner will help you access the benefits offered. Care Partners can listen to your concerns, guide you through your care options and connect you with the right provider or resources for your needs. Care Partners can even help you create a mental health care plan and schedule your first appointment.

To connect with a Care Partner:

- Call **833-721-2320** 24 hours a day, seven days a week.
- From [Costcobenefits.com](#), link to the Resources for Living website. You can chat live with a Care Partner or browse articles and other tools.

Services provided to you at no cost include:

- Counseling** – short-term evaluation and counseling sessions with a behavioral health professional. The plan provides up to six visits per year. You can choose to use your six sessions toward Talkspace, a network of providers that conducts counseling sessions exclusively through their telehealth virtual platform. When you choose a Talkspace counselor you also choose how to interact with your counselor – through video sessions or through text messaging through the Talkspace application.
- Information and resources** – to help with common life challenges, such as finding care for your children or elderly family members, or locating financial and legal information or assistance. Referrals are free and you pay for any services you choose to use.

If you require lengthier or more specialized services than Resources for Living is intended to provide, a Care Partner can help you determine your options. The decision to seek medical services is always up to you.

If you are enrolled in a Costco medical plan, behavioral health **covered expenses** beyond Resources for Living’s services may be partially paid through your health care coverage. See [Your Out-of-Pocket Costs on page 27](#) and the [Medical Plan Summary on page 30](#).

## Tobacco Quit Line

Resources for Living offers tobacco cessation coaching through the Tobacco Quit Line. The program is available to those age 18 and older, at no cost to you.

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How the Plan Works

The Tobacco Quit Line program offers personal coaching and online resources, plus access to over-the-counter nicotine replacement therapy. The program provides:

- *Telephone coaching* – You will connect with a coach who will help you develop an individualized quit plan. After this initial call, your coach will schedule up to five support sessions to review your progress and adherence to the quit plan. Coaches offer scheduled sessions Monday through Friday, from 8 a.m. to 8 p.m. Your coach will work with you to design a personal strategy for success.
- *Tobacco Quit Line website* – Link from [Costcobenefits.com](#) for access to online resources and support materials.

To get started, call Resources for Living at **833-721-2320**.

Nicotine Replacement Therapy

To help you through the stages of nicotine withdrawal, the plan offers over-the-counter nicotine replacement therapy in the form of Nicorette Gum, Nicoderm Patches, or Nicorette (Commit) Lozenges. When you enroll, the website or your Tobacco Quit Line coach will help you decide which form may work best for you. *You should consult with your personal physician to confirm these nicotine replacement aids are medically appropriate for you.*

Whichever form you elect, the plan covers a full course – that is, the dosage generally accepted by the medical profession to be adequate to complete your treatment.

The Tobacco Quit Line program **does not cover** prescription drug medications for smoking cessation. However, certain drugs are covered by the Prescription Drug Program (see [Prescription Drugs on page 50](#)).

myStrength

myStrength offers free and convenient support to help you learn to reduce stress, anxiety, depression or substance misuse.

myStrength’s custom online activities are designed to support your overall emotional well-being. As you use the program, you can monitor your progress and find inspiration from the myStrength community.

Link to myStrength from [Costcobenefits.com](#). The program is available to all employees and their family members.

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MEDICAL OPTIONS FOR HAWAII EMPLOYEES

This Medical section does not apply to Hawaii employees. If you are an eligible Hawaii employee, your medical options are:

- HMSA Health Maintenance Organization (HMO) and
- HMSA Preferred Provider Organization (PPO).

If you elect HMSA medical coverage, you automatically receive the coverage for [Prescription Drugs](#), [Vision and Hearing](#) described in this booklet, and you have the option of enrolling in [Dental](#) coverage.

A booklet describing your HMSA benefits is available at [hmsa.com](https://hmsa.com). Hawaii employees enrolled in HMSA medical coverage will receive a combined medical and dental ID card from HMSA, and a separate prescription drug card from Costco Health Solutions (CHS). For any questions related to your medical or dental benefits, call HMSA at **800-776-4672**.

The Costco Employee Benefits Program helps pay the costs of covered [medically necessary](#) and preventive care expenses.

For employees outside of Hawaii, Costco offers two medical plans administered by Aetna – Aetna Select and Aetna Select for Part-Time Employees. See the [Medical Plan Summary on page 30](#) for an overview of plan features. If you are a full-time employee classified during a [measurement period](#) as “part-time” for benefit purposes, you are only eligible for the part-time medical plan. See [Benefit Measurement Periods on page 5](#) for more information.

Aetna Select plans offer a network of participating [health care providers](#), including [behavioral health providers](#), [physicians](#), medical specialists, [walk-in clinics](#) and [hospitals](#).

**The plans do not pay benefits and you will get no credit toward your deductible or annual coinsurance and copay maximums for care you receive from a provider not in the plan’s network.**

If you enroll in an Aetna medical plan, you automatically receive [Prescription Drug](#) and [Vision and Hearing](#) coverage. You can choose to opt out of vision coverage. Medical plan participants also have the option of enrolling in [Dental](#) coverage.

YOUR OUT-OF-POCKET COSTS

When you incur [covered expenses](#), you may pay a share of the cost in the form of a copay, annual deductible, or coinsurance. These are called your out-of-pocket costs. As shown in the [Medical Plan Summary on page 30](#), your out-of-pocket costs will

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depend on the plan in which you are enrolled and the type of service or supply you receive.

**Copays**

A copay is the set dollar amount you must pay at the time you receive certain services or supplies. Aetna Select plans require a copay for any office visit with a primary care provider, specialist, or **behavioral health provider**, emergency room visits (waived if you're admitted as an inpatient to the **hospital**), hospital admissions, and certain other services and supplies.

**Annual deductibles**

Deductibles are the amounts (not including copays) that you will owe each calendar year toward the cost for **covered expenses** incurred in that year before your plan begins to pay benefits:

- *The individual deductible* applies separately to each covered family member.
- *The family deductible* applies to you and your covered family members on a combined basis. When the family deductible is satisfied, no further deductible needs to be met by any covered family member for the rest of that calendar year.

**Coinsurance**

Your coinsurance is the percentage of the cost for covered expenses you pay after you satisfy the annual deductible and any required copay. For example, if the plan pays 90% after the deductible for a covered service, the remaining 10% is your coinsurance.

**Annual coinsurance and copay maximums**

These are the most you will owe in coinsurance and copays per year for most covered expenses under your medical plan. If you reach

these maximums, the plan will pay 100% of most covered medical expenses for the rest of that calendar year.

Only your medical plan coinsurance can apply toward your annual coinsurance maximum, and only your medical plan copays can apply toward your annual copay maximum. The following amounts do not apply toward either maximum and your medical plan will not pay them even after you reach the annual maximums:

- Amounts for services or supplies that are not covered by the plan
- Amounts for non-network services or supplies
- Amounts you owe toward annual deductibles
- Your coinsurance and copays under the Prescription Drug Program (there is a separate maximum for this plan), Vision Care Plan, Dental Plan, or any other health care plan
- Penalties for failure to obtain pre-certification described in **Pre-Certification of Health Care Services on page 32**
- Your coinsurance and copays that are not for essential health benefits (as defined by law and the plan)

USING IN-NETWORK PROVIDERS

The Aetna medical plans only pay benefits for covered services and supplies if you and your enrolled family members use a participating provider from your plan's network, except in the case of an emergency, for involuntary services or if you are in an out-of-area plan.

There are several ways to find a participating provider:

- Click "Find a Provider"on [Costcobenefits.com](#).
- Use Aetna's mobile app (Aetna Health).
- Call Aetna at **800-814-3543**.



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**Carryover of deductibles, coinsurance maximum and copay maximum**

If your coverage starts and stops within the same calendar year, any amounts you previously paid toward the annual deductible and the annual copay and coinsurance maximums will count for the rest of that year.

The out-of-pocket expenses you incur in one calendar year do not count toward the next year’s maximum, even if you pay the expense in the next year.

**OUT-OF-NETWORK CARE EXCEPTION FOR EMERGENCIES AND INVOLUNTARY SERVICES**

The Aetna Select plans only cover in-network providers, except for:

- An emergency, and

- Unexpected bills from out-of-network providers (such as a lab or anesthesiologist) for a service or supply that was received at an in-network facility or from an in-network provider – an “involuntary service.”

These plans pay emergency and unexpected bills based on the lesser of the billed amount or the **Reasonable and Customary (R&C) charge** for the involuntary service or supply and you are responsible to pay the rest. This means you pay your copay, annual coinsurance and deductible for the amount under the R&C charge, and you receive no credit toward your out-of-pocket costs for the amount over R&C charges.

If you are billed by an out-of-network provider, patient advocacy services may be available to assist you in certain circumstances. You should contact Aetna Concierge at **800-814-3543** for more information.

**INSTITUTES OF QUALITY**

Aetna has developed a network of **hospitals** and other facilities that specialize in certain bariatric, cardiac, and orthopedic procedures. These facilities are known as Institutes of Quality (IOQ). Facilities earn IOQ status by showing a high level of quality, reasonable cost and other efficiencies, and other factors selected by Aetna.

If you choose to get your surgery done at an IOQ, Costco will cover 100% of the hospital or surgical facility charges. You will still have to pay your share of the charges associated with the surgeon, anesthesiologist and other non-facility charges. The procedure must meet all coverage requirements, such as being **medically necessary**.

**Find an IOQ**

Go to **Costcobenefits.com** and click “Find a Provider,” then select Aetna and search for hospitals. You’ll see the Institute of Quality note below the hospital’s name.

If there is no IOQ within 100 miles of your home address for a covered benefit, the program may reimburse you for pre-approved travel and lodging expenses for you and a companion as described in **Travel and Lodging on page 37**.

The program pays for IOQ charges, but you decide whether to receive care at an IOQ or other facility. Always consult with your doctor before making medical decisions – you are responsible for making your own health care choices.

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Aetna's Reimbursement Policies

Aetna applies their reimbursement policies to all out-of-network services, including involuntary services.

These policies consider:

The duration and complexity of a service

When multiple procedures are billed at the same time, whether additional overhead is required

Whether an assistant surgeon is necessary for the service

If follow-up care is included

Whether other characteristics modify or make a particular service unique

When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided

MEDICAL PLAN SUMMARY

The table below and on the following page shows your share of the cost for **covered expenses** for services and supplies received from a network covered provider. The cost is the **negotiated rate**. Benefits for **Prescription Drugs** and **Vision and Hearing** are outlined later in this booklet on **page 50** and **page 55**.

	Select Plan	Part-Time Select Plan
Plan features		
Annual deductible	\$250 individual \$500 family	\$550 individual \$1,100 family
Annual coinsurance maximum	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family
Annual copay maximum	\$4,800 individual \$9,600 family	\$3,500 individual \$7,000 family
Covered services	Amount you pay	
Preventive care (Routine physicals <sup>1</sup> , mammograms, sigmoidoscopies, colonoscopies, well-baby care)	\$0	\$0
Walk-in clinics	\$10 copay	\$15 copay
Primary care provider office visit	\$15 copay	\$20 copay

1 The plan also includes an Executive Physical Program for employees who also participate in the Costco Employee Benefits Program's medical benefits, which is described in a separate document that is incorporated herein by reference.

- The educational level, licensure or length of training of the provider
- Aetna's reimbursement policies may also consider:
- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate

Generally accepted standards of medical and dental practice

The views of **physicians** and dentists practicing in the relevant clinical areas

Aetna's own data and/or databases and methodologies maintained by third parties

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

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	Select Plan	Part-Time Select Plan
Covered services	Amount you pay	
Specialist office visit	\$25 copay	\$30 copay
98point6 visit	\$5 copay	\$5 copay
Outpatient services	10% after deductible	20% after deductible
Outpatient surgery	\$75 copay, then 10% after deductible	\$75 copay, then 20% after deductible
Emergency room <sup>2</sup>	\$150 copay, then 10% after deductible	\$150 copay, then 20% after deductible
Inpatient facility fees <sup>3</sup>	\$150 copay, then 10% after deductible	\$150 copay, then 20% after deductible
Institute of Quality (IOQ) facility fees	\$0	\$0
Physician services for surgery/hospital visits	10% after deductible	20% after deductible
X-rays	10% after deductible	20% after deductible
Lab tests	10% after deductible; \$0 at Quest Diagnostics	20% after deductible; \$0 at Quest Diagnostics
Alternative care (acupuncture, chiropractic, homeopath, naturopath) <sup>4</sup>	\$15 copay, up to 20 visits per year	\$20 copay, up to 20 visits per year
TMJ treatment (\$2,000 lifetime maximum for non-surgical treatment)	\$25 copay for office visit, 10% after deductible for other services	\$30 copay for office visit, 20% after deductible for other services
Short-term rehabilitation (Physical, speech and occupational therapy)	10% after deductible, up to 25 visits per condition	20% after deductible, up to 25 visits per condition
Habilitative services (to treat Cerebral Palsy, Autism Spectrum Disorder or Down syndrome)	10% after deductible	20% after deductible
Radiologist, anesthesiologist, pathologist services	10% after deductible	20% after deductible
Skilled nursing convalescent facility	10% after deductible, up to 60 days per year	20% after deductible, up to 60 days per year
Private duty nursing	10% after deductible, up to 70 shifts per year	20% after deductible, up to 70 shifts per year
Home health care	10% after deductible, up to 120 visits per year	20% after deductible, up to 120 visits per year
Hospice care (inpatient and outpatient)	10% after deductible	20% after deductible
Respite care, on a limited and temporary basis, when approved as part of the Aetna Compassionate Care Program. 15 days lifetime maximum.	10% after deductible	20% after deductible

2 If your ER visit to a non-participating facility results in an inpatient stay, pre-certification is required. \$200 penalty for failure to comply with pre-certification requirement when using out-of-network providers.

3 Copay applies to each admission. Stays separated by less than 10 days will be considered a single admission.

4 Alternative care is limited to a total of 20 visits per year for all practitioners (chiropractic, acupuncture, homeopath and naturopath). Claims for services provided by out-of-network naturopathic and homeopathic providers will be paid at the in-network benefit.

5 Based on medical necessity, Aetna may approve additional short-term rehabilitation visits of up to 90 per calendar year.

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IF YOU WORK IN ALASKA, OR CLARKSTON, WASHINGTON, OR EUREKA, CHICO, HANFORD, UKIAH OR VISALIA, CALIFORNIA: OUT-OF-AREA PLAN

Alaska, Clarkston, Washington, and Eureka, Chico, Hanford, Ukiah and Visalia, California are considered “out of area”, meaning few or no Aetna Select network providers are available nearby. For this reason, employees at these [locations](#) and their family members are eligible for the Aetna Select Out-of-Area medical plan, which will pay benefits at the in-network level for [covered expenses](#) from any qualified [health care provider](#).

If you are in the Aetna Select Out-of-Area plan, an Aetna network provider may still be available in your region. If so, you may want to use network providers because they’ve generally agreed to limit their charges for covered expenses to the [negotiated rate](#). If you use any other health care providers, Aetna pays covered expenses based on [Aetna’s Reimbursement Policies on page 30](#) and the [Reasonable and Customary \(R&C\) charges](#). Unless those providers have agreed to accept the R&C charge as payment in full, they may charge more than the R&C charge and you’ll be responsible for the excess.

You’ll be notified if your location is out of area and whether an Aetna network provider or other arrangement is available to you. For a list of these providers, you can click on “Find a Provider” at [Costcobenefits.com](#). You may also call Aetna at **800-814-3543**.

MEDICAL PLAN ID CARDS

You and your family members enrolled for health care coverage through Aetna will receive medical plan identification cards after you’re enrolled. If you are enrolled in dental coverage, your medical and dental information is printed on one card. The card contains important information about your coverage, such as your group plan number. Use your ID card when you visit a medical or dental plan provider. All employees enrolled for health care coverage will receive a separate prescription drug card from Costco Health Solutions (CHS).

You can link to the Aetna member website from [Costcobenefits.com](#) to print out temporary ID cards or request replacement cards. If you have employee-only coverage, you will get one card. If you have family coverage, you will get two cards listing the names of everyone enrolled for coverage, including you. Contact Aetna if you need additional cards.

PRE-CERTIFICATION OF HEALTH CARE SERVICES

If you are hospitalized or receive certain other kinds of health care, Aetna must pre-certify those services to determine whether they are [medically necessary](#) and otherwise considered a covered expense by your Aetna medical plan.

Even if your care is later determined to be medically necessary, without the required pre-certification your plan will not pay the first \$200 of covered expenses it would otherwise pay. In any case, pre-certification does not guarantee reimbursement of services or supplies.

In-network providers are responsible for submitting pre-certification requests to Aetna on your behalf. If they do not, you are not responsible for any pre-certification penalty. Out-of-network care is not covered and will be your responsibility to pay, except in the case of an emergency, involuntary services or if you are in the Aetna Select Out-of-Area plan. In addition, if there are no in-network providers in your area, you should contact Aetna to request an exception. For more information about how pre-certification claims are decided, see [Health Care Claim Determination Before Service or Treatment \(Pre-Certification\) on page 134](#).

Pre-certification is required for services and supplies related to:

1. Inpatient or overnight stays at an [inpatient facility](#) or other facility

2. [Partial hospitalization](#) or intensive outpatient visits or services

3. [Skilled nursing convalescent facility](#), skilled nursing facility, hospice facility, [psychiatric hospital](#), [residential treatment facility](#)

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or rehabilitation facility visits or overnight stays. (Emergency admissions will be reviewed retrospectively.

4. **The following services and supplies**, whether provided on an inpatient or outpatient basis:

- » Air ambulance, non-emergency
- » Arthroscopic hip surgery to repair impingement syndrome including labral repair
- » Autologous chondrocyte implant (such as cartilage implant to the knee)
- » Cataract surgery
- » Chiari malformation decompression surgery
- » Cochlear implants
- » Clinical trial therapies
- » Dorsal column neurostimulators
- » Genetic counseling and testing
- » Hyperbaric oxygen therapy
- » Limb prosthetics
- » Medical injections, certain injectable drugs which must be administered by a health care professional — Costco allows the first infusion or injection at the in-network location/[hospital](#) of choice (higher-cost facility). Infusions/injections continuing beyond 90 days, or, if shorter, the timeframe specified in your pre-certification, will only be covered if received through home care or an outpatient infusion center. Requests to continue treatment at a higher-cost facility will be denied unless there is an [emergency medical condition](#) or it is [medically necessary](#) to use the higher-cost facility.
- » Motorized wheelchairs
- » Oral and maxillofacial surgical procedures
- » Osseointegrated implant
- » Osteochondral allograft/knee
- » Plastic surgery, reconstructive surgery
- » Private duty nursing
- » Proton beam radiotherapy
- » Skilled nursing care and [home health care](#)
- » Shoulder replacement surgery
- » Spinal procedures such as artificial intervertebral disc surgery, cervical, lumbar and thoracic laminectomy, spinal fusion surgery (also requires an expert second opinion through 2nd.MD)
- » Surgery to treat the underlying cause of infertility
- » TMJ (temporomandibular joint) surgery
- » Transcranial Magnetic Stimulation (TMS)
- » Uvulopalatopharyngoplasty
- » Ventricular assist devices
- » Video EEG
- » Whole exome sequencing

The list of health care services and supplies that must be pre-certified may change from time to time – for the most up-to-date information, link to the Aetna member website from [Costcobenefits.com](#) or call Aetna at **800-814-3543**.



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EXPERT SECOND OPINION REQUIREMENT FOR SPINE SURGERY

In addition to pre-certification, spinal surgery of the neck and/or back for any patient age 18 or older requires an expert second opinion through 2nd.MD. The pre-certification process will not begin until you complete the second opinion requirement.

Expenses related to your surgery (surgeon, [hospital](#), anesthesiologist, etc.) will not be covered by your Costco Aetna Select medical plan unless you complete the expert second opinion requirement (in addition to the pre-certification requirement) prior to having surgery.

The expert second opinion requirement applies to any elective (excluding emergency medical conditions) spinal surgery on your neck and/or back, such as artificial intervertebral disc surgery, cervical,

Covered Services

Costco's medical plans cover [medically necessary](#) and certain preventive care services. This section provides details on some of the services covered, but it is not an exhaustive list of services covered by the plans.

COVID-19 TESTING

FDA-authorized COVID-19 diagnostic testing is covered 100% by the Aetna medical plans, to the extent required by the Families First Coronavirus Response Act.

PREVENTIVE CARE BENEFITS

Preventive care benefits are designed to encourage you and your family to make regular visits to your [physician](#) for routine preventive care. Regular check-ups and age-appropriate routine tests can lead to the early detection and treatment of potentially serious conditions – or even help you avoid some illnesses altogether.

lumbar and thoracic laminectomy, and spinal fusion surgery. You are not obligated to follow the recommendations provided through the expert second opinion.

To request an expert second opinion, go to [Costcobenefits.com](#) and click 2nd.MD, or call 2nd.MD at **833-579-2509**. Learn more about [2nd.MD on page 45](#).

Please note, when you initiate an expert second opinion with 2nd.MD for spine surgery, you are authorizing 2nd.MD to share with Aetna your written expert second opinion and other information submitted to 2nd.MD. Your surgery must still meet Aetna's medical necessity and clinical policy guidelines. 2nd.MD does not make decisions on whether a surgery is covered under the plan; this is ultimately determined by Aetna.

Routine preventive services and supplies are covered 100% by the Aetna medical plans, to the extent required by the Affordable Care Act. The plan uses reasonable medical management techniques (such as age, frequency, location and method) to determine whether a service or supply is preventive care and covered by the plan. Below is a brief summary of preventive care services covered by the medical plans. You can link to the most current preventive care guidelines from [Costcobenefits.com](#), or call Aetna at **800-814-3543**. Please remember that if you receive more than just preventive services during a doctor appointment, normal cost-sharing will apply to the non-preventive care.

• **Well baby and child care**, including routine office exams, lab services and supplies related to the exams, and immunizations for infectious disease as recommended by the American Medical Association for:

» 7 exams in the first 12 months of life



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What's Not Covered

- » 3 exams in the second 12 months of life
- » 3 exams in the third 12 months of life
- » 1 exam each year after that (ages 4 and 5)
- **Routine annual physical exams** for plan participants age 6 and above, one per person per calendar year. This includes a yearly physician's exam along with associated gender- and age-appropriate tests and screenings and immunizations for infectious diseases.
- **Other covered routine preventive care**, including:
  - » Annual gynecological exam, one per calendar year including a Pap smear
  - » Annual mammogram
  - » Annual prostate specific antigen (PSA) test, recommended one per calendar year starting at age 40
  - » Sigmoidoscopies (recommended once every 5 years starting at age 50), and colonoscopies (recommended once every ten years starting at age 50)
  - » Bone density screening for women who have been determined to be estrogen-deficient (pre-or post-menopausal) and men age 50 or older with specific risk factors for osteoporosis, for example, due to low body weight, weight loss, or physical inactivity
  - » Low-dose chest X-rays as described in Aetna's Clinical Policy Bulletin #0380
  - » Routine immunizations, as recommended by the Advisory Committee on Immunization Practices (ACIP) and required by the Affordable Care Act, are covered at 100%. This includes the following:
    - » Children (0-18 years): Haemophilus influenza type b, Hepatitis A and B, Human Papillomavirus, Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Tetanus, Diphtheria, Pertussis, Varicella
    - » Adults (19+ years): Hepatitis A and B, Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal,

Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella, Zoster (Herpes Zoster)

This includes shots you receive from a participating provider, Costco Pharmacy or Costco-designated network pharmacy. Immunizations for travel to foreign countries are not covered. Call Aetna at **800-814-3543** for a current list of immunizations covered at 100%.

ALTERNATIVE CARE

The Aetna medical plans cover the following alternative care, up to a combined maximum of 20 visits per calendar year for both kinds combined:

- *Spinal disorder treatment*, manipulative or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorder of the spine, including services performed by a chiropractor or Doctor of Osteopathy (DO)
- *Acupuncture, homeopath or naturopath treatment*, office visits and diagnostic and laboratory procedures

Benefits for services from out-of-network naturopathic and homeopathic providers will be paid at the in-network level. All other services must be received by in-network providers to receive coverage.

The plans do not cover vitamins (except certain prescribed prenatal vitamins, covered through the Prescription Drug plan), minerals, herbs, homeopathic preparations or care provided by a doula, Christian Science practitioner, massage therapist, or non-certified midwife.

APPLIED BEHAVIOR ANALYSIS BENEFITS

The Aetna medical plans cover applied behavior analysis (ABA) for the treatment of **Autism Spectrum Disorder**. ABA is a therapy that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for the observable improvement in behavior.

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What’s Not Covered

ABA providers must be independently licensed professionals such as clinical social workers, clinical psychologists, or master’s level therapists; or they must be behavior analysts certified by the Behavior Analyst Certification Board.

ABA may be provided in an office setting, in the home or in another community setting outside of the classroom. Services provided in the classroom setting are not covered.

MENTAL DISORDER AND SUBSTANCE USE DISORDER BENEFITS

The Aetna medical plans pay benefits for **medically necessary** treatment of **mental disorders** and **substance use disorders**. These benefits are subject to the same deductibles, copays and coinsurance as other **covered expenses**. For a quick look at how benefits are paid, see the **Medical Plan Summary on page 30**.

Using participating behavioral health providers

As with most covered expenses, your Aetna medical plan will only pay benefits for services you receive from in-network providers. Aetna offers a nationwide network of **behavioral health providers**, including:

- **Behavioral health professionals**, such as psychiatrists, **psychiatric physicians**, clinical psychologists, clinical social workers, masters-level licensed therapists, marriage, family and child therapists, and certified psychiatric behavioral health nurses
- **Facilities**, such as **hospitals**, **psychiatric hospitals**, and **residential treatment facilities**

You can locate a participating behavioral health provider near you by clicking on “Find a Provider” at **Costcobenefits.com**. You can also call Aetna at **800-814-3543**.

What the plans cover

Office visits to **behavioral health providers** are covered the same as any other **physician** office visits. (Don’t forget,

**Resources for Living described on page 25** offers short-term counseling services, up to six visits each year, free of charge.)

The plans also pay benefits for intermediate short-term or intensive hospital and other facility-based services. Examples include inpatient care (24-hour-a-day hospitalization), **detoxification**, **partial hospitalization** (stays for conditions that do not require full-time hospitalization), and **intensive outpatient treatment**.

GENDER AFFIRMING BENEFITS

The Aetna medical plans cover medically necessary services and supplies to support gender affirming care. This can include counseling, pharmacy benefits and reassignment surgery. Surgery benefits are limited to those outlined in Aetna’s Clinical Policy Bulletin #0615.

ORGAN TRANSPLANTS

The Aetna medical plans cover organ transplants that are pre-certified by Aetna and managed by the National Medical Excellence® (NME) program. Examples of transplants that may be covered include:

- Bone marrow/stem cell
- Eye
- Heart
- Intestine
- Kidney
- Liver
- Lung
- Pancreas
- Sequential transplants
- Simultaneous pancreas kidney (SPK)
- Tandem transplants (stem cell)
- Multiple organs replaced during one transplant surgery
- Any other single organ transplant unless otherwise excluded under your Aetna medical plan

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What the plans pay

If pre-certified by Aetna and managed by NME, the plans will pay benefits for covered services and supplies for organ recipients enrolled for Costco medical coverage as well as for their donors, even those who are not Aetna medical plan participants. Where your organ transplant is performed will determine how the medical plans pay your **covered expenses**.

- **Institute of Excellence** – Institutes of Excellence are hospitals that belong to a national network of facilities specializing in organ transplants. If you receive an organ transplant at an Institute of Excellence, the facility fees will be paid at 100%. Physician services and other fees are subject to the regular deductible, copay and/or coinsurance amounts.
- **In-network transplant hospitals** – Transplants, including stem cell and bone marrow transplants, received at an in-network hospital that is not an Institute of Excellence will be subject to the copays, deductibles and coinsurance that apply to any other hospital stay under the covered member's medical plan.
- **Medicare-certified organ transplant hospitals** – Organ transplants received at a hospital that is not an Institute of Excellence and is not in Aetna's network but has been certified by **Medicare** for that procedure will be subject to the copays, deductibles and coinsurance that apply to other in-network hospital stays.
- **All other medical facilities** – Transplants received at any other facility will not be covered.

TRAVEL AND LODGING

Travel and lodging benefits are available to enrolled patients for whom it is medically necessary to travel away from home to get the treatment they need.

Benefits are only provided for travel to a facility that is 100 miles or more from the patient's home or further than the facility's mileage and/or travel time requirements.

To qualify for payment, travel and lodging expenses must be pre-certified by Aetna. Subject to Aetna's pre-certification, travel and lodging benefits will be payable for each patient plus one companion as follows:

1. **Travel** – Round trip via the most direct route to the facility where treatment will be received.
  - **Air transportation** – round trip airfare up to the cost of coach class commercial air transportation
  - **Ground transportation** (if the distance exceeds 100 miles) – round-trip transportation to the facility by rental car, train or bus (fares for patient and one companion), or mileage if driving your car (at the standard IRS rate) for your travel to the facility from your home. Rental car reimbursement is limited to a mid-sized vehicle.
2. **Lodging** – up to \$200 per day, only for days that the patient is receiving services from the facility and regardless of the number of people traveling.
3. **Meals** – up to \$75 per day, regardless of the number of people traveling.

These benefits will be taxable to you to the extent they exceed IRS limits. Your W-2 will reflect the taxable amount.

Maximum reimbursement

The maximum reimbursement for travel and lodging is \$10,000 for any single **illness**. All receipts for expenses must be submitted to Aetna within six months of when they were incurred.

What's not covered

- Travel and lodging benefits are not payable for:
- Expenses incurred without pre-certification by Aetna
  - Medical conditions that are not covered by the Aetna medical plans
  - Audio, dental or vision care
  - Reimbursement of airline miles used to obtain tickets



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What’s Not Covered

- Meals and lodging except as specified
- Local ground transportation such as airport shuttles or taxi cabs

EMERGENCY AND URGENT CARE CONDITIONS

In the event of an [emergency medical condition](#), seek help immediately and go to the nearest [hospital](#) emergency room facility. However, *the plans do not cover emergency room care for a non-emergency medical condition.*

If you need treatment for an [urgent care condition](#), the plan will pay for the [covered expenses](#) of a network [urgent care provider](#), such as a freestanding clinic. Treatment at an out-of-network provider will not be covered.

WEIGHT MANAGEMENT SERVICES

The Aetna medical plans cover weight management services provided by [physicians](#), hospitals, licensed or certified dietitians or nutritionists for the non-surgical treatment of obesity on an outpatient basis. This includes:

- An initial medical history and physical exam,
- Diagnostic tests given or ordered during the initial exam,
- On-going visits with the above providers for the purpose of monitoring and evaluating progress.

If [medically necessary](#), surgical treatment for [morbid obesity](#) will be covered under the medical plan. The surgical treatment must comply with the guidelines set by the [National Institutes of Health](#) and be pre-certified by Aetna.

The Omada program, described on [page 46](#), can help Aetna Select medical plan members who are at risk for certain chronic diseases or who are living with diabetes.



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What's Not Covered

What's Not Covered

In addition to the other limitations and exclusions discussed throughout this and other sections of this booklet, the following are not covered.

1. Services or supplies that are not prescribed, recommended, or approved by your attending **physician** or dentist (if appropriate)

2. Services or supplies that are not **medically necessary** for the diagnosis, care, or treatment of **illness** or **injury** (even if they are prescribed, recommended, or approved by your attending physician or dentist) except for preventive care

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

4. Non-emergency or non-urgent services or supplies received outside the U.S.

5. Services or supplies for an illness, injury or condition that:

» Arises out of or is aggravated by, or in the course of, any activity engaged in for pay or profit, or

» Is eligible for payment under a workers' compensation or occupational disease law, regardless of whether the individual applied or was enrolled

6. Charges payable (or that would be payable in the absence of plan coverage) under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage

7. For Costco employees in Texas, services or supplies for an illness or injury that arises out of your "course and scope of employment," as those terms are defined in the Costco Wholesale Corporation Texas Injury Benefit Plan

8. Assisted reproductive technologies or any services or supplies to assist, facilitate, permit or promote conception or fertilization, although the plan will pay benefits for **covered expenses** related

to an illness underlying the infertility. Examples of excluded services include, but are not limited to:

» Artificial insemination

» In-vitro fertilization

» Gamete Intrafallopian Transfer (GIFT)

» Zygote Intrafallopian Transfer (ZIFT)

» Surrogate or gestational carrier

9. Temporomandibular joint (TMJ) or other **jaw joint disorder** treatment, except under the Aetna medical plans which may pay for covered expenses related to the treatment (maximum lifetime benefit for non-surgical treatment of \$2,000 per person)


10. Any claims or requests for authorization submitted more than one year after services have been rendered or supplies delivered (unless eligible through the Temporary Coronavirus Emergency Extension Rule)

11. Charges in excess of the **Reasonable and Customary (R&C) charge** or the **negotiated rate**, as applicable

12. Cosmetic treatment or surgery, plastic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance but do not correct or materially improve a physiological function, whether or not for psychological or emotional reasons. This exclusion does not apply to the extent services and supplies are medically necessary for any of the following:

» Surgery needed to improve a significant functional impairment of a body part that is not a tooth or structure that supports the teeth


» Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment and the surgery is needed to improve function




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What's Not Covered

- » As a direct result of [illness](#) or [injury](#) or surgery performed to treat an illness or injury
- » To reconstruct a breast following a mastectomy, as required under the Women's Health and Cancer Rights Act
- 13. Any services and supplies which are covered in whole or in part under any other part of the Costco Employee Benefits Program or any other group benefit plans provided by Costco. For example, your medical plan will not pay benefits for services paid by the dental plan and vice versa.
- 14. Acupuncture, except as described under the plan's alternative treatment benefit or when performed by a [physician](#) as a form of anesthesia in connection with surgery that is covered under this plan
- 15. [Experimental or investigational](#) services or supplies. However, this exclusion will not apply to drugs, devices, treatments or procedures under an approved clinical trial when you have cancer or a terminal illness, and **all** of the following conditions are met:
  - » Standard therapies have not been effective or are inappropriate
  - » Based on published, peer-reviewed scientific evidence, you may benefit from the treatment, and
  - » You are enrolled in an approved clinical trial that meets these criteriaAn approved clinical trial is a clinical trial that meets these criteria:
  - » The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
  - » The clinical trial has been approved by an Institutional Review Board that will oversee the investigation
  - » The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization

- » The trial conforms to standards of the NCI or other applicable federal organization
- » The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution
- » You are treated in accordance with the protocols of that study
- 16. Weight control services, including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications, exercise programs, exercise or other equipment, and other services and supplies that are primarily intended to control weight or treat obesity, including [morbid obesity](#), or for the purpose of weight reduction, regardless of the existence of co-morbid conditions, except as described under [Weight Management Services on page 38](#) or as required by law
- 17. Fraudulent claims
- 18. Expenses a person is not legally required to pay, or for which a provider waives the deductible or coinsurance, or made only because there is health coverage
- 19. Illness or injury arising or aggravated as a result of war, declared or undeclared; invasion; or participation in civil insurrection or a riot; or atomic explosion
- 20. Education, educational therapy, special education or job or vocational training, regardless of the treatment setting and whether or not given in a facility that also provides health, medical or psychiatric treatment
- 21. Treatment in a classroom, training facility or school
- 22. Non-emergency care received outside the United States (except for employees on U.S. payroll assigned to Costco [locations](#) outside of the United States)
- 23. Services or supplies while incarcerated or confined in jail or prison
- 24. Charges for missed appointments; interest charges on unpaid balances; charges for medical records, completing of forms or reports or patient management problems



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- 25. Any condition, disability, [injury](#) or [illness](#) resulting from being engaged in an illegal occupation or activity, or commission or attempted commission of an assault or illegal act
- 26. Services or supplies for illness or injury arising or aggravated during or as a result of duty as a member of the armed forces of any state or country (unless exclusion would violate the Uniformed Services Employment and Re-Employment Rights Act or applicable law)
- 27. Services or supplies required by an employer as a condition of employment; examinations that the employer is required to provide under a labor agreement; services or supplies required by any law of any government; or services or supplies that are required to be provided by any school system
- 28. Recreational services, supplies, treatment or therapy, self-help training
- 29. Services or supplies furnished by or for a governmental institution or agency or pursuant to any government or Indian Health Care program under which the individual is or could be eligible, unless this exclusion is prohibited by law
- 30. Court-ordered care, treatment, services or supplies
- 31. Charges payable under any other program, plan, or insurance, or recoverable from any third party (or that would be recoverable but for coverage under this plan), except as specified under the coordination of benefits or subrogation provisions of the Costco Employee Benefits Program
- 32. Medical food or any other food except for:
  - » [Medically necessary](#) food supplements ingested through a stomach tube (enteral feedings), or Phenylketonuria (PKU) formula, prescribed by a [physician](#) for an enrolled child
- 33. Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, vision therapy, orthoptic training/therapy, or carbon dioxide therapy
- 34. Sex therapy and all related services and supplies associated with sexual dysfunction, deviations or disorders, or inadequacies or

- complications arising there from, including therapy, supplies or counseling. However, the plan will cover services and supplies to support gender affirming care as described above.
- 35. Hormone replacement drugs, except to support gender affirming care
  - 36. Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ, except as medically necessary to support gender affirming care
  - 37. Surgery to treat gynecomastia, including breast reduction, surgical mastectomy or liposuction, either unilateral or bilateral
  - 38. Emergency room services for a condition that is not an [emergency medical condition](#)
  - 39. Services of a resident physician or intern rendered in that capacity
  - 40. Services and supplies furnished, paid for, or for which benefits are provided or required under any law of a government. This exclusion will not apply to “no fault” auto insurance if it is:
    - » Required by law
    - » Provided on other than a group basis, and
    - » Included in the definition of “other plan” in the coordination of benefits and subrogation provisions of the Costco Employee Benefits ProgramIn addition, this exclusion will not apply to a plan established by a government for its own employees or their eligible family members or to Medicaid.
  - 41. Hypnotism, personal blood storage, hair removal, or stress management
  - 42. Biofeedback, except when medically necessary in certain specific circumstances
  - 43. [Custodial care](#), including related services and supplies, domiciliary care, or care in a home for the aged



ELIGIBILITY AND ENROLLMENT	RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
DENTAL	DISABILITY INSURANCE	LIFE AND ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS	LIFE EVENTS	LEGAL AND CLAIMS INFORMATION
<div>Medical</div> <div>Medical Options for Hawaii Employees</div> <div>Your Out-of-Pocket Costs</div> <div>Using In-Network Providers</div> <div>Out-of-network care exception for emergencies and involuntary services</div> <div>Institutes of Quality</div> <div>Medical Plan Summary</div> <div>If You Work in Alaska, or Clarkston, Washington, or Eureka, Chico, Hanford, Ukiah or Visalia, California</div> <div>Medical Plan ID Cards</div> <div>Pre-Certification of Health Care Services</div> <div>Expert Second Opinion Required for Spine Surgery</div> <div>Covered Services</div> <div>COVID-19 Testing</div> <div>Preventive Care Benefits</div> <div>Alternative Care</div> <div>Applied Behavior Analysis Benefits</div> <div>Mental Disorder and Substance Use Disorder Benefits</div> <div>Gender Affirming Benefits</div> <div>Organ Transplants</div> <div>Travel and Lodging</div> <div>Emergency and Urgent Care Conditions</div> <div>Weight Management Services</div> <div>What's Not Covered</div>	<div>44. Respite care, which is care that allows the family member or usual caretaker a reprieve from the emotional and physical demands of caring for a <b>terminally ill</b> patient, except as pre-approved and provided through the Aetna Compassionate Care Program and limited to 15 days lifetime maximum</div> <div>45. Removal of scars or tattoos, repair of intentional piercings or tears</div> <div>46. Examinations or testing in order to obtain insurance</div> <div>47. Services or supplies solely for purposes of medical research, except to the extent required by law</div> <div>48. Services or supplies for judicial or administrative proceedings or orders, or to obtain a license or official document</div> <div>49. Durable medical equipment, including but not limited to whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids or telephone alert systems. However, the plan will cover an item of equipment, and the accessories needed to operate it, provided it is:<div>» Made to withstand prolonged use</div><div>» Made for and mainly used in the treatment of an <b>illness</b> or <b>injury</b></div><div>» Suited for use in the home</div><div>» Not normally of use to persons who do not have an illness or injury</div><div>» Not for use in altering air quality or temperature, and</div><div>» Not for exercise or training.</div>The plan will cover no more than one item of such equipment for the same or similar purpose.</div> <div>50. Abortions, unless deemed <b>medically necessary</b> because the life of the mother is in danger if the child is carried to full term; or in cases of incest, rape, congenital or genetic deformities</div> <div>51. Maternity benefits (other than preventive care required by law and the Aetna Maternity Support Program) for:<div>» eligible family members other than for spouses or domestic partners who are enrolled for medical plan benefits, or</div></div>	<div>» any covered person acting as a surrogate or gestational carrier for pay or profit</div> <div>52. The medical plan will not cover dental care, orthodontics or oral surgery, except for medically necessary care for injury to sound natural teeth</div> <div>53. External prostheses to replace prostheses due to loss, theft or destruction</div> <div>54. Eye surgery on a voluntary basis, such as Lasik, keratotomy or similar procedures to correct eyesight</div> <div>55. Reversal of sterilization procedures such as vasectomies or tubal ligations</div> <div>56. <b>Physical, speech</b> and <b>occupational therapies</b> for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate) or for <b>Autism Spectrum Disorder</b>, Down syndrome or Cerebral Palsy</div> <div>57. Chiropractic manipulation or therapy while under anesthesia</div> <div>58. Services provided by a massage therapist</div> <div>59. Immunization for travel outside the United States</div> <div>60. Home births, including related supplies or services</div> <div>61. Treatment of a covered <b>health care provider</b> who receives treatment as a part of their training in their field</div> <div>62. Treatment of:<div>» Impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use (except as otherwise covered under Resources for Living's Tobacco Quit Line program or the Prescription Drug plan)</div><div>» Antisocial personality disorders</div></div> <div>63. Wilderness, outdoor, survival, camp or similar programs, treatments or experiences</div> <div>64. Treatment of intellectual disability</div>			

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Covered Services

- COVID-19 Testing
- Preventive Care Benefits
- Alternative Care
- Applied Behavior Analysis Benefits
- Mental Disorder and Substance Use Disorder Benefits
- Gender Affirming Benefits
- Organ Transplants
- Travel and Lodging
- Emergency and Urgent Care Conditions
- Weight Management Services

What's Not Covered

- 65. Pastoral counseling, services or treatment for marriage, religious, family, career, social adjustment or financial counseling
- 66. Facility charges for services or supplies provided in rest homes, assisted living facilities, or similar institutions serving as an individual's primary residence or providing primarily custodial or rest care; health resorts; spas; sanitariums; or infirmaries at schools, colleges or camps
- 67. Charges for personal items primarily for convenience or comfort. Examples include: exercise equipment; telephone; television; internet; barber, beauty or guest services; housekeeping services such as cooking, cleaning, shopping; monitoring, security or other home services; travel, transportation, or living expenses; rest cures; recreational or diversional therapy.
- 68. Services provided where there is no evidence of pathology, dysfunction, [injury](#), [illness](#) or disease; except as specifically provided in connection with covered routine care and cancer screenings
- 69. Services for which an alternative less intensive place of service can provide a medically appropriate level of care (such as acute rehabilitation if skilled nursing rehabilitation is available, home infusion or outpatient infusion center for medicine in lieu of a [hospital](#), etc.)
- 70. Routine foot care. Foot care is considered non-routine and covered only in the following circumstances when [medically necessary](#):
  - » The non-professional performance of the service would be hazardous for the member because of an underlying condition or disease
  - » Routine foot care is performed as a necessary and integral part of an otherwise covered service (e.g., debriding of a nail to expose a subungual ulcer, or treatment of warts), or
  - » Debridement of mycotic nails is undertaken when the mycosis/dystrophy of the toenail is causing secondary infection and/

or pain, which results or would result in marked limitation of ambulation and require the professional skills of a provider.

- 71. Complementary and alternative medicine (except as described under [Alternative Care on page 35](#)), including:
  - » Aromatherapy
  - » Bioenergetic therapy
  - » Carbon dioxide therapy
  - » Chelation therapy (except for heavy metal poisoning)
  - » Computer-aided tomography (CAT) scanning of the entire body
  - » Educational therapy
  - » Gastric irrigation
  - » Hair analysis
  - » Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds as outlined in Aetna's Clinical Policy Bulletin: [aetna.com/cpb/medical/data/100\\_199/0172.html](#)
  - » Hypnosis, and hypnotherapy, except when performed by a [physician](#) as a form of anesthesia in connection with covered surgery
  - » Lovaas therapy
  - » LEAP, TEACCH, Early Start Denver Model, Pivotal Response Treatment, Verbal Behavior Therapy, Floortime, Relationship Development Intervention, and SCERTS (Social Communication/Emotional Regulation/Transactional Support)
  - » Non-evidence-based therapies
  - » Massage therapy
  - » Megavitamin therapy
  - » Primal therapy
  - » Psychodrama
  - » Psychiatric home care services
  - » Purging



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- » Recreational therapy
  - » Rolfing
  - » Sensory or auditory integration therapy
  - » Sleep therapy
  - » Thermograms and thermography
72. Prescription drugs that are not on the medical plan’s formulary list. Formulary drugs may be subject to step therapy protocols and/or additional pre-certification requirements. The drugs subject to these rules change from time to time. Contact Aetna for the current formulary, step therapy, and pre-certification lists.

Covered Services

- COVID-19 Testing
- Preventive Care Benefits
- Alternative Care
- Applied Behavior Analysis Benefits
- Mental Disorder and Substance Use Disorder Benefits
- Gender Affirming Benefits
- Organ Transplants
- Travel and Lodging
- Emergency and Urgent Care Conditions
- Weight Management Services

What’s Not Covered



Special programs and health support

International SOS

2nd.MD

Able To

98point6

Omada

Diabetes Prevention and Diabetes Management

Joint and Muscle Health

Rethink

Aetna Select Member Services

Informed Health Line, 24-Hour Nurse Line

Live Healthy Team

Aetna Compassionate Care Program

Aetna Maternity Support Program

Aetna WorldTraveler

HMSA’s Online Care

# Special Programs and Health Support

The Costco Employee Benefits Program offers special programs that can help you save money, find high-quality providers, and improve your health. Costco pays for these programs, but Costco and the program do not provide medical advice. You are responsible for selecting your doctor and making your own health care decisions.

## International SOS

The International SOS program provides services to employees traveling abroad (or more than 100 miles from their home in the U.S.) while on a Costco business trip, up to a maximum of 180 travel days in a 12-month period (no more than 90 consecutive days for any one business trip). Services may include, for example:

- Medical referrals
- Medical emergency travel arrangements
- Telemedicine consultations
- Delivery of prescription drugs and medical supplies not available at your travel destination
- Health information about your travel destination

International SOS provides additional services, including certain services for your eligible dependents while you’re traveling. To request assistance or to find out more about the program, including limitations and exclusions, please call **(215) 942-8226** or visit [internationalsos.com](https://internationalsos.com). Note that the program generally pays secondary to Aetna Select and other medical coverage.

## 2nd.MD

2nd.MD provides expert second opinions by phone or video, at no cost to you. If you have a serious medical condition or have been recommended for surgery, you can consult with board-certified specialists about your care.

2nd.MD can provide opinions regarding:

- A new or existing diagnosis or treatment plan
- Surgery or less invasive alternatives
- Medications
- A disease, cancer or chronic condition

2nd.MD’s services are available to Costco employees and family members who are enrolled in an Aetna or HMSA medical plan.

Aetna medical plan members age 18 and older are required to obtain an expert second opinion from 2nd.MD before spinal surgery of the neck and/or back will be eligible for pre-certification and coverage. See [Expert Second Opinion Requirement for Spine Surgery on page 34](#).

To get started, go to [Costcobenefits.com](https://Costcobenefits.com) and click 2nd.MD, or call 2nd.MD at **833-579-2509**.

2nd.MD does not determine whether a procedure is covered by your medical plan. For coverage determination, contact Aetna at **800-814-3543** or HMSA at **800-776-4672**. Always consult with your own doctor before making medical decisions – you are responsible for making your own health care choices.

Special programs and health support

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- Diabetes Prevention and Diabetes Management
- Joint and Muscle Health

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Aetna Select Member Services

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- Live Healthy Team
- Aetna Compassionate Care Program
- Aetna Maternity Support Program
- Aetna WorldTraveler

HMSA’s Online Care

AbleTo

AbleTo provides short-term counseling programs, at no cost to you. These programs can help you manage stress, anxiety or depression, or help you cope with a chronic health condition. The services are offered via phone or video chat, at times that are convenient for you – no need to travel to a provider’s office.

When you sign up for AbleTo, you’ll get access to:

- A licensed therapist
- A virtual program tailored to your needs and goals
- Confidential 1-on-1 support by video chat or phone

AbleTo is available to Costco employees and their family members who are enrolled in an Aetna or HMSA medical plan and are age 18 or older.

To get started, go to [Costcobenefits.com](#) and click AbleTo, or call **833-881-1444**.

98point6

98point6 provides on-demand, text-based primary care telemedicine visits with a doctor – 24 hours a day, seven days a week. 98point6 doctors can diagnose and treat a variety of conditions, as well as prescribe medication and order lab work, as appropriate. If needed, video support may be used.

You can get help for urgent concerns and conditions, including:

- Cough, colds and flu
- Muscle sprains and strains
- Medication interactions and side effects
- Rashes and skin-related problems
- Seasonal allergies
- Sleep issues
- Stomach problems
- Urinary tract infections

98point6 is available to Costco employees and their family members who are age 1 or older and enrolled in an Aetna or HMSA medical plan.

The copay is \$5 per visit for Aetna medical plan members, \$0 for HMSA plan members. Prescriptions and lab work are subject to the regular deductible, copay and/or coinsurance amounts. You are responsible for the full cost of any lab work you receive or prescriptions you fill that are not covered by your Aetna or HMSA medical plan.

To get started, go to [Costcobenefits.com](#) and click 98point6, or download the 98point6 app.

Omada

DIABETES PREVENTION AND DIABETES MANAGEMENT

Omada’s Diabetes Prevention and Diabetes Management programs are designed to help individuals who are at risk for certain chronic diseases, such as type 2 diabetes or heart disease, as well as individuals who are living with diabetes.

The program is available to Costco employees and their family members who are age 18 or older and enrolled in an Aetna or HMSA medical plan, and who Omada determines to be at risk for certain chronic diseases or who are living with diabetes. The program is offered at no cost to you.

Find more information and a link to Omada at [Costcobenefits.com](#), or call **888-409-8687**.

JOINT AND MUSCLE HEALTH

Omada for Joint & Muscle Health provides support for people who are recovering from an injury or who want to learn techniques to help prevent a future injury. The program includes:

- A video consultation with a licensed physical therapist. Additional consultations may be offered where medically appropriate.



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- Live Healthy Team

Aetna Compassionate Care Program

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Aetna WorldTraveler

HMSA’s Online Care

- A personalized exercise program
- Digital information and exercise guides

The program is available at no cost to Costco employees and their family members who are age 13 or older and enrolled in an Aetna or HMSA medical plan.

Find more information and a link to Omada at [Costcobenefits.com](#), or call **888-409-8687**.

Rethink

Rethink is a support and education system for Costco employees and their family members caring for children with learning, social or behavioral challenges such as [Autism Spectrum Disorder](#). The program is available to Costco employees and their family members who are age 18 or older and enrolled in an Aetna or HMSA medical plan. The program is offered at no cost to you.

The program includes:

- Six hours per year of consultation with a board-certified behavior analyst via video conference or telephone. Your behavior analyst may provide tailored recommendations to address learning or behavior challenges, skill building, Individualized Education Program (IEP) or 504 Plan support, and more. They can also help you make the most of all the resources offered through this program.
- A comprehensive library of over 2,400 step-by-step how-to videos to help you teach your child skills in the areas of socialization, language, pre-academic, pre-vocational and more
- A Social and Emotional Learning (SEL) curriculum designed to support your child’s self-awareness, self-management, social skills, social awareness and self-care
- Printable at-home learning materials
- A library of special topic webinars, quick-read articles and tip sheets

You can grant care team member access to family members, caregivers or teachers who may also interact with your child so they can access all the materials offered to you through Rethink.

Find more information and a link to Rethink at [Costcobenefits.com](#).

You can also contact Rethink participant support at **800-714-9285** or email [support@rethinkbenefits.com](mailto:support@rethinkbenefits.com).

Aetna Select Member Services

Aetna and Costco provide several services to help you save money and get the most from your medical plan coverage. If you’re enrolled in an Aetna Select medical plan, the following resources and services are available to you and your enrolled dependents.

INFORMED HEALTH LINE, 24-HOUR NURSE LINE

Aetna Select plan members can call Aetna’s Informed Health Line 24 hours a day, seven days a week, for help with immediate health concerns.

Call **800-556-1555** or TDD **800-270-2386** to speak with a registered nurse. The Informed Health Line is available to answer your questions and provide guidance for taking care of yourself or your family members, or seeking medical services when necessary.

LIVE HEALTHY TEAM

The Live Healthy Team is a dedicated resource for Costco employees and their family members enrolled in an Aetna Select plan. It is a comprehensive team made up of clinical coaches including registered nurses, behavioral health counselors, a registered dietician, a clinical pharmacist, and a social worker. This special team is designed to help you when you may need it most – whether it’s for an acute, chronic or complex medical issue, or for help coping with a difficult family medical situation.

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• Live Healthy Team

• Aetna Compassionate Care Program

• Aetna Maternity Support Program

Aetna WorldTraveler

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The Live Healthy Team is included in your Aetna medical plan coverage, at no additional cost to you. If Aetna determines that the Live Healthy Team may benefit you or an enrolled family member, you may receive an outreach call from a Live Healthy coach. Participation is completely voluntary.

To initiate services yourself, you can call the Live Healthy Team at **800-814-3543** (option 2). The line is staffed Monday through Friday, 5 a.m. to 5 p.m. Pacific Time.

A Live Healthy coach can provide confidential services tailored to your circumstances and particular needs. For example, a Live Healthy coach may:

- **Encourage you** to enhance your overall health by creating an action plan with you to help you lower your cholesterol, lose weight, or stop smoking
- **Get you connected** to the right resources – whether it’s to a dietician to help you make healthier food choices, or to a counselor to help you manage stress
- **Coordinate your care** and work directly with your doctor to ensure the level of care you receive is right for your needs
- **Listen to your questions** and give you answers in easy-to-understand, straight-talk terms so you can make sense of health care details or issues related to you
- **Stay in touch** during an issue or treatment, to find out how you are doing and provide additional support
- **Connect you** with public resources and educational programs

**AETNA COMPASSIONATE CARE PROGRAM**

When facing the advanced stages of an illness, the Aetna Compassionate Care Program can provide thoughtful guidance and easy access to helpful resources. Aetna nurses can work with your doctors to arrange for care, manage your benefits, find the right resources for you and help caregivers manage the patient’s pain

and symptoms. Just call the Live Healthy Team at **800-814-3543** (say “member” when prompted, then select option 2).

You can also find information about advanced planning, [hospice care](#) and more at [aetnacompassionatecare.com](#).

**AETNA MATERNITY SUPPORT PROGRAM**

Employees and their family members enrolled in an Aetna Select plan can participate in the Aetna Maternity Support Program, which includes:

- Information on making choices for a healthy pregnancy
- Education on the signs and symptoms of preterm labor
- Instruction on self-monitoring contractions
- Information on newborn care and ways to cope with postpartum depression
- Genetic testing and counseling through InformedDNA. These services are covered by the Aetna medical plans only if [medically necessary](#), and subject to the plan’s cost-sharing and pre-certification requirements. You may obtain genetic testing and counseling even if not medically necessary, but you will be responsible for the full cost of those services. Therefore, your doctor should obtain pre-certification from Aetna before you receive the services.
- Personalized support for those struggling to *diagnose the cause* of their infertility. (As a reminder, the Aetna medical plans do not cover infertility *treatments*.)

Participants also receive personalized support from an Aetna women’s health case manager if a health condition or other risk factors could affect the pregnancy or impact the probability of preterm labor.

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The program is not intended to replace the care received from an obstetrical provider, but rather to offer information and support. To connect with the Maternity Support Program, call **855-282-6344**.

**AETNA WORLDTRAVELER**

All full-time Costco employees between the ages of 18 and 69 who are enrolled in an Aetna Select plan are automatically covered by the Aetna WorldTraveler program.

The Aetna WorldTraveler program provides services and pays the costs of many expenses associated with a medical emergency or **urgent care** when you are traveling outside of your home country on a Costco business trip, up to a maximum of 270 travel days in a 12-month period (no more than 180 consecutive days for any one business trip). The program includes coverage for your eligible dependents who accompany you on the trip.

Services include:

- Medical referrals
- Coverage for urgent and emergency medical care of up to \$250,000
- Accidental death and dismemberment coverage of up to \$100,000
- Medical emergency evacuation and repatriation services
- Emergency travel arrangements and cash advances
- Interpretation and translation services

To request assistance or to find out more about the program, including limitations and exclusions, call **877-301-5042**. Note that the program pays secondary to Aetna Select and other medical coverage.

**HMSA's Online Care**

Employees in Hawaii can also see a doctor anywhere and anytime. Even if you are not enrolled in an HMSA medical plan, you can use HMSA's Online Care to speak to a doctor through your computer, phone or mobile device at no charge. A doctor can even call in a prescription for you, if needed.

**WITH HMSA'S ONLINE CARE, YOU CAN:**

- Get expert advice from an HMSA physician or specialist, online or by phone
- Update your health record
- Research a symptom or condition
- Review health references

To get started, register at [hmsa.com/wellness-programs/online-care](https://hmsa.com/wellness-programs/online-care).



Prescription Drugs

In-Network Pharmacies

Out-of-Network Pharmacies

Prescription Drug Plan Summary

How the Plan Works

Annual Out-of-Pocket Maximum

Costco's Online Pharmacy

Costco Specialty Pharmacy

What's Not Covered

# Prescription Drugs

The Costco Employee Benefits Program offers the following prescription drug coverage, designed to help pay the costs of certain **medically necessary** and preventive care expenses incurred while enrolled in the plan.

If you are enrolled in an Aetna Select or HMSA medical plan, you and your enrolled dependents automatically receive prescription drug coverage, administered by Costco Health Solutions (CHS).

Some drugs are not covered, and the list of covered drugs changes from time to time. Certain drugs also require pre-certification and/or have quantity limits. For example, strict quantity limits apply to certain pain medications. Your pharmacist can review your prescriptions and help obtain authorization for a higher limit if medically necessary. Contact CHS for a complete, up-to-date list of covered drugs and limitations.

## IN-NETWORK PHARMACIES

To receive prescription drug coverage, you must use in-network pharmacies. For all prescriptions other than specialty or compound drugs, only Costco pharmacies (including Costco's home delivery) are in-network.

For specialty drugs, you must use Costco Specialty Pharmacy. For compound drugs, you must use Miller's Pharmacy. If you try to fill these types of prescriptions at any other pharmacy, your claim will not be processed.

If you work at a **location** without a Costco pharmacy nearby, you will be provided with a specific pharmacy in your area that will be

designated as in-network. You will still be required to use Costco Specialty Pharmacy to receive coverage for specialty drugs and Miller's Pharmacy to receive coverage for compound drugs.

## OUT-OF-NETWORK PHARMACIES

All other pharmacies are considered out-of-network. You may use any pharmacy where your CHS card is accepted (except for specialty or compound drugs), but if you use an out-of-network pharmacy:

- The plan will only cover your first fill of eligible prescription drugs and supplies – **refills will not be covered**. If you want refills covered by the plan, you must use an in-network pharmacy.
- You may pay higher coinsurance than you would pay at an in-network pharmacy, and the coinsurance will not apply to your annual out-of-pocket maximum.
- Emergency prescriptions filled at a pharmacy that does not take your CHS card will be reimbursed at the **negotiated rate** less your copay or coinsurance (with coinsurance percentage applied to the negotiated rate, not to the amount you paid). You pay the full cost, then submit a claim along with an itemized receipt to:

Costco Health Solutions  
P.O. Box 999  
Appleton, WI 54912-0999  
Fax Number: 855-668-8550

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PREScription DRUG PLAN SUMMARY

The table below shows the amount you pay for covered prescription drugs. The amount you pay will depend on whether you use an in-network pharmacy.

	In-network pharmacy	Out-of-network pharmacy
Plan features		
Annual out-of-pocket maximum	\$2,000 individual \$4,000 family	No maximum
Covered expenses	Amount you pay*	
Prescription drugs and supplies	<b>Generic:</b> \$3 copay per 30-day supply <b>Brand-name:</b> 15% (minimum \$10, maximum \$50 per 30-day supply) <b>Specialty drugs:</b> 20% (maximum \$50 per 30-day supply) <b>Compound drugs:</b> 25% (minimum \$15, maximum \$100 per 30-day supply) When you use an in-network pharmacy, you may get up to a 90-day supply (not to exceed any quantity limits associated with the medication being filled).	<b>Generic or brand-name:</b> 25% (minimum \$15, maximum \$100 per 30-day supply) Up to a 30-day supply for your first fill only. Refills, compound drugs and specialty drugs not covered.
Over-the-counter (OTC) drugs	Kirkland brand antacids and antihistamines prescribed by a <b>physician</b> only: \$0 copay	Not covered

\* If your pharmacy can use a manufacturer's copay assistance program, such as a coupon or similar method, CHS may arrange for your copay or coinsurance to increase by the copay assistance amount, and the plan to pay less for your prescription drugs. A coupon or rebate will not require you to pay more and will not entitle you to cash back. Certain drugs may cost less than the amount you pay. Coinsurance for drugs is based on the [negotiated rate](#).

THE BENEFITS OF GENERICS

Generic drugs have the same active ingredients as brand-name drugs, and are dispensed in the same form and recommended dosage as the brand-name equivalent.

If you or your physician requests a brand-name prescription drug when a **therapeutic equivalent** generic drug is available, you'll pay the brand-name copay plus the cost difference between the brand-name and generic drug. This will not apply if:

- There is no generic drug equivalent to the brand-name drug
- The pharmacy was unable to supply the generic drug at the time the prescription was presented, or
- The brand-name equivalent is **medically necessary** because there has been a therapeutic failure with the generic drug, as documented by your physician and approved as medically necessary.

**Additional dispensing limits** (exact amounts may vary due to packaging):

- Injectable: Maximum 30-day supply
- Specialty drugs: Maximum 30-day supply

**Please note:** Not all drugs are covered by the plan. The plan has a formulary list which indicates whether a drug is covered by the plan. The plan also has a step therapy protocol. Step therapy means you must try the primary treatment first before the secondary treatment will be covered by the plan. If you choose to use excluded medications, you will be responsible for the full cost. Link to Costco Health Solutions from [Costcobenefits.com](#) to see the formulary and step therapy lists. If you have questions, please call Costco Health Solutions at **866-459-3322**.

Prescription Drugs

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HOW THE PLAN WORKS

Show your Costco Health Solutions (CHS) pharmacy ID card when you fill a prescription. You'll pay the applicable copay or coinsurance per prescription fill or refill. If you participate in the Health Care Reimbursement Account, you can use your HCRA debit card to pay for eligible expenses at a certified pharmacy. For more information, see [Health Care Reimbursement Account \(HCRA\) on page 95](#).

The plan will pay benefits for the following **covered expenses**, subject to the plan's limits and exclusions:

1. FDA-approved drugs to treat an **illness** or **injury** covered by the plan, and that may be dispensed under federal and state law only upon the written prescription of a **physician**.
2. Smoking cessation drugs. This includes prescription drugs for smoking cessation, including Wellbutrin, Bupropion, Chantix, Nicotrol Inhaler and Nicotrol NS.
3. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices (ACIP) and required by the Affordable Care Act,\* are covered at 100%. Immunizations for travel to foreign countries are not covered.
4. Certain preventive care drugs (including certain **over-the-counter medicines** if you have a prescription) are covered at 100%, to the extent required by the Affordable Care Act\*
5. Prescribed over-the-counter or generic contraceptives to the extent required by the Affordable Care Act\*
6. Insulin and needles/syringes to be used for insulin administration
7. Diabetic test strips
8. Compound medications when at least one ingredient is a prescription drug
9. Certain over-the-counter medicines, such as antacids, acid reducers and antihistamines, if you have a prescription and purchase the medicine at a Costco pharmacy

\* The plan uses reasonable medical management techniques (such as age, frequency, location and method) to determine whether an immunization or drug is preventive care and covered 100% by the plan under the Affordable Care Act. For a list of current preventive care drugs and immunizations, call CHS at **866-459-3322** or log on to [Costcobenefits.com](#) and link to Costco Health Solutions.

ANNUAL OUT-OF-POCKET MAXIMUM

This is the most you will owe in coinsurance and copays per year for most types of covered prescription drugs and supplies. If you reach the out-of-pocket maximum, the plan will pay 100% of most types of covered prescription drugs and supplies for the rest of that calendar year.

Only your prescription drug plan coinsurance and copays can apply toward this annual maximum. The following amounts do not apply toward the maximum, nor will the plan pay them after you reach the maximum:

- » Amounts for drugs or supplies that are not covered by the plan
- » Amounts for prescriptions filled at an out-of-network pharmacy
- » Your coinsurance or copays under the medical plan or other health care plan
- » Your coinsurance or copays that are not for essential health benefits (as defined by law and the plan)
- » Dispensed as written penalties (the cost difference between the brand-name drug and the generic equivalent)
- » Manufacturer coupons

Your out-of-pocket maximum renews each calendar year. That is, the coinsurance and copays you incur in one calendar year do not count toward the next year's maximum, even if you pay the expense in the next year. If your coverage starts and stops within the same calendar year, any amounts you previously paid toward the annual out-of-pocket maximum will count for the rest of that year.

COSTCO'S ONLINE PHARMACY

When you use Costco's online pharmacy, you'll pay the same copay or coinsurance percentage as you would at a Costco location. Just like at a Costco pharmacy, you are able to pay for medications you get online with your Health Care Reimbursement Account debit card.





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●

 Costco Specialty Pharmacy

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You can pick up prescriptions at a Costco location or have your order delivered to your home at no extra charge. You can also sign up for automatic refill notifications each month.

To register, click “Pharmacy” at [Costco.com](#). Once your account is set up, you can fill or transfer prescriptions.

**COSTCO SPECIALTY PHARMACY**

The plan pays benefits for specialty drugs only if you obtain them from Costco Specialty Pharmacy, even if you’re otherwise at a [location](#) which permits you to buy drugs elsewhere. Specialty medications are products that may require special handling, may not be available at a retail pharmacy, are expensive or are for a condition that would benefit from additional support. Examples include medications used to treat anemia, asthma, Crohn’s Disease, HIV/AIDS, Multiple Sclerosis, hepatitis and rheumatoid arthritis.

The list of covered specialty drugs changes from time to time. For a current list, to order a specialty drug and for more information on specialty drugs, call Costco Specialty Pharmacy at **866-443-0060**.

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## What's Not Covered

In addition to other limitations and exclusions discussed throughout this and other sections of this booklet, the following are not covered:

- Any supply or item greater than the amount prescribed by the attending [physician](#), or in excess of the plan's dispensing limitations
- Prescription drugs administered in a [hospital](#) or physician's office, although your medical plan may pay for these expenses
- Immunization agents, except as recommended by the Advisory Committee on Immunization Practices (ACIP) and required by the Affordable Care Act
- Drugs to promote fertility or conception, regardless of the intended use
- Therapeutic devices or appliances, and non-medical substances, regardless of intended use
- Hair restoration medication such as Propecia
- Retin-A other than for treatment of acne
- Any non-drug item, except for diabetic supplies
- Drugs for treatment of an [illness](#) or [injury](#) that is not eligible for benefits under the Costco medical or other health care plans
- Medication furnished by any medical or drug service for which no charge is made to the patient
- Drugs that are illegal under local, state or federal law
- Drugs purchased in a foreign country and imported into the U.S.
- Drugs taken for the purpose of weight loss except as required by law
- Drugs for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to sildenafil citrate; phentolamine; apomorphine; alprostadil; or any other drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes. This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms. Cialis for daily use, 2.5 and 5 mg strengths, may be covered with prior authorization if there is a diagnosis of Benign Prostatic Hyperplasia (BPH), and both a generic alpha reductase inhibitor and a generic alpha 1 adrenergic blocker have been tried for at least six months and failed.
- Performance, athletic performance or lifestyle enhancement drugs or supplies
- Any prescription refilled in excess of the number specified by the physician
- Replacement of lost, broken, destroyed or stolen prescriptions for specialty medications and controlled substances
- Drugs, devices, or supplies not approved for marketing or for prescribed use by the Food and Drug Administration

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Vision and Hearing

If you are enrolled in an Aetna Select or HMSA medical plan, you and your enrolled dependents automatically receive vision care and hearing-aid benefits. If you wish to opt out of vision benefits, you may do so.

Vision

The Costco Employee Benefits Program offers the following vision benefit, designed to help pay the costs of certain **medically necessary** and preventive care expenses incurred while enrolled in the plan.

The vision benefit provides for the **covered expenses** of routine eye exams and prescription eyewear for you and each eligible family member enrolled in medical coverage.

Prescription eyewear must be purchased from a Costco Optical Center, and coverage is administered by MESVision. Routine eye exams are provided through MESVision. You can go to any Costco Optical Center or MESVision network provider for your routine eye exam.

Please note, other medically necessary vision care services you receive from an ophthalmologist or other **physician** may be provided through your medical plan.

Vision ID cards are not issued. You and your dependents will need to provide your Costco Employee number and your date of birth when filling a prescription at Costco Optical.

VISION BENEFIT SUMMARY

Service or supply	Maximum annual benefit
Refractive eye exam	Up to \$80, once per calendar year
Covered eyewear, glasses (frames and lenses) and contacts (including disposable contacts) prescribed by a doctor	Up to \$175, once per calendar year

If you've enrolled in the Health Care Reimbursement Account and have funds available, you can use your HCRA debit card to pay many vision services and eyewear expenses that are not covered by the plan.

HOW THE PLAN WORKS

The plan pays benefits for the following services and supplies:

1. Eye exams

The plan will pay up to \$80 per enrolled person for one routine ("refractive") annual vision exam per calendar year. When you get your eye exam at a Costco Optical Center, if the eye exam is less than \$80 the remaining balance up to the maximum of \$80 can be applied toward retinal imaging and contact lens fittings. All services must be received in one visit.

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2. Eyewear purchased from a Costco Optical Center

The plan will pay up to \$175 per calendar year for prescription eyeglasses and contact lenses (including disposable lenses). Benefits are provided only once per year for expenses you incur on a single date. For example:

- » If you buy a set of eyeglasses and a pair of contacts during one visit, for a combined bill of \$200, the plan will pay \$175 and you'll pay the balance.
- » If you buy only one set of eyeglasses during one visit for \$100, the plan will pay \$100 but you will forfeit \$75 (the remainder of the maximum annual benefit). No further benefits will be payable and you will be responsible for the full cost of any other eyewear you buy for the rest of the year.

3. Eyewear purchased from non-Costco Optical Center providers

These expenses are subject to the same maximum annual benefit noted above and are only covered in the following circumstances:

- » If there is no Costco Optical Center within 25 miles of your [location](#), you may buy your prescription glasses or contacts from any qualified optical provider, then submit a claim for reimbursement along with proof of your purchase to the Costco Benefits Department.
- » If Costco Optical provides a written confirmation they could not provide the lens or appropriately fitting frames necessary to fill your prescription, you may go to a non-Costco optical provider for the eyewear you need. To get reimbursed, you must submit your claim along with the letter from Costco Optical to the [Costco Employee Benefits Department](#).

SPECIAL BENEFIT FOR KERATOCONUS

The vision benefit provides a higher benefit for the purchase of rigid gas permeable or scleral contact lenses prescribed to improve vision impairment caused by keratoconus. The covered eyewear benefit

for this diagnosis is \$500 per contact lens (maximum of two lenses) once per calendar year for purchases made on a single day. For these lenses only, Costco or any other eyewear provider may be used.

You must pay for the lenses and request reimbursement by submitting a claim form and required documents.

MEDICAL EYE SERVICES

The vision benefit also covers up to \$60 per visit for limited medical eye services provided by an optometrist operating in a Costco Optical Center. Services offered at any particular Costco Optical Center will depend on the optometrist's license and state laws, but services commonly offered include foreign object removal and treatment for conjunctivitis. You are responsible for any charges over \$60.

WHAT'S NOT COVERED

In addition to the other limitations and exclusions discussed throughout this and other sections of this booklet, the following are not covered.

1. Glasses, contact lenses or sunglasses with a non-prescription lens, including ophthalmic frames with polarized lenses, even if your doctor writes a prescription
2. Glasses, lenses or other eyewear designed for color blindness
3. Charges in excess of the amounts listed in the [Vision Benefit Summary on page 55](#)
4. Cosmetic contacts
5. Replacement of lost or broken frames and/or lenses
6. Frames, lenses or contacts purchased at other than a Costco Optical Center, except as provided under [How the Plan Works on page 55](#)

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## Hearing

Coverage for hearing aids is provided if you are enrolled in an Aetna Select or HMSA medical plan. Coverage is only provided for **medically necessary** hearing aids to treat hearing loss.

You must purchase your hearing aids at a Costco Hearing Aid Center, and benefits are administered by MESVision. In certain circumstances (as described below), you may purchase hearing aids from another in-network provider. In such cases, benefits are administered by Aetna.

### HOW THE PLAN WORKS

The plan covers up to \$1,750 of the cost of hearing aids, for both ears, every four years. You are responsible for any charges over this maximum. If you've enrolled in the Health Care Reimbursement Account, you can use your HCRA debit card to pay any remaining balance, if you have funds available.

This benefit must be used all at one time – you can't use part of it today and the rest on another date within the same four-year period.

The plan only provides coverage for hearing aids, not batteries or other hearing aid supplies. Hearing aids must be purchased at a Costco Hearing Aid Center, except under the following circumstances:

1. Covered dependents under the age of 18 can go to any in-network hearing aid center because Costco Hearing Aid Centers can't service this age group. To find an in-network provider, go to [Costcobenefits.com](#) and click "Find a Provider," or call Aetna at **800-814-3543**.
2. If you are 18 or older and the Costco Hearing Aid Center is unable to provide your hearing aids:
  - If you are enrolled in an Aetna plan, you can go to any network hearing aid center and your provider will submit your claim to Aetna.

- If you are enrolled in HMSA or Aetna Select Out-of-Area coverage, you can go to any hearing aid provider. You'll pay for the hearing aid upfront and submit a paper claim to Aetna for reimbursement. Send a completed claim form and your receipt to Aetna at the address on the claim form. The claim form is located at [Costcobenefits.com](#).

Only those employees working at the following **locations** do not have access to Costco Hearing Aid Centers within 25 miles and can go to any Aetna network provider:

- #107 Juneau, AK
- #932/#284 Laredo, TX Depot
- #267/#286 Morris, IL Depot
- #749 Mt. Laurel, NJ
- #549 Morrow, GA Business Delivery

### WHAT'S NOT COVERED

In addition to other limitations and exclusions discussed throughout this and other sections of this booklet, the following are not covered.

1. Hearing aids that are not prescribed, recommended or approved by the attending licensed hearing aid specialist
2. Hearing aids that are not medically necessary for the treatment of hearing loss
3. Charges in excess of \$1,750
4. Replacement of lost or broken hearing aids
5. Hearing aids purchased at other than a Costco Hearing Aid Center, except as described above

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# Dental

## Plan Options

The Costco Employee Benefits Program offers the following dental plans, designed to help pay the costs of certain [medically necessary](#) and preventive care expenses incurred while enrolled in the plan:

- Core Dental Plan
- Core Exclusive Provider Plan (EPP)
- Premium Dental Plan
- Premium Exclusive Provider Plan (EPP)

See the table below for a side-by-side comparison of the plans.

There are some special enrollment rules for these plans:

- You cannot elect dental coverage only – you must be enrolled in an Aetna or HMSA medical plan to enroll for dental

- If you elect dental for yourself, you must elect it for all your family members enrolled for medical coverage; either you and all covered family members are enrolled for dental, or none are. In addition, all family members must be in the same dental plan you choose for yourself.
- You may decline dental, even if you elect medical coverage
- If you were eligible for benefits on Jan. 1, 2020 or later, you can only enroll in the Core EPP or Premium EPP (unless these plans are unavailable at your [location](#))
- Full-time employees can elect any available dental plan. Part-time employees are limited to the Core Plan or Core EPP. (You are also limited to the Core plans if you are a full-time employee but classified as “part-time” for benefit purposes as described in [Benefit Measurement Periods on page 5.](#))

## DENTAL PLAN SUMMARY

The table below shows basic features of the plans and your share of the cost for covered services. Preventive care and orthodontic services are not subject to the deductible and do not count against the annual maximum benefit.

	Core Dental Plan		Premium Dental Plan		Core EPP	Premium EPP
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Plan features						
Annual deductible	\$50 individual		\$50 individual		\$50 individual	\$50 individual
	\$150 family		\$150 family		\$150 family	\$150 family
Annual maximum benefit	\$1,500 for basic and major services combined		\$2,000 for basic and major services combined		\$1,750 for basic and major services combined	\$2,500 for basic and major services combined



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	Core Dental Plan		Premium Dental Plan		Core EPP	Premium EPP
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Covered services	Amount you pay					
<b>Preventive care services</b> Routine exams and cleanings, twice per year	\$0		\$0		\$0	\$0
<b>Basic services</b> Fillings, extractions, root canals, periodontics (treatment of gums and soft tissues)	15% after deductible	20% after deductible	15% after deductible	20% after deductible	15% after deductible	15% after deductible
<b>Major services</b> Crowns, bridges, dentures, implants	45% after deductible	50% after deductible	45% after deductible	50% after deductible	45% after deductible	45% after deductible
<b>Orthodontic services</b>	50% Lifetime maximum benefit: <b>\$1,250</b>		50% Lifetime maximum benefit: <b>\$1,500</b>		50% Lifetime maximum benefit: <b>\$1,750*</b>	50% Lifetime maximum benefit: <b>\$2,000*</b>

\* If you or an enrolled family member were in phase one of treatment and orthodontia was paid by Aetna in one lump sum, you may **not** be eligible for this increased benefit for the current phase one treatment. Please contact Aetna to confirm your eligibility before you switch to an EPP plan

Please note, not all [locations](#) have enough in-network providers nearby to support the EPPs. The following locations **do not** offer the EPPs:

Alaska (all locations)	#1325 – Davenport, IA	#1176 – Syracuse, NY	#103 – Clarkston, WA
Hawaii (all locations)	#773 – Coeur D’Alene, ID	#1073 – Roseburg, OR	#639 – Sequim, WA
Montana (all locations)	#145 – Twin Falls, ID	#1059 – Warrenton, OR	#1013 – Union Gap, WA
#125 – Eureka, CA	#1191 – Kalamazoo, MI	#1159 – Sioux Falls, SD	#112 – Wenatchee, WA
#1297 – Ukiah, CA	#1279 – Traverse City, MI	#1184 – Charlottesville, VA	#1099 – Yakima, WA
#637 – Gypsum, CO	#1125 – Rochester, MN	#238 – Harrisonburg, VA	
#1111 – Coralville, IA	#1119 – West Fargo, ND	#314 – Colchester, VT	

### ANNUAL MAXIMUM DENTAL BENEFIT

Each Costco dental plan pays a maximum dollar amount per year for all covered basic and major services, in- or out-of-network:

- Core Dental Plan: \$1,500 per person per year
- Core EPP: \$1,750 per person per year

- Premium Dental Plan: \$2,000 per person per year
- Premium EPP: \$2,500 per person per year

Benefits for preventive and orthodontic services do not count against the annual maximum benefit.

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Once you've received the annual maximum benefit, your plan will pay no further benefits for any basic or major dental services for the rest of that calendar year. If your coverage starts and stops within the same year, any benefits previously paid by the plan will count toward the maximum benefit for the rest of that year.

**LIFETIME MAXIMUM ORTHODONTIC BENEFIT**

Each dental plan pays the following **lifetime maximum benefit** for orthodontic services:

- Core Dental Plan: \$1,250 per person
- Core EPP: \$1,750 per person
- Premium Dental Plan: \$1,500 per person
- Premium EPP: \$2,000 per person

These dollar maximums apply to all payments for orthodontic services for an individual for the entire time they are covered by all Costco dental plans combined. Once you reach the maximum, your dental plan will pay no further orthodontic benefits for the individual's lifetime.

If you leave Costco for any reason, then are re-hired, the lifetime maximum benefit payable for orthodontic benefits is always carried forward regardless of how long you were gone.

**DENTAL COVERAGE FOR HAWAII EMPLOYEES**

For HMSA members, the Core and Premium Dental Plans are administered by HMSA. The benefits and covered services are the same as are described here, but claims are filed with HMSA and you must use an HMSA dental provider to receive plan coverage. The EPPs are not available in Hawaii.

To find an HMSA dental provider, visit [hmsa.com](https://hmsa.com).

For any questions related to your medical or dental benefits, call HMSA at **800-776-4672**.

**PROVIDER NETWORKS**

The national network of participating dentists is the same for all four Aetna dental plans.

The Core EPP and Premium EPP **only** provide coverage for services and supplies provided by a participating Preferred Provider Organization (PPO) network dentist (there is no out-of-network coverage).

The Core and Premium Dental Plans pay for covered dental care from most qualified dentists, but it's to your advantage to use a participating PPO dentist. Here's why:

- Basic and major services are paid at a higher in-network level when you use a participating dentist.
- Participating dentists have contracted with Aetna or HMSA to provide covered services and supplies at **negotiated rates**. That means they accept payment from your dental plan and any required amounts you pay toward your annual deductible or coinsurance as payment in full. There are no further costs to you (subject to the limits on lifetime and annual maximum benefits).
- If you receive services from an out-of-network provider, that provider may charge more than the **Reasonable and Customary (R&C) charges** established by Aetna or HMSA. In that case, in addition to your other out-of-pocket expenses, you'll be responsible for any amount that exceeds R&C.
- Participating dentists will file claims for reimbursement of charges on your behalf. If you use a non-participating dentist, it will be your responsibility to file claims.

**Please note:** Charges by some out-of-network dental providers are never covered by the dental plan. Call Aetna to confirm that your dentist is approved for coverage before you receive care.

To find an Aetna PPO participating dentist near you, click on "Find a Provider" at [Costcobenefits.com](https://Costcobenefits.com) or call Aetna's dental line at **800-218-1458**. To find an HMSA PPO participating dentist, go to [hmsa.com](https://hmsa.com) or call HMSA member services at **800-776-4672**.

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For Aetna Select medical plan members, medical and dental ID information is printed on one card. You can access an electronic medical and dental card with Aetna’s mobile app (Aetna Health), call Aetna and request an ID card to be mailed, or you can print and request an ID card by logging on to [Aetna.com](#).

For HMSA medical plan members, you will receive an ID card that is for both medical and dental. You can print a copy of your card or request additional cards by logging on to [hmsa.com](#).

YOUR OUT-OF-POCKET COSTS

You pay a share of [covered expenses](#) and the dental plan pays the balance. Your share of expenses, called your “out-of-pocket costs,” include the following:

1. Annual deductibles

These are the amounts you must pay each calendar year toward all covered expenses (except preventive care or orthodontic services) before the plan begins to pay benefits.

- The individual deductible applies separately to each covered family member.
- The family deductible applies to you and your covered family members on a combined basis. When the family deductible is satisfied, no further deductible needs to be met by any covered family member for the remainder of that calendar year.
- If your coverage starts and stops within the same calendar year, any amounts you previously paid toward the annual deductible will count for the rest of that year. However, amounts you pay in one calendar year do not carry over into the next year.

2. Coinsurance

This is the percentage of covered expenses you pay after you satisfy the annual deductible. For example, if the chart above says

“15%,” that means the dental plan pays 85% after your deductible for a covered service and the remaining 15% is your coinsurance.

PREDETERMINATION OF BENEFITS

Whenever the charges for your dental care are expected to exceed \$250, you should ask your dentist to obtain a pre-determination of benefits. A pre-determination will give you an advance idea of whether the proposed procedure is a covered expense, the amount your plan may pay for the procedure, and what your financial responsibility may be.

Your dentist may request a pre-determination electronically or by submitting a standard American Dental Association (ADA) claim form to Aetna or HMSA:

Aetna	HMSA Dental Services
P.O. Box 14094	P.O. Box 69437
Lexington, KY	Harrisburg, PA
40512-4094	17106-9437

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The plans pay benefits only for the [covered expenses](#) listed below. As shown in the [Dental Plan Summary on page 58](#), benefits are paid after any applicable deductibles and are subject to annual or [lifetime maximum benefit](#) limits.

PREVENTIVE CARE SERVICES

1. Routine examinations (periodic oral evaluation), twice per calendar year
2. X-rays: One set of bitewing X-rays per calendar year; complete X-ray series including full mouth or panorex X-rays once in a three-year period; vertical bitewings limited to one set every three-year period
3. Emergency examinations (problem-focused exams), twice per calendar year
4. Dental cleaning (prophylaxis), twice per calendar year
5. Periodontal maintenance cleanings, twice per calendar year
6. Fissure sealants for children under age 16, once in a three-year period per tooth, available only for permanent molars
7. Topical application of fluoride, for children under age 18, twice per calendar year
8. Space maintainers to maintain space for eruption of permanent teeth

BASIC SERVICES

1. Amalgam, synthetic, composite (filled resin) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay). The Core and Premium EPP plans cover composite fillings on all teeth. The Core Dental and Premium Dental plans only cover composite fillings on front and bicuspid teeth – if a composite restoration is placed on a molar tooth, only the cost of the amalgam filling will be covered.

2. Stainless-steel crowns
3. Extraction of teeth
4. Surgical extractions of impacted teeth
5. General anesthesia/intravenous (deep) sedation covered:
  - In conjunction with certain covered endodontic, periodontic and oral surgery procedures, if [medically necessary](#), or
  - If medically necessary for children through age 6 or a physically or developmentally disabled person, when in conjunction with covered dental procedures.General anesthesia and intravenous sedation are not both covered when performed on the same day.
6. Periodontal services, surgical and nonsurgical treatment of the tissues supporting the teeth, including root planing, gingivectomy, and provisional splinting
7. Nightguards/occlusal guards only for bruxism (grinding of teeth), covered once in a three-year period
8. Root planing, limited to four separate quadrants per two rolling years
9. Limited occlusal adjustments
10. Root-canal therapy due to decay or trauma, including pulp exposure treatment, pulpotomy, apicoectomy and X-rays

MAJOR SERVICES

1. Crowns, inlays once in a two-year period per tooth, subject to [Replacement of Existing Items on page 63](#). This includes coverage of:
  - Gold substitute castings or combinations of those materials (but not processed resin)
  - Porcelain crowns on posterior teeth

**Note:** If a tooth can be restored with a filling material such as amalgam, synthetic, composite or filled resin, the

- The existing denture, crown, cast, or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least two years before its replacement
- The existing denture is an immediate temporary one to replace one or more extracted natural teeth and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

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2. Crown buildups
3. Dentures, fixed bridges, removable partial dentures, full, immediate and overdentures
4. Surgical placement or removal of implants and appliances on implants. Replacement of an appliance is covered once in a two-year period (see [Replacement of Existing Items at right](#)).
5. Replacement of an existing prosthetic device, once in a two-year period (see [Replacement of Existing Items at right](#))
6. Preparation for dentures, including preparation of the alveolar ridge and soft tissues (not including Iliac crest or rib grafts to alveolar ridges)
7. Temporary/interim partial dentures when they are used to replace any of the six anterior teeth, provided the permanent prosthesis is eligible for coverage
8. Partial dentures. If a more elaborate or precision device is proposed, subject to consultant review, the plan may pay benefits for an alternate treatment based on the negotiated rate or Reasonable and Customary (R&C) charge for a cast chrome or acrylic partial denture
9. Denture adjustments and relines, initial reline done more than six months after placement of permanent denture

The plan pays benefits for **covered expenses** related to **orthodontic treatment** (Aetna pays benefits quarterly; HMSA pays monthly). These include:

1. Comprehensive orthodontic treatment for adults and children, including post-treatment stabilization
2. Removable, fixed, or cemented inhibiting appliances to correct thumb-sucking

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The dental plans will generally not pay benefits for services you receive after your eligibility for the Costco Employee Benefit Program ends. The exception is if you began a service that requires multiple visits while you were still eligible, such as a root canal or installation of a crown or a prosthodontic.

For one of these procedures, your Costco dental plan will pay benefits for up to 30 days past the date coverage would normally end, as long as the service will be completed during that 30-day period.

ALTERNATE TREATMENTS

If more than one service can be used to treat a covered person’s dental condition, the Costco dental plans will only pay benefits based on the least costly covered service. This applies only if the least costly service:

- Is deemed by the dental profession to be an appropriate method of treatment, and
- Meets broadly accepted national standards of dental practice.

If you and the dentist decide to proceed with a more costly method of treatment, the excess amount will not be covered by the plan and you’ll be responsible for that amount. Please note, these alternate treatment rules do not apply to implants.



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In addition to other limitations and exclusions discussed throughout this and other sections of this booklet, the following are not covered.

1. Services provided outside the United States, except for care performed by a PPO participating dentist as listed on Aetna's customized provider directory for Costco employees. Link to the directory by clicking on "Find a Provider" at [Costcobenefits.com](#) or call Aetna's dental line at **800-218-1458**.
2. Replacement of a lost, missing, or stolen appliance, or of an appliance that has been damaged due to abuse, misuse, or neglect
3. Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or to correct attrition, abrasion, or erosion
4. An appliance, or modification of one, if an impression for it was made before the person became a covered person; a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person; root canal therapy, if the pulp chamber for it was opened before the person became a covered person
5. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
6. [Orthodontic treatment](#), except as described in this booklet
7. General anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service
8. Treatment by other than a dentist, except for scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist under the supervision and guidance of a dentist
9. Charges that exceed the [Reasonable and Customary \(R&C\) charge](#) payable for the services or the [negotiated rate](#), as applicable
10. Crowns or cast or processed restorations, unless treatment is for decay or traumatic [injury](#), or teeth cannot be restored with a filling

material, or the tooth is an abutment to a covered partial denture or fixed bridge

11. Pontics, crowns, cast or processed restorations made with high noble metals, except as specifically provided under major services
12. Surgical removal of teeth done primarily for orthodontic purposes
13. Surgical removal of wisdom teeth, unless [medically necessary](#)
14. Services needed solely in connection with non-[covered expenses](#)
15. Consultations or elective second opinions
16. Cosmetic dentistry, including teeth bleaching
17. Desensitizing agents; analgesics such as nitrous oxide, conscious sedation or euphoric drugs; injections or prescription drugs; general anesthesia/intravenous (deep) sedation, except for covered oral, periodontal or endodontic surgical procedures. This exclusion does not apply to Novocain.
18. Habit-breaking appliances, except for removable, fixed, or cemented inhibiting appliances to correct thumb-sucking as covered under orthodontic services
19. Temporomandibular joint (TMJ) treatment, although the Aetna or HMSA medical plans may pay benefits

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# Disability Insurance

Costco offers disability insurance, insured and administered by the Unum Life Insurance Company of America. Disability insurance is designed to protect you against loss of income if you become disabled due to sickness, [injury](#) or pregnancy.

There are two disability insurance plans:

- **Voluntary Short-Term Disability (STD) Insurance** is available to hourly employees, except those located in California, Hawaii, New Jersey or New York. In those states, employees may be covered under a state-mandated plan instead.

If you are eligible for Voluntary STD, you will be automatically enrolled unless you decline coverage. You will be notified when your coverage is scheduled to begin, and you may decline participation up to 31 days after that date. For more information, see [Special Initial Enrollment for Voluntary STD on page 17](#).

- **Long-Term Disability (LTD) Insurance** for hourly and salaried employees. Employees enrolled in the Executive Life Program do not receive this LTD Insurance. Coverage is otherwise automatic.

Once you have 10 years of [continuous service](#), your LTD coverage will include an additional benefit for severe disability. The plan will pay an additional 20% of base monthly earnings if you become severely disabled, as defined by the plan. This additional benefit will only apply if the date of initial disability is January 1, 2016 or later.

If you are absent from work due to injury or sickness or on a [Leave of Absence](#) on the date your disability insurance coverage would normally begin, your coverage will not begin until the date you return to [active employment](#).

## DISABILITY INSURANCE PLAN SUMMARY

The table below shows key features of the disability insurance plans.

Plan features	Voluntary Short-Term Disability (STD)	Long-Term Disability (LTD)
<a href="#">Elimination period</a>	Seven consecutive days of disability (no STD benefits are paid during this period)	180 consecutive days of disability (no LTD benefits are paid during this period)
<a href="#">Maximum payment period</a>	Up to 26 weeks of disability, including the elimination period	Up to age 67 (special maximum periods apply to disabilities that start after age 62 or are due to mental <a href="#">illness</a> or self-reported symptoms)
What the plan pays <i>(for disabilities beginning on or after January 1, 2021)</i>	Day 8 – 90: 65% of base weekly earnings  Day 91 – 180: 60% of base weekly earnings	60% of base monthly earnings (80% for a severe disability, if you have 10 years of continuous service or more)
Maximum benefit <i>(for disabilities beginning on or after January 1, 2021)</i>	\$1,750 per week	\$15,000 per month (\$20,000 per month for a severe disability, if you have 10 years of continuous service or more)
Minimum benefit	\$25 per week	Part-time employees: \$50 per month  Full-time employees: \$100 per month
If you work while disabled	Plan may continue to pay full or partial benefits depending on circumstances	

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YOUR COSTS FOR COVERAGE

If you are enrolled for Voluntary STD Insurance, you will pay the full cost of your coverage through payroll deductions. The cost will equal a percentage of your eligible earnings as shown in the current [Rate Booklet](#), available at [Costcobenefits.com](#) or from your Payroll Clerk. Contributions withheld from each paycheck will pay for your coverage through that pay date. Depending on the coverage start date, you may also have contributions for coverage before this pay period.

LTD Insurance is fully paid by Costco.

TAXATION OF BENEFITS

When and if you receive LTD benefits, some or all of those payments will be taxable to you. That’s because Costco pays the cost of your LTD coverage. Voluntary STD benefits you receive are not taxable to you because you pay the full cost of that coverage.

DEDUCTIBLE SOURCES OF INCOME

[Deductible sources of income](#) are amounts from sources such as Social Security and other government or group programs that are payable to you or your family due to your disability. Payments from a Costco disability plan and deductible sources of income combined can add up to, but not exceed, the full amount you would receive from the disability plan alone.

It’s important to apply for all such benefits to which you may be entitled because, whether or not you apply, Unum will estimate the benefit amounts for which you are likely to be eligible and deduct the amounts from your disability plan benefits. If you apply for a deductible source of income but your claim is denied, that amount will not be deducted from your disability plan payments.

If you receive a cost-of-living increase from a deductible source of income after your LTD benefits begin, your LTD plan payment will not be reduced further by the increase.

Unum offers a special advocacy program that can help you make or appeal a claim for Social Security disability benefits. For more information, call Unum at **877-403-9348**.

REHABILITATION AND RETURN-TO-WORK ASSISTANCE PROGRAM

The Rehabilitation and Return-to-Work Assistance Program is designed to help disabled employees return to work, at least on a limited basis. The program will be offered to you if it is determined you are medically able to participate and that the program would be appropriate for your circumstances. **If the program is offered to you but you decline to participate, your disability plan benefits will stop.**

Rehabilitation specialists will develop a personalized return-to-work plan based on your medical and work history. Depending on your circumstances, your plan might specify items or services designed to make it easier for you to work. Examples include coordination with Costco to help you return to work, adaptive equipment or job accommodations, job placement services, and education and retraining.

You will receive an additional payment equal to 10% of your regular disability insurance plan benefits while participating in the program, to a maximum of \$1,000 per month. Benefits from this program are not reduced by deductible sources of income. However, the total benefits paid to you by the plan, plus any deductible sources of income, cannot exceed more than 100% of your base weekly earnings (while on STD) or base monthly earnings (while on LTD).

If you are receiving LTD benefits, the Rehabilitation and Return-to-Work Assistance Program may also reimburse the cost of care for your eligible family members, including your children under age 15 and children or other family members over age 15 requiring personal care. The purpose of care must be to allow you to participate in the program. Reimbursement is available up to \$350 per month per eligible dependent, to a monthly maximum of \$1,000 for all eligible dependents combined.

If you recover from your disability but are unable to find a job, you may receive up to three plan payments after you are no longer disabled or until you return to work for Costco or any other employer – whichever comes first.

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## Voluntary STD Insurance

If you become disabled while enrolled for Voluntary STD Insurance, you will begin to receive weekly benefits after seven consecutive days of disability (the plan’s [elimination period](#)). **Note:** If you are working less than 10 hours a week you may not be eligible for benefits under this plan, even if you have paid premiums.

- For purposes of this plan, disabled means, due to your non-[occupational sickness or injury](#) or to pregnancy, you are:
- Limited from performing the [material and substantial duties](#) of your [own job](#) or a [reasonable alternative](#) offered to you by Costco,
  - Unable to earn at least 80% of your base weekly earnings, and
  - Under the [regular care of a physician](#).

### WHAT THE PLAN PAYS

Weekly benefits from the Voluntary STD Insurance Plan will equal 65% of your base weekly earnings for days 8-90 of your continued disability and 60% of your base weekly earnings for days 91-180 of your continued disability. This amount may be adjusted depending on the circumstances. For example, benefits are reduced by any amounts you receive or are eligible to receive from [deductible sources of income](#) (but not below the weekly minimum payment of \$25).

For an exact calculation of your benefit amount, call Unum at **877-403-9348**.

### IF YOU WORK WHILE DISABLED

- If you are disabled but return to work on a limited basis, the Voluntary STD Insurance Plan may continue to pay a full or partial benefit while you work:
- If you are unable to earn 20% or more of your base weekly earnings due to your disability, your plan benefit will continue with no reduction

- If you earn at least 20% but less than 80% of your base weekly earnings, you will receive a partial plan benefit based on your loss of income. Your partial plan benefit and your [disability earnings](#) combined will add up to more than you would receive from the plan alone.

Unum will not pay benefits for any week during which disability earnings exceed 80% of weekly earnings. If your weekly disability earnings exceed 80% of your base weekly earnings, payments will stop and your claim will end. However, if your disability earnings routinely fluctuate from week to week, the plan will average your

### BASE WEEKLY EARNINGS

- Your base weekly earnings, used to determine Voluntary STD benefits, are the greater of:
- The weekly average of your actual hourly earnings for the 13 pay periods just prior to the date of your disability, or
  - Your hourly rate of pay (as of your last day worked) multiplied by 36 for full-time employees or 23 for part-time employees.

This includes your total income before taxes, including premium pay if you are regularly scheduled to work and receive premium pay. This does not include commissions, overtime pay or other extra compensation, or any income received from sources other than Costco.

If you become disabled while on a [Leave of Absence](#), the above calculation would be used to determine your base weekly earnings. However, the 13 pay periods used to determine the weekly average would not include any pay periods with no earnings, such as pay periods when you were on the approved Leave of Absence.

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**disability earnings** over the most recent three weeks. In that case, your claim will not end unless that three-week average exceeds 80% of your base weekly earnings.

**DETERMINING A PARTIAL STD BENEFIT**

To determine a partial benefit:

1. Subtract your weekly disability earnings from your base weekly earnings at the time you became disabled. This is your “income loss.”
2. Divide your income loss by your base weekly earnings to arrive at a percentage.
3. Multiply this percentage by your weekly Voluntary STD Insurance Plan benefit. This is your partial benefit amount.

For example: A disabled employee’s base weekly earnings equal \$700 and STD Insurance provides a plan benefit of \$455 (65% x \$700) per week through the first 90 days of their disability (after the **elimination period**). If this employee has disability earnings of \$200 per week, the partial benefit is calculated as follows:

1. \$700 base weekly earnings – \$200 disability earnings = \$500 income loss
2. \$500 income loss ÷ \$700 base weekly earnings = 71%
3. 71% x \$455 Voluntary STD benefit = \$323 partial Voluntary STD benefit per week

Combined, \$200 disability earnings plus the \$323 partial plan benefit add up to \$523 per week.

**RECURRENT DISABILITIES**

If you receive benefits from the Voluntary STD Insurance Plan, return to **active employment** and then become disabled again, your benefits will be affected as follows:

1. If your **recurrent disability** happens within 90 consecutive days of the last day paid under your prior disability:
  - The disability will be treated as part of your prior claim and prior disability,
  - You will not have to complete another elimination period,
  - Plan benefits may continue for the remaining balance of the 26-week **maximum payment period**, and
  - Your claim will be subject to the same terms of this plan as your prior claim.
2. If your recurrent disability happens more than 90 consecutive days after the last day paid under your prior disability:
  - The disability will be treated as a new claim and a new disability,
  - You will be required to satisfy a new elimination period after which plan benefits are payable for up to 26 weeks of disability (including the elimination period), and
  - Your claim will be subject to the terms of the plan in effect at the time you become disabled again.



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If you become disabled while covered by LTD Insurance, you will begin to receive monthly benefits after the later of STD payments ending or 180 consecutive days of disability (the plan's **elimination period**).

For purposes of this plan, disabled means, due to sickness, **injury** or pregnancy, you are under the **regular care of a physician** and meet the following requirements.

1. For your first nine months of LTD payments:
- You are limited from performing the **material and substantial duties** of your **own job** or a **reasonable alternative** offered by Costco, and
  - You are unable to earn 80% or more of your indexed monthly earnings.

2. After nine months of LTD payments, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

Loss of a professional or occupational license or certification does not in itself constitute a disability.

- Severely disabled means, due to sickness or injury:
- You have lost the ability to independently perform two of six activities of daily living safely and completely without another person's assistance or verbal cueing, or
  - You have a deterioration or loss of intellectual capacity and need another person's assistance or verbal cueing for your protection or the protection of others.

The six activities of daily living for purposes of this plan are bathing, dressing, toileting, transferring, continence, and eating.

BASE MONTHLY EARNINGS

For hourly employees, your base monthly earnings used to determine LTD benefits are the greater of:

- The monthly average of your actual hourly earnings for the 13 pay periods just prior to the date of your disability, excluding periods without any earnings, or
  - Your hourly rate of pay (as of your last day worked), multiplied by 36 for full-time employees or 23 for part-time employees to determine weekly earnings, then converted to a monthly amount.

This includes your total income before taxes, including premium pay if you are regularly scheduled to work and receive premium pay. This does not include commissions, overtime pay or other extra compensation, or any income received from sources other than Costco.

For salaried employees, your base monthly earnings are your annual salary just prior to your date of disability divided by 12. This includes your earnings before taxes and any pre-tax contributions to a qualified deferred compensation plan or the **Cafeteria Plan**. This does not include commissions, bonuses, or any other extra compensation, or any income received from sources other than Costco. (For salaried non-exempt managers, base monthly earnings also include overtime, as averaged over the 8 pay periods prior to your disability date, not to exceed an average of 5 hours per week.)

If you become disabled while on a **Leave of Absence**, the plan will use your hourly wage or annual salary in effect just before your leave began to determine base monthly earnings.



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Monthly benefits from the LTD Insurance Plan will equal 60% of your base monthly earnings (80% for a severe disability, if you have 10 years of [continuous service](#) or more). This amount may be adjusted depending on the circumstances. For example, benefits are reduced by any amounts you receive or are eligible to receive from [deductible sources of income](#) such as workers' compensation (but not below the monthly minimum payment).

If you are entitled to benefits for less than an entire month, for that month you will receive 1/30th of your monthly benefit amount for each day you are entitled to benefits.

For an exact calculation of your benefit amount, call Unum at **877-403-9348**.

- Limit on Pre-Existing Conditions
- If you become disabled within the first 12 months after your coverage effective date, benefits will not be payable if Unum determines the disability is due to a pre-existing condition. For this plan, that means a sickness, [injury](#), or pregnancy for which, in the three months just prior to your effective date of plan coverage, you:
- Received medical treatment, consultation, care or services, including diagnostic measures,
  - Took prescribed drugs or medicines, or
  - Had symptoms for which an ordinarily prudent person would have consulted a [health care provider](#).

HOW LONG LTD BENEFITS MAY CONTINUE

For disabilities due to most conditions, the plan will continue to pay monthly LTD benefits for the [maximum payment period](#) in the following table or until you are no longer disabled, whichever comes first. The maximum payment period is counted from the day after you complete the 180-day [elimination period](#).

Maximum Payment Period

If your disability begins when you are:	Your LTD benefits may continue:
Under age 62	To age 67
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

- Disabilities Due to Mental Illness or Self-Reported Symptoms
- The maximum payment period is 18 months for all disabilities due to the following conditions. This includes all the LTD payments you may receive for these disabilities combined in your lifetime, counted from the day after you complete the 180-day elimination period:
- Mental illness:** Disabilities due to psychiatric or psychological conditions, regardless of cause, that are usually treated by a [behavioral health provider](#) or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment. Examples include schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and adjustment disorders.
  - Self-reported symptoms:** Disabilities due to symptoms not verifiable by tests, procedures, or clinical examinations according to accepted standards in the practice of medicine. Examples include fibromyalgia, chronic fatigue syndrome, and migraine headaches.

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LTD benefits for mental illness or self-reported symptoms may continue beyond the 18-month maximum payment period only in the following situations:

1. If you are confined in a hospital or institution at the end of the period, payments will continue during your confinement. The hospital or institution must be an accredited facility licensed to provide care and treatment for the condition causing your disability. After you are discharged, payments will continue for a 90-day recovery period counted from the day of discharge. If you are re-confined for at least 14 days in a row during that recovery period, payments will continue during that confinement and for one additional 90-day recovery period.
2. If you continue to be disabled after the 18-month period and are later confined to a hospital or institution for at least 14 days, you will receive payments for the length of the subsequent confinement.

These exceptions apply only to the extent that you remain disabled and would, except for the 18-month limit, have been entitled to receive LTD benefits. In no case will benefits be payable past the maximum payment period shown in the “maximum payment period” table shown above.

IF YOU WORK WHILE DISABLED

If you are able to continue working on a limited basis while you are disabled, a Unum rehabilitation specialist will work with you and Costco to identify and put in place workplace modifications that can help you work at your own job or a reasonable alternative.

The plan may continue to pay you a full or partial benefit while you work:

- If you are unable to earn at least 20% of your indexed monthly earnings due to your disability, your plan benefit will continue with no reduction.

INDEXED MONTHLY EARNINGS

Your indexed monthly earnings, used to determine your percentage of lost earnings if you work while disabled, are your base monthly earnings adjusted upward on the anniversary of benefit payments by the lesser of:

- 10%, or
- The current annual percentage increase in the Consumer Price Index published by the U.S. Department of Labor.

- If you earn at least 20% but less than 80% of your indexed monthly earnings:
  - » During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.
  - » After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability:
    1. Subtract your disability earnings, including the amount that you receive as additional income earned from another job as a result of increased hours worked, from your indexed monthly earnings.
    2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
    3. Multiply your monthly payment by the answer in Item 2. This is the amount Unum will pay you each month.

LTD benefits you receive while you work will continue to be reduced by any deductible sources of income. If your disability earnings routinely fluctuate from month to month, the plan will average your disability earnings over the most recent three months. If Unum

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averages your [disability earnings](#), we will not terminate your claim unless the average of your disability earnings from the last 3 months exceeds 80% of your indexed monthly earnings. Unum will not pay you for any month during which disability earnings exceed 80% of your indexed monthly earnings.

Notifying Unum

If you return to work while disabled, it's your responsibility to notify Unum that you are back on the job. You may be required to provide proof of your monthly disability earnings, including appropriate financial records, at least quarterly. Your plan payment will be adjusted based on your quarterly disability earnings and any overpayments or underpayments will be applied to benefits payable by the plan.

RECURRENT DISABILITIES DURING THE ELIMINATION PERIOD

If you recover from your disability, return to [active employment](#), and then become disabled again during the plan's [elimination period](#):

1. The time you were disabled before and after your return to active employment will count toward satisfying the elimination period if your disability recurs in less than 90 days
2. Your elimination period will start over, counted from the date you became disabled again if:

● You become disabled due to the same or related condition after you've been back 90 days or more, or

● You become disabled after one day of active employment due to a condition unrelated to your prior disability.

RECURRENT DISABILITIES AFTER BENEFITS BEGIN

If your LTD benefits have begun and you recover from your disability, return to active employment, then become disabled once again:

1. Within six consecutive months:

- The [recurrent disability](#) will be treated as part of your prior claim and your prior disability,

● You will not have to complete another elimination period,

● Plan benefits will continue up to the [maximum payment period](#), counted as if you had not returned, and

● Your claim will be subject to the same terms of this plan as your prior claim.
2. After six months of active employment or if you become disabled after one day of active employment due to a condition unrelated to your prior disability:

● The disability will be treated as a new claim and a new disability,

● You will be required to satisfy a new elimination period, after which LTD benefits will be payable for up to the maximum payment period, and

● Your claim will be subject to the terms of the plan in effect at the time you became disabled again.

HEALTHCARE PROTECT BENEFIT

The Healthcare Protect Benefit is a special provision of the LTD Insurance Plan, designed to help you pay the continued monthly costs of your health care coverage. If you qualify and your disability began January 1, 2021 or later, you will receive \$600 per month (part-time employees) or \$800 (full-time employees) in addition to your regular monthly LTD payments, after a 12-month waiting period. Your employment status prior to your date of disability is used to determine your Healthcare Protect Benefit.

The Healthcare Protect Benefit is not subject to [deductible sources of income](#) or other provisions that would otherwise increase or reduce your monthly LTD benefit. However, the total benefit payable to you by the LTD plan, including the Healthcare Protect Benefit plus any deductible sources of income, cannot exceed 100% of your base monthly earnings.

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Qualifying for the Benefit

Unum will notify you if you qualify for the Healthcare Protect Benefit. To qualify, you must:

- Have been continuously disabled during the Healthcare Protect Benefit 12-month waiting period,
- Have received six months of LTD payments, counted from the day after you complete the LTD plan's elimination period,
- Have been participating in a Costco or other employer's health care plan when you became disabled,
- Not be eligible for Costco health care coverage as an employee or as a family member of another employee, and
- Currently have other health care coverage – such as through [COBRA](#), a private insurance plan or another employer's medical plan – and provide Unum with proof of that coverage.

When the Healthcare Protect Benefit Begins

Payments may begin after you have been continuously disabled through the 12-month Healthcare Protect Benefit waiting period (including six months of LTD benefits). The days you are disabled but continue to work and have Costco health care coverage won't count toward the waiting period.

If you are still receiving Costco COBRA subsidy payments at the end of the 12-month waiting period, the benefit will only begin after the subsidy ends or is reduced.

How Long the Healthcare Protect Benefit May Continue

In general, payments may continue for a maximum of 12 months. However, payments may continue for up to 17 months if:

- The Social Security Administration makes a determination that you are disabled under Title II or Title XVI of the U.S. Social Security Act, and

- That determination is made during the first 24 months of your disability *and* you have been on COBRA for at least 60 days.

In any case, your payments from the Healthcare Protect Benefit will end the date your benefit payments under the LTD Insurance Plan stop or you no longer have health care coverage.

LTD SURVIVOR BENEFITS

If you die while you are receiving or are eligible to receive LTD benefits, the plan will pay a lump sum amount to your surviving spouse.

- If you do not have a surviving spouse, the lump sum will be paid in equal shares to your children under age 25.
- If you're not survived by a spouse or children under age 25, the sum will be paid to your estate.
- If there is no estate, the benefit will not be paid.

The survivor benefit is three times your monthly LTD benefit amount (not including any rehabilitation and return to work program benefits). The benefit amount is not reduced by [deductible sources of income](#).

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Making a Claim for Disability Benefits

To begin receiving benefits from these plans, you must file a claim and provide proof of your disability. Your benefits will begin only after Unum reviews and approves your claim. The exception is if you have been receiving Voluntary STD Insurance Plan benefits or benefits from New York or Hawaii state-mandated plans. In that case, you do not have to take any special steps to initiate a claim for LTD because Unum will coordinate those claims on your behalf.

See [Filing Benefit Claims on page 130](#) for general rules about applying for benefit payments. Also, as described in [If Your Claim is Denied on page 137](#), you have certain rights to appeal a denial of your claim.

FILING YOUR CLAIM

To start your claim, call Unum at **877-403-9348** as soon as possible after you become disabled, preferably within 30 days. You will provide information such as the nature and cause of your condition, your job title, and description of your [own job](#) duties.

PROVIDING PROOF OF YOUR DISABILITY

After you call, Unum will send you all the paperwork necessary to complete your claim. This includes an Attending Physician's Statement for your [physician](#) to complete and submit as proof of your disability. Depending on the circumstances, additional proof may be required. This might include, for example, an examination by a physician, other medical practitioner and/or vocational expert selected and paid for by Unum.

Proof of your disability should be submitted within 90 days after you complete the applicable plan's [elimination period](#). If it's not possible to meet that deadline, proof should be submitted as soon as reasonably possible. In any case, the plan will not pay benefits if the claim and proof of your disability is not submitted within one year after otherwise required (except in the absence of legal capacity).

DURING THE CLAIM REVIEW PROCESS

As your disability claim is being reviewed, Unum will keep you up to date on the status of your claim with phone calls and letters. You can also check your claim status on your tablet or smartphone using the Unum app, on your computer at [unum.com/claimant](#), or by calling Unum at **877-403-9348**.

AFTER BENEFITS BEGIN

Unum may periodically review your condition to determine whether you continue to qualify for plan benefits. For instance, you may be required to have a physical examination as often as reasonable or to be interviewed by Unum's representative.

WHEN BENEFITS END

- Costco disability insurance benefits will stop on the earliest of the following dates:
- You reach the plan's [maximum payment period](#)
  - You are no longer disabled under the terms of the plan
  - You are no longer under the regular and continuous care of a licensed physician or you refuse to follow the [treatment plan](#) recommended by your physician
  - You refuse to undergo a medical examination or fail to provide additional information following a written request by Unum
  - You refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit your disabling condition
  - For Voluntary STD:
    - When you are able to work in your own job or a [reasonable alternative](#) offered to you by Costco but you choose not to, or



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- Your [disability earnings](#) exceed 80% of your base weekly earnings as described in [If You Work While Disabled on page 72](#)
- 7. For LTD:
  - During the first nine months of LTD benefits, if you are able to work in your [own job](#) or a [reasonable alternative](#) offered to you by Costco, but you choose not to
  - After nine months of LTD benefits, if you are able to work in any [gainful occupation](#) but you choose not to
  - If your disability earnings exceed 80% of your indexed monthly earnings, as described in [If You Work While Disabled on page 72](#)
- 8. When you cease to participate in the Rehabilitation and Return-to-Work Assistance Program if it has been offered to you
- 9. For benefits payable under the Rehabilitation and Return-to-Work Assistance Program, when you cease to participate in the program or any other date on which payments would stop in accordance with the disability plans. In addition, this program's child care benefit will end when your children reach the maximum age or are otherwise no longer eligible.
- 10. After 12 months of payments if you are considered to reside outside the United States or Canada. You are considered to reside outside the United States or Canada if you have been outside these countries for a total period of six months or more during any 12 consecutive months of benefits.
- 11. You die, although your survivors may receive a lump sum payment from the LTD plan as described in [LTD Survivor Benefits on page 74](#)

WHAT'S NOT COVERED

In addition to the other limitations and exclusions discussed throughout this and other sections of this booklet, following is a list of additional exclusions as specified in the applicable insurance contracts. If you have questions about your particular circumstances, call Unum at **877-403-9348**.

The Costco disability insurance plans do not pay benefits for any of the following.

- Any disabilities caused by, contributed to by, or resulting from:
  - Intentionally self-inflicted injuries
  - Participation in a riot
  - Inability to work due to loss of a professional license, occupational license or certification, even if the loss of the license is the result of a disability
  - An attempt to commit a crime or commission of a crime for which you are convicted under state or federal law
- Disabilities due to war, declared or undeclared, or any act of war, unless the disability resulted from a war-related event or act that occurred prior to the date you became insured or eligible to be insured under this plan
- Any period of disability while you are in jail
- Disabilities during any period when you are not under the [regular care of a physician](#)
- In the case of the Voluntary STD Insurance Plan, any disabilities caused by, contributed to by, or resulting from an [occupational sickness or injury](#), including any disability covered by a state workers' compensation act or similar law or by the Costco Wholesale Corporation Texas Injury Benefit Plan
- For the Voluntary STD Insurance plan, cosmetic or elective procedures or surgeries, except when necessary due to sickness or [injury](#)



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Life and Accident Insurance

The Costco Employee Benefits Program includes the following life and accident insurance plans:

- **Life Insurance**, insured and administered by Unum Life Insurance Company of America, pays benefits if you die while covered. Available coverage includes:
  - » *Basic Life Insurance*, automatically provided for you and your family members enrolled for Costco medical or Long-Term Disability Insurance coverage
  - » *Supplemental Life Insurance*, for you and enrolled family members
- **Accidental Death and Dismemberment (AD&D) Insurance**, insured and administered by Unum Life Insurance Company of America, pays benefits for loss of life and certain other serious injuries resulting from an accident. Available coverage includes:
  - » *Basic AD&D Insurance* for you, if you are enrolled for Costco medical or Long-Term Disability (LTD) Insurance coverage
  - » *Supplemental AD&D Insurance* for you and eligible family members
- **Business Travel Accident (BTA) Insurance** for salaried employees, insured and administered by The Hartford insurance company, pays benefits for covered injuries or loss of life that occurs while you are traveling on behalf of the company.

If, on the date your Basic or Supplemental Life or AD&D Insurance is scheduled to begin, you are absent from work due to [injury](#), [sickness](#) or [Leave of Absence](#), coverage will not begin until the date of your return to [active employment](#). Life and AD&D Insurance will not increase while you're on a Leave of Absence. The amounts described in this section, if more than the amount before your leave, will go into effect on the date you return to active employment or the date that Unum approves the increase in coverage (if [Evidence of Insurability](#) is required), whichever is later. Decreases are effective on the date your earnings decrease or your employee classification changes, even

if you are on a Leave of Absence. This provision does not apply to BTA Insurance.

These are group term life insurance policies, with no cash value until a claim is paid to your beneficiaries due to your death.

YOUR COSTS FOR COVERAGE

Costco pays the full cost of your Basic Life, Basic AD&D and BTA Insurance. If you elect Supplemental Life or AD&D Insurance, the full cost will be withheld after-tax from each paycheck. Current costs for Supplemental Life and AD&D Insurance are listed in the [Rate Booklet](#), available at [Costcobenefits.com](#) or from your Payroll Clerk.

The cost of Supplemental Life Insurance for yourself is based on the benefit amount and your age (the higher your age bracket, the more you'll pay for coverage). The cost of Supplemental Life Insurance for your spouse or domestic partner is based on the benefit amount and your spouse or domestic partner's age. The cost of Supplemental AD&D Insurance is based on the amount of coverage and family coverage elected.

Contributions withheld from each paycheck pay for coverage through that pay date. Depending on the coverage start date, you may also have to pay contributions for coverage before this pay period.

DUPLICATE COVERAGE RULES

Duplicate coverage is not allowed for Basic Life, Basic AD&D, or BTA Insurance.

Supplemental Life Insurance and Supplemental AD&D Insurance allow for duplicate coverage:

- If both you and your spouse or domestic partner, child, or parent are eligible for Costco benefits, you and your family member may



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- each be covered under the plans twice – once as an employee and once as an eligible family member, subject to the dollar limits shown in [Supplemental Life Insurance on page 81](#), and [Supplemental AD&D Insurance on page 84](#).
- If you and your spouse or domestic partner are eligible for Costco benefits, you may both elect coverage for your eligible children.

DESIGNATING A BENEFICIARY

Your beneficiary is the person you name to receive the payment from your life and accident insurance plans if you die. Your beneficiary will receive payment of your coverage amount in the form of a single lump sum if the claim is for less than \$10,000. If the claim is for \$10,000 or more, your beneficiary can choose to receive either a single lump sum or several smaller payments.

You must designate your beneficiary in your enrollment record on the Enrollment Website, available at [Costcobenefits.com](#). If you need help, call the Enrollment Center at **800-541-6205**.

Any other beneficiary designations are invalid, including past designations made on paper forms (if not also reflected on the Enrollment Website).

You can designate or change your beneficiary at any time. When designating a beneficiary, keep these rules in mind:

- You can name anyone you want. However, before you designate a minor child as a beneficiary, consult an attorney about possible legal implications.
- You may name different beneficiaries for each plan, two or more beneficiaries per plan and the percentage of the benefit each will receive (otherwise it will be divided equally among them), and a secondary beneficiary to receive benefits if your primary beneficiary predeceases you.
- If you have designated your spouse and you get divorced or your marriage is annulled, that designation will be automatically revoked. However, you may re-name your spouse on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center.

- You are automatically the beneficiary for any enrolled family members.
- If you are a salaried employee covered by the Business Travel Accident Insurance Plan, your beneficiary for that plan will be the same as for Basic Life Insurance.

If You Die Without a Beneficiary

If you die without a beneficiary designation reflected on the Enrollment Website, or if all of your designated beneficiaries predecease you, life and accident insurance plan payments will be made to the first surviving family member shown below.

- Your spouse
- Your children in equal amounts
- Your parents in equal amounts
- Your sisters and brothers in equal amounts
- If you have no surviving family member, benefits will be paid to your estate

REDUCTION OF BENEFITS AT AGE 70

For Basic Life, Basic AD&D, and BTA Insurance, benefits are reduced to a percentage of the full benefit amount for enrolled employees and family members age 70 or older, as shown below.

Basic Life and Basic AD&D Insurance	
If you are this age:	Your Basic Life and Basic AD&D insurance benefit equals:
70 through 74	65% of full coverage amount
75 through 79	30% of full coverage amount
80 and over	15% of full coverage amount
Business Travel Accident Insurance	
If you are this age:	Your BTA insurance benefit equals:
70 through 74	65% of full coverage amount
75 through 79	45% of full coverage amount
80 through 84	30% of full coverage amount
85 and over	15% of full coverage amount

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COSTCO LIFE INSURANCE IF YOU ARE TERMINALLY ILL

If you are certified as [terminally ill](#), Costco will pay the cost of your Employee Life Insurance coverage for up to 24 months, counted from your last day of work. To qualify for this subsidy, you must apply and be approved for the Life Insurance [Accelerated Death Benefit \(ADB\) on page 82](#).

ASSIGNMENT OF INTEREST

The rights provided to you by Costco life and accident insurance plans are owned by you unless you assign these rights to someone else (an “assignee”). For more information, contact an attorney.

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As long as you are enrolled for Costco medical coverage or Long-Term Disability Insurance, Basic Life Insurance is automatic for you and your enrolled family members.

For more protection, if you are enrolled in Basic Life Insurance you may elect additional Supplemental Life Insurance for yourself and eligible family members, even those who are not enrolled for medical coverage. If you are required to provide [Evidence of Insurability \(EOI\)](#), Unum must approve your application in writing before your elected Supplemental Life Insurance goes into effect.

BASIC LIFE INSURANCE

The following table shows Basic Life Insurance coverage for employees and their enrolled family members.

Summary of Basic Life Insurance		
Employee classification	Years of continuous service	Benefit
Salaried and full-time hourly employees	0 up to 2 years	1 times <a href="#">annual earnings</a>
	2 up to 5 years	2 times annual earnings
	5 or more years	3 times annual earnings
Part-time employees	0 up to 2 years	\$15,000
	2 up to 5 years	\$25,000
	5 or more years	\$40,000
Employees who have been issued an Executive Life Insurance policy	Any number of years	\$50,000
Executive-level employees <b>without</b> an Executive Life Insurance policy	Any number of years	3 times annual earnings
Family coverage		
Eligible family members enrolled for Costco medical plan coverage		\$1,500 each

If your Basic Life Insurance benefit is based on your annual earnings (salaried and full-time hourly employees, and executives without an Executive Life Insurance policy):

1. Your benefit amount, if not a multiple of \$1,000, will be rounded up to the next higher \$1,000.
- For example: An employee has four years of service and annual earnings of \$27,440. That employee’s coverage would equal \$55,000 (2 x \$27,440 = \$54,880, rounded up to \$55,000).
2. Your benefit will increase or decrease on the date your earnings increase or your employee classification changes. The exception is if you are away from work due to [injury](#) or [sickness](#) or on a [Leave of Absence](#) at that time. In that case, any increase in coverage will not go into effect until you return to [active employment](#). Decreases are effective on the date your earnings decrease or your employee classification changes, even if you are on a Leave of Absence.
3. The maximum benefit, regardless of your service or annual earnings, is \$225,000.

Imputed Income on Your Basic Life Insurance

Under current tax regulations, the cost of your Costco-paid Basic Life Insurance over \$50,000 is considered “imputed income” to you. This amount, which is subject to income and FICA (Social Security/ [Medicare](#)) taxes, is added to your W-2 earnings and noted on your paycheck as “Group Term Life.”

ANNUAL EARNINGS

For part-time employees, hourly rate of pay times 1,560 hours

For full-time hourly employees, hourly rate of pay times 2,080 hours

For salaried and executive-level employees, annual salary as reported by Costco

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Imputed income is figured based on the value the IRS assigns to the premiums for each \$1,000 in coverage. While the dollar amount is modest for most employees, the older you are, the greater the value. If you don't want to be subject to this imputed income, you can apply to the [Costco Employee Benefits Department](#) to limit your Basic Life Insurance coverage to \$50,000.

SUPPLEMENTAL LIFE INSURANCE

The following table shows the elective supplemental coverage amounts available to employees who are enrolled in Basic Life Insurance coverage.

Summary of Supplemental Life Insurance	
Participant	Benefit options
Employee	<div>\$10,000 increments, from \$10,000 up to the lesser of:<ul style="list-style-type: none"><li>5 times <a href="#">annual earnings</a> (rounded down to the nearest \$10,000 increment), or</li><li>\$1 million</li></ul>For example: If your annual earnings are \$33,000, the maximum you can elect is \$160,000 (5 x \$33,000 = \$165,000, rounded down to \$160,000).</div>
Spouse or domestic partner*	<div>\$10,000 increments, from \$10,000 up to the lesser of:<ul style="list-style-type: none"><li>100% of employee's coverage, or</li><li>\$300,000</li></ul>For example: If your benefit is \$100,000, you can elect up to \$100,000 for your spouse or domestic partner.</div>
Eligible children	\$10,000 each

\* At the time a claim is filed, you will be required to provide documentation to prove that your spouse or domestic partner was eligible for coverage under the Costco Employee Benefits Program. If it is determined that they did not meet the eligibility requirements, benefits will not be paid.

If You Have Duplicate Coverage

You may be enrolled for Supplemental Life Insurance both as an employee and as the spouse or domestic partner of an employee. However, the combined maximum of your duplicate coverage cannot exceed the following total:

- As an employee, five times earnings or \$1 million (whichever is less), plus
- As a spouse or domestic partner, \$300,000.

When Evidence of Insurability (EOI) is Required

You are required to provide Unum with [Evidence of Insurability \(EOI\)](#):

- To elect more than \$350,000 of Supplemental Life Insurance for yourself, or more than \$150,000 for your spouse or domestic partner
- To enroll yourself or your spouse or domestic partner for any amount if you previously declined to enroll yourself or that family member
- To increase Supplemental Life Insurance for yourself or your spouse or domestic partner during [Annual Enrollment](#) or following a mid-year [change in status](#) by more than \$20,000

Submitting EOI

If you are required to provide Evidence of Insurability (EOI) to add or increase coverage, Unum will send the appropriate forms to you at your home address with instructions and due dates.

Unum must approve your election before your elected coverage will go into effect. It's your responsibility to be sure you have received Unum's written approval. Without written approval from Unum, you will not be covered by your elected amount. This applies even if your paycheck or Benefits Enrollment Notice erroneously shows you are enrolled in and paying for Supplemental Life Insurance.

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If you don't submit the forms by the specified deadlines, your application will not be processed – and you will have to wait until the next [Annual Enrollment](#) (or you have an appropriate mid-year [change in status](#)) before you may apply again.

**Imputed Income on Supplemental Life Insurance**

Under current tax regulations, if the amount you pay for supplemental life insurance (for you or a family member) is less than the IRS-determined premium value of the coverage, the difference may be “imputed income” to you. If this occurs, the imputed income amount is subject to taxes, and is added to your W-2 earnings and noted on your paycheck.

**ACCELERATED DEATH BENEFIT (ADB)**

Costco Life Insurance includes an Accelerated Death Benefit (ADB) available to enrolled employees, spouses and domestic partners who are [terminally ill](#). If you apply and are approved by Unum for this benefit:

- You may elect to receive a portion of your Life Insurance coverage while still alive. This can be any amount from \$1,000 up to 75% of your Basic and Supplemental Life benefit (maximum payment: \$500,000). After you die, the balance of your coverage will be paid to your beneficiary.
- Costco will subsidize the full cost of up to 18 months of [COBRA](#) coverage for you and your family.
- The balance of your Life Insurance coverage (after payment of the ADB) will be continued for up to 24 months at no charge to you.

**Applying for the ADB**

If you're ever diagnosed as terminally ill, contact the [Costco Employee Benefits Department](#) as soon as possible. Costco will work with you to apply for the benefit in a timely fashion. This is

very important because, to qualify for the ADB, you must apply before your eligibility for the Costco Employee Benefits Program ends.

To apply, you will need to complete and submit the following forms to Unum, along with written certification from your [doctor](#) that your life expectancy is less than 24 months:

- Benefit Continuation of Terminally Ill and Accelerated Death Benefit (ADB) form*
- Request for Medical Documentation form*

Payment of the ADB is subject to approval by Unum. Any disputes over your right to receive payment must be settled through specific steps set out in the Life Insurance contract. In certain circumstances, benefits may be taxable to you and might also affect your right to government benefits such as [Medicare](#), Medicaid or Social Security. To discuss possible implications for you, consult a tax advisor or attorney.

**When the ADB is Not Payable**

The benefit will not be payable if:

- You are required by law to use the benefit to meet the claims of creditors,
- You are required by a government agency to use this benefit to apply for, get or otherwise keep a government benefit or entitlement, or
- You have assigned your life insurance rights or made an irrevocable beneficiary designation, unless you provide written notice that the assignee or irrevocable beneficiary has agreed to this payment.



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Basic Accidental Death & Dismemberment (AD&D) Insurance is automatic if you are enrolled for Costco medical coverage. For additional protection, if you are enrolled in Basic AD&D Insurance you may elect Supplemental AD&D Insurance. Your Supplemental AD&D Insurance options are:

- Employee only
- Employee and children, or
- Employee and family (includes spouse or domestic partner and children).

Eligible family members may be enrolled for Supplemental AD&D Insurance even if they do not have Costco medical plan coverage. Any death benefits paid by the AD&D Insurance Plan are in addition to those paid by the Costco Life Insurance Plan.

HOW AD&D INSURANCE WORKS

AD&D Insurance pays benefits for a covered loss resulting from an **injury**. Plan participants are covered by a “primary benefit” amount. As shown on the following chart, plan payments equal a percentage of the primary benefit based on the nature of the loss. To qualify for benefits:

- The injury, and the accident which caused the injury, must occur while covered by the plan, and
- The loss must occur within 365 days after that accident.

The most each plan will pay per covered person for any combination of losses from any one accident is 100% of the primary amount.

For this loss:	AD&D pays this % of primary benefit:
Life	100%
Both hands or both feet	100%
Sight in both eyes	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Speech and hearing	100%
Quadriplegia (total and irreversible paralysis of the upper and lower limbs)	100%
Paraplegia (total and irreversible paralysis of both lower limbs)	75%
Triplegia (total and irreversible paralysis of three limbs)	75%
Hemiplegia (total and irreversible paralysis of upper and lower limbs of one side of the body)	50%
One hand or one foot	50%
One arm or one leg	50%
Speech or hearing	50%
Sight in one eye	50%
Thumb and index finger on the same hand	25%
Uniplegia (total and irreversible paralysis of one limb)	25%

Loss means, with regard to:

- A hand, severance of all four fingers at or above the knuckles joining each to the hand
- A foot, severance of the foot at or above the ankle joint
- Sight, an eye is totally blind and no sight can be restored in that eye
- Thumb and index finger, severance of the thumb and index finger at or above the joint closest to the wrist
- Speech, the total and irrecoverable loss of speech
- Hearing, the total and irrecoverable loss of hearing in both ears

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The following table shows Basic AD&D Insurance for employees.

Summary of Basic AD&D Insurance		
Employee classification	Years of continuous service	Primary benefit
Salaried and full-time hourly employees	0 up to 2 years	1 times annual earnings
	2 up to 5 years	2 times annual earnings
	5 or more years	3 times annual earnings
Part-time employees	0 up to 2 years	\$15,000
	2 up to 5 years	\$25,000
	5 or more years	\$40,000

If your Basic AD&D Insurance benefit is based on your annual earnings (salaried and full-time hourly employees):

- Your benefit amount, if not a multiple of \$1,000, will be rounded up to the next higher \$1,000. For example: An employee has four years of service and annual earnings of \$27,440. That employee's coverage would equal \$55,000 (2 x \$27,440 = \$54,880, rounded up to \$55,000).
- Your benefit will increase or decrease on the date your earnings increase or your employee classification changes. The exception is if you are away from work due to injury or sickness or on a Leave of Absence. In that case, any increase in coverage will not go into effect until you return to active employment. Decreases are effective on the date your earnings decrease or your employee classification changes, even if you are on a Leave of Absence.
- The maximum benefit, regardless of your years of service or annual earnings, is \$225,000.

SUPPLEMENTAL AD&D INSURANCE

The following table shows the Supplemental AD&D Insurance options available to you and your family.

Summary of Supplemental AD&D Insurance	
Participant	Benefit options
Employee	<ul style="list-style-type: none"><li>If you earn \$25,000 or less per year, you may elect any amount from \$50,000 to \$250,000 as your primary benefit.</li><li>If you earn more than \$25,000 per year, you may elect any amount from \$50,000 up to the lesser of the following amounts as your primary benefit:<ul style="list-style-type: none"><li>» 10 times annual earnings – in which case, your coverage will be rounded down to the next lowest \$50,000 increment. For example: If you earn \$32,000 per year, the maximum benefit you may elect is \$300,000 (\$32,000 x 10 = \$320,000 rounded down to \$300,000).</li><li>» \$1.5 million</li></ul></li></ul>
Family members	<p>If you elect employee and family insurance, eligible family members will be covered for the following percent of your Supplemental AD&amp;D Insurance benefit:</p> <ul style="list-style-type: none"><li>Your spouse or domestic partner<ul style="list-style-type: none"><li>» 65% if you do not have eligible children</li><li>» 55% if you have eligible children</li></ul></li><li>Each eligible child<ul style="list-style-type: none"><li>» 20% if you do not have a spouse or domestic partner</li><li>» 10% if you have a spouse or domestic partner</li></ul></li></ul> <p>Maximum coverage per child: \$50,000</p>

Any increases to Supplemental AD&D Insurance you elect will go into effect:

- January 1 following Annual Enrollment, or
- Following a mid-year change as described in Life Events on page 103.

If you are away from work due to injury or sickness or on a Leave of Absence, the increase will not go into effect until the date you return to active employment.

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- Basic Life Insurance
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If You Have Duplicate Coverage

You may be enrolled for Supplemental AD&D both as an employee and as an eligible family member of an employee. However, if you are an employee who earns more than \$25,000 (as described above), the combined maximum amount of your coverage will be limited to:

1. **As an employee**, 10 times **annual earnings** or \$1.5 million (whichever is less), plus
2. **As a spouse or domestic partner**, either:
  - 65% of your employee coverage if you have a spouse or domestic partner but no eligible children, or
  - 55% of your employee coverage if you have a spouse or domestic partner and eligible children.

SPECIAL AD&D BENEFITS

The Costco AD&D Insurance plans offer special benefits that may become payable if you die or sustain other covered losses in certain circumstances. These benefits may be paid by Basic AD&D Insurance, Supplemental AD&D Insurance, or both, in addition to the normal plan benefits.

Examples of these special benefits include:

- Extra payments if you die in a car accident and you were wearing a seat belt and airbags were deployed
- Educational benefits for eligible children
- Training costs for spouses and domestic partners
- Disaster, comatose, exposure, disappearance, paralysis, and felonious assault benefits

For more information, call Unum at **877-403-9348** or see the plan contract, available from the [Costco Employee Benefits Department](#).

ASSIST AMERICA INC. (AAI)

The Assist America Inc. program automatically applies to all employees enrolled in Costco Basic or Supplemental AD&D Insurance. If you are enrolled, your spouse and dependent children under age 26 are also eligible to use AAI program services, except when traveling on business for their own employer.

The AAI program provides services and pays the costs of many expenses associated with a medical emergency or **urgent care** that occurs while you are traveling more than 100 miles away from home. This may include, for example:

- Referral to medical care providers, interpreters, and legal personnel
- Round trip transportation for a person designated by you to the **hospital** where you have been confined
- Arrangement for medical emergency evacuation
- Payment to help cover the costs of the return of your body if you die from a covered accident outside the United States

To qualify for benefits under this program, you must have all services arranged or provided by Assist America. To get the help you need or to find out more about the program, call or email:

- **800-872-1414**
- U.S. access code + 609-986-1234 (toll-free outside the U.S.)
- [medservices@assistamerica.com](mailto:medservices@assistamerica.com)

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Business Travel Accident Insurance

The Business Travel Accident (BTA) Insurance Plan automatically covers salaried employees from the first day of work. If you are covered, the plan will pay benefits if you experience a covered **injury** resulting from an accident while:

- On a **business trip** including a personal **sojourn** from the trip, or
- Commuting** directly between your residence and place of regular employment.

Subject to prior approval from Costco, your eligible family members will also be covered while traveling with you on your business trip or **relocation trip**. It does not cover them if they are accompanying you while you commute.

BTA benefits are in addition to any benefit paid by other Costco plans, such as the Costco Life and AD&D Insurance plans.

HOW BTA WORKS

As an eligible employee, your primary BTA Insurance benefit is \$250,000. The primary benefit for eligible family members is \$100,000.

Depending on the covered loss, the plan will pay a percentage of the primary BTA benefit as shown in the following table. Plus, if you or a covered family member dies in a car accident while using a seat belt, the plan will pay an additional benefit of 10% to a maximum of \$25,000.

**Note:** If more than one person is injured in any one accident, the most the plan will pay for all benefits combined is \$5 million.

For this loss:	BTA pays this % of primary benefit:
Life	100%
Both hands or both feet, or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing (both ears)	100%
Either hand or foot, and sight of one eye	100%
Quadriplegia (movement of both upper and lower limbs)	100%
Paraplegia (movement of both lower limbs)	75%
Hemiplegia (movement of upper and lower limbs of one side of the body)	50%
Either hand or foot	50%
Sight of one eye	50%
Speech or hearing (both ears)	50%
Thumb and index finger on the same hand	25%

Loss means with regard to:

- Hands and feet, actual severance through or above the wrist or ankle joints
- Sight, speech or hearing, entire and irrecoverable loss of those
- Thumb and index finger, actual severance through or above the metacarpophalangeal joints
- Movement of limbs, complete and irreversible paralysis of the limbs

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SPECIAL CIRCUMSTANCES

As follows, BTA Insurance will pay benefits in certain special circumstances:

- Exposure to the elements is presumed to be an injury if it results from the forced landing, stranding, sinking or wrecking of a conveyance in which the insured person was an occupant at the time of the accident.
- Disappearance is presumed to have resulted in loss of life if the covered individual's body has not been found within one year after the disappearance of a conveyance in which they were an occupant at the time. The disappearance of the conveyance must have been due to its accidental forced landing, stranding, sinking or wrecking.

COVERAGE WHILE ON COSTCO AIRCRAFT

BTA Insurance covers **injury** resulting from an accident which occurs while you are on a trip as a passenger, pilot, operator or member of the crew on, boarding or alighting from, or being struck by **aircraft** that are owned, leased, borrowed, or operated by or on behalf of Costco.

The aircraft must be certified by the Federal Aviation Administration or its foreign equivalent and piloted by a qualified pilot who:

- Holds a current and valid certificate of competency with a rating that authorizes them to pilot the aircraft,
- Has been approved for coverage in writing by The Hartford, under Costco's Hull and Liability Policy, and
- Has logged a minimum of 500 hours as a pilot, at least 250 of those hours logged in an aircraft in a single or multi-engine of like basic design.

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Making a Claim for Benefits

A claim must be submitted to Unum for payment of Life or AD&D Insurance Plan benefits, or to The Hartford for payment of BTA Insurance Plan benefits. To get the process started, you, your beneficiary or [authorized representative](#) should contact the [Costco Employee Benefits Department](#). They will work to coordinate submission of the claim in a proper and timely manner.

Life Insurance claims must be submitted along with proof of the claim, such as a death certificate, within 90 days after death. AD&D Insurance claims must be submitted along with proof of the claim within 90 days after a covered loss. BTA Insurance claims must be submitted within 30 days after a covered loss and proof of the claim must be submitted within 90 days after the loss.

If it's not possible to meet these deadlines, the claim and proof of the claim should be filed as soon as reasonably possible. In any case, the plan will not pay benefits if the claim is not submitted within one year after otherwise required (except in the absence of legal capacity).

Payment will be made only after the [claims administrator](#) has approved the claim. As part of the proof of the claim, the claims administrator may require authorization to obtain additional medical and non-medical information.

To learn more about general rules that apply to claims, see Filing Benefit Claims on page 130. If a claim is denied, there are specific steps you or your beneficiary may take to appeal that denial. For more information, see [If Your Claim is Denied on page 137](#).



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Portability After Eligibility Ends

Life and AD&D Insurance is portable. That means, after your eligibility for the Costco Employee Benefits Program ends, you can continue this insurance for yourself and your family on an individual basis. This insurance is also portable for family members who lose their eligibility, for example, due to your death or divorce. When you “port” insurance, you’ll pay group rates with no **Evidence of Insurability (EOI)** required.

Here’s how it works:

- For the first 31 days after eligibility ends, Costco will pay the cost to continue coverage.
- Unum will send a letter notifying you of the option to port coverage. If interested, you must call Unum to request an application. The personalized application will include information about coverage options and costs, and the date by which you must send forms and payments directly to Unum. You may be able to change your elections under the Costco plans in a variety of ways, for example:
  - Continue Life Insurance but not AD&D Insurance, or vice versa
  - Continue Basic Life Insurance but not Supplemental Life Insurance
  - Continue your own insurance but not your family’s
  - Elect a lesser amount of insurance than you have now
- To continue your insurance after the 31-day period, return the application along with the first premium payment to Unum by the stated deadline.

Maximum Coverage Amounts You May Port

You may port up to the following amounts of coverage:

- For yourself**, your Basic and Supplemental Life and/or AD&D coverage up to a combined maximum of the lesser of 8 times your **annual earnings** or \$750,000 for all Unum Life and AD&D Insurance. (To continue Life Insurance for amounts above the \$750,000 maximum, you can apply to convert your coverage as described below.)
- For your family members**, the current amount of their Supplemental Life and/or AD&D coverage.

Converting to Individual Insurance

Employees who are not eligible to port their full Life Insurance coverage may be able to convert to individual Life Insurance after eligibility for the Costco Employee Benefit Program ends. Under this conversion option, no Evidence of Insurability (EOI) is required. However, unlike portable coverage, provisions, terms, benefits and costs of converted Life Insurance policies may differ substantially from those offered by the Costco Life Insurance Plans.

For more information about conversion options, contact Unum.

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In addition to the other limitations and exclusions discussed throughout this and other sections of this booklet, the following are additional exclusions as specified in the insurance contracts.

AD&D PLAN EXCLUSIONS

The AD&D Insurance plans do not pay any claim for a loss that is caused by, contributed to by, or resulting from the following.

1. Intentionally self-inflicted injuries while sane, or self-inflicted injuries while sane or insane
2. Suicide (in Missouri, while sane) or any attempt at suicide
3. War, declared or undeclared, or any act of war in specified countries
4. Service on full-time active duty in the armed forces of any country or international authority
5. Disease of the body or diagnostic, medical or surgical treatment, or **mental disorder** as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders
6. Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while:
  - It is being used for test or experimental purposes,
  - You or your family member is operating, learning to operate or serving as a member of the crew (this exclusion does not apply to pilots employed by Costco while they are a crewmember of a Costco-owned **aircraft**), or
  - It is being operated by or for or under the direction of any military authority (this exclusion does not apply to transport-type aircraft operated by the Military Airlift Command of the United States or similar air transport service of any other country).
7. Active participation in a riot
8. Death or **injury** sustained while attempting to commit or commission of a crime under state or federal law
9. The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance, unless used according

to the prescription or direction of you or your family member's physician. This exclusion will not apply if the chemical substance is ethanol.

BTA INSURANCE PLAN EXCLUSIONS

The Business Travel Accident Insurance plan does not cover any loss resulting from the following.

1. **Sickness** or disease (except a pus-forming infection which occurs through an accidental wound) or medical or surgical treatment of a sickness or disease
2. Intentionally self-inflicted injuries, suicide or attempted suicide, whether sane or insane (in Missouri, while sane)
3. War or act of war, declared or undeclared, except as provided for under the War Risk Rider
4. Injury sustained while on any aircraft unless, and only to the extent, it is described in the insurance contract or an attached rider (called a "hazard")
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician
6. Injury sustained while committing or attempting to commit a felony
7. Injury sustained while legally intoxicated from the use of alcohol (not applicable to Minnesota residents)
8. Injury that results from an accident while traveling on an aircraft owned by Costco if it is carrying passengers for hire
9. Injury resulting from an accident which occurs while on, boarding or alighting from any aircraft being used for or in connection with acrobatic or stunt flying, racing or endurance tests, crop dusting, seeding or spraying, exploration, pipe or power line inspection, hunting, bird or fowl herding, aerial photography, banner towing, any test or experimental purpose, or any flight which requires a special permit or waiver from the FAA, even if granted.

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REIMBURSEMENT ACCOUNT OPTIONS

Reimbursement Accounts can help you save money on your eligible expenses, because you pay no federal income or FICA (Social Security/[Medicare](#)) taxes on your contributions to the accounts or amounts you are reimbursed by the plans. In most cases, your money is exempt from state and local income taxes as well.

Costco offers three Reimbursement Accounts. You can choose to participate in any or all of these plans.

- **Dependent Care Assistance Plan (DCAP)**, to help pay the costs of care of your eligible [dependents](#), including children under age 13 and dependent elders
- **Health Care Reimbursement Account (HCRA)**, to help pay out-of-pocket health care costs for you, your spouse and your eligible dependents
- **Commuter Benefits Plan**, to help pay certain costs of commuting to and from work, including parking fees and mass transit passes

To be eligible for reimbursement from these accounts, expenses cannot be payable or reimbursable by any other source.

Your tax savings will depend upon your particular circumstances, such as your income and tax bracket. To estimate your potential savings, you can link to PayFlex from [Costcobenefits.com](#) and use the tax savings calculator. For details about your personal tax situation, consult a professional tax advisor.

Because of the tax advantages associated with plans like these, the IRS has strict rules governing their use. This applies, for example, to the kinds of expenses that are eligible for reimbursement and timelines for requesting reimbursement.

When you submit an expense reimbursement request or present your HCRA debit card as payment, you are attesting that you are purchasing a product or service eligible for reimbursement under the Program. It is fraud to later return the product for cash with intent to keep the cash, and violates the plan and tax law to fail to return the cash to the plan. See the [Employee Agreement](#) for applicable company policies and how this can affect you. See also the [Policy Statement on Benefits Fraud on page 111](#).

ONLINE ACCESS TO REIMBURSEMENT ACCOUNTS

To learn about and work with your Reimbursement Accounts, go to [Costcobenefits.com](#). From there, you can:

1. **For the DCAP and HCRA:**
  - Download forms to request reimbursement of eligible expenses
  - Link to PayFlex to check on the status of a claim, elect direct deposits of reimbursements, and view your current account balance
2. **For the Commuter Benefits Plan:**

Link to PayFlex to register for the plan and choose a transit pass, vanpool voucher, or parking voucher. You don't have to submit claims for this benefit – it will be funded or mailed to you automatically each month.

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Dependent Care Assistance Plan (DCAP)

Use the DCAP to set aside funds to pay for eligible expenses for the care of qualifying individuals who live in your home.

Qualifying individuals include the following people, as long as they share the same principal place of residence as you for more than half of the year:

1. Qualifying children under age 13, including your children, grandchildren, step-children, siblings, step-siblings, nieces or nephews, or eligible foster children. To be qualified individuals:

• They must not have provided over half of their own support for the year, and

• If you are divorced, legally separated or living apart from your spouse, you must be the custodial parent.

2. Your other dependents, such as elderly parents, who are physically or mentally incapable of self-care

3. Your spouse who is mentally or physically incapable of self-care

You cannot use the DCAP if someone else can claim you as a tax dependent for federal income tax purposes.

Domestic partners and their children are not qualifying individuals.

DCAP PLAN SUMMARY

Enrollment	You can enroll during your initial enrollment, or enroll or change contribution elections during <a href="#">Annual Enrollment</a> or as described in <a href="#">Life Events on page 103</a>
Eligible expenses	Expenses to care for qualifying individuals if: <ul style="list-style-type: none"><li>• The purpose of care is to allow you and, if you're married, your spouse, to work (unless your spouse is physically or mentally incapable of self-care or a full-time student), and</li><li>• The costs are incurred from January 1 through December 31 of the year in which you elect to participate.</li></ul>
Minimum annual contribution	None
Maximum annual contribution	Your plan contributions – combined with all other DCAP contributions you and your spouse make during the same year – may not exceed the lesser of: <ul style="list-style-type: none"><li>• \$5,000, or</li><li>• \$2,500, if you are married but you and your spouse file separate tax returns.</li></ul> You cannot be reimbursed for more than your <a href="#">earned income</a> or, if you are married, your spouse's earned income, in one year.
Claims submission deadline	April 30 of the calendar year after which you elected to participate

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ELIGIBLE EXPENSES

To be eligible, your **dependent care expenses** must be necessary to allow you, and if you are married, your spouse to be **gainfully employed**. This may include care provided inside or outside your home. Services outside the home must meet the following requirements to be eligible:

- If the care is for your spouse or other qualifying individual, that individual must regularly spend at least eight hours per day in your home
- If the care is for your dependent child under age 13, the services cannot be performed at an overnight camp
- If the care is provided by a **dependent care center**, the facility must be licensed and in compliance with all applicable state and local laws and regulations

For a detailed list of eligible expenses, go to [Costcobenefits.com](#). For more information, call PayFlex at **800-814-3543**.

HOW THE PLAN WORKS

You can enroll in the Dependent Care Assistance Plan during initial enrollment, **Annual Enrollment** or as described in **Life Events on page 103**. To continue participating from one year to the next, you must re-enroll during each Annual Enrollment period.

If you choose to participate, this is how it will work:

1. Elect your annual contribution amount

When you enroll, you decide how much you want to contribute for the year. The most you may contribute per year is \$5,000 or, if you're married but you and your spouse file separately, \$2,500.

As set by the **Tax Code**, it's your responsibility to make sure reimbursements from this plan do not exceed your **earned income** for the year or, if you are married, your spouse's earned income for the year – whichever is less.

USE IT OR LOSE IT

According to IRS rules, you forfeit any balance remaining in your account at the end of the calendar year. The last day you can file a claim for reimbursement of amounts in your account is April 30 of the following year. Forfeited amounts are used to offset plan administrative expenses and future costs. It's very important to carefully consider your potential expenses when making your contribution elections.

Temporary Coronavirus Carryover Allowance

Due to the COVID-19 pandemic, unused 2021 DCAP balances will carry over for use in 2022. Any balance remaining in your account after the 2022 claim filing deadline of April 30, 2023 will be forfeited.

This means, in general, you can't participate in this plan if you're married but your spouse has no earned income. The exception is if your spouse is a full-time student or physically or mentally incapable of self-care. In that case, they are deemed to have an earned income of:

- \$250 per month (if you have one qualifying individual in your family), or
- \$500 per month (two or more qualifying individuals).

2. Contributions come out of your paychecks

The amount deducted from each paycheck will equal your elected annual contribution divided by 26 pay periods. (If you enroll in the DCAP during the year, your deductions will equal your elected annual contribution divided by the pay periods left in the year.) Your contributions will go into a DCAP account in your name.

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3. Request reimbursement for eligible expenses

You can be reimbursed tax-free from your DCAP account for eligible expenses you incur after you begin participating and during the calendar year to which your election applies. An expense is “incurred” when you are provided with the service that gives rise to the expense. For example, even if you pay on the first day of the month for **dependent care expenses** provided during that month, the expense is not considered incurred until the end of that month.

After you incur an eligible expense, request reimbursement by submitting a *Dependent Care Reimbursement Account Claim Form* to PayFlex. Claim forms are available at [Costcobenefits.com](#) or on [PayFlex.com](#). You can submit your claim electronically by uploading your claim form and receipts in PDF format or you can mail it to PayFlex at the address on the form. You can also download the free mobile app to submit online reimbursement request and access forms.

- When you complete the claim form, you will need to provide all required information, including your provider’s Social Security or Tax Identification Number
- The claims submission deadline is April 30 of the year after which you elected to participate

4. Receive reimbursement

You will be reimbursed up to the current balance in your account. This is the amount you have contributed up to that date (minus any reimbursements received so far).

- If your claim is for more than your current account balance, the excess will be carried over into following months, to be paid out as your balance becomes adequate.
- If you lose benefits eligibility while participating in the DCAP, your contributions to the plan will end but you may request

reimbursement of eligible expenses you incurred prior to the date your eligibility for benefits ended. You will be reimbursed up to the balance left in your account when your eligibility ended.

- PayFlex will mail your reimbursement check to your home. If you prefer, you can elect to have the check deposited directly into your bank account. To elect direct deposit, log into your account at [PayFlex.com](#) and click on Financial Center. You can also find the direct deposit authorization form at [Costcobenefits.com](#) or call PayFlex at **800-814-3543** to request the form.
- If your claim is denied, there are procedures you can take to appeal the denial, as described in [If Your Claim is Denied on page 137](#).

FILING YOUR TAXES

To qualify for tax-free treatment of the DCAP benefit, the IRS requires you to file Form 2441 “Child and Dependent Care Expenses” with your annual tax return. On this form, you must provide information about the dependent care services for which you have claimed tax-free reimbursement during the year.

This includes the Social Security number or Taxpayer Identification Number of each dependent care provider (except for tax-exempt providers, such as a church group), since providers must declare the money you pay them as taxable income.

**Note:** If you participate in the DCAP, you can’t use the federal dependent care income tax credit for expenses you pay with DCAP account funds. However, dependent care expenses that are not reimbursed by the DCAP may be eligible for the dependent care credit. Consult a professional tax advisor for more information about how the DCAP works versus the federal income tax credit.



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Health Care Reimbursement Account (HCRA)

You can use the amount you set aside in this account to reimburse eligible health care expenses incurred by you, your spouse, and your eligible [dependents](#). Employees who have declined all coverage are not eligible to participate in HCRA (see Decline Option 3 under [If You Decline Coverage on page 19](#)). Costs incurred by or on behalf of your domestic partner or their children are not eligible for reimbursement, unless the individual is also your Section 152 tax dependent.

HCRA PLAN SUMMARY

Enrollment	You can only enroll or change contribution elections during <a href="#">Annual Enrollment</a>
Eligible expenses	Medical, dental, vision and other health care expenses incurred by you, your spouse and your dependents as specified by the <a href="#">Tax Code</a> . To be eligible for reimbursement, expenses must be incurred during the year in which you elect to participate.
Minimum annual contribution	\$120
Maximum annual contribution	\$2,750, or other amount announced by Costco If you and your spouse are both benefits-eligible Costco employees, you may each contribute the annual maximum
Carryover allowed	Up to \$550 of unused balance can be carried over to be used the following year
Claims submission deadline	April 30 of the calendar year after which you elected to participate

USE IT OR LOSE IT

According to IRS rules, you forfeit any balance over \$550 remaining in your account at the end of the calendar year. The last day you can file a claim for reimbursement of the prior year's expenses is April 30 of the following year. Forfeited amounts are used to offset plan administrative expenses and future claims and costs. It's very important to carefully consider your potential expenses when making your contribution elections.

You are allowed to carryover up to \$550 in unused funds to pay for eligible expenses incurred in the following year. Any amount over the \$550 carryover limit remaining in your account after the claim filing deadline of April 33 will be forfeited.

Temporary Coronavirus Carryover Allowance

Due to the COVID-19 pandemic, your entire unused 2021 HCRA balance will carry over for use in 2022. Any balance over the normal \$550 carryover allowance remaining in your account after the 2022 claim filing deadline of April 30, 2023 will be forfeited.

ELIGIBLE EXPENSES

To be eligible for reimbursement by the HCRA, expenses must qualify as [medical care expenses](#) under Section 213(d) of the Tax Code (although not all expenses specified by the Tax Code may be eligible under this plan). You can get a detailed, up-to-date list of eligible expenses at [PayFlex.com](#). You may also call PayFlex at **800-814-3543**.

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Following are examples of some expenses that are eligible for reimbursement by the HCRA:

1. Annual deductibles, office copays, coinsurance and other out-of-pocket expenses required by your Costco health care plan.
2. Expenses typically not covered or only covered in a limited amount by your health care plan, such as infertility treatments, laser eye surgery, hearing aids, extra prescription eyeglasses, acupuncture, chiropractic services, and orthodontia.
3. Over-the-counter (OTC) items needed to alleviate or treat personal injuries or sickness, such as acid controllers, sleep aids or flu remedies.

HOW THE PLAN WORKS

Annual Enrollment is the only time you may enroll in the HCRA. (The exception is if you return from military leave under USERRA, as described in Eligibility While on USERRA Military Leave on page 14.) To continue participating from one year to the next, you must re-enroll during each Annual Enrollment period.

If you choose to participate, this is how it will work:

1. Elect your annual contribution amount  
When you enroll, you decide how much you want to contribute for the year. The most you can contribute is \$2,750 per year, unless otherwise announced by Costco. If you and your spouse are both benefits-eligible Costco employees, each of you may elect up to the maximum annual contribution limit.
2. Contributions come out of your paychecks  
The amount deducted from each paycheck will equal your elected annual contribution divided by 26 pay periods. Your contributions will go into an HCRA in your name.
3. You incur eligible expenses  
You can be reimbursed tax-free from your HCRA for eligible expenses you incur during the calendar year to which your election applies.

TAX DEDUCTION OR HEALTH CARE REIMBURSEMENT ACCOUNT?

The Tax Code offers an itemized deduction for medical care expenses over 7.5% of your adjusted gross income. If you receive reimbursement of medical care expenses from your HCRA, you cannot claim the expenses for the federal tax deduction. Talk to a professional tax advisor to find out which option makes the most sense for you.

An expense is “incurred” when you are provided with the service that gives rise to the expense. The exception is if you are required to make advance payments for orthodontic services. In that case, services are considered to be incurred at the time of payment.

4. Receive reimbursement

After you incur eligible expenses, the plan will reimburse you via one of the methods described in Reimbursement Options on page 97.

- You may be reimbursed for up to the full annual amount of your elected contributions, regardless of the actual contributions credited to your account at the time of your claim. The amount available is reduced by your prior reimbursements during the year.
- If you lose benefits-eligibility while participating in the HCRA, you can be reimbursed for eligible expenses incurred before your eligibility ended, up to the amount you elected to contribute for the year. The exception is if you elect to continue participating in the plan under COBRA, as described in Continuation of Health Care Coverage (COBRA) on page 119.

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REIMBURSEMENT OPTIONS

There are several ways to use the money you've set aside in your HCRA:

1. Autopay

The HCRA is set up to automatically reimburse certain medical, dental, and vision plan out-of-pocket expenses, including copays, coinsurance, and deductibles. When Aetna processes health care plan claims submitted by you or your provider, you will be automatically reimbursed from the balance in your account. You will be reimbursed by check, or you can sign up for direct deposit.

If you prefer, you can turn off autopay. This might apply, for example, if you want to use your account for specific expenses, such as orthodontia, or if you have health care coverage through another employer and want to submit your claim to the other plan before seeking reimbursement.

You can turn autopay off (or back on) anytime by logging into your PayFlex account or by calling PayFlex at **800-814-3543**. After you log in:

- Click on "Financial Center", then
- Click on "Health Plan Activity Options."

The autopay option is turned off automatically if you enroll your domestic partner for health care coverage, since expenses incurred by your domestic partner and their children are generally not eligible for reimbursement from this account.

Also, PayFlex does not autopay reimbursements for:

- Expenses not covered by the Costco health care plans
- Prescription drugs
- Over-the-counter drugs or items
- Eyewear purchased from non-participating providers

2. Debit card

One HCRA debit card will be automatically mailed to you if you enroll in the HCRA.

When you buy prescription drugs, insulin or diabetic supplies from a Costco pharmacy (including Costco's online pharmacy), a Costco-designated network pharmacy or any IIAS-certified pharmacy, you can use your HCRA debit card to pay your copays. Prescription drug copays cannot be paid with the autopay option described above.

The debit card can also be used to pay for eligible over-the-counter items, prescription eye glasses, contacts, and hearing aids purchased at Costco.

You can't use it to pay your doctor, dentist, or other service provider. For these expenses, you can either use the autopay option or submit a paper claim form.

3. Claim forms

If autopay is not available or you have turned off the autopay option, you will have to submit a claim form to PayFlex to get reimbursed. The claim form is available at [Costcobenefits.com](#) or [PayFlex.com](#). You can submit your claim electronically by uploading your claim form and receipts in PDF format or you can mail it to PayFlex at the address on the form. You can also download the free mobile app to access online reimbursements and forms.

- You must include an itemized written statement or a bill from an independent third party, with such details as the patient's name, the type of service or supply, the date you incurred the expenses and how much you paid
- Claims must be submitted by April 30 after the calendar year in which you elected to participate



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PayFlex will mail your reimbursement check to your home, or you can elect to have the check deposited directly into your bank account. To elect direct deposit, log into your account at [PayFlex.com](#) and click on “Financial Center.” You can also find the direct deposit authorization form at [Costcobenefits.com](#), or call PayFlex at **800-814-3543** to request the form.

If your claim is denied, there are procedures you can take to appeal that denial, as described in [If Your Claim is Denied on page 137](#).

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Commuter Benefits Plan

The Commuter Benefits Plan lets you purchase commuting and parking products through PayFlex and pay for them with pre-tax payroll deductions. Some common types of commuter benefits products are bus passes, van pool checks, and pre-paid debit cards.

Commuting and parking products can only be used by you as an eligible Costco employee, not by your family or anyone else.

Find out more about the Commuter Benefits Plan at [Costcobenefits.com](https://www.costcobenefits.com), or call PayFlex at **800-814-3543**.

COMMUTER BENEFITS PLAN SUMMARY

Eligible expenses	<ul style="list-style-type: none"><li><b>Transit account</b> covers the costs of riding to and from work by bus, subway, train, vanpool, or other public transit</li><li><b>Parking account</b> covers the fees for parking at your <a href="#">worksites</a> or at a parking lot from which you commute to and from work</li></ul>
Maximum monthly payments	<b>Transit account:</b> \$280 per month <b>Parking account:</b> \$280 per month
Minimum annual contribution	None
Order deadline	The 10th of the month prior to the month you want to use your commuting product

HOW THE PLAN WORKS

If you choose to participate in the Commuter Benefits Plan, here's how it will work:

1. Register on the PayFlex site

You can register anytime. Go to [Costcobenefits.com](https://www.costcobenefits.com) to link to PayFlex.

USE IT OR LOSE IT

You will forfeit any part of a product that you do not use – the balance will not be refunded.

2. Order a commuting product for the coming month

The deadline for ordering a commuting product is the 10th of each month for the next month. For example, you must order by January 10th to get a commuting product for February expenses. You may order every month or just for the months in which you need to use the benefit.

On the PayFlex site, you'll find a menu of commuting products available to you. Depending on where you live, different products may be available for either or both of the following accounts. When you order, you must specify which account you want because the products are not interchangeable.

- Parking account** to pay for parking fees at a public lot. If the lot operator is a participating provider, you can elect to have your monthly parking payment sent directly to the operator. Otherwise, you can request a Commuter Check, which you may use to pay the operator just as you would a personal check. (It is up to the parking operator whether they will accept the Commuter Check.)
- Transit account** to pay for the costs of commuting by public or mass transit. If you commute by bus, train, or subway, for example, you can request a monthly pass. If you commute by publicly-operated vanpool, you can request a Commuter Check made out to your vanpool operator.

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The IRS sets limits on the amounts that may be paid as commuting and parking products. In 2022, the limit is \$280 per month for transit and \$280 per month for parking. These amounts may be adjusted annually.

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3. Receive your order

If you are eligible for payment, PayFlex will send a confirmation to your email address after you place your order. Then the product will be mailed to your home address on record with Costco. (Be sure to keep your email address up-to-date on the PayFlex site and keep your mailing address up-to-date on Costco Employee Self-Service (ESS), linked from [Costcobenefits.com](#).)

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You should receive your order before the first of the month in which you will be using it. If you don't receive your commuting product on time – or you get the wrong kind:

- First you must pay the charges out of your own pocket. Then, submit a “Commuter Benefit Refund Claim Form,” along with your receipt as proof of purchase, to PayFlex. (If you’re in a vanpool, as proof of purchase you will have to complete and submit the “Vanpool Proof of Payment Form.”)
- The deadline to request a reimbursement is the 10th of the month for which you wanted the commuting product. For example, if you didn't get your February product, you must file for a refund by February 10th.

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Refund claim forms are available on the PayFlex site.

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4. Pay through pre-tax payroll deductions

The cost of your order will be deducted pre-tax in equal increments from the paychecks you receive during the month for which you have placed your order.



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What's Not Covered

In addition to the other limitations and exclusions discussed throughout this and other sections of this booklet, below is a list of additional exclusions for the Reimbursement Accounts. Since these lists may change from time to time, for example, due to federal rulings, be sure to contact PayFlex if you have any questions about your particular circumstances.

DEPENDENT CARE ASSISTANCE PLAN EXCLUSIONS

The following expenses are not eligible for reimbursement by the Dependent Care Assistance Plan.

- Services by any of the following caregivers:
  - Your spouse
  - Your child who is under age 19 at the end of the year in which expenses are incurred
  - The parent of your child if the child is the qualifying individual and under age 13
  - An individual you or your spouse are entitled to claim as a tax dependent for federal income tax purposes
- Expenses incurred by or on behalf of your domestic partner or their children
- Services outside the home for your spouse or other qualifying individual if they do not regularly spend at least eight hours per day in your home
- Overnight camp for a child under age 13

HEALTH CARE REIMBURSEMENT ACCOUNT EXCLUSIONS

The following expenses are not eligible for reimbursement by the Health Care Reimbursement Account. Refer to the list of eligible expenses available at [Costcobenefits.com](https://www.costcobenefits.com) for the most up-to-date information.

- Expenses reimbursed or reimbursable through insurance or any other health plan

- Expenses that do not qualify as **medical care expenses** under Section 213(d) of the **Tax Code**, prohibited for reimbursement under Tax Code Section 125 and regulations, or excluded under the **Cafeteria Plan** or specifically described as exclusions in this booklet
- Expenses incurred by or on behalf of domestic partners or their children
- Over-the-counter items or medications** that may be beneficial for general health but are not needed to alleviate or treat personal **injuries** or sickness. Examples include products for routine dental or skin care, vitamins and supplements.
- Health care premiums of any kind, including **Medicare** Part B premiums (**Note:** this expense is eligible under the Tax Code, but not for reimbursement through your account)
- Weight-control products or services unless **medically necessary**
- Long-term care services or premiums for long-term care insurance
- Salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help or social activities, such as dance lessons, even though recommended by a physician
- Massage therapy unless it has been prescribed by a physician to treat a specific diagnosis, in which case you must submit a letter from a physician stating the specific diagnosis, and that they recommend massage therapy as treatment
- Custodial care**
- Health club dues or fitness programs, unless you submit a letter from a physician stating the specific diagnosis and that they recommend a specific fitness or exercise program as treatment
- Bottled water
- Maternity clothes
- Diaper service or diapers

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- 17. Automobile insurance premiums
- 18. Marijuana and other controlled substances, even if prescribed
- 19. Drugs purchased in a foreign country and imported without FDA approval

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COMMUTER BENEFITS PLAN EXCLUSIONS

The following costs are not eligible for reimbursement by the Commuter Benefits Plan.

- 1. Vanpool costs, if your van is not considered a commuter vehicle.  
To be considered a commuter vehicle, the van must:
  - Seat at least six adults (plus driver),
  - Use at least 80% of mileage to transport employees to and from their place of employment, and
  - Have at least half the adult seating capacity occupied by employees.
- 2. Highway or bridge tolls
- 3. Carpool charges
- 4. Mileage or gas
- 5. Expenses incurred by anyone who is not a Costco benefits-eligible employee

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Life Events

If you experience certain changes in your work, family or personal status, you may be allowed to make mid-year changes to your benefit elections. Any changes must be because of and consistent with the event, and made within specific deadlines. You can make mid-year changes on the Enrollment Website, available at [Costcobenefits.com](https://www.costcobenefits.com), or by calling the Enrollment Center at **800-541-6205**.

If payroll shows you have a work-related change that may allow you to change your elections, you will automatically receive a Benefit Enrollment Notice as notification. Personal and family events that allow you to make changes must be reported by you. Your coverage change will generally be effective the date of the qualifying event and your paycheck will be reduced to pay for benefit deductions associated with this change. See the chart beginning on [page 106](#) for specific examples.

**It is your responsibility to report any personal or family changes that affect eligibility for Costco benefits.** For example, if you get a divorce, your ex-spouse is no longer eligible for benefits. If you do not timely report such changes to the [Costco Employee Benefits Department](#), you may be subject to disciplinary action up to and including termination as provided for in the Costco [Employee Agreement](#) and applicable collective bargaining agreements. In addition, your spouse’s coverage will be retroactively terminated as of the date of divorce and you will be responsible for reimbursing the Program for any overpaid benefits.

See [Temporary Coronavirus Emergency Extension Rule on page 126](#) for provisions that may impact your deadline for reporting a [change in status](#).

SPECIAL RULES FOR MID-YEAR ELECTIONS

In addition to the other eligibility and enrollment rules described in this booklet, these special rules apply to mid-year election changes:

1. If you have an event that allows you to make a change to your medical or dental elections, you may add or drop coverage for an individual under your elected medical or dental plan. However, you cannot change your elected medical or dental plan unless:
  - The event caused you to become ineligible for that plan,
  - The event caused you to become eligible for another plan, or
  - Your election change is due to a [HIPAA Special Health Care Enrollment right, as described on page 104](#).
2. Mid-year changes to Health Care Reimbursement Account elections are not allowed for any reason (except for employees returning from [military leave](#) under provisions of USERRA).

QUALIFIED CHANGES IN STATUS

You may be allowed to change your elections due to the following events, but only if the change in status affects your, your spouse’s, or a dependent’s eligibility for benefits under this program or your spouse or dependent’s employer’s plan.

For purposes of determining qualified changes in status, your “dependents” means your eligible children – that is, your eligible biological and adopted children, stepchildren, and children for whom you or your spouse is the legal guardian or custodian. Not all changes in status permit you to enroll your domestic partner or your domestic partner’s children. Please see [Opportunities to Enroll Your Domestic Partner on page 105](#).

Life Events

Special Rules for Mid-Year Elections

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• HIPAA Special Health Care Enrollment

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1. Marital status: marriage, divorce, legal separation, or annulment

2. Death of your spouse

3. Number of children: birth, adoption, placement for adoption, legal guardianship, or death of your child

4. Employment status: start or end of employment by you, your spouse or a dependent, or a change between salaried and hourly employee status

5. Work schedule: reduction in hours, start of or return from unpaid [Leave of Absence](#), or change between full-time and part-time employee status by you, your spouse, or a dependent. (As described in [Benefit Measurement Periods on page 5](#), certain benefit changes are automatic for full-time employees whose status changes between “full-time” and “part-time” for benefit purposes.)

6. Residence or [worksite](#): a change in place of residence or work for you, your spouse, or a dependent to the extent that change affects benefits options available under this Program. For example, your medical enrollment may be affected if you move to or from Hawaii or Puerto Rico, since these [locations](#) have different plan options than those available at other Costco locations.

Also, if you are an hourly employee and you move from a state with mandated disability coverage to one without, you will be automatically covered by the Voluntary Short-Term Disability (STD) Insurance Plan the date of your move. Your cost for that coverage will be withheld from your paychecks as of that date. (If you prefer, you may decline coverage within 31 days after the effective date.) Conversely, if you are enrolled in the Voluntary STD Insurance Plan but move to a state with mandated disability benefits, your plan coverage will continue for six months, paid in full by Costco.

7. Eligibility of a dependent: any event that causes your dependent to gain or lose eligibility for coverage under this or another employer’s health plan. For example, most enrolled children will lose eligibility when they reach age 26.

8. Election changes under another employer’s plan: if you or your spouse or dependent changes benefit elections under another

employer’s health care plan, you may make a corresponding change to your elections under this program.

For example, if your spouse is covered under their employer’s health care plan and drops that coverage during that plan’s annual enrollment period (which is different from Costco’s [Annual Enrollment](#)), you could make a mid-year election change to enroll your spouse in Costco coverage after they drop the other coverage.

HIPAA SPECIAL HEALTH CARE ENROLLMENT

[HIPAA](#) is a federal law which allows you and your eligible family members to enroll for Costco health care coverage in the following special circumstances.

1. Loss of other health care coverage

You previously declined Costco health care coverage for yourself or eligible family members because you or they had other health care coverage, but that coverage is lost, for example:

• Due to legal separation, divorce, death, loss of dependent status, termination of employment, reduction in hours, or end of a maximum period of [COBRA](#)

• Because the other coverage was non-COBRA coverage and employer contributions for that coverage ended

2. Acquisition of new family members

You get married, you or your spouse give birth, adopt or have a child placed with you for adoption, or you or your spouse or enrolled domestic partner becomes the legal guardian or custodian of a child who is otherwise eligible for coverage.

3. Changes in Medicaid, Medicare or SCHIP eligibility

You may enroll yourself or any eligible family member who:

• Loses eligibility for [Medicare](#)

• Loses eligibility under a Medicaid plan or a state child health plan offered under the State Children’s Health Insurance Program (SCHIP)

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- Becomes eligible for a governmental subsidy for the cost of Costco health care under a Medicaid or SCHIP plan
- HIPAA special enrollment is available to domestic partners and their eligible children who have been approved for coverage by the [Costco Employee Benefits Department](#). Children of domestic partners can only be enrolled if the domestic partners are enrolled. Establishment of a domestic partnership does not trigger HIPAA special enrollment rights.

DROPPING COVERAGE AFTER BECOMING ENTITLED TO MEDICARE OR MEDICAID

If you or an eligible family member become entitled to [Medicare](#) or Medicaid (other than coverage consisting solely of benefits providing for pediatric vaccines) while enrolled for Costco health care plan coverage, you may cancel Costco medical plan coverage for that person. Please note, you are not permitted to drop coverage if you gain SCHIP coverage.

OPPORTUNITIES TO ENROLL YOUR DOMESTIC PARTNER

- You can enroll your eligible domestic partner for Costco health care coverage at only the following times:
- During your Initial Enrollment (see [Initial Enrollment on page 16](#))
  - During Annual Enrollment (see [Annual Enrollment on page 18](#))
  - Within 60 days of the date you and your domestic partner have a child together by birth, adoption or placement for adoption, or
  - Within 60 days of your domestic partner losing coverage under another employer's health care plan, Medicare, Medicaid or SCHIP.

DEPENDENT CARE ASSISTANCE PLAN (DCAP) CHANGES

You may make appropriate mid-year changes to your current DCAP elections in the following circumstances. Expenses incurred by children of a domestic partner are not eligible for DCAP reimbursement.

- Your provider costs go up significantly, but only if the cost increase is imposed by a dependent care provider who is not your relative by blood or marriage
- You acquire a new tax [dependent](#) who is eligible under terms of the plan. Dependents for whom expenses are eligible for reimbursement include children under age 13 and older dependents who are incapable of self-care. It does not include children of a domestic partner.
- Your tax dependent child turns age 13.
- You have a change with respect to your dependent care provider, in which case you may make an election change that is on account of and corresponding to the change. For example:
  - If you decide to change day care centers or go from using a babysitter to using a day care center, you may change your election to reflect the change in cost
  - If your child starts school during the year, you may decrease your election to reflect the lower cost of day care
  - If free family care becomes available, you may discontinue your dependent care election
- Your child care expenses cease to or begin to qualify for tax-free reimbursement under the [Tax Code](#). This might happen, for example, when you commence or return from a [Leave of Absence](#) or switch between being a part-time and a full-time employee.

Changes to the DCAP will go into effect the first pay period ending after you enter your elections. You cannot make retroactive changes or get a refund of any contributions that were already deducted from your paycheck.

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DEADLINES FOR MAKING MID-YEAR ELECTION CHANGES

After you experience a qualifying event, you must make your election changes within the following deadlines. You can make changes on the Enrollment Website, available at [Costcobenefits.com](https://www.costcobenefits.com), or by calling the Enrollment Center at **800-541-6205**.

- 1. 60 days** to enroll a new eligible child after birth, adoption or placement for adoption. If you enroll the child within the 60-day deadline, coverage will be retroactive to the date of the event.  
  
If you do not enroll the new child within this 60-day deadline, you may apply to enroll them up to 12 months after birth, adoption or placement for adoption. However, if Costco approves this later enrollment for your child:
  - Their coverage will not take effect until the first day of the month after Costco receives a copy of the state-certified birth certificate, and
  - You will pay the cost of the child’s coverage on an after-tax basis for the rest of that calendar year.
- 2. 60 days** to enroll yourself or other eligible family members after coverage is lost under another employer’s health care plan.
- 3. 60 days** to enroll yourself or an eligible family member after that person:
  - Becomes eligible for a government subsidy for the cost of Costco health care coverage under Medicaid or a state child health care plan offered by SCHIP, or
  - Loses coverage under [Medicare](#), Medicaid or a plan offered by SCHIP.

Coverage will be retroactive to the date of the event.

- 4. 60 days** to drop Costco program coverage for you or an enrolled family member after that person gains coverage under another employer’s health care plan, Medicare or Medicaid. Program coverage will end prospectively.

- 5. 60 days** to drop Costco program coverage for you or an enrolled family member after that person loses eligibility for Costco coverage, for example, due to divorce or annulment or the dissolution of a domestic partnership.  
  
You are **required** to notify Costco within the 60-day window in this situation. Costco program coverage will end retroactive to the date of event, even if you fail to notify Costco by the deadline.
- 6. 30 days** to make election changes after most other qualifying events, for example, to enroll your new spouse and their eligible children after you get married, or to enroll a child for whom you, your spouse or domestic partner become the legal guardian or custodian. Coverage will be retroactive to the date of the event.

When you enroll yourself or a family member following a mid-year event (except when you acquire a new child due to birth, adoption or placement for adoption), your payroll contributions for retroactive coverage will be withheld after-tax. Pre-tax contributions will only apply going forward, that is, for pay periods after you’ve entered your new elections. Contributions to pay for coverage of domestic partners and their children are always withheld after-tax.

EXAMPLES OF MID-YEAR ELECTION CHANGES

The chart on the following pages show certain common changes in employment, personal or family status that may allow you to make mid-year changes to your current elections under various Costco benefit plans. Keep in mind:

- Any benefit changes you make must be on account of and consistent with the qualified [change in status](#) or other event
- Adding or increasing Supplemental Life Insurance coverage may require [Evidence of Insurability \(EOI\)](#). In that case, your elected coverage will not go into effect unless the insurance company, Unum, approves your application in writing. It’s your responsibility to make sure you receive this written approval.



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This chart is only a quick guide to changes you **may** be allowed to make. Available election changes will depend on your actual circumstances. To find out the options for your circumstances, contact the [Costco Employee Benefits Department](#) at **800-284-4882** weekdays from 7:00 am to 5:00 pm Pacific Time.

Event	Changes allowed	Deadline after event	When changes take effect
<b>Birth, adoption or placement for adoption</b>	<b>Health care:</b> <ul style="list-style-type: none"><li>Enroll your new child and any other eligible family members (including yourself) not currently enrolled</li><li>Switch to other available medical and/or dental options</li></ul> <b>Supplemental Life Insurance:</b> <ul style="list-style-type: none"><li>Add or increase coverage</li><li>Enroll your new child and any other eligible family members not currently enrolled</li></ul> <b>Supplemental AD&amp;D Insurance:</b> Add family coverage <b>Dependent Care Assistance Plan (DCAP):</b> Enroll or increase contributions if your new child is a qualified individual	60 days after event (see <a href="#">Deadlines for Making Mid-Year Election Changes on page 106</a> for certain exceptions)	<b>Health care:</b> <ul style="list-style-type: none"><li>Retroactive to date of event (if enrolled within 60 days)</li><li>First day of the month after enrollment (if enrolled after 60 days)</li></ul> <b>Supplemental Life Insurance:</b> Retroactive to date of event <b>Supplemental AD&amp;D Insurance:</b> Retroactive to date of event <b>DCAP:</b> First payroll after you change your elections
<b>You, your spouse or enrolled domestic partner becomes the legal guardian or custodian of an eligible child</b>	<b>Health care:</b> Same as above <b>Supplemental Life:</b> Same as above <b>Supplemental AD&amp;D:</b> Same as above <b>DCAP:</b> Enroll or increase contributions if your new child is a qualified individual (not applicable if your domestic partner is the legal guardian or custodian)	30 days	<b>Health care:</b> Retroactive to date of event <b>Supplemental Life:</b> Retroactive to date of event <b>Supplemental AD&amp;D:</b> Retroactive to date of event <b>DCAP:</b> First payroll after you change your elections
<b>You get married</b>	<b>Health care:</b> <ul style="list-style-type: none"><li>Enroll yourself, your spouse, your stepchildren and any other eligible family members not already enrolled</li><li>Switch to other available medical and/or dental options</li></ul> <b>Supplemental Life:</b> <ul style="list-style-type: none"><li>Add or increase coverage for yourself</li><li>Enroll your new spouse and any other eligible family members not currently enrolled</li></ul> <b>Supplemental AD&amp;D:</b> Drop family coverage <b>DCAP:</b> Drop participation or decrease contributions if your dependent is no longer a qualified individual due to the event	30 days	<b>Health care:</b> Retroactive to date of event <b>Supplemental Life and AD&amp;D:</b> Retroactive to date of event <b>DCAP:</b> First payroll after you change your elections

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Event	Changes allowed	Deadline after event	When changes take effect
<b>A family member loses eligibility for any reason, such as divorce, end of a domestic partnership or your child no longer meets the definition of “eligible child”</b>	<b>Health care:</b> Coverage for the family member who has lost eligibility will end – you must notify Costco through the Enrollment Website, available at <a href="https://www.costcobenefits.com">Costcobenefits.com</a> or via the Enrollment Center at 800-541-6205 <b>Supplemental Life:</b> Increase or decrease coverage <b>Supplemental AD&amp;D:</b> Drop family coverage	60 days	<b>Health care:</b> Ends at midnight on date of event that causes loss of eligibility <b>Supplemental Life:</b> Retroactive to date of event <b>Supplemental AD&amp;D:</b> Retroactive to date of event <b>DCAP:</b> First payroll after you change your elections
<b>Your payroll classification changes between full-time and part-time</b>	<b>Health care:</b> <ul style="list-style-type: none"> <li>Switch to other medical and/or dental options available under your new classification</li> <li>Decline or enroll for coverage</li> </ul> <b>Supplemental Life:</b> Increase or decrease coverage <b>Supplemental AD&amp;D:</b> Increase or decrease coverage	30 days	<b>Health care:</b> Retroactive to date of re-classification <b>Supplemental Life:</b> Retroactive to date of re-classification <b>Supplemental AD&amp;D:</b> Retroactive to date of re-classification
<b>Your payroll classification changes between salaried and hourly</b>	<b>Voluntary STD:</b> If you were: <ul style="list-style-type: none"> <li>Previously hourly, now salaried, coverage ends automatically</li> <li>Previously salaried, now hourly, coverage begins automatically (does not apply to California, Hawaii, New Jersey or New York)</li> </ul>	31 days to decline Voluntary STD (if you’re changing from salaried to hourly)	<b>Voluntary STD:</b> Retroactive to date of re-classification (unless you’re an hourly employee and decline coverage)
<b>You or a family member loses coverage under another employer’s health care plan, Medicare, Medicaid or SCHIP</b>	<b>Health care:</b> <ul style="list-style-type: none"> <li>Enroll the individuals who lost the other coverage</li> <li>Switch yourself and enrolled family members to another available medical and/or dental option</li> </ul>	60 days	<b>Health care:</b> Retroactive to date of event

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<b>You or an enrolled family member become eligible for and enroll in another employer’s health plan, Medicare or Medicaid</b>	<b>Health care:</b> Drop Costco health care for the person who enrolls for the other coverage	60 days	<b>Health care:</b> Prospective
<b>You or an eligible family member qualify for a Medicare or SCHIP subsidy to help pay for Costco health care coverage</b>	<b>Health care:</b> <ul style="list-style-type: none"> <li>Enroll the person who gets the subsidy</li> <li>Switch yourself and enrolled family members to another available medical and/or dental option</li> </ul>	60 days	<b>Health care:</b> Retroactive to date of event
<b>You begin working at a new location</b>	<b>Health care:</b> <ul style="list-style-type: none"> <li>Switch to another available medical plan</li> <li>Decline coverage if you move to or from Hawaii or Puerto Rico</li> </ul> <b>Voluntary STD (hourly employees):</b> Coverage begins automatically if you move from California, Hawaii, New Jersey or New York to another state <b>DCAP:</b> Add, stop or adjust contributions to reflect your new childcare situation	30 days (31 days to decline Voluntary STD)	<b>Health care:</b> Retroactive to date of event <b>Voluntary STD:</b> Retroactive to date you move to new location (unless you decline coverage) <b>DCAP:</b> First payroll after you change your elections
<b>Your childcare situation changes</b>	<b>DCAP:</b> <ul style="list-style-type: none"> <li>Change contributions if you have an increase or decrease in provider costs</li> <li>End contributions if your <b>dependent care expenses</b> are no longer eligible for reimbursement, for example, because your child reaches age 13 or your spouse becomes unemployed</li> <li>Enroll if expenses become eligible for reimbursement, for example, because your spouse begins employment</li> </ul>	30 days	<b>DCAP:</b> First payroll after you change your elections

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This [Summary Plan Description](#) (SPD) is the plan document for Costco’s health care plans, including the medical (except Hawaii), vision, prescription drug and dental plans, and Resources for Living, and special health care programs such as Omada and 98point6. Certain employees are also eligible for the **Executive Physical Program**. You will receive a notice if this applies to you, and a separate description of benefits. There are also plan documents for other benefits as described in the [Welcome section on page 2](#).

Nothing contained in this booklet shall be construed as a contract of employment between Costco and any employee, or as conferring any right upon the employee to continue employment with Costco, or as a limitation on the right of Costco to discharge the employee at any time with or without cause.

COLLECTIVE BARGAINING AGREEMENTS

Some employees participate in the program pursuant to the terms of a collective bargaining agreement with Costco Wholesale Corporation and an employee organization.

Upon written request to the [Benefits Committee](#), you can obtain information on whether a particular employee organization has bargained for plan benefits, find out whether your plan benefits are subject to a collective bargaining agreement, and/or obtain a copy of that collective bargaining agreement.

POWERS OF THE PLAN SPONSOR

Costco Wholesale Corporation, as the employer, is the [plan sponsor](#). Costco has delegated to the Benefits Committee all plan sponsor

powers and functions, including but not limited to the power to:

- Design, establish, amend or terminate any or all of the plans in any manner, at any time, regardless of the health status of any plan participant or beneficiary,
- Execute the plan and trust agreement and any amendments thereto, and
- Appoint or remove a trustee.

The Benefits Committee may perform such powers and functions or delegate their performance to specific committee members, a subcommittee, other officers or employees of Costco, or third parties. In performing such powers and functions, the Benefits Committee (or a delegatee of the Committee) acts in a settlor capacity, not in a fiduciary capacity, and its exercise of discretion and determinations in all matters are final and binding and entitled to the highest deference permitted by law.

POWERS OF THE PLAN ADMINISTRATOR

The Benefits Committee is the [plan administrator](#) and named fiduciary for the Program’s ERISA plans, except where that role is delegated to another entity as provided below. The Committee exercises sole and exclusive discretionary authority and control over:

- Plan administration,
- The interpretation of all plan and trust documents, booklets, policies, rules or regulations,
- Granting or denying benefits under the plan, including coverage, eligibility and benefit determinations, and
- The management and disposition of plan assets.

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The Committee's exercise of discretion and determinations in all matters are final and binding and entitled to the highest deference permitted by law.

The Committee may delegate its [plan administrator](#) and named fiduciary role and authority to a subcommittee, specific committee members, other officers or employees of Costco or third parties. A third party named as a [claims fiduciary](#) is the formal plan administrator for jurisdictional purposes regarding benefit claim and appeal procedure determinations, and is the proper named defendant in a lawsuit contesting a benefit denial under the plan or other right under ERISA Section 502(a). In addition, such claims fiduciary delegates exercise sole and exclusive plan administrator discretionary authority and control described above as to their determinations regarding benefit claims and appeal procedures; such exercise of discretion is final and binding, entitled to the highest deference permitted by law, and may not be appealed to the [Benefits Committee](#). The Committee retains claims fiduciary authority regarding plan eligibility and enrollment determinations.

The Committee has the discretionary authority to engage and terminate the services of agents and professional service providers as it may deem advisable to assist it with the performance of its duties.

Costco shall indemnify, defend, and hold harmless the Benefits Committee and each of its members with respect to any and all loss or liability, including reasonable attorneys' fees and costs of defense, to which they may be subject by reason of any act or conduct (excluding willful misconduct or gross negligence) in their official capacities in the administration of the plan and the performance of their duties hereunder. Costco may also purchase insurance for committee members covering liability for breach of fiduciary duties.

**CURRENT COMMITTEE MEMBERS**

Benefits Committee members are appointed by the Board of Directors of Costco or by the committee. A committee member

remains a member until they resign, are removed by the Board or the remaining members of the committee, or terminate employment with Costco. The committee may increase or decrease the number of its members and remove or appoint new members, as it deems prudent.

The current members of the Costco Benefits Committee are:  
Pat Callans                      Mario Omoss      Brenda Weber      Darby Greek  
Yoram Rubanenko      Joe Moore              Jay Tihinen

**COMMUNICATIONS**

Written communications to a [claims administrator](#), a claims fiduciary, Costco, the Benefits Committee, or their agents or representatives must be received before the expiration of any time period expressed in this [Summary Plan Description](#) or related documents. You may be invited to communicate electronically, for example, through the Employee Self-Service site. And you may elect to receive certain notices electronically rather than in writing.

These parties' records determine whether a communication has been received and the date of such receipt, unless you can provide a United States Postal Service return receipt. The common law "mailbox rule" does not apply to determine receipt by these parties. (Under the mailbox rule, when a document is placed in the mail, it is considered received by the addressee on the date of mailing.)

**POLICY STATEMENT ON BENEFITS FRAUD**

Knowingly defrauding the Plan can be a crime under § 1027 of Title 18 of the United States Code. Violations of this law may result in a fine of up to \$250,000, imprisonment for up to five years, or both.

In addition, your Program coverage may be retroactively terminated if you (or a person seeking coverage on your behalf) perform an act, practice or omission that constitutes fraud or make an intentional misrepresentation of material fact. If your coverage is retroactively terminated, you are responsible for reimbursing the Program for any overpaid benefits.

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COORDINATION OF BENEFITS (COB)

The Aetna medical and dental plans have a Coordination of Benefits (COB) provision. This provision will apply if you or enrolled family members also have coverage under another plan that pays benefits for medical or dental expenses. The purpose of COB is to determine which of your plans will pay benefits first for the costs you incur and which will pay second. Together, all your plans combined may pay up to, but no more than, 100% of your allowable expenses.

If you are enrolled in an HMSA medical plan, please refer to your HMSA plan materials for COB rules.

Health care plans that are considered for COB purposes include:

1. Group, or non-group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors
2. Other prepaid coverage under service plan contracts, or under group or individual practice
3. Uninsured arrangements of group or group-type coverage
4. Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
5. Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts (however, such coverage is always primary to the Costco plans)
6. Medicare or other governmental benefits
7. Other group-type contracts. Group-type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

For purposes of the COB provision, medical and dental are considered separate plans. That means Costco medical benefits will be coordinated with other medical plans, and Costco dental benefits will be coordinated with other dental plans

**Note:** If a covered person is enrolled in two or more closed panel plans (plans requiring members to seek care from the plan's contracted or employed providers), Coordination of Benefits generally does not occur, except in the case of emergency services that would have been covered by both plans.

Notifying Costco of Other Plan Coverage

It's your responsibility to notify Costco if you or your family members have coverage under any non-Costco health plan. Failure to provide this notification may result in loss of your benefits under the plan. You will be required to fully reimburse the plan for any claims paid in excess of the amount that should have been paid under the plan, including the COB rules described in this section.

Primary Plan Versus Secondary Plan

When you have medical or dental coverage under more than one plan, the Costco plan will use the "Order of Benefit Determination Rules" shown below to determine which plan will pay benefits first (the primary plan) and which will pay second (the secondary plan).

*When a plan is primary*, its benefits will be determined before those of the other plan, without considering whether the other plan may cover some expenses.

*When a plan is secondary*, its benefits will be determined after those of the other plan. The secondary plan will:

- Calculate the benefits that it would pay on the claim if there were no other coverage, then apply that amount to any allowable expense



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that was unpaid by the primary plan. The payment amount will be reduced so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total **allowable expense**, and

- Credit to its annual plan deductible any amounts that would have been credited in the absence of other coverage.

If there are more than two plans covering the person, the Costco plan may be primary as to one or more of these plans and secondary to others.

**COB Order of Benefit Determination Rules**

When two or more medical or dental plans pay benefits, the rules for determining the order of payment are as follows.

A. A plan that does not contain a Coordination of Benefits provision consistent with this provision is always primary, unless the Costco plan is primary under the provisions of both plans. The exception is that coverage obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is secondary to the other parts of the plan. Examples are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

B. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

C. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use (except that special rules apply where the other plan is **Medicare**, as described in **Coordination With Medicare on page 114**):

- (1) *Non-dependent or dependent.* The plan that covers the person other than as a dependent (for example as an employee, member, subscriber or retiree) is primary and the plan that

covers the person as a dependent (for example, as a family member) is secondary. However, if the person is also a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person other than as a dependent, then the order of benefits between the two plans is reversed (so that the plan covering the person other than as a dependent is secondary and the plan that covers the person as a dependent is primary).

(2) *Child covered under more than one plan.* Unless there is a court decree stating otherwise, the order of benefits when a child is covered by more than one plan is as follows:

- (a) The primary plan is the plan of the parent whose birthday is earlier in the year if
  - The parents are married or living together,
  - A court decree awards joint custody without specifying that one party has the responsibility for health care expenses or to provide health care coverage, or if the decree states that both parents are responsible for health care expenses or health care coverage.If both parents have the same birthday, the plan that covered either of the parents longer is primary.
- (b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the child's health care expenses, but that parent's spouse does have coverage, the plan of the parent's spouse is the primary plan.
- (c) If the parents are legally separated or divorced or are not living together (whether or not they ever have been married) and there is no court decree allocating responsibility for health care expenses or health care coverage, the order of benefits is:
  - The plan of the **custodial parent**,

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- The plan of the spouse of the [custodial parent](#),
  - The plan of the non-custodial parent, and then
  - The plan of the spouse of the non-custodial parent.
- (d) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
- (3) *Active employee or retired or laid off employee.* The plan that covers the person as an active employee (that is, an employee who is neither retired nor laid off) or as a dependent of an active employee is primary. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the non-Costco plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (4) *Continuation coverage.* If a person whose coverage is provided under a right of continuation provided by federal or state law (such as [COBRA](#)) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (5) *Longer or shorter length of coverage.* The plan that has covered the person as an employee, member, or subscriber longer is primary.
- (6) *If the preceding rules do not determine the primary plan, the [allowable expenses](#) shall be shared equally between the plans considered for COB purposes under this provision. The Costco plan will not pay more than it would have paid had it been primary.*

COORDINATION WITH TRICARE

If you or family members are eligible for both health care coverage under a Costco plan and for TRICARE coverage, TRICARE will be secondary to Costco plan coverage. This applies to coverage under the TRICARE Standard, TRICARE Prime, or TRICARE Extra plans.

COORDINATION WITH MEDICARE

Costco plans coordinate with [Medicare](#) as required by Medicare law. In short:

- If you or your family member is covered by Medicare on the basis of age (65+) or disability, Costco plan coverage is primary unless it is COBRA coverage or you are not an active employee. In that case, Medicare is the primary payer.
- If you or your family member becomes eligible for or covered by Medicare as a result of having end-stage renal disease (ESRD), Medicare is the secondary payer for the first 30 months and becomes the primary payer after that. (However, if Medicare was already primary due to your or your family member's age or disability, Medicare will remain primary.)

Making Medicare Claims if Costco Health Care Coverage is Primary

If you or family members are covered by a Costco plan and are also eligible for Medicare benefits, you should submit your claims to the Costco plan for payment first.

After this plan makes its payment, send Medicare a copy of the claim and a copy of this plan's explanation of benefits paid so that any balance can be considered for payment under Medicare. It will be your responsibility to follow up with Medicare. You should advise all your physicians that this plan is the primary payer and they should bill your Costco plan before billing Medicare.

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## Confidentiality of Health Information

Costco and the Costco Employee Benefit Program respect your right to keep your health information, known as **Protected Health Information (PHI)** private. Use of your PHI is limited to plan-related purposes.

The Health Insurance Portability and Accountability Act of 1996 as amended, and regulations thereunder, (known as HIPAA) provide specific privacy rights and protections for plan participants related to their PHI. These privacy rules apply to your benefits provided under these health benefit programs:

- Medical, including any wellness programs
- Vision
- Prescription drug
- Employee assistance
- Dental
- Health care reimbursement account

In accordance with HIPAA, the health benefit programs have created Notice of Privacy Practices. You are provided with a copy of the complete Notice of Privacy Practices when you enroll for coverage in a health benefit program and whenever the Notice is materially changed. You may also request a copy of the Notice of Privacy Practices at any time by contacting the Benefits Department at **800-284-4882** or at [benefits@costco.com](mailto:benefits@costco.com). The following is a summary of the health programs' privacy practices.

### COSTCO EMPLOYEE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Certain Costco employees may access, use, or disclose your PHI to administer the health benefit programs, assist participants with their health benefit program claims, and comply with applicable federal, state, or local law. Typically, Costco employees will access, use, or

The permitted uses and disclosures of your "protected health information," or "PHI," by these health benefit programs are summarized in the Costco Wholesale Health Plans Notice of Privacy Practices. The Notice also contains a list of the rights you have as a participant in the health benefit programs.

A copy of this notice is available at [Costcobenefits.com](http://Costcobenefits.com) or from the **Costco Employee Benefits Department** at the following address:

**Costco Wholesale Corporation**  
Benefits Department  
999 Lake Drive  
Issaquah, Washington 98027  
  
Phone: **800-284-4882**  
Fax: **425-427-3069**  
Email: [benefits@costco.com](mailto:benefits@costco.com)

- disclose your PHI to perform the following health benefit program responsibilities:
- Assist employees and eligible family members with health benefit program questions and problems.
  - Respond to participant requests for access to health benefit program records, amendment of PHI, accounting of disclosures, restrictions on the use and disclosure of PHI, and confidential communication.
  - Investigate and respond to complaints and reports of privacy violations.
  - Administer the health benefit programs.

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Costco Employee(s)	Health Benefit Program Functions
Privacy Officer/ Security Officer	Responsible for implementing the health benefit programs' privacy and security policies and procedures for safeguarding participants' health information.
Employees of the Costco Employee Benefits Department	Assist Employees and Eligible Family Members with health benefit program questions and problems. Respond to participant requests for access to health benefit program records, amendment of PHI, accounting of disclosures, restrictions on the use and disclosure of PHI, and confidential communication. Investigate and respond to complaints and reports of privacy violations. Determine eligibility to participate in health benefit programs. Perform enrollment functions. Make health benefit program design recommendations.
Information Services Department Employees	Design and support information systems that are used to store or transmit health information. Perform electronic transmissions of health information between Costco and the health benefit program administrators and service providers.
Legal Department Employees	Advise Costco with regard to health benefit program activities, such as service contract negotiation and privacy policy design and compliance. The Legal Department does not use PHI for employment or other non-health benefit program matters without your express authorization.
Internal Audit Department Employees	Perform audits of health benefit program operations for quality control and compliance purposes.
Benefit Committee	Makes final determinations on appeal for certain benefit plans, as listed under <a href="#">Claims Administrators and Fiduciaries on page 130</a> .

Costco Employee(s)	Health Benefit Program Functions
Costco Health Solutions Employees	Collect, review and approve claims for services and supplies covered under the pharmacy benefits provided to employees through the Costco Employee Benefits Program. Make final determinations on appeals related to pharmacy benefits.

- The above Costco employees may also access, use, or disclose your PHI as described below.
- To determine proper payment of your benefit claims. The health benefit programs use and disclose your PHI to reimburse you or your doctors or healthcare providers for covered treatments and services.
  - For the administration and operation of the health benefit programs, including quality control, fraud and abuse detection, and data analysis activities.
  - To inform you or your [health care provider](#) about treatment alternatives or other health-related benefits that may be offered under a health benefit program.
  - To a health care provider if needed for your treatment.
  - To a health care provider or to a [non-Costco health plan](#) to determine proper payment of your claim under the other plan, such as for coordination of benefits purposes.
  - To a non-Costco health plan or a healthcare provider who has a relationship with you for the plan's or provider's own administration or operations purposes.
  - To a family member, friend, or other person involved in your healthcare unless you object (or it can reasonably be inferred that you do not object) to the sharing of your PHI, or in the event of an emergency.
  - To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.

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9. For public health reasons, including (1) to a public health authority for the prevention or control of disease, [injury](#) or disability, (2) to a proper government or health authority to report child abuse or neglect, (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration, (4) to notify individuals of recalls of medication or products they may be using, or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.
10. To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.
11. To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to healthcare provision or public benefits or services.
12. To the U.S. Department of Health and Human Services to demonstrate the health benefit program's compliance with federal health information privacy law.
13. To respond to an order of a court or administrative tribunal.
14. To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.
15. To a law enforcement official for a law enforcement purpose.
16. For purposes of public safety or national security.
17. To allow a coroner or medical examiner to identify you or determine your cause of death.
18. To allow a funeral director to carry out their duties.
19. To respond to a request by military command authorities if you are or were a member of the armed forces.
20. For purposes of research as approved by an Institutional Review Board or privacy board. Alternatively, we may disclose information in a limited data set for purposes of research, public health or health plan operations under a data use agreement. For example,

we may engage a researcher to study the effects of payment levels on compliance with treatment programs.

Costco Employees do not use your PHI without your written authorization except as necessary to perform health benefit program activities described above.

USE AND DISCLOSURE OF ENROLLMENT INFORMATION AND SUMMARY HEALTH INFORMATION

The Plan may disclose to Costco, as the employer, whether an individual is participating in the Plan, or is enrolled in or has disenrolled from coverage. In addition, the Plan may disclose Summary Health Information to Costco, provided Costco requests the information for the purpose of (1) obtaining premium bids from health plans for providing health insurance under the plan or (2) modifying, amending or terminating the Plan.

COSTCO'S PLAN SPONSOR REQUIREMENTS

Regarding your [Protected Health Information \(PHI\)](#) used or disclosed by the above-listed Employees, Costco has certified that it will:

1. Not use or further disclose your PHI other than as described above or as required by law,
2. Take reasonable steps to ensure that any Costco agents and subcontractors that create or receive PHI agree to the same restrictions and conditions that apply to Costco with respect to your PHI, including the requirement to implement reasonable and appropriate measures to protect electronic PHI,
3. Not use or disclose your PHI for employment-related actions or decisions or in connection with a non-health program benefit or non-health benefit plan without your written authorization,
4. Report to the Privacy Officer any improper use or disclosure of your PHI or any security incident of which Costco becomes aware,
5. Make your PHI available to you for inspection and copying upon request,





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- Make your PHI available for amendment and incorporate any amendments to your PHI,
- Make information available to provide you with an accounting of disclosures of your PHI,
- Make Costco's internal privacy policies, practices, books, and records relating to the use and disclosure of PHI available to the Department of Health and Human Services for purposes of determining the health benefit programs' compliance with [HIPAA](#) privacy law,
- Return or destroy all PHI maintained by Costco in any form, including all copies, when no longer needed for the purpose for which Costco received the PHI, if feasible. If return or destruction is not feasible, Costco will limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible,
- Take reasonable steps to ensure adequate separation between the health benefit programs and Costco's activities in its role as [plan sponsor](#) and employer and implement reasonable and appropriate security measures to support such adequate separation, and
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that Costco creates, receives, maintains or transmits on behalf of the health benefit program.

Costco Employees who improperly use or disclose PHI will be subject to disciplinary action under the Costco disciplinary policy, as described in the [Employee Agreement](#). All Costco Employees are required to cooperate in any investigation into a health information privacy violation, and must not retaliate against any person for reporting a violation or making a complaint to the Privacy Officer.



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## Continuation of Health Care Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that gives health care plan participants the right to purchase continued coverage if their eligibility for coverage would otherwise end because of a “qualifying event.”

COBRA continuation coverage is a temporary continuation of coverage, the length of which depends on the nature of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

***Any qualified beneficiary for whom COBRA is not elected within the specified periods and according to the procedures discussed below will lose their right to elect COBRA coverage.***

This section describes COBRA in detail, including your rights and responsibilities under COBRA. To protect these rights for yourself and your family, be sure to keep the [Costco Employee Benefits Department](#) informed of any address changes. Also, retain copies of any notices you send to the Benefits Department or to BenefitConnect COBRA regarding COBRA.

The COBRA continuation coverage provisions of any insurance booklet or insurance contract under the program are inapplicable, and this section will control.

**Note:** COBRA coverage runs concurrently with rights for continued coverage provided under the [Family and Medical Leave Act \(FMLA\)](#) and the Uniformed Services Employment and Reemployment Rights Act (USERRA).

See [Temporary Coronavirus Emergency Extension Rule on page 126](#) for provisions that may impact your COBRA deadlines.

### HOW COBRA WORKS

COBRA applies to the three group health care components offered under the Costco Employee Benefits Program, including the medical and dental plans and the Health Care Reimbursement Account. It does not apply to other program benefit plans, such as life insurance, disability insurance, or accidental death and dismemberment insurance.

After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your eligible children could become qualified beneficiaries if health care coverage under the program is lost because of the qualifying event.

Qualified beneficiaries may elect to continue coverage under the various components of the program as follows:

- *Medical only* (including vision and prescription drug programs) if they were covered by the medical plan the day before the qualifying event.
- *Both medical and dental* if they were covered under both the medical and dental plans on the day before the qualifying event. Note that qualified beneficiaries may not elect to continue the dental component only.
- *Health Care Reimbursement Account* alone or in combination with the medical or medical and dental components.

In addition, after a qualifying event, qualified beneficiaries may elect to switch out of their current Costco medical or dental option into any other available Costco medical or dental option for which they are eligible.

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COBRA FOR DOMESTIC PARTNERS

Domestic partners and their children are not considered qualified beneficiaries under COBRA. However, if your domestic partner and their children are enrolled in the program, they will have the rights afforded to qualified beneficiaries:

- To the extent and while you have elected COBRA, or
- If you die.

COBRA CONTINUATION OF HEALTH CARE REIMBURSEMENT ACCOUNT

If you are a qualified beneficiary, you may elect to continue Health Care Reimbursement Account coverage under COBRA (or you may make the election on behalf of all qualified beneficiaries who are covered), but only if:

- You participated in the account on the day prior to the qualifying event, and
- Your account has a positive balance on the day before the qualifying event (your year-to-date contributions to the account exceed the year-to-date claims paid from the account).

QUALIFYING EVENTS

If you are an employee, you will become a qualified beneficiary if you lose your health care coverage under the program because:

- Your employment ends for any reason other than your gross misconduct, or
- Your hours of employment are reduced. A reduction of hours of employment includes a [Leave of Absence](#) in which your absence exceeds the length of time permitted to maintain your eligibility under the program.

Please note, failure to pay your regular employee premiums while on a Leave of Absence is not a COBRA qualifying event.

Your spouse and eligible children enrolled in the program will become qualified beneficiaries if they lose health care coverage because:

- You die,
- Your hours of employment are reduced,
- Your employment ends for any reason other than gross misconduct,
- You and your spouse become divorced or legally separated or your marriage is annulled, or
- In the case of your children, they stop being eligible for coverage under the program as eligible children.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.

PAYING FOR YOUR COBRA COVERAGE

Participants must pay the full monthly cost plus an administrative fee for elected COBRA coverage. While you are on a Leave of Absence, Costco may subsidize a portion of the monthly COBRA cost for a period of time as described in [COBRA Subsidy While You Are on Leave of Absence on page 124](#). The federal government may also provide COBRA subsidies in certain cases for limited periods of time. Any such federal COBRA subsidies will be described in materials accompanying your COBRA election form or in other notices required under federal law.

You must send your payments to BenefitConnect COBRA by the first of each month for COBRA coverage in that month, without waiting for a bill or other notice. A 30-day grace period is allowed for payment to be received. However, COBRA coverage will not be in effect until the payment is made, after which coverage will be reinstated. If you or your family members fail to make any required premium payments, COBRA coverage will stop.

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Your monthly premium payments should be made payable to Costco and mailed to:

Costco  
7144 Solutions Center  
Chicago, IL 60677-7001

BenefitConnect COBRA will accept overnight payments from UPS and FedEx. Overnight payments must be sent to this address::

PNC Bank c/o Costco  
Lockbox Number 777144  
350 E. Devon Avenue  
Itasca, IL 60143

NOTIFYING COSTCO OF A QUALIFYING EVENT

Costco will provide notification of COBRA coverage rights to you and other qualified beneficiaries in your family if the qualifying event is:

- The end of your employment,
- Reduction of your hours of employment,
- Your death, or
- Your enrolled child reaches age 26.

For any other qualifying event, it is your responsibility to notify the [Costco Employee Benefits Department](#). This would apply, for example, if a family member becomes ineligible due to divorce, legal separation, or the end of a domestic partnership.

To notify Costco, you must change your family elections on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**. The system will prompt you to enter the kind of event you have experienced along with other necessary information.

You will be informed if additional documentation is required.

Deadlines for Submitting Your Notification and Documentation

If you are responsible for notifying Costco of a qualifying event, you must do so within 60 days after either of the following events, whichever comes later:

- The date of the qualifying event, or
- The date on which the qualified beneficiary loses or would lose coverage under the terms of the program as a result of the qualifying event.

After you've submitted your changes on the Enrollment Website, available at [Costcobenefits.com](#), or by calling the Enrollment Center at **800-541-6205**, the system will inform you of any required supporting documentation, how to submit that documentation and the deadline for making the submission. Generally, the deadline is 30 days after the 60-day notification period.

**Important: You will lose your right to elect COBRA if you don't notify Costco within the 60-day deadline or if you fail to submit supporting documentation within the specified time period.**

Electing COBRA After Notification

A COBRA notification and the Continuation of Coverage (COBRA) election form will be mailed to you within 14 days after the program is notified of the qualifying event. If you have not received this material within 30 days, contact BenefitConnect COBRA at **877-29-COBRA** [26272] to request a duplicate notice.

The person who wants to purchase continued coverage must complete and return the election form within 60 days from the later of:

- Termination of normal coverage under the plan, or
- Receipt of the COBRA notice and election form.

Mail the completed form to BenefitConnect COBRA at the address noted on the application with a postmark within the 60-day period. If

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you or your covered family members do not make a timely election to continue coverage under COBRA, no COBRA coverage will be provided.

HOW LONG COBRA COVERAGE MAY CONTINUE

When the qualifying event is the end of your employment or a reduction of your hours of employment, coverage may be continued for up to 18 months.

COBRA continuation coverage for your family members who are qualified beneficiaries may last up to a total of 36 months when the qualifying event is:

- Your death,
- Your divorce, annulment of marriage, or legal separation, or
- For your child, their loss of program eligibility as an eligible child (not applicable to children of domestic partners).

This period of continuation coverage may be extended past these time limits if:

1. You become eligible for [Medicare](#),
2. You or a family member is determined to be disabled by the Social Security Administration, or
3. You or a family member has a second qualifying event.

Under no circumstances can COBRA coverage of the Health Care Reimbursement Account be extended beyond the end of the year in which the qualifying event occurs.

If You Become Eligible for Medicare

When the qualifying event is the end of your employment or a reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you may last until 36 months after the date of Medicare entitlement.

For example, say you become entitled to Medicare eight months before the date on which your employment terminates. COBRA continuation coverage for your enrolled family can last up to 36 months after the date of your Medicare entitlement. This is 28 months after the date of the qualifying event (36 months minus 8 months).

If the Social Security Administration Determines You or a Family Member Is Disabled

If you or anyone in your family covered under the program is determined by the Social Security Administration to be disabled, you and your entire family (if covered under the program) may be entitled to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of your termination of employment or reduction of hours. Also:

- The qualified beneficiary must have been determined by the Social Security Administration to be disabled during or before the first 60 days of COBRA continuation coverage, and
- The disability must last at least until the end of the 18-month period of continuation coverage.

The disability extension is available only if you provide written notice of disability (including the nature of the disability) and a copy of the Social Security Administration determination of disability to BenefitConnect COBRA within 60 days after the latest of:

- The date of the Social Security Administration's disability determination,
- The date of your termination of employment or reduction of hours, or
- The date on which the qualified beneficiary loses or would lose coverage as a result of your termination of employment or reduction of hours.

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In addition, the notice must be provided before the end of the first 18 months of continuation coverage. Send your notice and the determination of disability to:

BenefitConnect COBRA  
P.O. Box 1185  
Pittsburgh, PA 15230

You must mail your written notice and supporting documentation and your envelope must be postmarked by no later than the 60-day deadline specified above. You may also send your written notice and supporting documentation by overnight courier such as FedEx or UPS, and your delivery envelope must show a delivery order date within the 60-day deadline specified above.

Other forms of notice to BenefitConnect COBRA, including hand delivery, fax, verbal notice including telephone notice, and electronic notice including email notice are not acceptable.

***If your written notice and Social Security Administration determination of disability are not mailed or sent by courier to BenefitConnect COBRA within the 60-day period specified above, there will be no disability extension of COBRA coverage.***

This extension of COBRA coverage ends if the Social Security Administration makes a determination that the disabled person is not or is no longer disabled. You or your family member must notify the plan within 30 days of a determination of non-disability by Social Security.

**Note:** If the Social Security Administration determines you do not have enough work credits to qualify for Social Security disability benefits, you may qualify for this COBRA extension provided you are:

- Receiving Costco Long-Term Disability (LTD) Insurance plan benefits, and
- On a waiting list for an approved organ transplant covered by a Costco medical plan.

For more information, please call BenefitConnect COBRA at **877-29-COBRA** [26272].

**If a Family Member Has a Second Qualifying Event**

If your spouse and/or eligible children experience a second qualifying event while on COBRA, COBRA coverage may be extended for up to an additional 18 months, for a total maximum of 36 months.

This applies only to family members who are on COBRA because of your termination or reduction in hours (including COBRA coverage during a disability extension period as described above).

If the event would have caused the individual to lose health care coverage under the program had the first qualifying event not occurred, this extension may be available to:

- Your spouse and any children receiving COBRA continuation coverage, if you die or in case of your divorce, annulment of your marriage, or legal separation, or
- Your child, if the child stops being eligible under the program as an eligible child (not available to children of domestic partners).

The extension is available only if you notify BenefitConnect COBRA in writing and provide supporting documentation within 60 days after the later of:

- The date of the second qualifying event, or
- The date on which the qualified beneficiary would lose coverage under the terms of the program as a result of the second qualifying event.

You must mail the notice or send it by overnight courier to:

BenefitConnect COBRA  
P.O. Box 1185  
Pittsburgh, PA15230

Your envelope must be postmarked by or show a delivery order date that is no later than the 60-day deadline specified above. Other forms of notice to BenefitConnect COBRA, including hand delivery, fax, verbal notice including telephone notice, and electronic notice including email notice are not acceptable.



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***If you do not provide timely written notice according to these procedures, there will be no extension of COBRA coverage due to a second qualifying event.***

**Other Extensions**

Certain employees who lose health coverage as a result of a termination of employment or reduction in hours who qualify for a trade adjustment allowance or assistance under a federal law called the Trade Act of 1974, and who did not elect COBRA coverage when first eligible, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage).

The second COBRA election period begins on the first day of the month in which the employee is eligible to receive the health care tax credit and lasts for 60 days, but only if the election is made within six months after the eligible employee’s health coverage ended.

If you may qualify under the Trade Act of 1974, you must provide notice to Costco promptly, or you may lose any special right to a second COBRA election period.

**WHEN COBRA COVERAGE ENDS**

Coverage under COBRA will terminate on the earliest of:

- The date on which Costco ceases to provide a group health plan to any employee
- The date the covered person becomes covered under any other group health plan, if the new plan does not limit coverage for any of the covered person’s pre-existing conditions
- The date the covered person becomes entitled to [Medicare](#) benefits after electing COBRA
- The date the covered person fails to make the full monthly premium payment on time
- For continued medical or dental coverage, the end of the applicable 18-, 29- or 36-month period

- For the Health Care Reimbursement Account, the end of the year in which the qualifying event occurred

**COSTCO SUBSIDIES FOR COBRA COSTS**

In certain circumstances, Costco will pay or reimburse a portion of the cost of COBRA coverage for you and your eligible family members. These subsidies apply to your medical and dental continuation coverage only, it does not apply to a continuation of a Health Care Reimbursement Account.

Subsidies are available only if you and each qualified beneficiary are eligible for COBRA, you elect COBRA in a timely manner and you pay for COBRA coverage on a timely basis.

Please note, Costco subsidies are not required by law and Costco may change or discontinue them at any time.

**COBRA Subsidy While You Are on Leave of Absence**

After your eligibility for Costco health care coverage ends, Costco will subsidize a portion of your COBRA premiums for up to six months of leave. To receive the subsidy, you must pay your share of the cost of COBRA and Costco will pay its share. As shown on the following table, the subsidy will depend on your length of [continuous service](#).

Length of continuous service	Costco subsidy of COBRA costs
12 months or less	No subsidy
Over 12 months but less than 5 years	25% of monthly cost for up to 6 months
5 years or more	50% of monthly cost for up to 6 months

If you qualify for Long-Term Disability (LTD) Insurance Plan benefits, after 12 months of receiving LTD benefits you may be eligible for the special LTD Healthcare Protect Benefit. This is an extra monthly payment to help you with the cost of continued health care coverage after your Costco COBRA subsidy ends. For more information, see [Healthcare Protect Benefit on page 73](#).



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COBRA Subsidy if You Are Terminally Ill

For **terminally ill** employees and their eligible family members, Costco will subsidize the full cost of COBRA coverage for up to 18 months. To qualify, you must apply for the [Life Insurance Plan Accelerated Death Benefit \(ADB\) on page 82](#).

If Unum certifies you are terminally ill based on your ADB application, Costco will reimburse your COBRA premiums, starting from the first day after your Costco health care coverage ends. Reimbursement will continue until the end of the 18-month period or until you die, whichever comes first.

COBRA Subsidy for Your Family if You Die

When a benefits-eligible employee dies, for a period of time Costco will pay the full cost of COBRA coverage for their enrolled family members, including a spouse or domestic partner and eligible children. This subsidy is also available to biological children born within nine months after the employee's death, provided the child is enrolled for coverage within 60 days after being born.

To qualify for this Costco COBRA subsidy, the family members:

- Must have no other health care coverage available to them, and
- Be enrolled for Costco health care or COBRA coverage when the employee dies (or properly elect COBRA after the employee's death).

If the employee dies due to a non-work-related condition, Costco will pay the full cost of COBRA coverage for these family members for up to 12 months after the death.

If the death is work-related, Costco will pay the full cost of the family's COBRA coverage for up to 36 months after the employee dies. In this case, Costco will also allow these family members to self-pay for continued COBRA for an extended time – for children until they reach age 26, and for spouses and domestic partners until all covered children reach age 26.

Except as specified above, your surviving family's right to COBRA coverage is otherwise subject to COBRA rules and limits.

OTHER COVERAGE OPTIONS BESIDES COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid or 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. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [healthcare.gov](#).

ADDITIONAL INFORMATION

COBRA continuation coverage is administered by BenefitConnect COBRA. If you would like more information, correspondence (not payments) or questions regarding your COBRA rights should be directed to BenefitConnect COBRA at **877-29-COBRA** [26272] or in writing to BenefitConnect COBRA, P.O. Box 1185, Pittsburgh, PA 15230.

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# Temporary Coronavirus Emergency Extension Rule

The federal government has changed certain deadlines regarding **COBRA** continuation coverage, special enrollment for health plan coverage, and submission of benefit claims and appeals.

The United States Department of Labor and Internal Revenue Service have adopted an Extension Rule requiring that certain Program deadlines be extended during the coronavirus "Outbreak Period" – that is, the period from March 1, 2020, through the end of the federal declaration of emergency regarding the coronavirus, plus 60 days. (At the time of sending this notice, the federal declaration of emergency regarding the coronavirus is currently still in effect.) Under this federal Extension Rule, if any of the following deadlines falls during the Outbreak Period then applicable plans under the Program will disregard the part of that deadline that falls during the Outbreak Period, up to a maximum of one year:

- COBRA election deadlines
- COBRA payment deadlines
- Requirements to notify the Plan regarding a COBRA Qualifying Event
- Mid-year **HIPAA** Special Health Care Enrollment deadlines
- Deadlines to submit initial claims for benefits
- Deadlines to appeal denied claims for benefits, and regarding requests for external review

For further detail regarding these deadlines, see the applicable sections of this booklet.

For any of these deadlines falling between March 1, 2020, and the end of the Outbreak Period, that deadline is extended by the number of days of the deadline that passed during the Outbreak Period, up to a maximum one-year extension of each deadline involved.

- Special notes:**
- If you or a family member make a proper COBRA election and COBRA payment during the additional time allowed by the Extension Rule, but all required payments are not made by the end of the extended deadline for all months of COBRA eligibility, COBRA coverage will only be provided for the earliest months for which required premiums have been paid.
  - The Extension Rule does not provide any additional months of COBRA eligibility (so, for example, if you are eligible for a maximum of 18 months of COBRA continuation coverage, that will not change even if the Extension Rule allows you to make some payments for COBRA continuation coverage after that 18-month period has ended).
- Examples:**
- Jane gets married on September 30, 2020. The one-year period from October 1, 2020, to September 30, 2021, is covered by the Outbreak Period, and that maximum one-year extension period is therefore not counted against Jane's normal 30-day deadline to enroll her new spouse for coverage under the health plan's HIPAA Special Health Care Enrollment rules. Jane's new deadline to enroll her spouse is October 30, 2021, 30 days after September 30, 2021.
  - Robert gets married on January 1, 2022. Assume that the coronavirus national emergency ends on July 30, 2022, meaning that the Outbreak Period ends 60 days later, on September 28, 2022. The period from January 2, 2022, to September 28, 2022, does not count against Robert's normal 30-day deadline to enroll his new spouse for health plan coverage. Robert's new deadline to enroll his spouse is October 28, 2022, 30 days after September 28, 2022.

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## Your ERISA Rights

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

1. 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.
  - Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated [Summary Plan Description](#). The administrator may make a reasonable charge for the copies.
  - Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
2. Continue group health plan coverage. Continue health care coverage for yourself, your spouse, or your eligible children if there is a loss of coverage under the plan as a result of a qualifying event. You or your family members may have to pay for such coverage. For more information, see [Continuation of Health Care Coverage \(COBRA\) on page 119](#).

**PRUDENT ACTIONS BY PLAN FIDUCIARIES**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Costco Employee Benefit Program. The people who operate your plan,

called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

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

**ENFORCING YOUR ERISA RIGHTS**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules under the plan's claims procedures. For more information, see [If Your Claim is Denied on page 137](#).

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. The court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only if you have completed the plan's required administrative appeal procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek

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assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the appropriate [plan administrator](#), or the [claims administrator](#) as listed in [Claims Administrators and Fiduciaries on page 130](#). 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, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

**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.

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# Other Health Care Rights

In addition to rights guaranteed by ERISA, the following rights are available to participants in employer group health care plans.

## NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any [hospital](#) length of stay in connection with childbirth for the mother or the newborn child to less than:

- 48 hours following a vaginal delivery, or
- 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 following a cesarean section).

In any case, under federal law, plans and issuers may not:

- Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours), or
- Set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For more information, see [Health Care Claim Determination Before Service or Treatment \(Pre-Certification\)](#) on page 134.

## NOTICE REGARDING WOMEN’S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to the following mastectomy-related benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA):

- 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, and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage will be provided in a manner determined in consultation with the attending [physician](#) and the patient. Benefits are payable only for expenses incurred while you are covered by a Costco health care plan and will be subject to the same plan provisions that apply to the mastectomy. This includes deductibles, coinsurance and other plan limitations described in this booklet.

For more information on benefits available under WHCRA, call Aetna, the medical plan [claims administrator](#), at **800-814-3543**.



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## Filing Benefit Claims

Before the component plans of the Costco Employee Benefits Program will pay benefits, a claim for benefits must be filed with the appropriate [claims administrator](#). These are listed in the chart of [Claims Administrators and Fiduciaries](#) shown on the following page.

As described in other sections of this booklet, each component plan has specific procedures and deadlines for filing claims. However, the procedures discussed in this section apply to all the Costco plans except for HMSA of Hawaii, for which applicable claim procedures are set out in the HMSA plan booklets.

If you need to file a claim, medical, dental, vision, and prescription drug claim forms are available at [Costcobenefits.com](#) or from your Payroll Clerk.

### GENERAL RULES FOR FILING CLAIMS

- Depending on the plan, you, your [authorized representative](#), or your provider may file the claim. When you use a provider who belongs to your plan's network of participating providers, that provider should file a claim on your behalf. When you use a non-participating provider, you are responsible for making sure that claims are filed in a timely and proper manner. If your provider fails to submit a claim as required, you will be responsible for any unpaid cost.
- The timely filing period for all claims submitted for reimbursement is no more than one year after services have been rendered or supplies delivered. Claims submitted after more than one year will not be reimbursed.
- The program, at its own expense, has the right to require examination by a [physician](#) or other [health care provider](#) designated by the program of the person whose [injury](#) or [illness](#) is the basis of any claim. This may be requested when and as often as may be reasonably required.

- If you have not cashed or claimed a check 90 days after the claims administrator writes that check, the check is void. If you want a replacement check, you must make a written request for another check within the original time frame for making a claim for plan benefits. Otherwise, your claim for benefits will be untimely and therefore void, unless there are extenuating circumstances that will have no adverse consequences to the plan.
- Initial claim determinations are made by the applicable claims administrator. If you think the claims administrator has incorrectly denied your claim, you have certain rights to appeal as described in [If Your Claim is Denied on page 137](#).
- See [Temporary Coronavirus Emergency Extension Rule on page 125](#) for provisions that may impact your deadline for filing a claim.

### CLAIMS ADMINISTRATORS AND FIDUCIARIES

The chart on the following pages shows the claims administrators and [claims fiduciaries](#) for the various plans included in the Costco Employee Benefits Program. The entity named as the claims fiduciary is, for jurisdictional purposes, the formal [plan administrator](#) regarding benefit claims and appeal procedures for the plan at issue and the proper named defendant in a lawsuit against the plan or plan administrator contesting a benefit denial under ERISA § 502(a).

While this chart includes contacts for each plan, refer to your most recent enrollment materials for the most up-to-date information.



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<b>Aetna Select Medical Plan</b>	Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 <b>800-814-3543</b>	Aetna Life Insurance Company National Accounts Customer Resolution Team P.O. Box 14463 Lexington, KY 40512-4089 <b>800-814-3543</b>
<b>Aetna Select Medical Plan for part-time employees</b>		
<b>Aetna Select Out-of-Area Plan</b>		<i>Mental Disorder and Substance Use Disorder Claims Fiduciary:</i> Aetna Life Insurance Company BH Medical Resolution Team PO Box 2293 Blue Belle, PA 19422
<b>HMSA HMO</b>	HMSA P.O. Box 860 Honolulu, HI 96814 <b>800-776-4672</b>	HMSA P.O. Box 860 Honolulu, HI 96814
<b>HMSA PPO</b>		
<b>Aetna dental plans (Core, Premium and Exclusive Provider Plans)</b>	Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 <b>800-218-1458</b>	Aetna Life Insurance Company P.O. Box 14597 Lexington, KY 40512-4079 <b>800-218-1458</b>
<b>HMSA dental plans (Core and Premium)</b>	HMSA Dental Services P.O. Box 69437 Harrisburg, PA 17106-9437 <b>800-776-4672</b>	HMSA P.O. Box 860 Honolulu, HI 96814 <b>800-776-4672</b>
<b>Vision benefit</b>	MESVision, Inc. P.O. Box 25209 Santa Ana, CA 92799	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027
<b>Hearing aid benefit</b>	<i>If purchased at Costco:</i> Costco Employee Benefits Department 999 Lake Drive Issaquah, WA 98027  <i>Otherwise:</i> Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 <b>800-814-3543</b> (or fax to the number listed on the Hearing Aid Claim Form)	<i>If purchased at Costco:</i> Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027  <i>Otherwise:</i> Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 <b>800-814-3543</b>
<b>Prescription drug program</b>	Costco Health Solutions P.O. Box 999 Appleton, WI 54912-0999 <b>866-459-3322</b>	Costco Health Solutions P.O. Box 999 Appleton, WI 54912-0999 <b>866-459-3322</b>



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Benefit	Claims administrator	Claims fiduciary
Resources for Living	Aetna Resources for Living 151 Farmington Avenue, RSAA Appeals - 1250 Hartford, CT 06156	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027
Life and AD&D Insurance (Basic and Supplemental) Voluntary Short-Term Disability Insurance Long-Term Disability Insurance	Unum Life Insurance Company of America The Benefits Center P.O. Box 100158 Columbia, SC 29202-3158 877-403-9348	Unum Life Insurance Company of America 2211 Congress St. Portland, ME 04122
Business Travel Accident Insurance	Hartford Life and Accident Insurance Company Group Travel Claims P.O. Box 2999 Hartford, CT 06104 800-523-2233	Hartford Life and Accident I Group Travel Claims P.O. Box 2999 Hartford, CT 06104
Aetna WorldTraveler	Aetna International P.O. Box 981543 El Paso, TX 79998-1543 877-301-5042	Aetna International P.O. Box 981543 El Paso, TX 79998-1543
Dependent Care Assistance Plan (DCAP) Health Care Reimbursement Account Commuter Benefits Plan	PayFlex Systems P.O. Box 14879 Lexington, KY 40512-4879	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027
COBRA	BenefitConnect COBRA P.O. Box 1185 Pittsburgh, PA 15230 877-29-COBRA [26272]	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027
Omada	Omada Health Incorporated 455 Market St., Suite 1670 San Francisco, CA 94105 888-987-8337	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027
2nd.MD	2nd.MD 9655 Katy Freeway, Suite 300 Houston, TX 77024 833-549-2509	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027



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98point6	Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 800-814-3543	Aetna Life Insurance Company National Accounts Customer Resolution Team P.O. Box 14463 Lexington, KY 40512-4089 800-814-3543
Executive Physical Program	Costco Employee Benefits Department 999 Lake Drive Issaquah, WA 98027	Costco Benefits Committee 999 Lake Drive Issaquah, WA 98027 Attn: Costco Benefits Department

GENERAL PROVISIONS APPLICABLE ONLY TO MEDICAL AND DISABILITY BENEFIT CLAIM DETERMINATIONS

Initial denial decisions and appeal decisions on review will be provided in a culturally and linguistically appropriate manner in a non-English language upon request, but only if you live in a county where 10% or more of the population is literate only in the same non-English language as determined by applicable federal guidance.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-982-3862. [SPANISH]

注意：如果使用繁體中文，可以免費獲得語言援助服務。請致電 888-982-3862。[CHINESE]

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-982-3862. [TAGALOG]

Díí BAA AKÓ NíníZIN: Díí saad bee yáníti’go Diné Bizaad, saad bee áká’ánída’áwo’déé’, t’áá jiik’eh, éí ná hóló, koji’ hódíílnih 888-982-3862. [NAVAJO]

If the above percentage standard is met, the following three conditions will apply to claimants in such counties: Oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing

claims and appeals; the [claims administrator](#) and [claims fiduciary](#) will provide upon request a notice in the applicable non-English language; and will include in the English version of all notices a statement in the applicable non-English language clearly indicating how to access the language services.

The plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons, such as medical or vocational experts or a claims adjudicator, involved in making decisions and no hiring, compensation, termination, promotion, or other similar matters will be based upon the likelihood that the person will support a denial of benefits.

If the claims administrator and claims fiduciary fail to adhere to all the requirements of the claims review process, you may be deemed to have exhausted the internal claims and appeal process and may submit a request for external review if applicable. A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis violations that do not cause, and are not likely to cause prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the plan and occurred in the context of an ongoing good faith exchange of information between you and the claims administrator or claims fiduciary. You may request a written explanation of the violation from the respective administrator, which must be provided within 10 days, including the basis for asserting that the violation should not cause

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the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

Please note that the provisions in this General Provisions section apply only to medical benefit claims, including prescription drug, and disability benefit claims. These provisions, however, do not apply to dental, vision, HCRA, Resources for Living, International SOS or Aetna WorldTraveler benefits, which for purposes of this section are excepted benefits.

**HEALTH CARE CLAIM DETERMINATION BEFORE SERVICE OR TREATMENT (PRE-CERTIFICATION)**

Under provisions of the Costco medical plans, you are required to get prior approval for certain covered services or treatments in order to receive benefits. This review program is known as pre-certification. The following procedures apply if your claim is for a pre-certification required by the plan, in contrast to an optional or voluntary pre-approval request.

**PRE-CERTIFICATION OF URGENT CARE CLAIMS**

If your pre-certification claim is determined by the [claims administrator](#) to be a claim involving [urgent care](#), notice of the plan's decision will be provided to you as soon as possible, taking into account medical urgency, but no later than 72 hours after receipt of your claim by the claims administrator. For this purpose, the plan will defer to a determination of urgent care by the attending doctor.

The exception is if you do not provide sufficient information to decide your claim. In that case, notice requesting specific additional information will be provided to you within 24 hours of receipt of your

claim. The plan's decision regarding your claim will then be issued as soon as possible but no later than 48 hours after the earlier of:

- The plan's receipt of the requested information, or
- The expiration of the time period set by the plan for you to provide the requested information (at least 48 hours).

**PRE-CERTIFICATION OF NON-URGENT CARE CLAIMS**

If your pre-certification claim is not an urgent care claim, written notice of the plan's decision will generally be provided to you within a reasonable period of time, but no later than 15 days after receipt of your claim by the claims administrator.

If matters beyond the control of the claims administrator so require, one 15-day extension of time for processing the claim beyond the initial 15 days may be taken. Written notice of the extension will be provided to you before the end of the initial 15-day period.

An extension notice will explain the reasons for the extension and the expected date of a decision. If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information. The period beginning on the date this notice is sent to you and ending on the earlier of:

- the date the plan receives your response to the request for additional information, or
- the date set by the plan for your response (which will be at least 45 days) will not count against the required time period for processing your claim.

**Note:** If your communication to the claims administrator concerning pre-certification does not comply with the plan's procedures for filing pre-certification claims, notice of the proper procedures will be provided to you within five days of the communication. If the communication involves urgent care, notice will be provided within 24 hours.

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Such corrective notice will be provided only if your communication specifically names the claimant, medical condition or symptoms, and the treatment, service, or product being requested. Notice may be oral, unless you request written notice.

OTHER CLAIM DETERMINATIONS

This section describes how benefit claims are determined under the various plans, other than for pre-certification of health care claims described above. As follows, the procedures and timelines for the determination of a claim may differ depending on the plan and the circumstances of the claim.

Keep in mind, the [claims administrator](#) must receive your claim for benefits within one year of when the service is rendered or the supply is furnished. Otherwise, the program will pay no benefits. The exception is the Health Care Reimbursement Account, for which claims must be submitted no later than April 30 after the year in which you elected to participate.

HEALTH CARE CLAIM DETERMINATION AFTER SERVICE OR TREATMENT

If your claim for a benefit does not require pre-certification in advance of receiving medical care, written notice of a denial will generally be provided to you within a reasonable period of time, but no later than 30 days after receipt of your claim by the claims administrator.

If matters beyond the control of the claims administrator so require, one 15-day extension of time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be provided to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension

will specifically describe the required information. The period beginning on the date this notice is sent to you and ending on the earlier of:

- the date the plan receives your response to the request for additional information, or
- the date set by the plan for your response (which will be at least 45 days) will not count against the required time period for processing your claim.

HEALTH CARE CLAIM DETERMINATION FOR CONCURRENT CARE

If the plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal.

Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated, so that generally your benefits for an ongoing course of treatment would continue pending an appeal.

If your request that the plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves [urgent care](#), you will be notified of the decision by the claims administrator within 24 hours after its receipt of the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.



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A written denial notice will generally be provided to you within 90 days after the date your claim is received by the [claims administrator](#).

If special circumstances require an extension of time for processing the claim beyond the initial 90-day period, written notice of the extension will be furnished to you before the end of the initial 90-day period, explaining the reasons for the extension and the expected date of a decision. An extension of time will not exceed 90 days from the end of the initial 90-day period.

Please note that a dispute solely as to whether you have met the requirements for enrollment or eligibility under the plan is subject to the plan’s internal claim and appeal procedures set forth in this booklet, as if it were a non-medical benefit claim. The internal appeal procedures need to be exhausted for such disputes before you can bring a civil action under Section 502(a) of ERISA. The Costco Benefits Committee is the [claims fiduciary](#) for such claims and has the sole and exclusive discretionary authority to make determinations regarding enrollment or eligibility under the plan pursuant to the internal appeal procedures.

DISABILITY CLAIM DETERMINATION

A written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the claims administrator.

If matters beyond the control of the claims administrator require an extension of the time for processing your disability claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period.

In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the claims administrator

may be taken. Written notice of a second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed 60 days from the end of the initial 45-day period.

An extension notice will explain:

- The reasons for the extension,
- The expected date of a decision,
- The standards for a benefit entitlement,
- Any unresolved issues that prevent a decision on your claim, and
- Any additional information needed to resolve those issues.

If an extension is required because you have not provided the information necessary to decide your claim, the period beginning on the date this notice is sent to you and ending on the earlier of:

- the date the plan receives your response to the request for additional information, or
- the date set by the plan for your response (which will be at least 45 days) will not count against the required time period for processing your claim.



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If your claim for a benefit is denied (including situations where a part of your claim is granted and a part is denied), you will be notified in writing by the [claims administrator](#). If your claim for benefits is denied in whole or in part, you may take certain steps to appeal that denial. As outlined further below in the provisions regarding appeals, the procedures and timelines for the appeal of a denied claim may differ depending on the plan and the circumstances of the denial.

### CONTENT OF INITIAL DENIAL DECISION ON A MEDICAL OR DISABILITY CLAIM

The written notice will include the following:

- The specific reason or reasons for the decision,
- References to the specific plan provisions on which the decision is based,
- If the decision was based on a [medical necessity](#) or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request,
- A statement of your right to receive upon request, free of charge, reasonable access to and copies of all [relevant documents](#),
- A description of any additional material or information necessary in order for you to perfect your claim, and an explanation of why such material or information is needed,
- An explanation of the plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review (claims involving [urgent care](#) will have a description of expedited appeal procedures), and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse appeal decision.

If your claim is for medical benefits (except for dental, vision, HCRA, Resources for Living, International SOS and Aetna WorldTraveler benefits, which for purposes of the following are excepted benefits), the notice will also include the following:

- Information sufficient to identify the claim involved, including the date of service, the [health care provider](#), the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings,
- The specific reason or reasons for the denial will include, to the extent applicable, the denial code and its corresponding meaning and a description of the plan's standard, if any, that was used in denying the claim,
- A copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and that a copy will be provided free of charge upon request,
- The explanation of the plan's review procedure will include both internal appeal and external review processes, and information regarding how to initiate an appeal, and
- The availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

**Note:** In the case of urgent care for a medical condition, benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within three days after the oral notice.

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If your claim is for disability benefits, the notice will also include the following:

- A copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such does not exist, and
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you presented to the plan of health care professionals that treated you and vocational professionals that evaluated you, (2) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and (3) any disability determination made by the Social Security Administration about you, which you presented to the plan.

CONTENT OF INITIAL DENIAL DECISION ON A NON-MEDICAL OR NON-DISABILITY CLAIM

The written notice will include the following:

- The specific reason or reasons for the decision,
- References to the specific plan provisions on which the decision is based,
- A statement of your right to receive upon request, free of charge, reasonable access to and copies of all [relevant documents](#),
- A description of any additional material or information necessary in order for you to perfect your claim, and an explanation of why such material or information is needed,
- An explanation of the plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse appeal decision.

APPEALING A DENIED MEDICAL OR DISABILITY CLAIM

If you wish to appeal a denial of a medical or disability claim, you or your [authorized representative](#) must file a written appeal (or, in the case of uninsured medical, dental, prescription drug, and vision claims, a telephonic appeal) for a review of your claim with the applicable [claims fiduciary](#) within 180 days after receiving notice of denial. Claims fiduciaries for all the plans appear in [Claims Administrators and Fiduciaries on page 130](#).

You or your authorized representative may submit a written statement (or, in the case of claims for which telephonic appeals are permitted, a telephonic statement), documents, records, and other information. The claims fiduciary has the right to refuse to review your medical or disability claim if it is not appealed within 180 days after receiving notice of denial from the [claims administrator](#). Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

A denial of a claim includes a denial in whole or in part, and for purposes of appeal rights, includes a rescission of coverage whether or not the rescission has an adverse impact on any particular benefit at that time and can include a rescission of a determination that you are disabled.

See [Temporary Coronavirus Emergency Extension Rule on page 123](#) for provisions that may impact your deadline for filing an appeal.

Review by the Claims Fiduciary

The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. In addition:

- The appeal decision will not defer to the initial decision denying your claim and will be made by the claims fiduciary who is not a person who made the initial decision, nor a subordinate of such person,

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- If the initial denial decision was based in whole or in part on a medical judgment, the [claims fiduciary](#) will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment,
  - Any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person,
  - Any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon, and
  - If your claim involves [urgent care](#), your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the plan and you by telephone, facsimile, or other similarly expeditious method.
- If your claim is for medical or disability benefits (except for dental, vision, HCRA, Resources for Living, International SOS and Aetna WorldTraveler benefits, which for purposes of the following are excepted benefits), the following will also apply:
- You will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the plan or at the direction of the plan in connection with the claim, and such information will be provided as soon as possible and sufficiently in advance of the date the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date; and
  - If a final internal appeal decision is based on a new or additional rationale, you will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

### When You Will Receive a Decision on Your Appeal for Medical Claims

There is a two-level appeals process for all medical claims for which Aetna or Costco Health Solutions (CHS) is the claims fiduciary. Following receipt of your appeal, Aetna or CHS (as applicable) will notify you of the first-level decision on your appeal within:

- 36 hours for pre-certification claims for urgent care
- 15 days for pre-certification claims for non-urgent care
- 30 days for other claims

If your first-level appeal is denied, you will then have 60 days after receiving notice of the denial to appeal the denial to the second-level appeal stage. A second-level appeal decision will be issued to you within the same time period set out above for the timing of first-level appeal decisions, that is, within:

- 36 hours for pre-certification claims for urgent care
- 15 days for pre-certification claims for non-urgent care
- 30 days for other claims

If you do not appeal the denial of your first-level appeal to the second-level appeal stage, you have not completed the administrative appeal process and you will not be allowed to request a Voluntary External Review as described in [Voluntary External Review Appeal for Medical Claims on page 142](#), nor will you be able to bring a lawsuit in court regarding your claim.

For all other medical claims, there is a one-level appeals process. Following receipt of your appeal, the claims fiduciary will notify you of the decision on your appeal within:

- 72 hours for pre-certification claims for urgent care
- 30 days for pre-certification claims for non-urgent care
- 60 days for other claims

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When You Will Receive a Decision on Your Appeal for Disability Claims

The **claims fiduciary** will notify you of the decision on your appeal not later than 45 days after an appeal is received, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after an appeal is received.

Written notice of any extension of time will be sent before the end of the initial 45-day period, explaining the reason for the extension and the expected date of the appeal determination.

If an extension is required because you have not provided the information necessary to decide your appeal, the period beginning on the date this notice is sent to you and ending on the earlier of the following will not count against the required time period for processing your appeal:

- The date the plan receives your response to the request for additional information, or
- The date set by the plan for your response (which will be at least 45 days).

APPEALING A NON-MEDICAL OR NON-DISABILITY CLAIM

If you wish to appeal a denial of a claim for non-medical or non-disability benefits, you or your **authorized representative** must file a written appeal with the claims fiduciary within 60 days after receipt of written notice of the denial, unless the denial notice specifies a longer appeal period.

The claims fiduciary has the right to refuse to review your claim if it is not appealed within this timeline after receiving notice of denial from the **claims administrator**. Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with plan documents and, where appropriate, plan provisions are applied consistently to similarly situated claimants.

When You Will Receive a Decision on Your Appeal

A decision on your appeal will be made not later than 60 days after an appeal is received, unless special circumstances require an extension of time for processing, in which case a decision will be rendered no later than 120 days after an appeal is received. Written notice of any extension of time will be sent before the end of the initial 60-day period explaining the reason for the extension and the expected date of the appeal determination.

If an extension is required because you have not provided the information necessary to decide your appeal, the period beginning on the date this notice is sent to you and ending on the earlier of the following will not count against the required time period for processing your appeal:

- The date the plan receives your response to the request for additional information, or
- The date set by the plan for your response (which will be at least 45 days).

CONTENT OF APPEAL DENIAL DECISION ON A MEDICAL OR DISABILITY CLAIM

If your appeal is denied, you will be notified in writing by the claims fiduciary. The notice will include:

- The specific reason or reasons for the decision,
- References to the specific plan provisions on which the decision is based,

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- If the decision was based on a [medical necessity](#) or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request,
- A statement of your right to receive upon request, free of charge, reasonable access to and copies of all [relevant documents](#), and
- A statement of your right to bring a civil action under Section 502(a) of ERISA, including a statement of the plan's limitation period that applies and the calendar date on which the limitations period expires for the claim.

If your claim is for medical benefits (except for dental, vision, HCRA, Resources for Living, International SOS and Aetna WorldTraveler benefits, which for purposes of the following are excepted benefits), the notice will also include the following:

- Information sufficient to identify the claim involved, including the date of service, the [health care provider](#), the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings,
- The specific reason or reasons for the decision will include, to the extent applicable, the denial code and its corresponding meaning and a description of the plan's standard, if any, that was used in denying the claim that includes a discussion of the decision
- A copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and that a copy will be provided free of charge upon request,
- An explanation of the plan's available external review process for denied claims, including information regarding how to initiate the external review and the applicable time limits,
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your

local U.S. Department of Labor Office and your State insurance regulatory agency," and

- The availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process

If your claim is for disability benefits, the notice will also include the following:

- A copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such does not exist, and
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you presented to the plan of health care professionals that treated you and vocational professionals that evaluated you, (2) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and (3) any disability determination made by the Social Security Administration about you, which you presented to the plan.

CONTENT OF APPEAL DENIAL DECISION ON A NON-MEDICAL OR NON-DISABILITY CLAIM

If your appeal is denied, you will be notified in writing by the [claims fiduciary](#). The notice will include the following information:

- The specific reason or reasons for the decision,
- References to the specific plan provisions on which the decision is based,
- A statement of your right to receive upon request, free of charge, reasonable access to and copies of all relevant documents, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA.



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VOLUNTARY EXTERNAL REVIEW APPEAL FOR MEDICAL CLAIMS

Please note that the provisions in this External Review section apply only to medical benefit claims. These provisions, however, do not apply to dental, vision, HCRA, Resources for Living, International SOS and Aetna WorldTraveler benefits, which for purposes of this section are excepted benefits.

If Aetna or Costco Health Solutions (CHS) is the [claims fiduciary](#) and denies your appeal after you have followed the plan's appeal procedures (or you are deemed to have exhausted the internal claim appeal process), you may have the option to file a voluntary appeal for external review by an independent review organization. You may submit a request for external review of the denial only if the denial involves:

1) Medical judgment (including but not limited to requirements for [medical necessity](#), appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is [experimental or investigational](#)), as determined by the external reviewer; or

2) A rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. Denial determinations on the basis that you failed to meet enrollment or eligibility requirements under the plan are not subject to review by the external review process.

The request must be filed with the claims fiduciary within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

Within five business days following the date of receipt of the external review request, the claims fiduciary will complete a preliminary review of the request to determine whether:

- The claim was covered under the plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the plan at the time the health care item or service was provided;
- The denial decision does not relate to the claimant's failure to meet enrollment and eligibility requirements under the terms of the plan;
- You have exhausted the plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- You have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the claims fiduciary shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number **866-444-EBSA** (3272) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The claims fiduciary has contracted with IROs and uses unbiased methods for selecting the IRO for your claim.



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The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan. It will provide you a written notice of your request's eligibility and acceptance for external review which will include a statement that you may submit within 10 business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after 10 business days. Within five business days after assignment of the IRO, the plan shall provide the IRO the documents and information considered in making the denial decision. If the plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the plan of its decision within one business day after it is made. The IRO shall forward information submitted by you to the plan within one business day. Upon receipt of the information, the **claims fiduciary** may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claim and appeal process. In addition to the documents and information provided, the IRO, to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and documents submitted by the plan, you and your treating provider;
- The terms of the plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;

- Applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with terms of the plan or applicable law; and
  - The opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.
- The IRO shall provide written notice of the final external review decision to you and the plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:
- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, **health care provider**, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - A discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the plan;
  - A statement that judicial review may be available to you; and
  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

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After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the plan or applicable governmental oversight agencies upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the plan shall immediately provide coverage or payment for the claim.

**Expedited External Review Process for Denied Claims**

If your claim is eligible for the external review process, you may request an expedited external review if:

- An initial determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- A final internal appeal decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the **claims fiduciary** shall determine whether the request meets the reviewability standards set for preliminary reviews under the standard external review process discussed above. The claims fiduciary shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The claims fiduciary shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the plan.

**LIMITATIONS PERIOD FOR LAWSUITS**

In order to bring a lawsuit in court regarding your claim, you must file suit within two years after your appeal (or your external review, if you requested one) is denied or, if earlier, the date your cause of action first accrued. If a different limitations period is specified in an insured plan's contract, then that limitations period applies to that plan.

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Payment is made for claims based upon your representations and those of your covered family members and/or providers concerning the services tendered and is contingent upon benefits being covered under the terms of the plan.

By accepting benefits, you and your covered family members agree:

- To promptly refund to the plan any amount that exceeds the amount covered by the plan or any amount that is subject to the plan's subrogation or reimbursement rights, discussed in the following section,
- That the plan may reduce or deny coverage of your claims or the claims of your covered family members as a way of obtaining reimbursement, even if any such claims do not relate to the overpayment, and
- To reimburse the plan in full for any benefits from the plan to which the individual is later found not to be entitled.

The plan may also recover interest on the amounts paid by the plan from the time of the payment until the time the plan is reimbursed.

### ANTI-ASSIGNMENT

Health benefits and other rights related to the program may not be sold, transferred, pledged or assigned, and any attempt to do so will be void. The payment of benefits directly to a [health care provider](#), if any, will be done as a convenience to you and your covered dependents and will not constitute an assignment of health benefits or other rights under the program.

### PLAN'S SUBROGATION AND REIMBURSEMENT RIGHTS

The plan does not cover any health expenses for an [injury](#) or [illness](#) if someone else (a "third party") is responsible to pay the expenses or other damages related to the injury or illness. If the plan believes

a third party is or may be liable for an injury or illness, the plan may refuse to pay any related health expenses. Alternatively, the plan may advance payment of benefits while you pursue recovery of the health expenses or other damages from a third party, subject to the plan's right to be fully reimbursed out of any payment that a third party makes to you, your family members, your attorney or to anyone else in connection with the injury or illness (a "third-party payment"). Third-party payments are assets of the plan and cannot be transferred or paid to you or any other person until the plan has been fully reimbursed. This is called the plan's *right to reimbursement*.

In addition, the plan has the right to take your place in recovering payments directly from the third party. The plan's right to do this is called its *right of subrogation*.

For instance, if you are injured in an automobile accident, the plan is entitled to both subrogation and reimbursement as follows:

- If your insurance company or the other driver's insurance company is responsible for making a payment to you because of the accident, the plan has the right to demand that the insurance company first pay the plan directly for the expenses covered by the plan, before you get any excess amount.
- If you make a claim or file a lawsuit against the other driver and get any kind of recovery, the plan again has the right to be paid first, even if you don't agree it should. If you obtain any kind of payment before the plan gets its share, you must reimburse the plan immediately.

Under its rights of subrogation, the plan may make a claim or file a lawsuit for you, or act on your behalf in any claim or legal proceeding, and would be entitled to reimbursement for court costs, expenses, and attorneys' fees, in addition to the benefits advanced by the plan.

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The plan's rights to subrogation and reimbursement also constitute a "constructive trust" or "equitable lien" against any and all third-party payments made now or in the future, regardless of how the payments are characterized. The plan's lien is in the full amount of all the health expenses paid by the plan in connection with the [illness](#) or [injury](#), regardless of when the expenses are paid or incurred (including, for example, expenses incurred after you receive a third-party payment). In the plan's sole discretion, the plan's lien may also include interest on the amounts paid by the plan from the time of payment until the time the plan is reimbursed. The plan is not required to pay any fees to the attorney you hire to pursue a third-party payment, or to reduce its lien for any costs or attorney's fees you incur or for any other reason.

The Plan's Rights to Third-Party Payments

The plan is entitled to full reimbursement for all health expenses it pays relating to the illness or injury and has a "first dollar" right of reimbursement. That is, the plan has the right to be reimbursed first from the total amount of any and all third-party payments, without reduction for any attorney's fees or costs that you may incur in the pursuit of the recovery. The plan has the right to be reimbursed – even if the third-party payments are not payment for medical or disability expenses. This includes, for example, the following payments:

- Any judgment, settlement, or other payment relating to the illness or injury, from any source.
- Any payment made by your insurance or a third party's insurance, including vehicle insurance, no-fault automobile insurance, uninsured or underinsured motorist coverage, business insurance, homeowner's insurance, personal umbrella insurance, or any other insurance or insurance-type coverage, or a payment made under any workers' compensation program.
- Payments designated as medical benefits, as disability payments, as compensation for pain and suffering, as attorneys' fees, as

economic, non-economic, or punitive damages, or as other specified or general damages.

- Any partial payment made for any reason, even if you are not made whole. This means that the plan has the right to be repaid in full first, even if you do not expect to receive full compensation for your damages from the third party.

Your Notification and Cooperation Are Required

By accepting benefits under the plan, you agree that the plan has the rights of subrogation and reimbursement, and you agree to promptly provide information and execute documents as requested by the [claims administrator](#) and to take no action that may prejudice the plan's rights.

You must notify the claims administrator within 45 days of the date that you have an injury or illness that might be the responsibility of a third party and when you or your attorney gives notice to any third party that you intend to investigate or pursue a claim to recover damages. You must also notify the third party of the plan's lien against any recovery.

The claims administrator may require that, as a condition of the plan advancing further benefits relating to the illness or injury, you or your covered family members, as well as any attorney or [authorized representative](#) for you or your covered family members, sign a reimbursement agreement within 45 days of request by the claims administrator. This reimbursement agreement may:

- 1) Incorporate any or all of the rules of the plan regarding the plan's rights to subrogation and reimbursement,
- 2) Require that your attorney agree to honor the plan's lien on third-party payments and that the plan is not obligated to pay any portion of your attorney's fees or costs, and/or
- 3) Contain any terms necessary or appropriate to enforce the plan's rights or to ensure that the contract will be enforceable in state or federal court, at the plan's election.

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Any benefits the plan advances in absence of a signed reimbursement agreement will nonetheless be fully subject to the plan's subrogation and reimbursement rights.

If you receive a third-party payment, you must promptly notify the plan and hold the total amount of the payment in an escrow or trust account acceptable to the plan (or, if you are represented by an attorney, you must direct your attorney to hold such funds in trust) until the plan has been fully reimbursed for the current amount of its lien. You must promptly reimburse the plan in full, regardless of the manner in which the third-party payment is structured. A third-party payment constitutes plan assets under ERISA, to the extent of the plan's lien. That means that you have a fiduciary responsibility to protect the plan's lien and reimbursement rights.

If you or your attorney do not timely provide the requested information, do not timely sign the plan's reimbursement agreement, do not timely reimburse the plan following receipt of a third-party payment, or otherwise fail to cooperate, the plan will stop advancing benefits related to the [injury](#) or [illness](#), and any expenses previously advanced by the plan will be considered an overpayment of plan benefits. To recoup the overpayment, the plan may reverse (i.e., deny) payment of such benefits, deny coverage of your other benefit claims or the claims of your covered family members (even if the claims do not relate to the injury or illness), and/or take legal action. You will be responsible for all reasonable attorney's fees and costs the plan incurs due to your failure to cooperate with the plan. The plan's lien continues to apply to a third-party payment regardless of whether the funds have been disbursed or commingled with other funds. In addition, failure to reimburse the plan may result in termination of plan coverage for you and your family members.

**More About Subrogation and Reimbursement**

- After you have received a third-party payment, the plan may pay no further expenses relating to the illness or injury, regardless of when the expenses are incurred. As a condition of advancing payment

of any further expenses, the plan may require that you continue to hold all or a portion of the total third-party payment in trust for the purpose of reimbursing the plan.

- The plan's subrogation and reimbursement rights (and your obligations related to the plan's rights) also apply to: your covered spouse and other family members; your (or their) guardians or other representatives in the event of incapacity; your (or their) estates, personal representatives of estates, and beneficiaries or heirs in the event of death; and, if the covered spouse or family member is a minor, to the minor's parents, guardians, or other representatives. Any recovery they obtain that relates to or arises out of an illness or injury for which the plan has paid health expenses (including, for example, a recovery for wrongful death) is a third-party payment that is subject to the plan's reimbursement rights. In the case of a wrongful death or survival claim, no allocation of a third-party payment shall be valid if it does not fully reimburse the plan for its lien, unless the plan provides written consent to the allocation.
- If disbursements from a third-party payment are subject to approval by a probate or other court, you must take all reasonable action to obtain court approval of full reimbursement of the plan's lien. The plan's lien is not affected by any allocation or similar court order that is inconsistent with the plan's reimbursement rights.
- If you violate the plan's subrogation and reimbursement rights, plan coverage for you and your family members may be terminated.
- If you file a petition for bankruptcy, you acknowledge that the plan's lien existed prior to the creation of the bankruptcy estate.
- If requested by the plan, you will instruct the third party to reimburse the plan's lien via a check made payable and mailed directly to the plan, or via a joint check made payable to you and the plan, at the plan's option.
- The plan's subrogation and reimbursement rights apply even if you receive a third-party payment before the plan has paid any expenses relating to the injury or illness. In that case, you are responsible to use the third-party payment to pay the health expenses.



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- Where the plan advances benefits related to an [illness](#) or [injury](#), it pays secondary to any other insurance coverage (for example, personal injury protection (PIP), medical payments, specific loss, or homeowner's insurance). Charges that are payable by such other coverage, or that would be payable in the absence of plan coverage, are not covered by the plan. The plan will pay secondary even if benefits under such other coverage are paid directly to you instead of your [health care providers](#), or if you choose to use the benefits for a purpose other than payment of health expenses.
- The [claims administrator](#)'s determination of whether a health expense is related to the illness or injury controls. For purposes of the plan's subrogation and reimbursement rights, an "illness" also includes a disability. A health expense will not be removed from the plan's lien if you treated the expense as related to the injury or illness while pursuing a third-party payment, or if you released a third party from liability for the health expense (or related treatment) in connection with obtaining a third-party payment.
- The plan is an employee welfare benefit plan governed by ERISA. As shown in the [Administrative Facts](#) section starting on [page 149](#) of this booklet, the medical benefits provided through Aetna are self-funded by Costco.
- The plan may reject a reimbursement agreement that has been signed on your behalf pursuant to a power of attorney, unless you are incapacitated, legally incompetent, or on [military leave](#), and the power of attorney is valid under applicable state law.
- The plan's rights of subrogation and reimbursement are not affected in any way by claims that you must be made whole, or that a "common fund" or any other apportionment or equitable doctrine applies under any statute, regulation or common law, or that the third-party payment was limited by a collateral source rule or any other law, or by your comparative fault or contributory negligence,

pre-existing conditions, or other factors. The plan disclaims all such doctrines and defenses. In addition, the plan's rights are not dependent on a finding or admission of the third party's negligence or wrongdoing, or on whether you made a claim for health expenses against the third party.

- The plan may share information (including but not limited to information relating to its lien, a third-party payment, or the illness or injury) with others for purposes of administering or enforcing its reimbursement rights.

The [plan administrator](#) has the sole and exclusive discretionary authority and control over interpretation of the terms of the plan and of reimbursement agreements. To the extent any term relating to the plan's subrogation and reimbursement rights is determined to be invalid or unenforceable for any reason, it shall be fully severable and shall not affect the other terms.

By accepting plan benefits, you agree to these conditions and you agree not to raise any contrary claims in any action impacting the plan's subrogation or reimbursement rights.

FACILITY OF PAYMENT

The plan may pay benefits directly to a health care provider as a convenience to you and your covered dependents. Furthermore, whenever any benefit payments which should have been made under the plan have been made by another party, the plan will be authorized to pay such benefits to the other party. Any payment made by the plan in accordance with this provision will fully release the plan of any liability to you. In addition, Aetna may debit amounts owed to a provider for a [covered expense](#) by applying a credit for overpayments to the provider involving this or another plan.



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## Administrative Facts

The Costco Employee Benefits Program includes four official ERISA plans, which together provide many component benefits. This is the [Summary Plan Description](#) for those four ERISA plans, the names of which, numbers, plan year, funding information, type of administration, and the type of benefit offered by each can be found in the following table.

For purposes of compliance with the requirements of Title XXVII of the Public Health Services Act (42 USC 300gg et seq.), the Program's non-excepted healthcare plans described herein plus the Executive Physical Program are part of a single plan.

**The plan sponsor of these plans** is the Costco Wholesale Corporation, Employer Identification Number (EIN): 91-1223280. In addition, the program has been adopted by the following subsidiaries of Costco:

- Costco Wholesale Membership, Inc. EIN: 88-0433970
- CWC Travel, Inc. EIN: 91-2051883
- CWC WDC LLC EIN: 45-4963453

**Costco Wholesale Corporation and the [Benefits Committee/plan administrator](#)** can be reached at the following address and phone number:

999 Lake Drive  
Issaquah, WA 98027  
**425-313-8100**

**The agent for service of legal process is:**

John Sullivan, General Counsel  
Costco Wholesale  
999 Lake Drive  
Issaquah, WA 98027  
**425-313-8100**

Service of legal process also may be made on the Benefits Committee/plan administrator or the [claims fiduciary](#) of the plan in question.

### ONLINE SECURITY TIPS

The U.S. Department of Labor provides online security tips to reduce the risk of benefit fraud and identity theft. A link to these tips can be found at [Costcobenefits.com](#).

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Plan and year	Component benefits	Administration	Funding
<b>Plan name:</b> Costco Wholesale Corporation Employee Benefits Program <b>Plan number:</b> #510 <b>Plan year:</b> Fiscal 52/53-week year ending on the Sunday closest to August 31	<ul style="list-style-type: none"> <li>Aetna Select and Aetna Select for Part-Time Medical Plans</li> <li>Core and Premium Dental Plans</li> <li>Vision benefit (eye exams)</li> </ul>	Third-party contract administrator	Benefits paid from general assets
<b>Plan name:</b> Costco Wholesale Corporation Employee Benefits Program II <b>Plan number:</b> #501 <b>Plan year:</b> Fiscal 52/53-week year ending on the Sunday closest to August 31	<ul style="list-style-type: none"> <li>HMSA medical for Hawaii employees</li> <li>Basic and Supplemental Life Insurance Plan</li> <li>Basic and Supplemental AD&amp;D Insurance Plan</li> <li>Business Travel Accident Insurance Plan for salaried employees</li> <li>Voluntary Short-Term Disability Insurance Plan</li> <li>Long-Term Disability Insurance Plan</li> <li>Aetna WorldTraveler Plan</li> <li>International SOS</li> </ul>	Insurer administrator	Fully insured, premiums paid from general assets
	<ul style="list-style-type: none"> <li>Resources for Living</li> <li>2ndMD</li> <li>98point6</li> <li>Omada</li> <li>Rethink</li> <li>AbleTo</li> </ul>	Third-party contract administrator	Benefits paid from general assets
<b>Plan name:</b> Costco Wholesale Corporation Cafeteria Plan <b>Plan number:</b> #511 <b>Plan year:</b> Calendar year	<ul style="list-style-type: none"> <li>Pre-Tax medical and dental premiums</li> <li>Health Care Reimbursement Account</li> <li>Dependent Care Assistance Plan</li> </ul>	Third-party contract administrator	Benefits paid from general assets
<b>Plan name:</b> Costco Wholesale Corporation Vision and Prescription Drug Programs <b>Plan number:</b> #512 <b>Plan year:</b> Fiscal 52/53-week year ending on the Sunday closest to August 31	<ul style="list-style-type: none"> <li>Prescription Drug Program</li> <li>Vision benefit (prescription glasses and contacts)</li> <li>Hearing aids</li> </ul>	Third-party contract administrator	Benefits paid from general assets

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LEGALLY REQUIRED BENEFITS

The plan provides benefits as required by law, notwithstanding anything herein to the contrary.

NOTICE REGARDING WELLNESS PROGRAMS

Costco offers voluntary wellness, disease management and employee assistance programs. Some of these programs are available to all employees, some are available to all employees and their family members, and others are only available through the Costco medical plans.

This notice applies to programs that involve disease-related inquiries or medical examinations. These programs may ask you questions about your health-related activities and behaviors and whether you have or had certain medical conditions. For example, Omada is a weight-loss program for individuals at risk for diabetes or another chronic disease – so if you want to participate, Omada will ask you questions such as whether you’ve been diagnosed with prediabetes. Similarly, if you take Aetna’s Health Risk Assessment, Aetna will ask health-related questions in order to provide you with a personalized report. For details on the information that may be requested in connection with a particular program, please contact the provider of that program. Contact information can be found at [Costcobenefits.com](#) or by calling the Benefits Department.

Again, these programs are completely voluntary. If you choose to participate, the health information you provide to these programs is protected by federal law, including [HIPAA](#). Costco respects your right to keep your health information private and only accesses, uses and discloses your health information for certain limited purposes. See this plan (under [Confidentiality of Health Information on page 115](#)) for more information. In no event will the health information you provide to these programs be used to discriminate against you, nor will you be subject to retaliation if you choose not to participate.

## Contact Information

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Visit [Costcobenefits.com](https://www.costcobenefits.com), your first stop for benefits information. Find details on all your benefits, find in-network providers, access tools and resources, and much more. If you have questions, call the Costco Employee Benefits Department at **800-284-4882**. To enroll in or change your benefits, call the Enrollment Center at **800-541-6205**.

<b>Aetna</b>	<a href="https://www.aetna.com">aetna.com</a>
Informed Health Line (24/7 nurse line)	<b>800-556-1555</b>
Medical, hearing and vision, Live Healthy Team	<b>800-814-3543</b>
Dental	<b>800-218-1458</b>
<b>HMSA</b>	<a href="https://www.hmsa.com">hmsa.com</a>
Hawaii medical and dental plans	<b>800-776-4672</b>
<b>Resources for Living</b>	Link from <a href="https://www.costcobenefits.com">Costcobenefits.com</a>
Employee Assistance Program (EAP)	<b>833-721-2320</b>
<b>Costco Health Solutions</b>	<b>866-459-3322</b>
Prescription drugs	
<b>2nd.MD</b>	Link from <a href="https://www.costcobenefits.com">Costcobenefits.com</a>
Second opinions	<b>833-579-2509</b>
<b>PayFlex (Aetna)</b>	<a href="https://www.payflex.com">payflex.com</a>
Dependent Care Assistance Plan (DCAP), Health Care Reimbursement Account (HCRA), Commuter Benefits Plan	<b>800-814-3543</b>
<b>Tobacco Quit Line</b>	Link from <a href="https://www.costcobenefits.com">Costcobenefits.com</a>
Smoking Cessation	<b>833-721-2320</b>
<b>98point6</b>	Link from <a href="https://www.costcobenefits.com">Costcobenefits.com</a>
24/7 virtual care	
<b>Unum</b>	<b>877-403-9348</b>
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# Glossary

This glossary lists, in alphabetical order, various terms used throughout this booklet as they apply to the Costco Employee Benefits Program. In some situations, plan coverage may depend on the detailed definition of a specific term. Do not rely on commonly understood definitions of terms.

Definitions of other key terms may be found in:

- Applicable contracts for the Costco disability insurance plans, life and accident insurance plans, or
- The Costco Wholesale Corporation Cafeteria Plan for the Health Care Reimbursement Account and Dependent Care Assistance Plan.

## A

**Active employment** means you are:

- Working for Costco for pay at your location (or at a location to which your job requires you to travel) or else you are on paid vacation, holiday or sick day, and
- Working at least the minimum number of hours necessary to remain eligible for coverage for the Costco Employee Benefits Program.

In addition, for purposes of the Costco disability insurance plans, it means you are performing the material and substantial duties of your own job or a reasonable alternative offered to you by Costco.

**Active military service** is “service in the uniformed services,” as defined in the Uniformed Services Employment and Re-Employment Rights Act (USERRA).

**Aircraft** means any vehicle or device that is used for aerial navigation in the earth’s atmosphere.

**Allowable expense**, for purposes of determining Coordination of Benefits, means a health care service or expense that is covered at least in part by an individual’s health care plan. This includes coinsurance, copays and deductibles. When a plan, such as a Health Maintenance Organization (HMO), provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

Allowable expenses do not include expenses not covered by any of the plans, or expenses that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person. Examples of supplies and services that are not allowable expenses include:

1. The difference between the cost of a semi-private room in a hospital and a private room (does not apply if one of the plans provides coverage for a private room).

2. If a person is covered by two or more plans that determine benefits based on any amount:

- In excess of the highest of the negotiated charges, or
- That exceeds those reasonable or recognized charges.

Note: If one of the plans determines benefits based on reasonable or recognized charges and the other plan determines benefits based on negotiated charges, the primary plan’s payment arrangements will be the allowable expense for both plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, the lowest negotiated rate will be the allowable expense used by the secondary plan to determine benefits.

3. The amount a benefit is reduced or not reimbursed by the primary plan because a covered person does not comply with

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A	<p>the plan provisions, such as requirements to obtain second surgical opinions or pre-certification of services or to use preferred provider arrangements.</p> <p><b>Annual earnings</b> means, for purposes of the life and accident insurance plans:</p> <ul style="list-style-type: none"><li>For part-time employees, hourly rate of pay times 1,560 hours</li><li>For full-time hourly employees, hourly rate of pay times 2,080 hours</li><li>For salaried employees, annual salary as reported by Costco</li></ul> <p><b>Annual Enrollment</b> means the period, established annually by Costco, during which employees may elect or change existing elections for benefits under the program. Choices made during this period are effective for the following calendar year. Annual Enrollment is typically held in November.</p> <p><b>Authorized representative</b> means a person you authorize, in writing, to act on your behalf (for example, to file a health care claim or appeal an adverse benefit determination). For purposes of the Aetna medical plans, in order to appoint an authorized representative to act on your behalf, you must file a <i>Designation of Authorized Representative</i> form, available from the Aetna member website. Link to the Aetna member website from <a href="https://www.costcobenefits.com">Costcobenefits.com</a> or call Aetna at <b>800-814-3543</b>. Except in the following two cases, any appointment of an</p>	<p>authorized representative that does not use this form is invalid:</p> <ul style="list-style-type: none"><li>For a health care claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.</li><li>Any person authorized by court order to submit claims on your behalf may act as your authorized representative.</li></ul> <p><b>Autism Spectrum Disorders</b> means a group of neurological disorders characterized by delays in the development of socialization and communication skills as defined by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.</p>	<p><b>Business trip</b> means, for purposes of Business Travel Accident Insurance, any trip you take while on assignment or at the direction of Costco to further company business:</p> <ul style="list-style-type: none"><li>It begins when you leave your residence or place of regular employment, whichever occurs last, to start your trip.</li><li>It ends when you return to your residence or place of regular employment, whichever occurs first.</li></ul> <p>A business trip does not include travel to and from work, or travel while you are on a Leave of Absence or vacation.</p>	<p><b>C</b></p> <p><b>Cafeteria Plan</b> means the plan document for the Costco Wholesale Corporation Cafeteria Plan under which you may:</p> <ul style="list-style-type: none"><li>Make pre-tax contributions to the Health Care Reimbursement Account and Dependent Care Assistance Plan, and</li><li>Pay pre-tax for health care premiums.</li></ul> <p><b>Change in status</b> means a qualified change, summarized in <a href="#">Life Events on page 103</a> and described in the Costco Wholesale Corporation Cafeteria Plan, that permits employees to make limited changes to their benefit elections pursuant to Code Section 125 and Treasury Regulations issued thereunder.</p>		
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**Claims administrator** means the third-party that processes claims and handles the day-to-day claims administration of a plan described in this booklet. Claims administrators for the Costco plans are listed in [Claims Administrators and Fiduciaries on page 130](#).

**Claims fiduciary** has the sole and exclusive discretionary authority and control to determine claims for benefits and is the entity identified in [Claims Administrators and Fiduciaries on page 130](#). Claims fiduciaries for each plan serve as plan benefits administrators solely with respect to their determinations regarding claims for benefits under the plan and are, for jurisdictional purposes, the proper named defendant in a lawsuit under ERISA Section 502(a) against the plan or plan administrator for contesting claims for benefits.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law that gives health care plan participants the right to purchase continued coverage if their eligibility for coverage would otherwise end because of a “qualifying event.”

**Commuting** means, for purposes of Business Travel Accident Insurance, traveling directly between your home and the Costco location where you normally work, while you are traveling as a pedestrian or traveling in or on, boarding or alighting from a conveyance.

**Continuous service** means the period during which you maintain a continuous employment relationship with Costco. Periods of continuous service begin on the date you were last hired, after which there was no termination or separation from service, and continue during approved Leaves of Absence. A period of continuous service ends when Costco’s payroll records reflect you have terminated employment. Your work for Costco in any other country counts towards continuous service if you transfer to the U.S. without interruption.

For purposes of determining your maximum benefit continuation period while you are on a Leave of Absence or for your COBRA subsidy, length of continuous service is the time you worked for Costco from your last hire date to the first day of your Leave of Absence.

**Costco** means Costco Wholesale Corporation, Costco Wholesale Membership, CWC Travel and CWC WDC LLC.

**Costco Employee Benefits Department** means the central Costco Wholesale Employee Benefits Department, located at corporate headquarters, 999 Lake Drive, Issaquah, WA 98027.

**Covered expense** means the health care charges or expenses incurred for treatment

of an individual covered by the applicable plan when that coverage is in force which are:

- Made for care and treatment of an illness or injury
- Medically necessary or for preventive care
- No more than the Reasonable and Customary charge or the negotiated rate, as applicable, and
- Covered (and not excluded) under provisions of the applicable plan.

Plan copays, deductibles, coinsurance, network, quantity, annual and lifetime maximums and similar plan features apply to reduce reimbursement for covered expenses.

**Custodial care** means services and supplies furnished to a person mainly to help them in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care regardless by whom they are prescribed, recommended, or performed.

**Custodial parent**, for purposes of determining Coordination of Benefits, means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

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A	<p><b>D</b></p> <p><b>Deductible sources of income</b> means, for purposes of the disability insurance plans, payments you receive or are entitled to receive from the following sources as a result of your disability, the amounts of which will be deducted from any weekly or monthly benefits you receive from the plans:</p> <ul style="list-style-type: none"> <li>• Payments under a workers' compensation law, an occupational disease law, or any other act or law with similar intent (applies only to Long-Term Disability Insurance Plan because Voluntary STD benefits are not payable for work-related disabilities)</li> <li>• Payments from the Costco Wholesale Corporation Texas Injury Benefit Plan</li> <li>• Disability income payments under any state compulsory benefit act; law or automobile liability insurance policy; or governmental retirement system as the result of your job with Costco</li> <li>• Any amount you receive under Title 46, United State Code Section 688 (The Jones Act)</li> <li>• Amounts from the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any other government plan or act payable to you, your spouse or your children as disability payments because of your disability or as retirement payments because of your retirement</li> <li>• The amount you receive as disability payments under your employer's</li> </ul>	<p>retirement plan, voluntarily elect to receive as retirement payments under your employer's retirement plan, or receive as retirement payments when you reach the later of age 62 or normal retirement age as defined by the retirement plan. This includes only benefits which are based on your employer's contribution to the retirement plan. Payments from the Costco 401(k) Plan do not count as deductible sources of income.</p> <ul style="list-style-type: none"> <li>• The amount paid by a third party, by judgment, settlement or otherwise, after subtracting expenses and attorney's fees. An example of a third-party payment is a legal settlement that a participant receives after becoming disabled due to a car accident.</li> <li>• Vacation pay, if you earned the vacation while you were disabled and working, but receive the pay after you are no longer working</li> </ul> <p>Note: If you receive a cost of living increase from a deductible source of income after your LTD benefits begin, your plan payment will not be reduced any further for that increase.</p> <p><b>Default coverage</b> means the benefit coverage that will automatically apply to you if you do not complete initial enrollment or to re-enroll when you return to work within certain deadlines. This includes coverage for you only but not your family under the following plans:</p>	<ul style="list-style-type: none"> <li>• Medical – Aetna Select if you are a full-time employee; Aetna Select for Part-Time Employees if you are a part-time employee; HMSA HMO if you are a Hawaii employee</li> <li>• Prescription Drug – Costco Health Solutions</li> <li>• Dental – Core Exclusive Provider Plan (EPP)</li> <li>• Vision – eye exams and hardware</li> <li>• Basic Life and AD&amp;D Insurance</li> <li>• Long-Term Disability Insurance</li> <li>• Business Travel Accident Insurance (salaried employees only)</li> </ul> <p>The costs of your default coverage will be deducted from your paychecks and you will not be able to change your elections until the next Annual Enrollment or following certain mid-year changes in status. While in default, you cannot participate in the Supplemental Life Insurance, Supplemental AD&amp;D Insurance, Health Care Reimbursement Account or Dependent Care Assistance plans. However, you may participate in Resources for Living and Voluntary Short-Term Disability Insurance Plan (if applicable to you).</p> <p><b>Dependent</b> means, for purposes of the Reimbursement Accounts, any individual who is your tax dependent as defined in Tax Code Section 152, without regard to subsections (b)(1), (b)(2) and (d)(1)(B). For the Health Care Reimbursement Account, if you are divorced, this also includes any of your children who are under age 27 as of the end of the taxable year who either you or your former spouse may claim as dependents under the Tax Code.</p>			
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A	<b>Dependent care center</b> means a facility which:		<b>Detoxification</b> means the process by which an alcohol-intoxicated, drug-intoxicated or alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate — by metabolic or other means — the intoxicating alcohol or drug, alcohol or drug-dependent factors or alcohol in combination with drugs, as determined by a physician. The process must:	<ul style="list-style-type: none"> <li>Who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.</li> </ul>		
B	<ul style="list-style-type: none"> <li>Provides care for more than six individuals (other than individuals who reside in the facility)</li> </ul>		<ul style="list-style-type: none"> <li>Keep the physiological risk to the patient at a minimum, and</li> </ul>	For purposes of these plans, “doctor” does not include you, your spouse or domestic partner, your children or your parents or siblings.		
C	<ul style="list-style-type: none"> <li>Receives a fee, payment or grant for providing services for any of these individuals, and</li> </ul>		<ul style="list-style-type: none"> <li>Take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.</li> </ul>			
D	<ul style="list-style-type: none"> <li>Complies with all applicable laws and regulations of the state or unit of local government where it is located.</li> </ul>		<b>Disability earnings</b> means the earnings you receive (including vacation pay you earn) while you are disabled and working. Your disability earnings also include:			
E	<b>Dependent care expenses</b> means, for purposes of the Dependent Care Assistance Plan (DCAP), employment-related household and dependent care expenses as defined under Tax Code Section 21(b)(2). A dependent care expense must be incurred to pay for care of a qualifying individual that enables you and, if you’re married, your spouse to be gainfully employed. (An expense does not qualify merely because you are gainfully employed.)		<ul style="list-style-type: none"> <li>Amounts you receive as additional income earned from another job as a result of increased hours, and</li> <li>Earnings you could receive if you were working at your maximum capacity.</li> </ul>	<b>E</b>		
F	Household expenses are considered dependent care expenses only if incurred in connection with the care of a qualifying individual. This may include:		<b>Doctor</b> , for purposes of the Costco life and accident insurance plans, means a person:	<b>Earned income</b> , for purposes of the Dependent Care Assistance Program, means all income derived from wages, salaries, tips, self-employment, and other employee compensation (such as disability or wage continuation benefits) includible in gross income for the employee’s taxable year. It does not include any amounts received:		
G	<ul style="list-style-type: none"> <li>Ordinary and usual household services done in and about your home necessary to the maintenance of your household and attributable to the care of a qualifying individual</li> </ul>		<ul style="list-style-type: none"> <li>Performing tasks that are within the limits of their medical license and licensed to practice medicine and prescribe and administer drugs or to perform surgery</li> <li>With a Doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients, or</li> </ul>	<ul style="list-style-type: none"> <li>Pursuant to any dependent care assistance program,</li> <li>From a pension or annuity, or</li> <li>Pursuant to workers’ compensation.</li> </ul>		
H	<ul style="list-style-type: none"> <li>Services of a housekeeper if they are provided, at least in part, for the care of a qualifying individual</li> </ul>			<b>Eligible paid hours</b> means hours of work for which a participating employer pays you regular, overtime, vacation or sick pay as defined in the Costco Employee Agreement. It does not include sick leave payoff (defined in the Costco Employee Agreement) or any other incentive pay. Eligible paid hours are counted from your last date of hire – work and hours before an earlier termination of employment is not counted for any purpose under the Program.		
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A	<p><b>Elimination period</b>, for purposes of the Costco disability insurance plans, means the period of continuous disability you must complete before you may begin to receive payments from the applicable plan. The Voluntary Short-Term Disability Insurance Plan and the Long-Term Disability Insurance Plan each have a different elimination period.</p> <p><b>Emergency medical condition</b> means a recent and severe medical condition including, but not limited to, severe pain which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that their condition, illness or injury is of such a nature that failure to get immediate medical care could result in:</p> <ul style="list-style-type: none"><li>• Placing the person’s health in serious jeopardy</li><li>• Serious impairment to bodily function</li><li>• Serious dysfunction of a body part or organ, or</li><li>• In the case of a pregnant woman, serious jeopardy to the health of the fetus.</li></ul> <p>Examples of emergency conditions include:</p> <ul style="list-style-type: none"><li>• Sudden onset of chest pain</li><li>• Spinal injuries</li><li>• Uncontrollable bleeding</li><li>• Serious breathing difficulties</li><li>• Unconsciousness</li><li>• Caustic substance in eyes</li><li>• Major burns</li></ul>	<ul style="list-style-type: none"><li>• Shock</li><li>• Seizures</li><li>• Emergency mental disorders or substance use disorders, meaning:<ul style="list-style-type: none"><li>» A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity which could result in your actions causing harm to yourself or placing others in danger, unless immediate transport, supervision, or intervention by a public safety representative or licensed medical professional is obtained, or</li><li>» A prudent layperson possessing an average knowledge of health and medicine would judge the request emergent.</li></ul></li></ul> <p><b>Employee</b> means a person classified on Costco’s payroll system as an employee, and who receives a Form W-2 as a result. If an individual excluded from coverage is subsequently determined by a court, government agency or settlement agreement to be a common law employee of Costco, that determination does not alter the individual’s classification as a non-employee for purposes of the Program.</p> <p><b>Employee Agreement</b> means the Costco Wholesale Employee Agreement which is amended periodically, generally every three years.</p> <p><b>Evidence of Insurability (EOI)</b> means a health questionnaire that, depending on the circumstances, you may</p>	<p>have to complete and submit to Unum along with your application for Supplemental Life Insurance coverage. As EOI, Unum may also require further Evidence of Insurability, such as blood or urine samples, blood pressure readings, medical test results, a physical exam, or a physician’s statement.</p> <p><b>Experimental or investigational</b> means a drug, device, procedure or treatment if:</p> <ul style="list-style-type: none"><li>• There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved, or</li><li>• Approval required by the FDA has not been granted for marketing, or a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or</li><li>• It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services, or</li><li>• The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written</li></ul>			
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A	<p>informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.</p> <p><b>F</b></p> <p><b>Family and Medical Leave Act (FMLA)</b> means the federal law of the same name as defined in the Employee Agreement.</p> <p><b>G</b></p> <p><b>Gainfully employed</b>, for purposes of the Dependent Care Assistance Plan, means working for pay or profit. It does not include work as a volunteer or for nominal consideration. Gainful employment may consist of service within or outside your home, including self-employment. It also includes the active search for employment.</p> <p><b>Gainful occupation</b>, for purposes of the Long-Term Disability Insurance Plan, means an occupation for which you are reasonably fitted by education, training or experience that is or can be expected to provide you with an income at least equal to 60% of your indexed monthly earnings within 12 months of your return to work.</p>	<p><b>H</b></p> <p><b>Health care provider</b> means persons:</p> <ul style="list-style-type: none"> <li>Licensed and practicing within the scope of their licenses as specified by the states in which they are practicing, and</li> <li>Who are not related by blood or marriage to the covered individual.</li> </ul> <p>Health care providers are physicians; physician's assistants; osteopaths; dentists, podiatrists, nurses (R.N., L.P.N., L.V.N., R.N.P.); registered midwives; psychiatric behavioral health nurses (C.R.N.A., R.N.A., or N.A.); optometrists; physical, occupational or speech therapists; chiropractors; audiologists; substance abuse or behavioral health counselors; acupuncturists; naturopaths; homeopaths; pharmacists; licensed and certified dieticians and nutritionists; and marriage therapists. The plan does not cover services of providers that are not listed, such as Christian Science practitioners.</p> <p><b>HIPAA</b> means the Health Insurance Portability and Accountability Act of 1996 (HIPAA).</p> <p><b>Home health care</b>, for purposes of the Aetna medical plans, means care provided by an agency that:</p> <ul style="list-style-type: none"> <li>Mainly provides skilled nursing and other therapeutic services</li> <li>Is associated with a professional group which makes policy which</li> </ul>	<p>includes at least one physician and one R.N.</p> <ul style="list-style-type: none"> <li>Has full-time supervision by a physician or an R.N. keeps complete medical records on each person</li> <li>Has a full-time administrator, and</li> <li>Meets licensing standards.</li> </ul> <p><b>Hospice care</b> means, for purposes of the Aetna Compassionate Care Program, care given to a terminally ill person by or under arrangements with a hospice care agency. Such care may include skilled nursing services; medical social services; and psychological and dietary counseling. Care can be provided in different settings such as in the home, at a hospice facility, in a hospital, or convalescent facility. The care must be part of the hospice care program.</p> <p><b>Hospice care agency</b> means, for purposes of the Aetna Compassionate Care Program, an agency or organization which:</p> <ul style="list-style-type: none"> <li>Has hospice care available 24 hours a day</li> <li>Meets any licensing or certification standards set forth by the jurisdiction where it is located</li> <li>Provides skilled nursing services, medical social services, and psychological and dietary counseling</li> <li>Provides or arranges for other services which will include services of a physician, physical and occupational therapy, part-time home health aide services which mainly consist of caring for terminally ill</li> </ul>			
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A	<p>persons, and inpatient care in a facility when needed for pain control and acute and chronic symptom management</p> <ul style="list-style-type: none"><li>Has personnel which include at least: one physician, one registered nurse (R.N.); and one licensed or certified social worker employed by the agency</li><li>Establishes policies governing the provision of hospice care</li><li>Assesses the patient’s medical and social needs and develops a hospice care program to meet those needs</li><li>Provides an ongoing quality assurance program, including reviews by physicians, other than those who own or direct the agency</li><li>Permits all area medical personnel to utilize its services for their patients</li><li>Keeps a medical record on each patient</li><li>Utilizes volunteers trained in providing services for non-medical needs, and</li><li>Has a full-time administrator.</li></ul> <p><b>Hospice care program</b> means, for purposes of the Aetna Compassionate Care Program, a written plan of hospice care which is established by and reviewed from time to time by a physician attending the person and appropriate personnel of a hospice care agency; is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families; and includes an assessment of the person’s medical and social needs and a description of the care to be given to meet those needs.</p>	<p><b>Hospital</b> means a place that mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons, and:</p> <ul style="list-style-type: none"><li>Is not mainly a place of rest, for the aged, for drug addicts, for alcoholics or a nursing home,</li><li>Is accredited by The Joint Commission</li><li>Is approved by Medicare as a hospital</li><li>Is supervised 24 hours per day by a staff of physicians, and</li><li>Provides 24-hour-per-day R.N. services for illness or injury through the medical, surgical and diagnostic facilities on its premises.</li></ul> <p><b>Illness</b> means a disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. Physical illnesses, substance use disorders and mental disorders are covered by the Costco health care plans, to the extent described in this booklet.</p> <p><b>Injury</b> means, for the:</p> <ol style="list-style-type: none"><li><i>Costco health care plans</i>, physical harm sustained as the direct result of an accident or other harm effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident or harm. Injuries are</li></ol>	<p>covered by the Costco health care plans to the extent described in this booklet.</p> <p>2. <i>Costco life and accident insurance plans</i>, a bodily injury that is the direct result of an accident and not related to any other cause.</p> <p><b>Inpatient facility</b> means a provider charging a facility fee, including but not limited to:</p> <ul style="list-style-type: none"><li>Free-standing psychiatric facility</li><li>Psychiatric unit in a hospital</li><li>Free-standing facility for the treatment of substance use disorder</li><li>Substance use disorder rehabilitation facility</li><li>Residential treatment center</li><li>Hospital</li><li>Hospice care agency</li><li>Skilled nursing convalescent facility</li><li>Rehabilitation facility</li><li>Facilities that offer partial hospitalization or intensive outpatient treatment</li><li>Urgent care provider</li><li>Walk-in clinic</li></ul> <p><b>Intensive outpatient treatment</b> means a planned and structured (intensive) program of medically necessary services delivered by a behavioral health provider at least six hours weekly, at least two hours per day of treatment. Treatment modalities include individual, group, and family, psycho-educational and adjunctive therapies such as medication monitoring.</p>			
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**J**

**Jaw joint disorder** means a Temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint; or a myofacial pain dysfunction (MPD); or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

**L**

**Layoff** is defined in the Employee Agreement.

**Leave of Absence** means an approved Leave of Absence as described in the Costco Employee Agreement.

**Legally placed for adoption** means you have assumed a legal obligation for total or partial support of a child who has been placed with you in anticipation that you will adopt the child.

**Lifetime maximum benefit** means the most the plan will pay in benefits for the entire time you are covered.

**Location** means the Costco location where you are assigned to work.

**M**

**Material and substantial duties** means duties that cannot be reasonably omitted or modified in the performance of your own job or a reasonable alternative.

**Maximum capacity** means, due to the restrictions and limitations of your disability, under the:

- Voluntary Short-Term Disability (STD) Insurance Plan, the greatest extent of work you are able to do in your own job or reasonable alternative.
- Long-Term Disability (LTD) Insurance plan, for the first nine months of LTD benefits, the greatest extent of work you are able to do in your own job or reasonable alternative. After nine months of LTD, it means any gainful occupation that is reasonably available to you.

**Maximum payment period** means the longest period of time a Costco disability insurance plan will make payments for any one period of disability.

**Measurement period** means the semi-annual period that is used to determine your ongoing eligibility for program coverage as well as your status for “full-time” versus “part-time” employee benefit options.

**Medical care expense**, for purposes of the Health Care Reimbursement Account, means amounts paid for “medical care” as defined in Section 213(d) of the Tax Code including,

for example, amounts for certain hospital bills, doctor and dentist bills and prescription drugs. It does not include expenses not reimbursable under Code Section 125, such as premiums paid for other health coverage and long-term care coverage.

**Medically necessary or medical necessity** means a service or supply furnished by a particular provider that is appropriate for the diagnosis, care or treatment of the illness or injury involved. To be appropriate, the service or supply must:

- Be for care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome, than any alternative service or supply, both as to the illness or injury involved and the person’s overall health condition, and
- Be provided in a setting that is no more intensive than the minimum required for a medically-appropriate level of care, or
- Be a diagnostic procedure, indicated by the health status of the person and as likely to result in information that could affect the course of treatment as, and not more likely to produce a negative outcome than, any alternative service or supply, both as to the illness or injury involved and the person’s overall health condition, and
- Be no more costly (taking into account all health expenses incurred in connection with the service or supply) as to diagnosis, care or treatment than any alternative

ELIGIBILITY AND ENROLLMENT		RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
DENTAL	DISABILITY INSURANCE	LIFE AND ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS	LIFE EVENTS	LEGAL AND CLAIMS INFORMATION	
A	service or supply to meet the above tests, and		• Those that are experimental or investigational.		<b>Morbid obesity</b> means a person is:	
B					• 100 lbs. or more over ideal body weight	
C	• In the case of hospitalization, be necessary because the symptoms or condition cannot safely and adequately be treated on an outpatient basis.		The fact that a health care provider may prescribe, order, recommend or approve a service or supply does not mean that such a service or supply will be considered medically necessary for the coverage provided by the Costco health care plans. Aetna's clinical policy bulletins guide whether a service or supply is medically necessary.		• Has a Body Mass Index (BMI) of 40 or higher, or	
D					• Has a BMI of 35 or higher which results in a significant increase in the risk of one or more obesity related conditions (also known as co-morbidities) such as hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.	
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F	Hospice care is considered medically necessary if the covered person's life expectancy is 12 months or less, even though the person may be receiving active or curative care while in the hospice.					
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J	Other than for hospice care, in no event will the following services or supplies be considered to be medically necessary:		<b>Medicare</b> means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.		<b>N</b>	
K					<b>National Institutes of Health</b> means a part of the U.S. Department of Health and Human Services which is the primary federal agency for conducting and supporting medical research.	
L	• Those that do not require the technical skills of a medical, a behavioral health or a dental professional		<b>Mental disorder</b> means a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning, and defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as of the date services are rendered.		<b>Negotiated rate</b> means:	
M	• Those furnished mainly for the personal comfort or convenience of the person, any person who cares for them, any person who is part of their family, or any health care provider or health care facility				1. <i>For purposes of the Costco dental plans</i> , the charge a participating dentist or third-party vendor has agreed to accept for the covered service, drug or supply (including any administrative fee).	
N	• Those furnished solely because the person is an inpatient on any day on which the person's illness or injury could safely and adequately be diagnosed or treated while not confined				2. <i>For purposes of the Aetna medical plans</i> , the amount a network provider or third-party vendor has agreed to accept from Aetna and Aetna agrees to pay for the covered service, drug or supply (including any administrative fee).	
O	• Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting, or		<b>Military leave or Military Leave of Absence</b> means a leave for Active Military Service as defined in the Costco Military Leave Notification Form and in the Costco Employee Agreement.		3. <i>For purposes of the prescription drug plan</i> , the amount Costco Health Solutions (CHS) charges the plan for a drug or supply,	
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ELIGIBILITY AND ENROLLMENT		RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
DENTAL	DISABILITY INSURANCE	LIFE AND ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS	LIFE EVENTS	LEGAL AND CLAIMS INFORMATION	
A	<p>which is based on the cost of the drug or supply, pharmacy charges, any applicable sales tax, and dispensing, administration and other fees.</p> <p>The above negotiated rates are before reduction for any copay, coinsurance or deductible. There may be instances in which a network provider may bill a participant for charges in excess of the negotiated rate (for example, certain third-party liability situations).</p> <p><b>Non-Costco health plan</b> means one of the following non-Costco programs that provides benefits, services or supplies for medical or dental care or treatment:</p> <ul style="list-style-type: none"><li>Individual, group, blanket, or franchise health coverage</li><li>Other prepaid coverage under service plan contracts, or under group or individual programs, policies, or a practice</li><li>Uninsured arrangements of group or group-type coverage</li><li>Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans</li><li>Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts</li><li>Other group-type contracts, that is, those which are not available to the general public and can be obtained and maintained</li></ul>	<p>only because of membership in or connection with a particular organization or group</p> <p><b>Occupational sickness or injury</b> means, for purposes of the Costco disability insurance plans, either of the following:</p> <ol style="list-style-type: none"><li>An illness incurred or aggravated while:<ul style="list-style-type: none"><li>Performing a job-related task, or</li><li>Engaging in any activity for wage or profit, or for which compensation would be available if the person was enrolled in and application was made under a workers’ compensation or occupational injury law or similar legislation,</li></ul></li><li>For employees in Texas, an illness or injury that arises out of the “course and scope of employment” as defined in the Costco Wholesale Corporation Texas Injury Benefit Plan.</li></ol> <p><b>Occupational therapy</b> means therapy expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function. Occupational therapy (except for vocational rehabilitation or employment counseling) is</p>	<p>covered for non-chronic conditions and acute illnesses and injuries. Additionally, coverage for therapy is available for the treatment of Autism Spectrum Disorder, Down syndrome or Cerebral Palsy (as an exception to the non-chronic condition coverage criteria).</p> <p><b>Orthodontic treatment</b> means any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite or the jaws or jaw-joint relationship, whether or not for the purpose of relieving pain. This does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.</p> <p><b>Over-the-counter (OTC) medicines</b> means drugs generally available without a prescription. However, a written prescription from your physician is required for OTC drugs which may be covered by the prescription drug program.</p> <p><b>Own job</b> means the job with Costco you are routinely performing when your disability begins, as it is normally performed at Costco.</p> <p><b>Partial hospitalization</b> means medical, psychiatric, nursing, counseling, or therapeutic services that are:</p> <ul style="list-style-type: none"><li>For a condition that does not require full-time confinement and is in accord</li></ul>			
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A	with accepted medical practice for that condition	Physical therapy is covered for non-chronic conditions and acute illnesses and injuries. Additionally, coverage for therapy is available for the treatment of Autism Spectrum Disorder, Down syndrome or Cerebral Palsy (as an exception to the non-chronic condition coverage criteria).	partner, children, parents or siblings for a claim that you submit.
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C	<ul style="list-style-type: none"> <li>Carried out on a less than full-time inpatient basis in a hospital, psychiatric hospital, residential treatment facility, or free-standing facility, and</li> </ul>		
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E	<ul style="list-style-type: none"> <li>For mental disorders and substance use disorders, supervised by a psychiatric physician who weekly reviews and evaluates its effect.</li> </ul>		
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I	Partial hospitalization may be daytime hospitalization or nighttime hospitalization. If nighttime hospitalization, it must be provided by a hospital, psychiatric hospital, or residential treatment facility which has a room charge and makes such care available at least eight hours in a row per night and five days per week.		
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O	<b>PHI</b> means protected health information.		
P	<b>Physical therapy</b> means treatment that is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. The therapy should follow a specific treatment plan that: <ul style="list-style-type: none"> <li>Allows therapy services, provided in your home if you are homebound</li> <li>Details the treatment, and specifies frequency and duration, and</li> <li>Provides for ongoing reviews and is renewed only if continued therapy is appropriate.</li> </ul>	<b>Physician</b> means: <ol style="list-style-type: none"> <li>For purposes of the Aetna medical plans, a legally qualified physician, other than yourself or a close relative, treating illness, injury or pregnancy within the scope and limitations of his/her license. The physician must be licensed to practice medicine in either the U.S. or Canada.</li> <li>For purposes of the Costco disability insurance plans, a person:               <ul style="list-style-type: none"> <li>Performing tasks within the limits of their medical license, who is licensed to practice medicine and prescribe and administer drugs or to perform surgery</li> <li>With a doctoral degree in psychology (Ph.D. or Psy.D) whose primary practice is treating patients, or</li> <li>Who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.</li> </ul> </li> </ol> <p>For the first 35 days after your last day at work, for purposes of the plans a physician may also include a psychiatric clinician who is not a D.O., an MD or Ph.D. The term “physician” does not include you, or your spouse or domestic</p>	<b>Plan administrator</b> means the Costco Benefits Committee, unless specified otherwise in this booklet. Claims fiduciaries for each plan serve as plan benefits administrator solely with respect to their determinations regarding claims for benefits under the plan and are for jurisdictional purposes the proper named defendant in a lawsuit under ERISA Section 502(a) against the plan or plan administrator contesting claims for benefits.  <b>Plans</b> means the Costco Wholesale Employee Benefits Program, the Costco Wholesale Corporation Cafeteria Plan, the Costco Wholesale Corporation Vision and Prescription Drug Program and the Costco Wholesale Business Travel Accident Plan.  <b>Plan sponsor</b> means the Costco Wholesale Corporation.  <b>Program</b> means the Costco Employee Benefits Program.  <b>Protected health information (PHI)</b> means information that is created or received by the plan and: <ul style="list-style-type: none"> <li>Relates to the past, present, or future physical or behavioral health or condition of an individual; or the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and</li> </ul>
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ELIGIBILITY AND ENROLLMENT		RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
DENTAL	DISABILITY INSURANCE	LIFE AND ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS	LIFE EVENTS	LEGAL AND CLAIMS INFORMATION	
A	<ul style="list-style-type: none"><li>Identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual.</li></ul> <p>PHI includes information of persons living or deceased. This definition includes PHI transmitted by or maintained in electronic form, also known as electronic protected health information. PHI also includes “genetic information” which is defined to include genetic tests (including those of a family member) and the manifestation of a disease or disorder in family members of an individual (not the manifestation of a disease of the individual).</p> <p><b>Psychiatric hospital</b> means an institution that:</p> <ul style="list-style-type: none"><li>Mainly provides a program for the diagnosis, evaluation, and treatment of mental disorders or substance use disorders, including alcoholism</li><li>Provides infirmary-level medical services but also arranges with a hospital in the area for any other medical service that may be required</li><li>Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly</li><li>Is staffed by psychiatric physicians involved in care and treatment and has a psychiatric physician present during the whole treatment day</li><li>Provides, at all times, psychiatric social work and nursing services and skilled</li></ul>	<p>nursing services by licensed nurses who are supervised by a full-time registered nurse (R.N.)</p> <ul style="list-style-type: none"><li>Prepares and maintains a written plan of treatment which is supervised by a psychiatric physician for each patient based on medical, psychological and social needs</li><li>Makes charges</li><li>Meets licensing standards and is appropriately licensed by the state Department of Health or its equivalent, and</li><li>Is not mainly a school or a custodial, recreational or training institution.</li></ul> <p><b>Psychiatric physician</b> means a physician who specializes in psychiatry or has the training or experience to do the required evaluation and treatment of substance use disorders, including alcoholism, or mental disorders.</p>				
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				<p><b>R</b></p> <p><b>Rate Booklet</b> means the booklet you receive during initial enrollment that describes the payroll deduction amounts for the various options offered by the Costco Employee Benefits Program. After initial enrollment, updated Rate Booklets are available at <a href="https://www.costcobenefits.com">Costcobenefits.com</a> or from your Payroll Clerk.</p> <p><b>Reasonable alternative</b> means a job position offered to you by Costco:</p> <ul style="list-style-type: none"><li>Within the same general geographic location as your own job</li><li>The essential duties of which you are able to perform taking into consideration your prior education, training and experience, and</li><li>Which provides a rate of pay greater than 60% of your base weekly earnings (while receiving Short-Term Disability benefits) or 60% of your indexed monthly earnings (while receiving Long-Term Disability benefits).</li></ul> <p>Reasonable and Customary (R&amp;C) charges:</p> <ol style="list-style-type: none"><li>For purposes of the Aetna medical plans, first account for <a href="#">Aetna's Reimbursement Policies on page 30</a>. Then it means the amount payable for a health care service or supply that is calculated in accordance with the following:<ul style="list-style-type: none"><li>If your service was received from a National Advantage Program (NAP) provider, a pre-negotiated charge will be</li></ul></li></ol>		
				<p><b>Q</b></p> <p><b>Qualified Medical Child Support Order (QMCSO)</b> means an order issued by a court or a National Medical Support Notice from a child support agency, under which an employee must provide medical coverage for their eligible child.</p>		



ELIGIBILITY AND ENROLLMENT		RESOURCES FOR LIVING		MEDICAL		SPECIAL PROGRAMS AND HEALTH SUPPORT		PRESCRIPTION DRUGS		VISION AND HEARING	
DENTAL		DISABILITY INSURANCE		LIFE AND ACCIDENT INSURANCE		REIMBURSEMENT ACCOUNTS		LIFE EVENTS		LEGAL AND CLAIMS INFORMATION	
A		paid. NAP providers are out-of-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers.				and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. Aetna may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, Aetna may make an adjustment if it is determined that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.				<ul style="list-style-type: none"><li>• The provider’s usual charge for furnishing it</li><li>• The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, or</li><li>• The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.</li></ul>	
B										In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area Aetna may take into account factors, such as:	
C		» If your service was not received from a NAP provider, a claim-specific rate or discount may be negotiated by Aetna or a third-party vendor.								<ul style="list-style-type: none"><li>• The complexity</li><li>• The degree of skill needed</li><li>• The type of specialty of the provider</li><li>• The range of services or supplies provided by a facility, and</li><li>• The prevailing charge in other areas.</li></ul>	
D										In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement. In all cases, the R&C charge may also include an administrative fee.	
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ELIGIBILITY AND ENROLLMENT		RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
DENTAL	DISABILITY INSURANCE	LIFE AND ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS	LIFE EVENTS	LEGAL AND CLAIMS INFORMATION	
A	<p><b>Recurrent disability</b> means a disability which is caused by a worsening in your condition and which is due to the same cause or causes as a prior disability for which you were receiving benefits from a Costco disability insurance plan.</p> <p><b>Regular care of a physician</b> means, according to generally accepted medical standards, you:</p> <ul style="list-style-type: none"><li>• Personally visit a physician as frequently as is medically required to effectively manage and treat your disabling condition, and</li><li>• You are receiving appropriate treatment and care for your disabling condition by a physician whose specialty or experiences is appropriate for your disabling condition.</li></ul> <p><b>Relevant document</b> means any document, record or other information that:</p> <ul style="list-style-type: none"><li>• Was relied upon in making a decision to deny benefits</li><li>• Was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits</li><li>• Demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the plan and that plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals, or</li></ul>	<ul style="list-style-type: none"><li>• If your claim is a medical or disability claim, constitutes a statement of policy or guidance with respect to the plan concerning a denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.</li></ul> <p><b>Relocation trip</b> means a trip you take for the purpose of relocating to a new residence, as requested and paid for by Costco. It begins when you and, if applicable, your eligible family members leave your former residence. It ends when you and your family arrive at your new residence. For your eligible family members, a relocation trip does not include any time over three days during which they take a personal trip, vacation or sojourn.</p> <p><b>Residential treatment facility (mental disorders)</b> means an institution that meets all of the following requirements:</p> <ul style="list-style-type: none"><li>• Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna</li><li>• Meets all applicable licensing standards established by the jurisdiction in which it is located</li></ul>	<ul style="list-style-type: none"><li>• Performs a comprehensive patient assessment preferably before admission, but at least upon admission</li><li>• Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission</li><li>• Has the ability to involve family/support systems in the therapeutic process</li><li>• Has the level of skilled intervention and provision of care that is consistent with the patient’s illness and risk</li><li>• Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care</li><li>• Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director, and</li><li>• Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.</li></ul> <p>In addition to the above requirements, for mental health residential treatment programs:</p> <ul style="list-style-type: none"><li>• A behavioral health professional must be actively on duty 24 hours per day for 7 days a week</li><li>• The patient is treated by a psychiatrist at least once per week, and</li></ul>			
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ELIGIBILITY AND ENROLLMENT		RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
DENTAL	DISABILITY INSURANCE	LIFE AND ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS	LIFE EVENTS	LEGAL AND CLAIMS INFORMATION	
A	<ul style="list-style-type: none"> <li>The medical director must be a psychiatrist.</li> </ul> <p><b>Residential treatment facility (substance use disorders)</b> means an institution that meets all of the following requirements:</p> <ul style="list-style-type: none"> <li>Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna</li> <li>Meets all applicable licensing standards established by the jurisdiction in which it is located</li> <li>Performs a comprehensive patient assessment preferably before admission, but at least upon admission</li> <li>Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission</li> <li>Has the ability to involve family and/or support systems in the therapeutic process</li> <li>Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk</li> <li>Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care</li> <li>Provides treatment services that are managed by a behavioral health provider</li> </ul>		who functions under the direction/ supervision of a medical director, and		<p>but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system or union pension plan.</p> <p><b>S</b></p> <p><b>Short-term rehabilitation</b>, for purposes of the Aetna medical plans, means therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, disease or congenital defect. These services may consist of outpatient physical therapy, occupational therapy or speech therapy which is expected to result in significant improvement of the person's condition within 60 days from the date the therapy first begins.</p> <p><b>Sickness</b>, for purposes of the Costco life and accident insurance plans, means an illness or disease.</p> <p><b>Skilled nursing convalescent facility</b> means an institution that is licensed to provide, and does provide, on an inpatient basis for persons convalescing from disease or injury:</p> <ul style="list-style-type: none"> <li>Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N., and</li> <li>Physical restoration services to help patients to meet a goal of self-care in daily living activities.</li> </ul>	
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C			<ul style="list-style-type: none"> <li>Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.</li> </ul>			
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I			In addition to the above requirements, for substance use disorder residential treatment programs:			
J			<ul style="list-style-type: none"> <li>Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC)</li> <li>Is actively on duty during the day and evening therapeutic programming, and</li> <li>The medical director must be a physician who is an addiction specialist.</li> </ul>			
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R			In addition to the above requirements, for substance use disorder detoxification programs within a residential setting:			
S			<ul style="list-style-type: none"> <li>An R.N. is onsite 24 hours per day for seven days a week, and</li> <li>The care must be provided under the direct supervision of a physician.</li> </ul> <p><b>Retirement plan</b>, as it applies to deductible sources of income for the Costco disability insurance plans, means a defined benefit plan such as a pension plan which provides retirement benefits to employees and that is not funded entirely by employee contributions. This includes</p>			
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**Tax Code** means the Internal Revenue Code of 1986, as amended.

**Terminally ill** means that Unum, the claims administrator for the Costco life insurance plans, has certified that you:

- Suffer from an incurable, progressive and medically recognized disease or condition, and
- To a reasonable medical probability based on a generally accepted prognostic protocol, will not survive more than 24 months.

**Therapeutic equivalent** means prescription medications that are chemically different, but treat the same condition and have the same mechanism of action.

**Treatment plan** is a program for continued care and treatment established in writing by the patient's attending physician.

**U**

**Urgent care condition or urgent care** means immediate care for a medical condition where pre-service prior authorization is needed to avoid a penalty or loss of coverage but for which application

ELIGIBILITY AND ENROLLMENT	RESOURCES FOR LIVING	MEDICAL	SPECIAL PROGRAMS AND HEALTH SUPPORT	PRESCRIPTION DRUGS	VISION AND HEARING
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A	of the normal time periods for deciding your claim:		<b>Urgent care provider</b> means either of the following:	<b>W</b>	
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C	<ul style="list-style-type: none"><li>• Could seriously jeopardize your health or your ability to regain maximum function, or</li></ul>		1. A freestanding medical facility which:	<b>Walk-in clinics</b> mean medical clinics which do not require appointments for limited primary care services, such as care and treatment for common family illnesses such as strep throat, bronchitis and ear, eye and sinus infections. Typically, these clinics are staffed by nurse practitioners or physician assistants with physicians on call during all hours of operation.	
D	<ul style="list-style-type: none"><li>• In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment being sought.</li></ul>		<ul style="list-style-type: none"><li>• Provides unscheduled medical services to treat an urgent medical condition if the person's physician is not reasonably available</li></ul>		
E			<ul style="list-style-type: none"><li>• Routinely provides ongoing unscheduled medical services for more than eight consecutive hours</li></ul>		
F			<ul style="list-style-type: none"><li>• Makes charges for the services and supplies it provides</li></ul>		
G			<ul style="list-style-type: none"><li>• Is licensed and certified as required by any state or federal law or regulation</li></ul>		
H	If a physician with knowledge of your medical condition determines that your claim meets this definition of urgent care, the claim will be treated by the plan as involving urgent care. Examples of urgent conditions include:		<ul style="list-style-type: none"><li>• Keeps a medical record on each patient</li></ul>		
I			<ul style="list-style-type: none"><li>• Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the facility</li></ul>		
J			<ul style="list-style-type: none"><li>• Is run by a staff of physicians, with at least one physician on call at all times, and</li></ul>		
K			<ul style="list-style-type: none"><li>• Has a full-time administrator who is a licensed physician.</li></ul>		
L	<ul style="list-style-type: none"><li>• Heat exhaustion</li></ul>		2. A physician's office, but only one that has contracted with Aetna to provide care for urgent conditions and is, with Aetna's consent, included in the plan's Directory of Providers as a preferred urgent care provider.		
M	<ul style="list-style-type: none"><li>• Lacerations</li></ul>				
N	<ul style="list-style-type: none"><li>• Minor broken bones</li></ul>				
O	<ul style="list-style-type: none"><li>• Objects in eye, ear or nose</li></ul>				
P	<ul style="list-style-type: none"><li>• Sprained or strained joints</li></ul>				
Q	<ul style="list-style-type: none"><li>• Persistent pain</li></ul>				
R	Examples of non-urgent conditions include, but are not limited to:				
S	<ul style="list-style-type: none"><li>• Routine or preventive care, including immunizations</li></ul>				
T	<ul style="list-style-type: none"><li>• Follow-up care</li></ul>				
U	<ul style="list-style-type: none"><li>• Physical therapy</li></ul>				
V	<ul style="list-style-type: none"><li>• Elective surgical procedures</li></ul>				
W	<ul style="list-style-type: none"><li>• Any lab and radiologic exams not related to the treatment of the urgent condition</li></ul>		An emergency room or outpatient department of a hospital is not an urgent care provider.		
X					
Y					
Z					