Summary Plan Description

for the

Flexible Spending Plan*

a part of the

Genesco Master Plan

January 1, 2026

* This includes the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account; it also includes the Premium Expense Account for the payment of certain premiums, and Health Savings Account (HSA) contributions, all on a pre-tax (salary reduction) basis.

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FLEXIBLE SPENDING PLAN

INTRODUCTION

This Summary Plan Description ("SPD") describes the Cafeteria Plan that Genesco Inc. ("Genesco") maintains for eligible employees as a part of the Genesco Master Plan—the Cafeteria Plan is commonly referred to, including in this Summary Plan Description, as the "Flexible Spending Plan" (or "Plan") and it includes the Health Care and Dependent Care Flexible Spending Accounts. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join, and the laws that protect your rights.

One of the most important features of this Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under the Plan, these same expenses will be paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan, which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code ("Code") and other federal and state laws that may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service ("IRS") or other federal agencies. Genesco may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD materially change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Section of this SPD entitled "General Information About the Plan."

I

ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules that you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan (the application form(s) may be in electronic form—refer to the enrollment materials for the Plan for details).

2. What are the eligibility requirements for the Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan, as described in the enrollment materials. The application includes your personal choices for each of the benefits that are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II

OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to federal income or Social Security taxes. In other words, this allows you to use pre-tax dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a

reimbursement for an expense under the Plan, you cannot claim a federal income tax credit or deduction on your return for the same expense. (See the Section entitled "General Information About the Plan" for the definition of "Plan Year.")

III

CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

3. When must I decide which accounts I want to use?

You are generally required by federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for the Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Section entitled "General Information About the Plan" for the definition of Plan Year.) Refer to the enrollment materials for details.

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents (for example, special enrollment rights). If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an

option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's, or dependent's employer.

These rules on change due to a change in cost or coverage do not apply to the Health Care Flexible Spending Account, and you may not change your election to the Health Care Flexible Spending Account if you make a change due to a change in cost or coverage for other coverage(s).

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

To request an election change during the Plan Year due to one of these permissible events, you must timely contact the Plan, as described in the enrollment materials. You may be required to provide proof of the event.

The rules described above do not limit your elections to contribute to your Health Savings Account, or "HSA," during the year. Instead, you may make a prospective change to your Health Savings Account election at any time during the Plan Year, subject to the contribution limits applicable to the Plan Year (as required by the Code). Refer to Question 4 under "IV Benefits" below, for details.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate in the Flexible Spending Accounts or to make any contributions to a Health Savings Account, if applicable (see Question 4 under "IV Benefits" below), for the upcoming Plan Year. Refer to the enrollment materials for details.

IV

BENEFITS

1. Health Care Flexible Spending Account

The Health Care Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Code that are not covered or reimbursed by another plan and save taxes at the same time. The Health Care Flexible Spending Account allows you to be reimbursed for eligible expenses incurred by you and your dependents.

The Health Care Flexible Spending Account is not available to you if you are enrolled in a High Deductible Health Plan (this will help ensure you are eligible to make contributions to a Health Savings Account)—refer to Question 4 below for details. Also note that if you do enroll in the Health Care Flexible Spending Account, because that account automatically covers the expenses incurred by your spouse and other dependent(s), your participation in the Health Care Flexible Spending Account could disqualify your spouse (or other dependent(s)) from establishing and making/receiving tax-favored contributions to their own Health Savings Account(s).

Drug costs, including insulin, may be reimbursed. You may be reimbursed for "over the counter" drugs only if those drugs are prescribed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of eligible expenses is available from the Administrator. You may also refer to the Optum Financial. website at www.optumfinancial.com for examples of eligible expenses.

The most that you can contribute to your Health Care Flexible Spending Account each Plan Year is subject to IRS limitations and will be determined by the Plan Sponsor and described in the enrollment materials for the year (for 2026, the maximum contribution is $3,400). Similarly, the minimum amount that you may contribute to the Health Care Flexible Spending Account for a particular Plan Year will be determined by the Plan Sponsor and described in the enrollment materials for the year (for 2026, the minimum contribution is $260).

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on IRS Form 2441 "Child and Dependent Care Expenses" (available at: https://www.irs.gov/pub/irs-pdf/i2441.pdf (form) and https://www.irs.gov/pub/irs-pdf/i2441.pdf (instructions)). Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements that qualify include:

(a) a Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) an Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) an "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under the Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $7,500 (if you are married filing a joint return or you are head of a household) or $3,750 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). The minimum amount that you may contribute to the Dependent Care Flexible Spending Account for a particular Plan Year, if any, will be determined by the Plan Sponsor and described in the enrollment materials for the year.

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan (see IRS Publication 503, available at: https://www.irs.gov/pub/irs-pdf/p503.pdf, for information). You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under the Plan. Ask your tax adviser which is better for you.

3. Premium Expense Account

A Premium Expense Account allows you to use pre-tax dollars to pay for certain premium expenses under various coverages offered to you. These premium expenses include:

-- Health care premiums under our self-funded medical plan.

-- Dental insurance premiums.

-- Vision insurance premiums.

Under the Plan, we will establish sub-accounts for you for each different type of coverage that is available—these are bookkeeping accounts only. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any coverage(s) to be provided to you will be provided only after (1) you have provided the Administrator the necessary information to apply for such coverage, and (2) the coverage is in effect for you.

If you cover your spouse and/or you children up to age 26 under these coverage(s), you can pay for their coverage through the Plan.

4. Health Savings Account (HSA) Contributions

This Plan also permits a participant in Genesco's High Deductible Health Plan ("HDHP") to make pre-tax contributions to their Health Savings Account ("HSA") (each, as defined in Section 223 of the Code).

An HSA is a personal savings account you establish with a custodian or trustee to be used primarily for reimbursement of "eligible medical expenses" you (the account beneficiary) and your spouse and other eligible dependents (as defined in

Section 152 of the Code) incur, as set forth in Section 223 of the Code. The HSA is administered by the HSA custodian or trustee or its designee and the terms of the HSA are set forth in the custodial or trust agreement you will receive.

Your Employer may contribute a discretionary amount to participants' HSAs, if applicable (any such amount will be determined before the applicable Plan Year and described in the enrollment materials for that year). Contributions to an HSA from all sources are limited by the Code for each Plan Year. For 2026, these limitations are, for self-only HDHP coverage, $4,400; and for family HDHP coverage, $8,750. These amounts may be reduced if you are married and your spouse also contributes to an HSA. If you reach age 55 by the end of the current Plan year, and additional $1,000 "catch-up" contribution is also permitted. Consult with your tax advisor about how these limitations apply to you (you might also find helpful information in IRS Publication 969, available at: www.irs.gov/pub/irs-pdf/p969.pdf).

Only individuals who satisfy the following conditions are eligible to contribute to an HSA under this Plan:

(a) You are enrolled in a qualifying HDHP maintained by your Employer;

(b) You have opened an HSA with the custodian or trustee chosen by Genesco;

(c) You are not covered under any other non-HDHP maintained by the Employer that is determined by the Employer to offer disqualifying health coverage (note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not, including but not limited to coverage maintained by your spouse's employer, and it is solely your responsibility to ensure that any other coverage you have does not disqualify you from contributing to an HSA under Section 223 of the Code);

(d) You have certified that you are otherwise eligible to participate in the HSA (i.e., you: (1) cannot be claimed as a tax dependent; (2) are not enrolled in Medicare coverage; (3) have qualifying High Deductible Health Plan coverage; and (4) have no disqualifying coverage from any other source); and

(e) You are otherwise eligible for this Plan.

The HSA is not an Employer-sponsored employee benefit plan. Your Employer's role with respect to the HSA is limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through Employer contributions, if applicable, and/or pre-tax contributions you elect). The Employer may choose to restrict contributions made through this Plan to HSAs maintained by a particular custodian or trustee; however, you will be permitted to rollover funds from the HSA offered under this Plan to another HSA of your choosing (in accordance with the terms of the custodial or trust agreement). The fact that contributions to the HSA are made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited in your HSA. As such, the HSA is not subject to ERISA.

V

BENEFIT PAYMENTS

1. When will I receive payments from my Flexible Spending Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements that are made from the Plan are generally not subject to federal income tax or withholding; nor are they subject to Social Security taxes. The provisions of the insurance contracts and other official plan documents will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all of my Flexible Spending Account contributions during the Plan Year, and what is a Grace Period?

If you have not spent all the amounts in your Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account by the end of the Plan Year and you are still a Participant on the last day of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account.

Important Information About the Impact of the Current Year's Health Care Flexible Spending Account Grace Period on Eligibility for a Health Savings Account in the Subsequent Year

If you participate in the Health Care Flexible Spending Account during the current year, and you want to enroll in the HDHP Plan in a subsequent year, you should be aware that, if you have any balance remaining in your Health Care

Flexible Spending Account on December 31 of the current year (determined on a "cash basis"), you will be prevented (under current federal tax law) from contributing to an HSA during the months of January through March of the subsequent year because of the availability of the Grace Period (January – March 15) in which to incur and be reimbursed for expenses from your current year Health Care Flexible Spending Account election.

"Cash basis" means the cash balance in your Health Care Flexible Spending Account on December 31, without taking into account expenses incurred but not yet been reimbursed as of that date. Thus, any pending claims, claims submitted, claims received, or claims under review that have not been paid as of December 31 will not be taken into account for the purpose of determining whether you have a $0 balance in your Health Care Flexible Spending Account on December 31.

Any monies left at the end of the Plan Year and the Grace Period (if applicable) will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year or during the Grace Period (if applicable) for which you seek reimbursement after the end of such Plan Year and Grace Period (if applicable) will be paid first before any amount is forfeited.

For the Health Care Flexible Spending Account, you must submit claims no later than 120 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for group health plan coverage, including the Health Care Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Care Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask the Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to Flexible Spending Account benefits will be determined in the following manner:

(a) For health benefit coverage and Health Care Flexible Spending Account coverage on termination of employment, please see the Section entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Care Flexible Spending Account will cease on your termination date, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Care Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

(b) For Dependent Care Flexible Spending Account coverage, your participation will end on your termination date, and you will be able to request reimbursement for qualifying dependent care expenses incurred during the Plan Year, and only while you are participating in the Plan, from the balance remaining in your dependent care account at the time of termination of employment. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

(c) Your Health Savings Account will remain yours even if you terminate employment.

For other coverages, your rights upon termination are determined in accordance with the terms of those plans.

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive pre-tax benefits under the Plan, it reduces the amount of contributions that you make to the federal Social Security system as well as your Employer's contribution to Social Security on your behalf.

VI

HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII

PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your Flexible Spending Account(s) periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

On or before January 31st of each calendar year, the Administrator will also furnish you with a statement showing the amount of dependent care assistance you received (if any) under the Dependent Care Flexible Spending Account during the prior Plan Year. This information will be reported on your W-2.

VIII

GENERAL INFORMATION ABOUT THE PLAN

This Section contains certain general information that you may need to know about the Plan.

1. General Plan Information

The Plan described in this Summary Plan Description is formally called the Cafeteria Plan, though it is commonly referred to as the "Flexible Spending Plan," including in this Summary Plan Description. This Plan is a part of the Genesco Master Plan. The terms described in this Summary Plan Description are effective on January 1, 2026.

Your Employer has assigned Plan Number 516 to the Genesco Master Plan.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Plan Sponsor Information

The Plan Sponsor's name, address, and employer identification number (EIN) are:

Genesco Inc.

535 Marriott Drive, 11th Floor
Nashville, Tennessee 37214

EIN: 62-0211340

In addition to the Plan Sponsor, other Employers may from time to time participate in the Plan. Participants and beneficiaries may receive from the Plan Administrator, upon written request (contact information is provided below), information as to whether a particular Employer is participating in the Plan.

3. Plan Administrator Information

The name, address and business telephone number of the Plan's Administrator are:

Genesco Inc.
535 Marriott Drive, 11th Floor
Nashville, Tennessee 37214

Telephone: 615-367-7852

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Administrator may delegate certain responsibilities under the Plan; therefore, any reference in this SPD to the "Plan Administrator" or "Administrator" means the Administrator or its delegate.

You may also contact the Benefits Team, which acts on behalf of the Administrator with respect to day-to-day matters concerning the Plan, for any information about the Plan. The Benefits Team's contact information is:

Telephone: 615-367-7852

Email: benefits@genesco.com

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Genesco Inc.
Attn: Director, Total Rewards
535 Marriott Drive, 11th Floor
Nashville, Tennessee 37214

Service may also be made on the Plan Administrator (contact information is provided above).

5. Type of Funding and Administration

Benefits under the Plan are paid from the Employer's general assets. The Plan is administered by the Plan Administrator,

above. Genesco has engaged Optum Financial. to assist with the administration of the Plan—Optum Financial's contact information appears under "Claims Submission," immediately below.

6. Claims Submission

Claims for expenses should be submitted to:

Optum Financial
Claims Department
P.O. Box 872168
Kansas City, MD 64187-2168

Telephone: 844-881-5934

Website: www.optumfinancial.com

IX

ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

The following statement of ERISA rights is required by federal law and regulation. It only applies to the Health Care Flexible Spending Account portion of the Flexible Spending Plan.

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, 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, 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; and

Continue Group Health Plan Coverage

- continue health care coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing COBRA continuation rights.

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 an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request the 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Care Flexible Spending Account, you must submit claims no later than 120 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

Claims that are insured or self-funded will be handled in accordance with procedures contained in the insurance policies or contracts. All other general requests should be directed to the Administrator of the Plan.

Decisions on Claims and Appeal Rights—Dependent Care Flexible Spending Account

If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

Decisions on Claims and Appeal Rights—Health Care Flexible Spending Account

In the case of a claim for benefits under the Health Care Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Participant's deadline for requesting mandatory first level of review (appeal) following adverse determination on claim	**180 days**
Review of claim denial – mandatory first level of review (appeal)	30 days
Participant's deadline for requesting mandatory second level of review (appeal) following adverse determination on first level appeal	**30 days**
Review of claim denial – mandatory second level of review (appeal)	30 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial after completion of all mandatory levels of review;

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a claim denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan (see the timetable above). This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

The Plan has two mandatory levels of review. If, after the first level of review, the Plan Administrator upholds the denial of your claim for benefits, in whole or in part, **you may file a second request for review within 30 days after receiving the decision on the first level of review**. The second level of review will generally follow the same procedures as are outlined above. You must exhaust both of the Plan's mandatory levels of review of Health Care Flexible Spending Account claims before bringing a civil action against the Plan.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

4. No Assignment of Benefits or Other Rights and Obligations Under the Plan

Except as specifically provided in this SPD or the Plan, the benefits under this Plan:

(a) are not in any way subject to your debts or other obligations;

(b) may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered; and

(c) shall not be subject to being taken by your creditors by any process whatsoever.

Any attempt to cause the benefits under this Plan to be so subjected will not be recognized, except to the extent required by law (e.g., as required by the tax withholding provisions of applicable law).

Similarly, except as specifically provided in this SPD or the Plan, any other rights and/or obligations under the Plan to or with respect to you may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered, and any attempt to cause such right or obligation to be so subjected will not be recognized except to the extent required by law (e.g., by the designation of any authorized representative pursuant to the Plan's claims and review procedures).

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is

intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA applies only to the Health Care Flexible Spending Account portion of this Plan, though it may also apply to other group health plan coverages offered under the Genesco Master Plan. **Special limitations on COBRA apply to the Health Care Flexible Spending Account—refer to Question 17 below for details.**

The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries"). The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available 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 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.

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended (FMLA) does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.
- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas—so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you may pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance

Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Genesco Inc.
535 Marriott Drive, 11th Floor
Nashville, Tennessee 37214

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

You may be required to provide proof of the Qualifying Event; for example, if the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator, as applicable.

9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage as described in Question 8, above. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified

Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. How is my participation in the Health Care Flexible Spending Account affected?

Special COBRA rules apply to the Health Care Flexible Spending Account:

First, you can elect to continue your participation in the Health Care Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions: You may only continue to participate in the Health Care Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Care Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

Second, the maximum period for COBRA continuation coverage under the Health Care Flexible Spending Account generally runs only through the end of the Plan Year in which your Qualifying Event occurred.

If You Have Questions

If you have questions about the Plan or your COBRA continuation coverage rights, you should contact the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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