The Macy's
Health Care Plan

THE MACY'S HEALTH CARE PLAN

This booklet describes the benefits offered under the Macy's Health Care Plan to active, **Benefits-Eligible Colleagues** of Macy's, Inc. and its business units and affiliated companies.

Eligibility rules specific to your business unit or affiliated company are described in a separate Macy's Health Care Plan Supplement, which is available upon request. The key terms used in the Supplement in bold print also appear in bold print in this booklet. Also, depending on the health care options you choose, you will receive a separate benefits summary booklet from the appropriate insurance carrier(s) ("carriers") or health maintenance organization(s) ("HMOs") (sometimes called a Certificate of Coverage, Member Handbook, Evidence of Coverage or Summary of Material Modifications) that summarizes the respective insured, HMO and/or self-funded health care options they administer under the Plan. The Supplement and carrier and HMO benefits summary booklets are also considered a part of this booklet, however, the Company cannot and does not guarantee the accuracy or completeness of any information provided by a carrier or HMO. Read all of these documents together for a complete description of the benefits available to you under the Macy's Health Care Plan.

Any questions you may have about this booklet should be directed to the Colleague Support Center through My Total Rewards on My IN-SITE or at 1-800-234-6229, Option 3**.**

July 2020

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INTRODUCTION

Macy's, Inc. (referred to in this booklet as "Macy's" or the "Company") and its business units and affiliated companies (referred to in this booklet as "Participating Employers") have designed medical, dental and vision health care options to help cover the costs of your medical and dental treatment. These benefits are available to **Benefits-Eligible Colleagues** and their eligible dependents. The following pages describe the health care benefits available to you and your family so that you may better understand these benefits.

Please keep in mind that you and the Company share the cost of medical benefits. Therefore, as health care costs continue to rise, it is in your best interest to be a wise consumer of health care services. We must work together to control health care costs while maintaining quality health care protection.

If you have questions about how to use these health care options to your best advantage after you have read this booklet, please contact the Colleague Support Center through My Total Rewards on My-IN SITE or at 1-800-234-6229, Option 3.

MACY'S RESERVES TO ITSELF, PURSUANT TO ITS SOLE AND ABSOLUTE DISCRETION, THE RIGHT TO CHANGE, AMEND, OR TERMINATE THIS PLAN, AT ANY TIME, IN WHOLE OR IN PART, WITHOUT REGARD TO SATISFACTION OF PRIOR ELIGIBILITY CONDITIONS. BENEFITS DESCRIBED HEREIN MAY NOT APPLY TO COLLEAGUES COVERED UNDER A LABOR AGREEMENT.

ELIGIBILITY AND ENROLLMENT

WHO IS ELIGIBLE? WHEN SHOULD I SIGN UP FOR COVERAGE?

If you are a **Benefits-Eligible Colleague** and wish to enroll in health care coverage, you must enroll online through My Total Rewards on My IN-SITE. If you do not enroll timely, your coverage will not become effective on your **Eligibility Date**. Coverage may subsequently become effective:

- on the annual enrollment date indicated during an annual enrollment period if you complete the required annual enrollment process; or

- on the date of certain qualified change in status events (described beginning on page 5) if you complete the required enrollment process.

Please refer to your Macy's Health Care Plan Supplement for a description of the requirements for becoming a **Benefits-Eligible Colleague**. Please note that different eligibility rules may apply with respect to certain grandfathered colleagues and dependents who meet specific eligibility criteria based on prior employment history and service, date of hire and Plan participation. Please contact the Colleague Support Center at 1-800-234-6229, Option 3 for the specific criteria for your location.

Colleagues covered under a collective bargaining agreement are eligible to participate in the Macy's Health Care Plan if participation has been agreed to by the Company and the bargaining representatives. However, if you are eligible to participate in a multi-employer medical plan because of a collective bargaining agreement, you are not eligible to participate in the Macy's Health Care Plan. For information regarding whether a particular collective bargaining agreement addresses participation in the Macy's Health Care Plan, contact the Colleague Support Center at 1-800-234-6229, Option 3.

You will not be considered a **Benefits-Eligible Colleague** for any period during which you are not or were not on a Participating Employer's employee payroll or during which you are or were a Leased Employee. In particular, the Company expressly intends that if you are not treated by a Participating Employer as an employee on its employee payroll records (for example, when the Participating Employer treats you as an independent contractor and/or reports your compensation from the Participating Employer on any type of Form 1099) you will not be considered a **Benefits-Eligible Colleague** for purposes of this Plan even if a court or administrative agency determines that you are a common law employee of the Participating Employer.

NOTE: When applying for coverage under any health care option (including dental and vision coverage), you must provide complete and accurate information. If you misstate or fail to disclose important information, errors in eligibility could result. If this happens, your coverage will be adjusted or terminated, as appropriate, based upon the correct information and/or you will be obligated to refund any benefit payments incorrectly paid. Any misrepresentation or willful omission of information may be cause for disciplinary action up to and including dismissal from employment by your Participating Employer or suspension or termination of coverage.

You may elect to change your coverage among the health care options offered by Macy's and your Participating Employer during each annual enrollment period. Coverage changes will take effect on the annual enrollment date indicated during the annual enrollment period. Once a new health care option is elected, your and your dependents' then-current coverage will end at the end of the day before your coverage begins under the new health care option. No benefits are payable under the new coverage option for any charges rendered for supplies or services furnished while you and your covered dependents were participating in your previous coverage.

Dependent Coverage

In addition to yourself, the following dependents also are eligible for coverage:

Your Spouse:

- if you are legally married under the laws of any state (you may be asked to submit proof of legal marriage).

If you and your spouse both work for a Participating Employer, either of you may be covered as a colleague or a dependent, but not both.

Your Domestic Partner:

- If you meet the requirements below (you will be required to provide supporting documentation):
  - Neither person is married to someone else;
  - Both are at least 18 years old; and
  - Both are capable of consenting to the domestic partnership.

Your Children:

- who are under age 26 (unless the Plan is subject to a state law that requires the Plan to provide coverage until a later age), or

- who are any age if they are physically or mentally impaired or disabled and incapable of self-sustaining employment, provided that the incapacity commenced prior to age 26. You will be required to submit proof of the child's incapacity within 31 days after the date coverage would normally end and upon request thereafter.

In all situations except a child reaching age 26 (in which case the Company will automatically remove the child from coverage and if necessary, adjust your coverage and contributions accordingly), you must contact the Colleague Support Center at 1-800-234-6229, Option 3 to delete any other dependent from coverage within 31 days after his or her loss of eligibility. If you fail to timely notify the Colleague Support Center, you may be unable to make changes to your contributions and your dependent may be ineligible for continuation coverage under the Federal law known as COBRA.

"Children" includes

- stepchildren and children of your domestic partner,
- legally adopted children or children placed for adoption,
- children for whom you are the legal guardian or children for whom you have legal custody (temporary or permanent),
- prospective adoptive children, even though the adoption agency may retain legal guardianship of the child until the adoption is final. You will be required to submit proof of adoption, guardianship, or custody,
- children who are required to be covered pursuant to a qualified medical child support order ("QMCSO").

If you decide to include dependents in your coverage, they must be enrolled in the same health care option(s) you choose for yourself, unless coverage is required under a QMCSO for a dependent living in a different service area than yourself. If you and your spouse both work for a Participating Employer and wish to cover your children, only one parent may enroll the children as dependents.

WHAT IS A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)?

A Qualified Medical Child Support Order ("QMCSO") is any judgment, decree, or order issued by a court of competent jurisdiction or governmental agency which relates to the provision of health care coverage to a child or children of a **Benefits-Eligible Colleague**. If the Company determines that an order is qualified, the colleague-parent and the affected child or children may be enrolled in the Plan.

In order to be considered "qualified," the order must clearly specify all of the following information:

- the name and last-known mailing address of the child(ren) to be covered, their custodian/guardian and the colleague-parent,

- a reasonable description of coverage to be provided,

- the period for which coverage is to be provided (i.e., a beginning and ending date or event), and

- the name of the plan to which the order applies (i.e., the Macy's Health Care Plan).

The Company, in its sole discretion, will review the order to determine if it is qualified and will notify the guardian/custodian, the colleague-parent and the child(ren) (if required) of the determination as soon as reasonably possible after receipt of the order. No coverage will be provided by the Plan until the order is determined to be qualified. Participants and beneficiaries can obtain a description of the Company's procedures for determining the qualified status of Medical Child Support Orders at no charge by contacting the Colleague Support Center through My Total Rewards on My IN-SITE or at 1-800-234-6229, Option 3.

WHAT IF I DO NOT ENROLL WHEN FIRST ELIGIBLE?

If you decline enrollment for yourself and/or your dependents (including your spouse or domestic partner), you may only enroll yourself and your dependents during a future annual enrollment or if you experience a qualified change in status event (see below) that would allow you to change your health care election(s).

WHAT IS A QUALIFIED CHANGE IN STATUS?

A qualified change in status is a life event such as a birth, adoption, death, marriage, divorce or change in employment that affects your family's need or eligibility for health care coverage. When a qualified change in status event occurs, you may change your health care coverage election(s) by visiting My Total Rewards on My IN-SITE or contacting the Colleague Support Center at 1-800-234-6229, Option 3 to report the change **within 31 days after the date of the event**. The change in your election must be consistent with the qualified change in status event.

Some examples of these types of changes are:

- If you are enrolled in the Macy's Health Care Plan, you may

  - add a new spouse,

  - add a newborn child,

  - add a newly adopted child,

  - drop your spouse as a dependent, at your divorce or legal separation,

  - drop your spouse as a dependent, when your spouse begins to participate in group coverage through a new employer,

- drop your coverage, if added to your new spouse's group health care coverage.

- If you have waived coverage, you may

  - enroll yourself and your dependents, when you lose other group health care coverage due to your spouse's annual enrollment election, termination of employment, or death,

  - enroll yourself, when you lose other group health care coverage because of divorce or legal separation.

NOTE: In the event of a divorce or legal separation, you must report the event through My Total Rewards on My IN-SITE to delete your spouse or domestic partner from coverage within 31 days after his or her loss of eligibility. If you fail to timely report the event, you may be unable to make changes to your contributions and your dependent may be ineligible for continuation coverage under the Federal law known as COBRA.

A qualified change in status also includes:

- Loss of eligibility under Medicaid or a State Children's Health Insurance Program ("CHIP") under Title XXI of the Social Security Act,

- Becoming eligible for a premium assistance subsidy under Medicaid or CHIP.

NOTE: If you and/or your dependents experience either of the above two qualified change in status events, you will have up to 60 days (rather than the usual 31 days) from the date of the event to report the change by contacting the Colleague Support Center at 1-800-234-6229, Option 3 to enroll due to the loss of eligibility under Medicaid or CHIP, or qualifying for premium assistance.

- A change in employment status event that results in you changing to a job classification that is reasonably expected to work less than an average of 30 hours per week; provided that you 1) intend to enroll in another health plan providing minimum essential coverage and 2) contact the Colleague Support Center at 1-800-234-6229, Option 3 to complete the Verification of Enrollment Due to a Status Change form.

To change your election due to a qualified change in status event, you must visit My Total Rewards on My IN-SITE or contact the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days after the event to report the event. Your online election must be completed through My Total Rewards on My IN-SITE by the deadline indicated. If your online election is not confirmed by the deadline indicated, you may be unable to add/drop coverage until the next annual enrollment. Any changes to your coverage, such as enrollment, addition of a dependent(s), or cancellation of coverage, requested as a result of a qualified change in status event will generally be effective the date of the event provided that you report the event within the time limits provided. Retroactive contributions may be required.

The Company, in its sole discretion, will determine if you have had a qualified change in status and if your requested change is consistent with the qualified change in status event and permitted under the Plan and applicable law. If you have not had a qualified change in status, or if your requested change is not consistent with your qualified change in status event, you may not be able to change your election until the next annual enrollment.

WHAT IS MARKETPLACE ENROLLMENT?

If you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Health Insurance Marketplace or you seek to enroll in a Qualified Health Plan through a Marketplace during that Marketplace's annual open enrollment period, you may cancel your pre-tax medical coverage through Macy's, Inc.; provided your cancellation of Macy's, Inc. coverage corresponds with your intended enrollment, and the enrollment of any related individuals who cease Macy's coverage as a result of your cancellation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of your Macy's, Inc. coverage that is being cancelled.

If you intend to enroll in Qualified Health Plan coverage through the Health Insurance Marketplace and want to make changes to your Macy's, Inc. health care benefits, you must report the event by visiting My Total Rewards on My IN-SITE or by contacting the Colleague Support Center at 1-800-234-MACY (6229), Option 3.

WHEN DOES COVERAGE BEGIN AND END?

If you enroll through the online election process on My Total Rewards on My IN-SITE by the specified due date when you are first eligible for coverage under the Plan, your coverage begins on your **Eligibility Date**. Coverage may subsequently become effective:

- on the annual enrollment date indicated during an annual enrollment period if you complete the required annual enrollment process;

- on the date of certain qualified change in status events (described beginning on page 5) if you complete the required enrollment process.

Coverage will end as described in this section unless continuation coverage is available to you and is properly elected. For additional information on continuation coverage, see page 31

Employee: Your health care coverage ends on the earliest of the following:

- the end of the pay period in which you last made the appropriate payroll contribution or timely payment required for your coverage (including if your payments are in arrears);

- the end of the pay period in which you are no longer eligible for coverage;

- the date of a qualified change in status event; provided that you report the event within the time limits specified;

- the end of the month before your Marketplace Enrollment is effective when enrolling in the Marketplace during the Marketplace annual enrollment period; provided you report your Marketplace enrollment through My Total Rewards on My IN-SITE within the time limits specified;

- the end of the pay period in which you stop working for a Participating Employer (unless state law mandates that coverage continue for a certain time period);

- the end of the month in which you stop working for a Participating Employer if you meet the criteria to elect Retiree Medical coverage upon termination of employment;

- upon notice if you knowingly provide the Plan with false, incorrect or incomplete information that is material to your eligibility for coverage, or if you or any of your dependents commit any fraudulent or dishonest acts to obtain benefits or otherwise violate any terms of the Plan;

- upon notice if you knowingly provide a false tobacco designation for yourself and/or any enrolled dependent;

- the date you die; or

- the date Macy's or your Participating Employer no longer offers group health care coverage.

For Your Spouse: Coverage ends for your spouse on the earliest of the following "Loss of Dependent Status Events:"

- the end of the pay period in which you last made the appropriate payroll contribution or timely payment required for dependent coverage;

- the date of a qualified change in status event; provided that you report the event within the time limits specified;

- the end of the month before your Marketplace Enrollment is effective when enrolling in the Marketplace during the Marketplace annual enrollment period; provided you report your Marketplace enrollment through My Total Rewards on My IN-SITE within the time limits specified;

- the date on which your marriage terminates (i.e., divorce or legal separation);

- the date your spouse dies; or

- the date your coverage terminates.

For Your Domestic Partner: Coverage ends for your domestic partner on the earliest of the following "Loss of Dependent Status Events:"

- the end of the pay period in which you last made the appropriate payroll contribution or timely payment required for dependent coverage;

- the end of the pay period in which you cancel your domestic partner's coverage;

- the date of a qualified change in status event; provided that you report the event within the time limits specified;

- the end of the month before your Marketplace Enrollment is effective when enrolling in the Marketplace during the Marketplace annual enrollment period; provided you report your Marketplace enrollment through My Total Rewards on My IN-SITE within the time limits specified;

- the date your domestic partnership terminates;

- the date your domestic partner dies; or

- the date your coverage terminates.

For Children: Coverage ends for your children on the earliest of the following "Loss of Dependent Status Events:"

- the end of the pay period in which you last made the appropriate payroll contribution or timely payment required for dependent coverage;

- the date of a qualified change in status event; provided that you report the event within the time limits specified;

- the end of the month before your Marketplace Enrollment is effective when enrolling in the Marketplace during the Marketplace annual enrollment period; provided you report your Marketplace enrollment through My Total Rewards on My IN-SITE within the time limits specified;

- the last day of the month in which the child becomes age 26 (unless the Plan is subject to a state law that requires the Plan to provide coverage until a later age);

- the last day of the month in which your handicapped child over age 25 ceases to be incapacitated or in which you fail to submit proof of incapacity upon request;

- the date your child dies; or

- the date your coverage terminates.

If any of your dependents lose eligibility as described above, you must report the event by visiting My Total Rewards on My IN-SITE or by contacting the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days after the Loss of Dependent Status Event. Coverage will end on the date indicated for the event as described above. If you do not report the event within 31 days after the Loss of Dependent Status Event, you may be required to continue paying the contributions for that dependent until the next annual enrollment; however, the dependent who lost eligibility has no right to continued coverage after a Loss of Dependent Status Event because of such payments.

WHAT IF I RETIRE?

Coverage may be continued for certain grandfathered colleagues who meet specific eligibility criteria based on age, service, date of hire and Plan participation. Please contact the Colleague Support Center at 1-800-234-6229, Option 3 for the specific criteria for your location.

WHAT IF I TRANSFER TO A DIFFERENT MACY'S LOCATION OR AFFILIATED COMPANY?

If you are covered under the Macy's Health Care Plan, upon transfer to a different Participating Employer, your health care coverage will transfer automatically if the same health care option is available at your new location. If your contribution amount for that same coverage changes effective with the transfer, or if the same coverage is not available at the new Participating Employer location, then then new coverage may be elected from the options available at that new location within 31 days after the transfer. Your new election must be consistent with your qualified change in status event (i.e. your change in work location), which may limit the options available to you at the new Participating Employer. For example, in most cases, you will be required to continue your benefits in the new health care option at the same coverage level that was in place prior to your transfer (i.e. if you had single coverage prior to your transfer, you will be required to continue with single coverage at the new Participating Employer unless you experience a corresponding qualified change in status event, such as marriage, that would allow you to change your coverage level).

To elect new coverage at the new Participating Employer, you must make elections online through My Total Rewards on My IN-SITE by the specified due date. If you do not make a new election by the specified due date, you will be defaulted into your current same coverage (or your coverage will end if your current same coverage is not available at the new Participating Employer location).

If you do not participate in a Company-sponsored health care option prior to the transfer, you may not enroll in a health care option upon transfer until the earlier of:

- the date you first become eligible;
- the next annual enrollment period; or
- when a qualified change in status event occurs.

WHAT IF I TERMINATE AND REHIRE?

If you were enrolled in the Macy's Health Care Plan when your employment terminated and you are rehired at a Participating Employer (except as noted on your Supplement) within 28 days of your termination, or more than 28 days but less than 91 days after your termination and your length of service prior to the termination of your employment was longer than or equal to the period of time between your termination and your rehire, you will be treated as an ongoing employee and reinstated in health care coverage available at the Participating Employer immediately upon rehire. In all other circumstances, you will be treated as a new colleague and

must satisfy the eligibility criteria for that Participating Employer before you may enroll in coverage.

If you are eligible for reinstatement and the same health care options are available, you will be reinstated in the same health care options and at the same coverage level (including the same pre-tax Flexible Compensation Plan election) that were in place prior to your termination. If the same health care options are not available, you may elect new health care option(s) upon rehire, but must continue your benefits at the same coverage level that was in place prior to your termination. For example, if you had single coverage prior to your termination, you will be required to continue with single coverage upon rehire unless you experience a corresponding qualified change in status event, such as marriage, that would allow a change in coverage level.

Also see the Macy's Health Care Plan Supplement for your Participating Employer.

WHAT IF I AM ABSENT FROM WORK ON THE DAY MY COVERAGE SHOULD BEGIN?

If you are absent from work as a result of an accidental injury, illness, or approved or unapproved leave of absence (including vacation day, personal day, holiday, regularly scheduled day off or an approved leave under the Family and Medical Leave Act) on the day you would ordinarily become covered under a Company-sponsored health care option, the effective date of coverage for you and your covered dependents will not be delayed if you enroll through the online election process on My Total Rewards on My IN-SITE. Your coverage and your eligible dependents' coverage, if any, will begin on your **Eligibility Date**, or if later, the date that your coverage would otherwise begin if you enroll during annual enrollment or as a result of a qualified change in status event.

WHAT IS THE FAMILY AND MEDICAL LEAVE ACT (FMLA)?

The Family and Medical Leave Act ("FMLA") entitles eligible colleagues to take up to 12 weeks of unpaid, job-protected leave each year for specified family and medical reasons.

If you take an approved FMLA leave and your health care coverage is effective when your FMLA leave begins, the FMLA protects your health care coverage in two ways:

- You may continue to maintain your health care coverage under the condition that coverage would have been provided if you had continued to work during the leave period. Any changes in your health care options must be communicated to you while you are out on an FMLA leave.

- You may choose not to retain health care coverage during FMLA leave. When you return from your FMLA leave, your coverage may be reinstated at the same coverage level and with the same coverage terms that were in effect prior to taking the leave, with no waiting period or exclusion of pre-existing conditions provided you contact the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days and make elections online through My Total Rewards on My IN-SITE by the specified due date.

If your health care coverage is terminated before your FMLA leave starts for reasons unrelated to your FMLA leave (for example, if you fail to make the necessary colleague contributions to

continue your coverage through the date on which your FMLA leave starts), you will not be entitled to continue your coverage during your FMLA leave, and when you return to work at the end of your FMLA leave, you may not re-enroll for coverage until the next annual enrollment.

You must continue to pay the required colleague portion of your health care coverage cost while you are out on FMLA leave in order for coverage to continue during the FMLA leave period. If you do not receive a paycheck with compensation sufficient to cover the contributions due, you must pay your colleague's share of the cost on an after-tax basis by check, money order or by paying online through My Total Rewards on My IN-SITE. If rates are increased during your leave, you will be required to pay the new rate.

If you decide to discontinue health care coverage during an FMLA leave, your coverage must be reinstated upon your return to work without any qualifying period, physical examination or exclusion of pre-existing conditions. You must contact the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days after your return from leave to request reinstatement. Once you contact the Colleague Support Center, to maintain coverage you will have to make elections online through My Total Rewards on My IN-SITE by the specified due date. However, you may be required to make up colleague contributions the Company may have paid on your behalf while you were on FMLA leave to qualify to come back into the Plan.

If during FMLA leave your premium payment is not paid by the due date specified on your bill, health care coverage may be discontinued and you and your dependents will not be entitled to elect continuation coverage during the remainder of the FMLA leave. However, upon your return to work, you will still be entitled to reinstatement of health care coverage, without restrictions other than repayment of colleague contributions the Company may have paid on your behalf to maintain your qualified status.

Regardless of whether you continue your health care coverage through the date your FMLA leave ends, if your health care coverage was in effect when your FMLA leave began, you are entitled to elect continuation coverage under the Plan if you do not return to work from the FMLA leave. In that case, the qualifying event date is the last day of your FMLA leave. You will not be entitled to elect continuation coverage if your health care coverage was not in effect when your FMLA leave began unless coverage first became effective after the first day of your FMLA leave.

You should contact the Colleague Support Center at 1-800-234-6229, Option 3 if you have any questions regarding FMLA eligibility and administration at your Participating Employer.

WHAT IS THE UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)?

The Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA") protects the rights of colleagues who voluntarily or involuntarily leave their jobs to undertake military service by establishing requirements for continuation of health care coverage and re-employment that apply to military leaves of absence.

If you take an approved USERRA military leave, the USERRA protects your health care coverage in the following ways:

Continuation of Coverage:

For leaves of six months or less, you may continue coverage for yourself and your dependents as follows:

- If your military leave is 31 days or less, your health care coverage will be continued under the same conditions and at the same colleague contribution rate that coverage would have been provided if you had continued to work during the leave period.

- If your military leave lasts longer than 31 days, up to a total of six (6) months of leave, you may continue active coverage for yourself and your dependents during your leave by paying for 102% of the total cost of your health care coverage.

For leaves of more than six months, you may continue coverage for yourself and your dependents as follows:

- Your and your dependents' active Plan coverage will end after six months of military leave. You may continue to maintain your health care coverage after the first six months of military leave by electing COBRA continuation coverage (see the section entitled "COBRA Continuation Coverage"). Under USERRA, you are permitted to maintain your COBRA continuation coverage until at least the earliest of the following:

  - 24 months from your last day of employment with a Participating Employer, if you timely elect COBRA continuation coverage;

  - the day after you fail to return to work; or

  - the date Macy's no longer offers group health care coverage.

- You will be required to pay 102% of the total cost of your health care coverage.

- Following continuation of health coverage per COBRA and USERRA requirements, a conversion program is only available for colleagues enrolled in a fully-insured health care option at the time continued coverage under COBRA terminates.

You must pay the required contributions for the cost of your COBRA continuation coverage while you are out on the USERRA military leave in order for coverage to continue during the USERRA military leave period. If rates are increased during your leave, you will be required to pay the new rate.

If during USERRA military leave your premium payment is not paid by the due date, health care coverage may be discontinued and you and your dependents will not be entitled to elect health care coverage during the remainder of the USERRA military leave. However, upon your return to work, you may still be entitled to reinstatement of health care coverage, as explained below.

Reinstatement of Coverage:

If your coverage ends during your leave of absence (for example, because you did not timely pay your required contributions) and you are reemployed by a Participating Employer, coverage for you and your dependents may be reinstated if:

- You gave your Participating Employer advance written or verbal notice of your military service leave; and

- The duration of all military leaves while you are employed with a Participating Employer does not exceed five (5) years.

You must contact the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days after your return from leave to request reinstatement. Once you contact the Colleague Support Center to reinstate coverage, you will have to make elections online through My Total Rewards on My IN-SITE by the specified due date.

Your coverage will be reinstated upon your return to work without any waiting period or pre-existing condition exclusions, except for service-connected illnesses and injuries, in which case the full limitations of your health care option, if any, will apply.

Any 63-day break-in-coverage rule regarding credit for time accrued toward a pre-existing condition limitation waiting period will be waived with respect to any period of no coverage during your USERRA military leave.

The above information represents the minimum protections offered by USERRA. Enhanced military leave provisions may be available at your Participating Employer. Please contact the Colleague Support Center at 1-800-234-6229, Option 3 for more information on the military leave benefits available.

HOW DO I SUBMIT A REQUEST FOR REVIEW OR APPEAL OF AN ENROLLMENT OR ELIGIBILITY DECISION?

The following review and appeal procedures have been adopted to ensure that any review or appeal of an enrollment or eligibility decision will be handled promptly and in a fair, reasonable, and consistent manner.

It is important for you to comply with the deadlines set forth below.

Review Procedure

If you think you or your dependents' enrollment has been denied or terminated in error, you may request a **review** of your circumstances by the Plan Administrator within 90 days after you receive notice that enrollment was denied or terminated. To request a review of an enrollment decision, you may email your request to benefitappeals@macys.com or write to:

Colleague Support Center
145 Progress Place
Springdale, Ohio 45246
Attn: Enrollment Decision Review

Generally, you will be notified of the Plan Administrator's decision within 90 days after the Colleague Support Center receives your request for review. If special circumstances require an extension of time for processing, obtaining more information or conducting an investigation of the facts, you will be notified of the reasons for the extension before the end of the 90-day period. The additional extension of time will not exceed 180 days from the date the Colleague

Support Center receives your initial request for review. If your request is denied, the decision will be in writing and will include specific reasons for the decision, specific references to the pertinent provisions on which the decision is based, a description of any additional information necessary to complete the review, if applicable, and a description of the procedure to be followed to appeal the denial.

Appeal Procedure

If you disagree with the review decision, or you do not receive a decision within the time periods specified above, you may submit an **appeal** to the Plan Administrator within 60 days after you receive notice of the denial, or after expiration of the applicable time period. You have the right to review any pertinent documents and submit any additional information or comments you consider important. To submit an appeal to the Plan Administrator, you may email your request to benefitappeals@macys.com or write to:

Colleague Support Center
145 Progress Place
Springdale, Ohio 45246
Attn: Enrollment Decision Appeal

Generally, a final decision regarding your appeal will be made not later than 60 days following the date the Colleague Support Center receives your written appeal. If special circumstances require an extension of time for processing or obtaining more information, you will be notified of the reasons for the extension before the end of the 60-day period. The additional extension of time will not exceed 120 days from the date the Colleague Support Center receives your appeal. If your appeal is denied, the final decision will be in writing and will include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based. The decision made by the Plan Administrator will be final and binding.

COST OF COVERAGE

Your contribution toward the cost of the coverage described in this booklet is determined by the health care option and the level of coverage (i.e., the number of dependents covered) you choose. The amount of your contribution may be changed from time to time. Current **Colleague Contribution Rates** for the available health care options are shown in the enrollment materials and on My Total Rewards on My IN-SITE. The contribution you make for medical coverage covers only part of the total cost.

The "cost" of coverage in an insured health care or HMO option is an amount established by the insurance carrier or HMO. Company contributions paid to the carrier or HMO equal the amount by which the total cost of the insured health care option exceeds colleague contributions. The "cost" of coverage in a self-funded health care option is an amount established by the Company based on claims and administrative expenses. Company contributions toward the cost of coverage in a self-funded health care option equal the amount by which the total cost of the health care option expenses exceed colleague contributions.

As an active colleague, your contributions will be deducted automatically from your pay after you enroll and authorize your payroll deduction through the online election process on My Total Rewards on My IN-SITE and provide your electronic signature. If your available pay does not cover the full contribution amount due for the benefit coverage elected, any remaining contribution amount owed will be deducted from your pay the next pay period. All past due contribution amounts will be collected at one time, if possible, or up to the amount of available net earnings.

Your contributions will be calculated from your effective date of coverage (not the date you actually enroll on My Total Rewards on My IN-SITE) and retroactive contributions may be required. For example, if you enroll on June 15 for coverage effective June 1, you will be required to pay your portion of the premium retroactively to June 1. This retractive deduction will be taken on the next payroll cycle.

If you are absent from work and not receiving pay for any period of time greater than one week, contact the Colleague Support Center at 1-800-234-6229, Option 3 regarding the payment of your contributions. ***IF YOU FAIL TO MAKE THE REQUIRED COLLEAGUE CONTRIBUTION ON A TIMELY BASIS, YOUR COVERAGE MAY BE TERMINATED AND YOU WILL NOT BE ENTITLED TO CONTINUATION COVERAGE.***

Under the Macy's, Inc. Flexible Compensation Plan, you will pay your portion of the cost of coverage under the Macy's Health Care Plan on a pre-tax basis. Making payments on a pre-tax basis offers the advantage of tax savings. This is because, when you pay on a pre-tax basis, your payments are deducted from your pay before federal (and often state and local) income taxes and Social Security taxes are calculated. So, most income taxes as well as Social Security taxes are paid on a lower salary amount. However, because Social Security taxes are paid on a reduced salary amount when pre-tax payments are made, your Social Security

benefits may also be reduced. For more information, contact the Colleague Support Center at 1-800-234-6229, Option 3.

When paying for your cost of coverage on a pre-tax basis, you may change your pre-tax election only once each year during annual enrollment, unless you have a qualified change in status event or intend to enroll in Marketplace coverage during a Marketplace Special Enrollment Period or Annual Enrollment Period, as described previously. The Company has the right to revoke your pre-tax election, including retroactively, if it finds that it is advisable or required under applicable tax laws.

In addition to the payroll contributions discussed above, you may be required to satisfy certain deductibles, copayments and/or coinsurance amounts based on the terms of your health care option.

The amount of any deductible, copayment and/or coinsurance depends on the health care option you choose, and is described in more detail in the benefits summary booklet available on My Total Rewards on My IN-SITE, which is incorporated as part of this Summary Plan Description.

Federal regulations require that contributions for a domestic partner's coverage be paid on an after-tax basis. This means that the contributions for any children of a domestic partner also must be paid on an after-tax basis. If you enroll a domestic partner in coverage under this Plan, you will have to pay income taxes on the value of the coverage benefits provided for your domestic partner and your domestic partner's eligible dependents (known as "imputed income"). You should consult a tax advisor concerning the tax consequences of obtaining benefits for your domestic partner.

HEALTH CARE COVERAGE

Depending on your location, the Plan gives you a choice of medical, dental and vision health care options. Your choice of coverage is a personal decision. Carefully consider the needs and desires of your family and the coverage provided by each health care alternative before making a decision. Information on the services provided by the health care options offered at your location can be obtained by:

- contacting the Colleague Support Center at 1-800-234-6229, Option 3, or calling the appropriate carrier's or HMO's customer service number;
- reviewing the benefits information available online through My Total Rewards on My IN-SITE; and
- reviewing the separate benefits summary booklets from the appropriate carrier(s) or HMO, which you can request by mail or through their websites, or by calling their customer service numbers or visiting their facilities and talking with their representatives.

HEALTH CARE OPTIONS

Some health care options that the Plan offers are HMO programs. HMO programs require participants to receive care from a select panel, or network, of participating providers, hospitals and other facilities. Charges for covered services and supplies must be incurred while the coverage is in effect. Managed medical care programs do not reimburse for charges incurred before coverage begins or (except as specifically stated) after coverage ends. Specific benefit coverage may vary with each health care option, and benefits are generally subject to deductibles, copayments and/or coinsurance.

Health care options can include:

Health Maintenance Organizations. A Health Maintenance Organization ("HMO") option provides a range of covered services through a network of doctors, hospitals and other participating providers. Generally, services received from providers outside the HMO's network are not covered unless there is an emergency situation as defined by the HMO. The HMO option usually serves participants who live in a limited geographic area. Most HMOs require you to name a Primary Care Physician ("PCP") for you and each covered dependent. Your PCP coordinates your care and usually must be your first contact when services are needed. Your PCP may refer you to network specialists or other providers. If you do not choose a PCP, one may be assigned.

Point Of Service Programs. With a Point of Service ("POS") option, you may choose between in-network and out-of-network providers. Most POS options require you to name a Primary Care Physician ("PCP") for you and each covered dependent. Your PCP coordinates your care in-network and may refer you to network specialists or other providers. However, you may also

receive care from a provider outside the network, but costs for services are generally greater and benefits may be lower when you choose an out-of-network provider. If you do not choose a PCP, one may be assigned.

Preferred Provider Organization Programs. A Preferred Provider Organization ("PPO") option allows you to use in-network and out-of-network providers as desired, but reimbursement is generally higher if you use in-network providers. You are not required to name a Primary Care Physician.

Please refer to the information you received and/or to which you were directed when first eligible or at annual enrollment to determine what options may be available to you. You may also obtain this information through My Total Rewards on My IN-SITE or by contacting the Colleague Support Center at 1-800-234-6229, Option 3. Provider directories are available by calling the carriers directly or visiting their website(s).

Unless dental and vision coverage is provided under the available medical option, dental and vision coverage is optional for all colleagues and may be elected even if medical coverage is not elected.

Dental and vision options generally work in much the same way as medical options.

Dental Maintenance Organizations. A Dental Maintenance Organization ("DMO") option provides a range of covered services through a network of dentists and specialists. The DMO requires you to name a Primary Care Dentist ("PCD") for you and each covered dependent. Your PCD coordinates your care and usually must be your first contact when services are needed.

Dental Preferred Provider Organization. A dental Preferred Provider Organization ("PPO") option allows you to use in-network and out-of-network dentists and specialists as desired, but benefits generally are higher if you use in-network providers. You are not required to name a Primary Care Dentist.

Vision coverage. Vision coverage is optional for all colleagues and may be elected even if medical coverage is not elected.

HOW DO I OBTAIN INFORMATION CONCERNING A HEALTH CARE OPTION?

Each carrier or HMO that insures or administers a health care option for **Benefits-Eligible Colleagues** of Participating Employers and their eligible dependents will supply you with written materials concerning:

- the nature of the services provided to participants and a description of preventative services that may be covered;

- the conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the medical/dental coverages offered by Macy's and the Participating Employers), including circumstances under which such services may be denied;

- conditions and limits on the use of emergency care;

- the procedures to be followed in obtaining such services, including the procedures available for review of claims for services which are denied in whole or in part;

- the composition of the provider network, provisions governing the use of network providers and whether and under what circumstances coverage is provided out of network; and

- conditions and limits on the selection of a primary care physician or specialist.

These benefits summary booklets from the carriers and HMOs are also incorporated as part of this Summary Plan Description.

A listing of network providers may be obtained directly from the carrier or HMO or by accessing the carrier's or HMO's website, which is listed on My Total Rewards on My IN-SITE.

DOES THE PLAN HAVE A PRE-EXISTING CONDITION LIMITATION?

The Plan does not have any pre-existing condition limitations that would exclude coverage for medical conditions present before you enroll.

HOW DO I FILE A CLAIM?

Most health care programs are designed to minimize the need for you to file claims. When you receive Covered Services from an in-network provider, you are generally **not** responsible for filing a claim to obtain benefits – the in-network provider will generally submit the claim for you. However, if you receive services from an out-of-network provider, or if a doctor, hospital or specialist otherwise bills you, you should follow the directions for filing a claim that can be found in your carrier's or HMO's benefits summary booklet. If you have a concern or disagreement about services provided by your carrier or HMO, you must contact that organization directly to have the question answered or the dispute resolved.

If you do not follow all of the claims procedures specified by the carrier or HMO when submitting your claim (for example, if you do not submit all required or requested information with your claim, or you do not submit the claim within the required time period), your claim may be denied.

WHEN WILL I KNOW IF MY CLAIM IS APPROVED OR DENIED?

Federal regulations generally require that carriers or HMOs pay claims promptly and fairly, in accordance with specific guidelines. The time period in which you will be notified if your claim is approved or denied varies based on the type of claim you have. These time periods (including any time periods by which you or your provider must respond to requests for additional information related to your claim) and the types of claims they apply to are described in detail in your carrier's or HMO's benefits summary booklet.

Whether payment is made to you or directly to the provider, you will receive an Explanation of Benefits ("EOB") statement showing what expenses are covered and what benefits are being paid or denied.

HOW DO I APPEAL A CLAIM DECISION?

If you disagree with a claim decision made by a carrier or HMO and want to file an appeal of that decision, you should follow the directions for filing an appeal that can be found in your carrier's or HMO's benefits summary booklet, on its website, or by calling its customer service department. If you do not follow all of the appeals procedures specified by the carrier or HMO when submitting your appeal (for example, if you do not submit all required or requested information with your appeal, or you do not submit the appeal within the required time period), your appeal may be denied.

Please note that only you and/or your dependents who are covered participants under the Macy's Health Care Plan may appeal an adverse claim decision. If you and/or any covered dependent disagrees with a claim decision, your and/or your covered dependents' claim for benefits and right to appeal that adverse claim decision may not be assigned to any other person or entity. For more information on prohibited assignments, see page 29.

WHAT IS THE NEWBORNS AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)?

The NMHPA is a Federal law that states group health plans and health insurance issuers generally may not, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and insurers may not require that the provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

WHAT IS THE WOMEN'S HEALTH AND CANCER RIGHTS ACT?

The Women's Health and Cancer Rights Act is a Federal law which states that group health care plans, health insurance issuers and HMOs that provide coverage for a mastectomy must provide coverage, in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which a mastectomy has been performed;
- surgery and reconstruction on the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of a mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the Plan.

You should call your carrier or HMO directly if you have additional questions about this coverage.

WHAT IS MEDICARE?

Medicare is a Federal health insurance program for people age 65 and older and certain people with disabilities. Medicare generally consists of one or more of the following options:

- Medicare Part A (hospital expense coverage),
- Medicare Part B (supplementary medical expense coverage),
- Medicare Part D (prescription drug coverage), and
- Medicare Advantage plans (managed care options that may provide expanded coverage beyond basic Medicare).

Most people get Medicare Part A automatically when they turn age 65 and do not pay for coverage. The other three Medicare options, however, are optional and require you to enroll and pay an additional monthly premium for coverage. Your local Social Security Administration office takes applications for Medicare and can provide you with more information about the Medicare program and the options available in your area.

SHOULD I ENROLL IN MEDICARE IF I AM ACTIVELY WORKING WHEN I BECOME ELIGIBLE FOR MEDICARE?

Medicare generally becomes available at the beginning of the month in which you turn age 65, whether you are retired or still working. If you enroll in Medicare, your health care coverage under this Plan generally remains the primary payer of benefits while you are actively working and Medicare will pay secondary (this rule may not apply to all Medicare Advantage Plans, however).

You should carefully consider all of your options and make sure you understand all of the advantages and disadvantages of enrolling in Medicare Part A when you first become eligible. If you are still actively employed and enroll in a Macy's high deductible health plan option, enrolling in Medicare (even Part A, which is no cost to you) will make you ineligible to contribute to a Health Savings Account. Additionally, if you plan to work beyond age 65, you should carefully evaluate your health care needs and available Medicare options before deciding whether or not to enroll in any of the optional Medicare programs (i.e., Medicare Part B, Medicare Part D or a Medicare Advantage plan). Generally, you will have limited future enrollment opportunities and you will have to pay a penalty through higher future Medicare premium costs if you do not enroll in these optional programs when first eligible at age 65. Medicare Part B, however, does have a special option that may allow you to delay enrollment in Medicare Part B without paying a penalty, if you enroll in Medicare Part B as soon as you retire and your coverage under this Plan ends.

You should contact the Social Security Administration, or your local Social Security Administration office, before you reach age 65 to request Medicare program information to help you fully understand your available options and make an informed decision.

NOTE: The explanation of Medicare benefits set forth above is provided only for your convenience. If you have any questions about Medicare benefits or enrollment requirements, please consult your local Social Security Administration office.

THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION (PHI)

THE PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

Neither the Plan nor any health insurance carrier, HMO or business associate servicing the Plan will disclose your or your dependents' protected health information to Macy's or any Participating Employer unless Macy's certifies its compliance with the applicable privacy and data security provisions of the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as subsequently amended by the Health Information Technology and Clinical Health ("HITECH") Act, and the regulations issued thereunder, as amended from time to time (collectively referred to as the "Privacy Rule") as set forth below, and agrees to abide by such Privacy Rule.

RESTRICTIONS ON DISCLOSURE OF PROTECTED HEALTH INFORMATION TO MACY'S

The Plan and any health insurance carrier, HMO or business associate servicing the Plan will disclose protected health information about you or your dependents to Macy's (defined solely for purposes of this Privacy Article as Macy's, Inc. or any Macy's affiliated company involved in Plan administration) only to permit the Company to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to, and use by, Macy's of the protected health information about you or your dependents will be subject to, and consistent with, the provisions of the sections "Macy's Obligations Regarding Protecting Health Information," and "Adequate Separation Between Macy's and the Plan."

Neither the Plan nor any health insurance carrier, HMO or business associate servicing the Plan will disclose the protected health information about you or your dependents to Macy's unless the disclosures are explained in the Notice of Privacy Practices distributed to you and your covered dependents.

Neither the Plan nor any health insurance carrier, HMO or business associate servicing the Plan will disclose protected health information about you or your dependents to Macy's for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company.

MACY'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION

Macy's will:

- neither use nor further disclose protected health information about you or your dependents except as permitted or required by the Plan documents, as amended, or as permitted or required by law.

- ensure that any agent, including any subcontractor, to whom it provides protected health information about you or your dependents agrees to the restrictions and conditions of the Plan documents, including this section, with respect to such protected health information.

- not use or disclose protected health information about you or your dependents for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company.

- report to the Plan any use or disclosure of protected health information about you or your dependents that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

- make protected health information available to the Plan participant who is the subject of the information in accordance with the Privacy Rule.

- make protected health information about you or your dependents available for amendment, and will, on notice, amend that protected health information about you or your dependents in accordance with the Privacy Rule.

- track disclosures it may make of protected health information about you or your dependents so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

- make available its internal practices, books and records, relating to its use and disclosure of protected health information about you or your dependents to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the Privacy Rule.

- if feasible, return or destroy all protected health information about you or your dependents in whatever form or medium (including in any electronic medium under the Company's custody or control) received from the Plan, including all copies of, and any data or compilations derived from such protected health information, and allowing identification of any participant who is the subject of the protected health information, when such protected health information is no longer needed for the plan administration function for which the disclosure was made. If it is not feasible to return or destroy all such protected health information, the Company will limit the use or disclosure of any such protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN MACY'S AND THE PLAN

Certain colleagues or classes of colleagues or other workforce members under the control of Macy's may be given access to protected health information about you or your dependents received from the Plan or a carrier, HMO or business associate servicing the Plan.

Every colleague or class of colleagues or other workforce members under the control of Macy's who may receive protected health information about you or your dependents relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business are listed in the Macy's Health Care Plan Supplement. The identified colleagues, classes of colleagues or other workforce members will have access to protected health information about you or your dependents only to perform the plan administrative functions that the Company provides for the Plan, or as otherwise permitted under the Company's HIPAA privacy policy as set forth in the Macy's, Inc. Group Health Plan Compliance Manual.

The identified colleagues, classes of colleagues or other workforce members will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with Macy's or any Participating Employer, for any use or disclosure of protected health information about you or your dependents in violation of, or noncompliance with, the provisions of this Privacy Article. Macy's will:

- promptly report such violation or noncompliance to the Plan;

- determine whether a violation or instance of noncompliance compromises the privacy or security of your or your dependents' protected health information by performing and documenting a risk assessment of the level of harm, if any, that the impermissible use or disclosure of protected health information may cause;

- provide notice of a breach, if required, to the following:

    - Each affected individual, by first-class mail at the individual's last known address, or by e-mail if the individual specifically indicated a preference for e-mail communication;
    - Prominent media outlets in the state or other jurisdiction if the breach involves more than 500 residents of the state or jurisdiction;
    - The Department of Health and Human Services if the breach affected 500 or more individuals.

- cooperate with the Plan to correct the breach, violation or noncompliance; and

- impose appropriate disciplinary action or sanctions on each colleague or other workforce member causing the breach or violation of the protected health information of any participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

THIRD PARTY INJURY PROVISION

The Macy's Health Care Plan does not cover expenses incurred for injuries received in, or resulting from, an accident for which a third party is liable. The carriers and HMOs administer third-party injury provisions for the various health care options under the Plan. If, in the opinion of the carriers or HMOs, a third party may be liable, the injured person may be required to sign a reimbursement agreement before receiving any Plan benefits. However, the failure to obtain a signed reimbursement agreement does not in any event limit or diminish the legal subrogation rights of the Plan for any payments or benefits paid by the Plan with respect to expenses incurred for injuries received in, or resulting from, an accident for which a third party is liable. If and when the injured person receives an award or settlement relating to expenses from the third party who caused the injury, the injured person must promptly refund the benefit payments made under the Plan or, if less, the amount actually received from the third party for such expenses.

Benefits under this Plan will be reduced, as permitted under the laws of the state in which you are employed, by amounts you receive from any insurance or other arrangement established to comply with a disability benefit statute or pursuant to a "no fault" statute, unless the applicable statute provides otherwise. Plan benefits will not be paid for any expenses for which you are paid under any other program sponsored by Macy's and your Participating Employer. Benefits will not be paid for expenses resulting from an accident or illness for which workers compensation benefits are paid.

If benefit payments are made under this Plan, the Plan shall be entitled to reimbursement and subrogation to the full extent of such payments, to all the rights of recovery which the colleague to or on behalf of whom such payments are made may have against any person or entity, and the colleague shall execute and deliver instruments and papers and do whatever else is necessary to secure the Plan's rights. The colleague shall do nothing to prejudice such rights.

To enable the carriers and HMOs to obtain reimbursements of benefit payments made under this provision, you must respond to requests to provide information concerning any claim you or your covered dependents may have against a third party for injuries caused by that party. If you willfully fail to cooperate, Macy's may suspend your coverage until you comply with the request. If you do not reimburse the Plan for benefit payments for which you also received recovery from a third party, such recovery may be treated as an advance of future benefit payments and reduce any future benefit payments until the obligation to reimburse has been satisfied.

If payments for which a third party is liable are made under this Plan,

- The Plan shall be entitled to reimbursement for all payments made under this Plan out of any settlement or judgment that may result from the exercise of the rights of recovery of the colleague against any person or entity legally responsible for the colleague's injury for which such payment is made; and before benefits are received for any disability caused by injury from a third party, the colleague shall execute a reimbursement agreement in the form required by this Plan;

- The Plan shall not be responsible for any attorney fees or other legal expenses incurred by the colleague in recovering the value of any payments to which the Plan is entitled under the reimbursement and subrogation provisions of this Plan, whether incurred in a lawsuit for damages or otherwise;

- The colleague shall hold in trust for the benefit of the Plan all rights of recovery, which the colleague shall have against such other person or entity for any expense, amount or payment, which the Plan has made to the colleague under the Plan;

- The colleague shall do whatever is proper to secure and shall do nothing after loss to prejudice the Plan's right of subrogation or reimbursement and shall notify Macy's in advance of an intent to settle or release any claim or lawsuit for damages against the third party; and

- The colleague shall execute and deliver to the Plan such instruments and papers as may be appropriate to secure the rights and obligations of the colleague and the Plan established by this Plan.

ASSIGNMENT

For the purposes of this section, any reference to “you” or “your” applies only to you, the participant, and any of your covered dependents under the Macy’s Health Care Plan.

PROHIBITION ON TRANSFERRING BENEFITS OR RIGHTS TO ANOTHER

The Macy’s Health Care Plan (“Plan”) specifically prohibits the assignment to any other person or entity, including a health care or medical service provider, of any medical benefits or claims for medical benefits to which you may become entitled under the Plan, as well as any administrative, statutory, or legal rights or causes of action to which you may become entitled arising out of or flowing from your participation in the Plan, the administration of medical benefits under the terms of the Plan, or pursuant to the Employee Retirement Income Security Act (ERISA). Specifically, this section prohibits you from assigning to any other person or entity, including a health care or medical service provider, any administrative, statutory, or legal rights or causes of action you may have under the terms of the Plan or ERISA against the Company, the Participating Employers, the Macy’s Health Care Plan and/or any carriers or HMOs administering health care options under the Plan, including but not limited to claims asserting that the Macy’s Health Care Plan failed to make payment of benefits due on any particular claim in whole or in part, did not provide timely disclosure of requested information, or did not adhere to or follow the Plan’s administrative or claims procedures. Any attempt by you to assign, transfer, sell, pledge, or encumber in any way medical benefits, claims for medical benefits or administrative, statutory or legal rights under the Macy’s Health Care Plan to another person or entity shall be void and unenforceable, regardless of whether you provided your written, oral and/or electronic consent and authorization to such person or entity, including a health care or medical service provider. This includes, but is not limited to, the filing of claims, appeals and grievances with the Macy’s Health Care Plan or lawsuits under ERISA Section 502(a) or any other applicable section of ERISA.

Notwithstanding the above prohibition on assignment, the Macy’s Health Care Plan may, in its sole and absolute discretion when deemed appropriate by the Plan, permit the filing of claims by and/or payment of benefits directly to health care or medical service providers, or validly authorized personal representatives of a participant; for example, when an in-network provider submits an initial claim for benefits for you, or if a carrier or HMO administering the applicable health care program arranges to pay the provider directly following an approved claim determination or appeal, or if a duly appointed attorney-in-fact or personal representative is acting on behalf of an incapacitated or deceased participant. However, this discrete administrative authorization of accepting direct claim filings by, and/or payment of benefits to a health care or medical service provider is not, and shall not be construed as, an assignment of all rights or benefits or the grant of any right to ‘step into the shoes’ of you or your covered dependents for purposes of asserting and pursuing any claims or appeals under the Plan’s claims procedures, or pursuant to any lawsuits.

A FINAL WORD ABOUT COVERAGE

Enrollment in a health care option (medical, dental or vision) is entirely a personal decision of the enrolling colleague. Although the number of health care providers who may provide in-network covered benefits may be limited under the health care options, the selection of a health care provider under any health care option available under the Macy's Health Care Plan is, nonetheless, a completely independent act of the covered individual. Macy's and the Participating Employers express no opinion concerning, and disclaim any and all responsibility and liability in connection with, any physician/patient relationship arising with respect to any individual covered under the Macy's Health Care Plan. A carrier's or HMO's criteria for selecting health care providers for its network may be different than yours when choosing a doctor, hospital or pharmacy. Therefore, when you receive care from your health care option's in-network participating providers, you should rely on your own judgment of the provider's quality.

WHAT IS THE EFFECT OF OTHER COVERAGE I MAY HAVE?

The Macy's Health Care Plan does not provide duplicate benefits for services that may be covered by another health care plan. For this reason, the Plan has a coordination of benefits provision known as non-duplication of benefits. Under this provision, the amount normally reimbursed is reduced to take into account payments made (or payable) by "other programs." "Other programs" refers to any other medical coverage provided under group insurance or any other arrangement of coverage for individuals in a group, whether or not the "other program" is insured. If you or your covered dependents have coverage through another group program (e.g., coverage through your spouse's employer), benefits under the Macy's Health Care Plan will be determined in accordance with the coordination of benefits rules described in your carrier's or HMO's benefits summary booklet for your health care option.

COBRA CONTINUATION COVERAGE

On April 7, 1986, a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") was enacted requiring that most employers sponsoring group health plans offer colleagues and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the COBRA law. Both you and your spouse should take the time to read this section carefully.

Macy's has contracted with Alight Solutions LLC ("Alight") to administer COBRA enrollment and billing on behalf of the Macy's Health Care Plan. Alight Business Service Center customer service representatives are available by contacting the Colleague Support Center at 1-800-234-6229, Option 3.

Coverage under a Macy's-sponsored medical/dental/vision health care option may be continued under continuation coverage for you and/or your eligible covered dependents for a specified period provided that one of the qualifying events listed below occurs. Unless dental coverage is provided under the medical option in which you enrolled, you may continue dental coverage separately, regardless of whether you also continue coverage under a Macy's-sponsored medical option. You may also continue vision coverage regardless of whether you continue coverage under a medical or dental option. Macy's offers continuation coverage, which is substantially similar to COBRA continuation coverage, to eligible domestic partners and their covered dependents.

In order to elect continuation coverage:

- Coverage for you and/or your covered dependents must have been in effect on the day before the qualifying event occurred, and

- You or your covered dependents must have lost coverage due to a qualifying event listed below, and

- You and/or your covered dependent must timely elect and pay for continuation coverage.

If you are a colleague of a Participating Employer covered by the Macy's Health Care Plan, you have a right to elect continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse or domestic partner of a colleague covered by the Macy's Health Care Plan, you have the right to elect continuation coverage for yourself if you lose group health coverage for *any* of the following four reasons:

- The death of your spouse or domestic partner;

- A termination of your spouse's or domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse's or domestic partner's hours of employment with a Participating Employer;

- Divorce or legal separation from your spouse or termination of your domestic partnership; or

- Your spouse or domestic partner becomes entitled to Medicare.

In the case of a child of a colleague or domestic partner covered by the Macy's Health Care Plan, he or she has the right to elect continuation coverage if group health coverage under the Macy's Health Care Plan is lost for *any* of the following five reasons:

- The death of the colleague;

- A termination of the colleague's employment (for reasons other than gross misconduct) or reduction in the colleague's hours of employment with a Participating Employer;

- The colleague's divorce or legal separation;

- The colleague becomes entitled to Medicare; or

- The child ceases to be a "dependent" under the Macy's Health Care Plan.

A child who is born to or placed for adoption with the covered colleague during a period of continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Macy's Health Care Plan and the requirements of Federal law, these qualified beneficiaries can be added to continuation coverage upon proper notification to Alight by contacting the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days after the birth or adoption.

You do not have to show that you are insurable to elect continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage under the terms of the Plan. Macy's reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible.

WHAT IS A QUALIFYING EVENT?

1. **REDUCTION IN HOURS** - If the number of hours you work are reduced to below the number of working hours required to be a **Benefits-Eligible Colleague**, you and/or your eligible covered dependents may elect continuation coverage for up to 18 months.

2. **TERMINATION OF EMPLOYMENT** - If your employment with your Participating Employer terminates for a reason other than gross misconduct, you and/or your eligible covered dependents may elect continuation coverage for up to 18 months.

3. **DIVORCE, LEGAL SEPARATION OR TERMINATION OF DOMESTIC PARTNERSHIP** - If you divorce, are legally separated, or terminate your domestic partnership, your covered dependents may be eligible to elect continuation coverage for up to 36 months. You, or your former spouse or domestic partner, must notify the Colleague Support Center at 1-800-234-6229, Option 3 within 60 days of your divorce, separation or termination of domestic partnership. If the Colleague Support Center is not notified within 60 days of the divorce, separation or termination of domestic partnership, your former spouse or domestic partner may not be eligible to enroll in continuation coverage.

4. **DEATH** - If you die, your eligible covered dependents may elect continuation coverage for up to 36 months. If your surviving spouse elects continuation coverage and then remarries, your surviving spouse's new spouse will be eligible for continuation coverage for the remainder of the 36-month period. If your surviving domestic partner elects continuation coverage and then enters into a new domestic partnership, your surviving domestic partner's new domestic partner may be enrolled in the Plan at the annual enrollment following the 12-month anniversary of the new domestic partnership and will be eligible for continuation coverage for the remainder of the 36-month period. Coverage will be effective as of the date of the remarriage provided the remarriage is reported to Alight by contacting the Colleague Support Center at 1-800-234-6229, Option 3 within 31 days.

5. **LOSS OF DEPENDENT STATUS** - If coverage for your child(ren) is terminated because he/she is no longer an eligible dependent as described below, he/she may elect continuation coverage for up to 36 months. You must notify the Colleague Support Center at 1-800-234-6229, Option 3 within 60 days of an event described below in order for your dependent to be offered the opportunity to elect continuation coverage:

- on the last day of the month in which the child becomes age 26 (unless the Plan is subject to a state law that requires the Plan to provide coverage until a later age);

- on the last day of the month in which your disabled child over age 25 ceases to be incapacitated or in which you fail to submit proof of incapacity upon request.

Under the law, the colleague or a family member has the responsibility to report through My Total Rewards on My IN-SITE or inform the Colleague Support Center at 1-800-234-6229, Option 3 of a divorce, legal separation, or a child losing dependent status under the Macy's Health Care Plan within 60 days of the date of the event (except in the case of a child reaching age 26 (in which case the Company will automatically remove the child from coverage and adjust your coverage and contributions accordingly). The Company has the responsibility to notify Alight of the colleague's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if Macy's commences a bankruptcy proceeding and these individuals lose coverage.

HOW DO I ELECT CONTINUATION COVERAGE?

You and/or your covered dependents will receive written notification within 44 days from the qualifying event date. Under the law, you and/or your covered dependents have up to 60 days from the later of the loss of coverage or the notice of the qualifying event to elect continuation

coverage by returning the COBRA election form to Alight at the address specified in the notice or by making your election online through My Total Rewards on My IN-SITE or at mytotalrewards.macysinc.com.

If you do not elect continuation coverage in a timely manner, your group health coverage will end. If you elect continuation coverage, Macy's is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly-situated active colleagues or family members.

Your covered dependents may elect continuation coverage even if you do not.

IS MY DOMESTIC PARTNER ELIGIBLE FOR CONTINUATION COVERAGE?

Federal regulations only require that COBRA continuation coverage be offered to spouses and dependent children who are covered at the time of a qualifying event. However, Macy's will offer continuation coverage that is substantially similar to COBRA continuation coverage to domestic partners and their dependents.

HOW DO I PAY FOR CONTINUATION COVERAGE?

Under the law, you may have to pay all or part of the premium for your continuation coverage. The initial payment of premiums, including all monthly premiums due since the qualifying event, must be paid within 45 days of the date you make the continuation coverage election. There is a grace period of at least 30 days for payment of the regularly scheduled premium payments. For example, payment is due the first of each month and must be postmarked within 30 days of that date or continuation coverage will be terminated.

HOW MUCH DOES CONTINUATION COVERAGE COST?

If you elect continuation coverage, you will be required to pay a COBRA rate for coverage equal to 102% of the total premium cost for your continuation coverage. A person whose COBRA coverage is extended to 29 months because of disability must pay a COBRA rate equal to 150% of the total premium cost for the 19th through 29th months of coverage. Full payment must be postmarked by the 30th day after the due date for each monthly premium or coverage will be terminated.

CAN CONTINUATION COVERAGE EVER BE EXTENDED?

The law requires that you be offered the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18–month period may be extended for affected individuals to 36 months from termination of employment if other qualifying events (such as a death, divorce, or legal separation) occur during that initial 18-month period. In no event will continuation coverage last beyond 36 months from the date of the qualifying event that originally made a qualified beneficiary eligible to elect continuation coverage.

The 18–month period may also be extended up to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify Alight of that disability determination as soon as possible, but not later than the end of the original 18-month period by contacting the Colleague Support Center at 1-800-234-6229, Option 3. The affected individual must also notify Alight by contacting the Colleague Support Center at 1-800-234-6229, Option 3 within 30 days of any final determination that the individual is no longer disabled, in which case continuation coverage will terminate before the end of the extended 29-month period.

CAN I CHANGE MY CONTINUATION COVERAGE OPTION?

At the time you (or your covered dependents) elect continuation coverage, you will be eligible to maintain coverage under the same medical/dental health care option you participated in immediately prior to the qualifying event. However, if you relocate to an area where the same health care option is not available or the cost of the same health care option significantly increases, you may be eligible to enroll in a different Macy's-sponsored health care option offered in the area of your new residence.

During the period you and/or your covered dependents have continuation coverage, you and/or your dependents will be able to switch to another health care option during the annual enrollment period. At that time, your covered dependents may choose an option that is different from the one you choose. If you or they want to change health care options, you (or they) must make elections online by visiting My Total Rewards on My IN-SITE or at mytotalrewards.macysinc.com or by contacting the Colleague Support Center at 1-800-234-6229, Option 3.

WHAT IF I RELOCATE?

If you relocate while enrolled in continuation coverage, you must notify Alight of your address change by contacting the Colleague Support Center at 1-800-234-6229, Option 3. If the contribution amount for your current continuation health care option increases or you lose eligibility for coverage under your current health care option upon relocation outside of that option's service area, you may elect any health care options available to you in your new location. If no Macy's-sponsored health care option is offered in your new location, continuation coverage will not be available.

CAN CONTINUATION COVERAGE BE TERMINATED?

The law also provides that continuation coverage may be cut short for *any* of the following five reasons:

- Macy's no longer provides group health coverage to any of its Participating Employers' colleagues;
- The premium for continuation coverage is not paid on time;

- After the date he or she elects continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;

- After the date he or she elects continuation coverage, the qualified beneficiary becomes entitled to Medicare;

- The qualified beneficiary extends coverage for up to 29 months due to a disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations, as subsequently amended by Section 2704 of the Public Health Service Act, provide that group health plans may not impose any preexisting condition limitation beginning with the first plan year starting on or after January 1, 2014.

IS A CONVERSION PROGRAM AVAILABLE?

A conversion program is an individual policy that you purchase at the end of your continuation coverage. A conversion program is only available for colleagues enrolled in a fully-insured health care option at the time coverage terminates.

OTHER IMPORTANT INFORMATION

The benefits described in this booklet are provided to eligible colleagues and dependents through the Macy's Health Care Plan ("Plan"). The Plan is sponsored by Macy's, Inc. ("Macy's" or the "Company") and the Macy's business units and affiliated companies whose colleagues are also covered under the Plan ("Participating Employers").

The following is important additional information about the administration and funding of the Plan, and other information required to be provided under the Employee Retirement Security Income Act of 1974, as amended ("ERISA").

PLAN NAME AND IDENTIFICATION NUMBERS

Plan Name:	Macy's Health Care Plan (as a component of the Macy's, Inc. Welfare Benefits Plan)
Employer ID Number:	13-3324058
Plan Number:	941

TYPE OF PLAN

The Plan is an "employee welfare benefit plan" as the term is defined by ERISA. The Plan is maintained for the purpose of providing participants with health care benefits.

PLAN YEAR

The Plan's financial records are kept on a fiscal plan year basis beginning each July 1st and ending on the following June 30th.

TYPE OF ADMINISTRATION

The Plan is either fully insured or self-funded with respect to the various health care options. The Company administers the Plan except insofar as authority to administer the Plan has been delegated to others.

PLAN ADMINISTRATOR

Macy's, Inc. is responsible for interpreting and administering the terms of the Plan, making Macy's the "Plan Administrator" and "named fiduciary" for purposes of ERISA. Macy's can be reached at:

Macy's, Inc.
Group Benefits Department
145 Progress Place
Springdale, OH 45246

In addition, under ERISA, other persons or entities who exercise any discretionary authority or responsibility in the administration of the Plan are also fiduciaries with respect to the Plan.

Subject to Macy's delegation of discretionary authority as indicated below, Macy's has the sole and absolute authority and discretion to interpret the provisions of the Plan (including, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in the language of, the Plan), to determine the rights and status of the participants and other persons under the Plan, to decide disputes arising under the Plan, and to make any determination and findings with respect to benefits payable thereunder and the individuals entitled thereto, as may be required for purposes of the Plan. All decisions of Macy's as to the facts of a case, interpretation of any provisions of the Plan or its application to any case and any other interpretive matter, determination, or question under the Plan shall be final and binding on all parties affected thereby.

DELEGATION OF DISCRETIONARY AUTHORITY

As Plan Administrator, Macy's has the authority to delegate some or all of its rights, powers, duties, and responsibilities, with respect to the operation and administration of the Plan that are permitted to be delegated under ERISA.

Macy's has created an "Employee Benefits Committee," consisting of one or more members appointed (and removable) by Macy's. This Employee Benefits Committee is a "named fiduciary" for purposes of ERISA and Macy's delegates to the Employee Benefits Committee all of Macy's powers, duties, and responsibilities with respect to the operation and administration of the Plan that are not otherwise delegated to the Plan's carriers and HMOs, below.

As Plan Administrator, Macy's delegates to each of the respective carriers and HMOs the complete and sole discretionary authority and responsibility to interpret and apply Plan terms, administer claims for benefits, pay Plan benefits and to make factual determinations in connection with their review of claims and appeals under the respective insured, HMO and/or self-funded health care programs they administer under the Plan. Macy's further delegates to each independent review organization providing voluntary independent external claims reviews on behalf of the Plan the complete and sole discretionary authority and responsibility to interpret and apply Plan terms and to make factual determinations in connection with their review of claims and appeals under the external claims review procedures of the respective insured, HMO and/or self-funded health care programs they provide services to under the Plan. When exercising this discretionary authority, most of the carriers, HMOs and independent review organizations are Plan fiduciaries. Such discretionary authority includes, but is not limited to,

the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments. As Plan Administrator, Macy's also delegates to each of the carriers, HMOs, and when applicable, the independent review organizations the complete and sole discretionary authority and responsibility to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his or her duly authorized representative.

SOURCE AND FUNDING OF BENEFITS

The Plan's health care options are either fully insured or self-funded.

Benefits which are payable from a fully-insured health care option are provided through an insurance policy or contract with the applicable carrier or HMO. The method for funding these fully insured options is for the Company to remit premiums to the insurance carriers or HMOs. The source of these premium payments are the colleague contributions taken from colleagues by payroll deduction, and Company contributions which equal the amount by which the total cost of the insured health care options exceed colleague contributions.

Benefits which are attributable to Company contributions under the Plan's self-funded health care options are paid from the general assets of Macy's and the other Participating Employers. Colleague contributions taken with respect to the Plan's self-funded health care options are paid to a trust established by Macy's ("Welfare Benefit Trust"). Claims for benefits generally are paid first from amounts held in the Welfare Benefit Trust, and then from the general assets of Macy's and the other Participating Employers. Macy's and the other Participating Employers may purchase "stop loss" insurance to reimburse themselves for the payment of unusually large individual and/or aggregate claims under the Plan's self-funded health care options.

Currently, the Trustees of the Welfare Benefit Trust (and their address) are:

Ms. Felicia Williams, Senior Vice President, Controller & Enterprise Risk
Mr. Greg Whitson, HRBP
Ms. Chris Meier, Corporate HRBP
Mr. Matthew Schroeder, Vice President, Tax

Macy's Corporate Services, Inc.
145 Progress Place
Springdale, OH 45246

COLLEAGUE COST OF COVERAGE

Colleague contributions for coverage under the Plan are determined by Macy's (and the other Participating Employers) in their sole discretion. Among other factors, the claims experience for the prior periods is considered in making this determination. The amount of colleague contributions required for participation in the Plan may be adjusted for any class of colleagues at any time. Colleague contributions are not refundable and shall be used only for the benefit of Plan participants.

AGENT FOR SERVICE OF LEGAL PROCESS

Chief Legal Officer
Macy's, Inc.
151 West 34th Street
New York, NY 10001

Service of legal process also may be made on one or more of the Trustees or the Employee Benefits Committee. For disputes arising under any fully-insured health care option, service of legal process may be made upon the carrier or HMO.

PLAN AMENDMENT, TERMINATION AND OTHER LIMITATIONS ON BENEFITS

The Company hopes and expects that this Plan will continue indefinitely, but the Company reserves to itself, pursuant to its sole and absolute discretion, the right to change, amend or terminate the Plan, in whole or in part, at any time, with or without prior notice, without regard to any individual's prior satisfaction of the Plan's eligibility conditions. The Plan may be changed, amended or terminated by written amendment, or by other written record of corporate action, signed by the Company's Secretary or by any other person so authorized by or pursuant to authority of the Company's Board of Directors.

Benefits described herein may not apply to colleagues covered under a labor agreement.

LOSS OF BENEFITS

This booklet describes the benefits, coverage, eligibility and colleague contribution rules in effect under the Plan as of July 1, 2019, any of which may be modified or eliminated at any time. In addition to any loss of benefits under the Plan that may occur as the result of its amendment or termination, this booklet describes specific limitations on, and other events that may give rise to a loss of benefits, coverage and eligibility under the Plan.

PLAN DOCUMENTS

This booklet, together with the accompanying Supplements and carrier and HMO benefits summary booklets, constitute the summary plan description for the benefits provided to **Benefits-Eligible Colleagues** of Macy's (and other Participating Employers) and their dependents under the Plan, as described above. In addition, this booklet and the Supplements and benefits summary booklets, together with any other summary plan descriptions issued to a class of colleagues that is provided benefits under the Plan, constitute the plan document for the Macy's Health Care Plan.

NO ENLARGEMENT OF EMPLOYMENT RIGHTS

Neither the existence of the Plan nor the coverage provided thereunder to eligible colleagues and their eligible dependents constitutes a contract of employment and will not give any individual the right to continued employment with Macy's, Inc. or any other Participating Employer.

YOUR RIGHTS UNDER ERISA

The following statement is required by Federal law and regulations.

As a participant in the Macy's Health Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- receive information about the Plan and benefits;
- continue group health plan coverage;
- prudent actions by Plan fiduciaries;
- enforce their rights; and
- obtain assistance with questions

Receive Information About Your Plan And Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan 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 (formerly known as the "Pension and Welfare Benefit Administration").

You may 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 descriptions. The Plan administrator may make a reasonable charge for the copies.

You are entitled to 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.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including Macy's, your Participating Employer 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.

Enforce Your Rights

If your claim for a welfare benefit is denied, 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 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or 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 this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the "Pension and Welfare Benefits 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, DC 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.