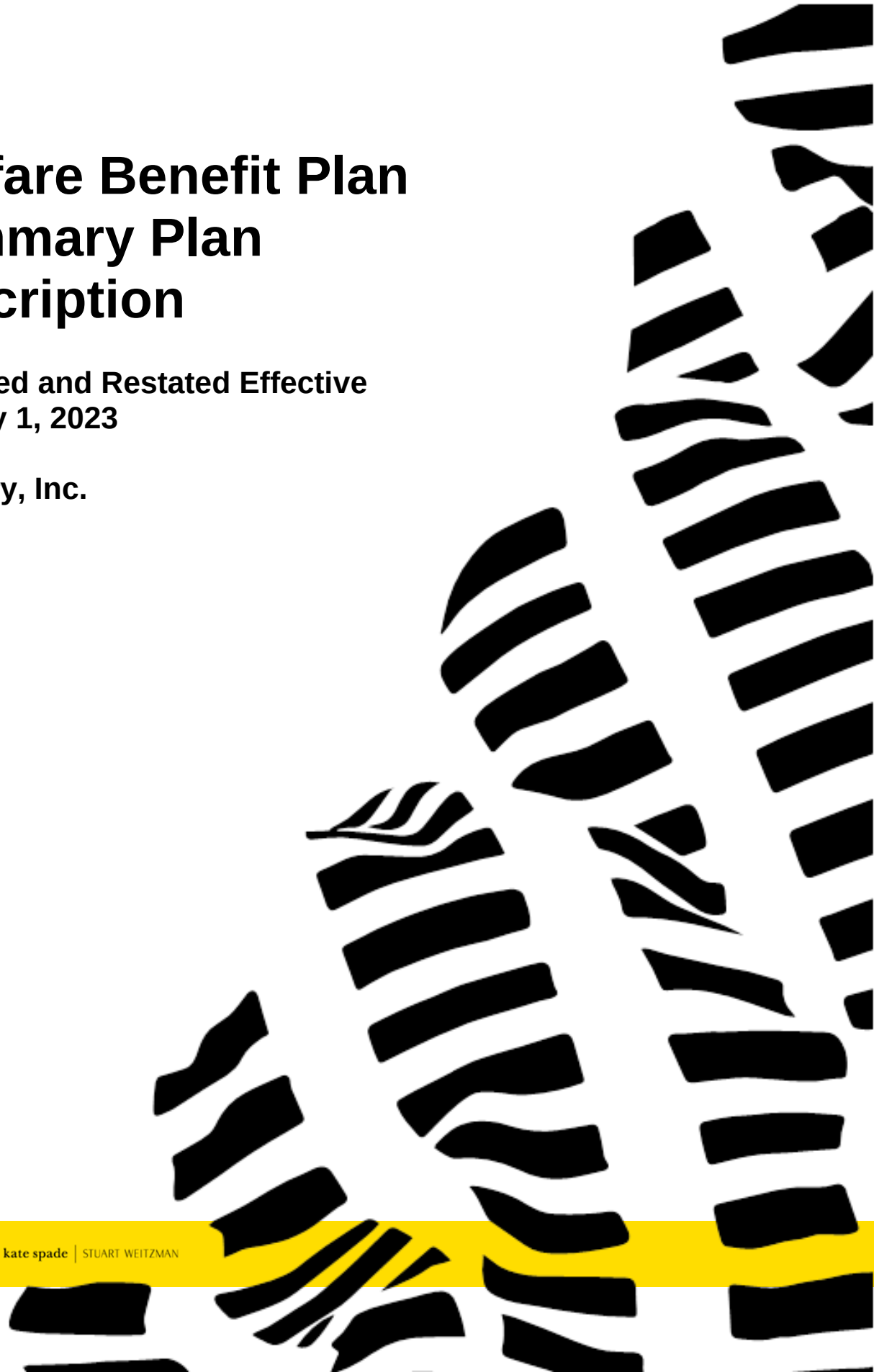
Welfare Benefit Plan Summary Plan Description

Amended and Restated Effective January 1, 2023

Tapestry, Inc.



tapestry COACH | kate spade | STUART WEITZMAN

This document, together with the documents incorporated herein by reference, is your Summary Plan Description (SPD). To request one of the following SPDs, contact My Health Benefits Center from 9:00 a.m. to 6:00 p.m. ET, Monday through Friday, at 833-692-6387 (833-MYBNFTS):

- Medical – Aetna
- Medical – Cigna
- Medical – Dean / Prevea360 (generally available in Wisconsin)
- Medical – Empire BCBS
- Medical – Geisinger (generally available in Pennsylvania)
- Medical – Health Net (generally available in Arizona, California, Oregon, and Washington)
- Medical – Kaiser Permanente (formerly Group Health in Washington)
- Medical – Kaiser Permanente (generally available in California, Colorado, District of Columbia, Georgia, Maryland, Virginia, Oregon, and southwest Washington)
- Medical – UnitedHealthcare
- Medical – UPMC Health Plan (generally available in Pennsylvania)
- Medical – Triple-S (Puerto Rico residents only)
- Dental – Aetna
- Dental – Cigna
- Dental – DeltaDental (Bronze, Silver, and Gold)
- Dental – DeltaCare USA (Platinum)
- Dental – MetLife
- Dental – UnitedHealthcare
- Vision – EyeMed
- Vision – MetLife
- Vision – UnitedHealthcare
- Vision – VSP
- Aetna Global Benefits (Medical/Dental/Vision) – Aetna International
- Life – The Hartford
- Accidental Death and Dismemberment (AD&D) – The Hartford
- Disability – Lincoln Financial Group
- Business Travel Accident – AXIS Insurance Company
- Flexible Spending Account – Alight Smart-Choice Accounts
- Employee Assistance Program (EAP) – ComPsych

IRS Circular 230 Disclosure. To ensure compliance with requirements imposed by the Internal Revenue Service (IRS), we inform you that any information contained in this summary was not intended or written to be used as tax advice and cannot be used for purposes of (i) avoiding tax-related penalties under federal, state, or local tax law or (ii) promoting, marketing, or recommending to another party any matter addressed herein.

January 1, 2023

Whom to Contact		
	Contact	**Reasons to Access**
My Health Benefits Center	**https://yourbenefitsresources.com/tapestry** **833-692-6387 (833-MYBNFTS)** Representatives are available between the hours of 9:00 a.m. and 6:00 p.m. ET, Monday through Friday	• Verify overall eligibility and coverage. • Review personal benefits information. • Obtain a benefit summary. • Compare health care coverage options. • Update beneficiary information.
Aon Active Health Exchange Medical Options **(NOTE: Your prescription drug coverage is provided through your insurance carrier's pharmacy benefit manager)** • Platinum Option • Gold or Gold II* Option • Silver Option • Bronze Plus Option The following insurers provide coverage for each option: — Aetna — Cigna — Dean / Prevea360** — Empire BCBS — Geisinger** — Health Net** — Kaiser Permanente** — UnitedHealthcare — UPMC Health Plan** *In California, the Gold option is offered by Aetna and UnitedHealthcare; the Gold II option is offered by Cigna, Health Net, and Kaiser. **Not available in all areas. In certain states, some options may cover in-network benefits only.	**Aetna** **https://www.aetna.com** **855-496-6289** **Cigna** **https://my.cigna.com** **855-694-9638** **Dean / Prevea360** **http://aon.deanhealthplan.com** **877-232-9375** **Empire BCBS** **https://www.anthem.com/ca/** **844-424-8089** **Geisinger** **https://www.geisinger.org/member-portal** **844-390-8332** **Health Net** **https://www.healthnet.com/myaon** **888-926-1692** **Kaiser Permanente (formerly Group Health in Washington)** **https://wa-member.kaiserpermanente.org** **855-407-0900** **Kaiser Permanente** **http://www.kp.org** **800-464-4000 (California)** **303-338-3800 (Colorado)** **404-261-2590 (Georgia)** **800-777-7902 (District of Columbia, Maryland and Virginia)** **800-813-2000 (Oregon and southwest Washington)** **UnitedHealthcare** **http://myuhc.com** **888-297-0878**	• Request coverage information. • Locate participating providers. • Request information about a network provider, free of charge. • Submit claims, if necessary. • Check on the status of a claim. • Call to avoid penalties if you have an emergency or need surgery, hospitalization, or certain other procedures requiring precertification. • Order an ID card or print a temporary one. • Fill or refill a prescription. • Locate a participating pharmacy near you. • Obtain prescription medication information (such as side effects). • Learn about patient care. • Estimate costs for common treatments. **Mail-Order Prescription Drugs:** • Obtain prescription medication information (such as pricing and side effects). • Print a mail-order form or extra mail-order envelopes. • Send online member services inquiries. • Order claim forms. • Learn about patient care. • Link to other sites for information about diseases, diagnoses, prevention, and treatment.

Whom to Contact		
	Contact	**Reasons to Access**
	UPMC Health Plan **https://www.upmchealthplan.com/members** **844-252-0690**	
Aon Active Health Exchange Dental Options • Platinum Option • Gold Option • Silver Option • Bronze Option The following insurers provide coverage for each option: — Aetna — Cigna — DeltaCare USA — Delta Dental Insurance Company — MetLife — UnitedHealthcare	**Aetna** **https://www.aetna.com** **855-496-6289** **Cigna** **https://my.cigna.com** **855-694-9638** **DeltaCare USA (Platinum Option)** **http://www.deltadentalins.com** **800-471-7614** **Delta Dental Insurance Company (Bronze, Silver and Gold Options)** **http://www.deltadentalins.com** **800-471-7614** **MetLife** **https://www.metlife.com/mybenefits** **888-309-5526** **UnitedHealthcare** **https://www.myuhc.com** **888-571-5218**	• Request coverage information. • Locate a participating dentist. • Request a provider directory. • Submit claims, if necessary. • Check on the status of a claim. • Obtain useful information about oral health. • Order an ID card.
Aon Active Health Exchange Vision Options • Gold Option • Silver Option • Bronze Option The following insurers provide coverage for each option: — EyeMed — MetLife — UnitedHealthcare — VSP	**EyeMed** **https://www.eyemedvisioncare.com/member/public/login.emvc** **844-739-9837** **MetLife** **https://www.metlife.com/mybenefits** **888-309-5526** **UnitedHealthcare** **https://www.myuhcvision.com** **888-571-5218** **VSP** **https://www.vsp.com/signon.html** **877-478-7559**	• Verify vision care eligibility. • Review your benefits. • Locate a participating network provider. • Speak with member services. • Request or download a claim form.

Whom to Contact		
	Contact	**Reasons to Access**
Puerto Rico Health Care	**Triple-S** **www.ssspr.com** **800-981-3241** **787-774-6060**	• Request coverage information. • Locate participating providers. • Request information about a network provider, free of charge. • Submit claims, if necessary. • Check on the status of a claim. • Call to avoid penalties if you have an emergency or need surgery, hospitalization, or certain other procedures requiring precertification. • Order an ID card or print a temporary one. • Fill or refill a prescription. • Locate a participating pharmacy near you. • Obtain prescription medication information (such as side effects). • Learn about patient care. • Estimate costs for common treatments. **Mail-Order Prescription Drugs:** • Obtain prescription medication information (such as pricing and side effects). • Print a mail-order form or extra mail-order envelopes. • Send online member services inquiries. • Order claim forms. • Learn about patient care. • Link to other sites for information about diseases, diagnoses, prevention, and treatment.

Whom to Contact		
	Contact	**Reasons to Access**
Aetna Global Benefits (Medical/Dental/Vision)	**Aetna** **https://www.aetnainternational.com** **800-231-7729**	• Request coverage information. • Locate participating providers. • Request information about a network provider, free of charge. • Submit claims, if necessary. • Check on the status of a claim. • Call to avoid penalties if you have an emergency or need surgery, hospitalization, or certain other procedures requiring precertification. • Order an ID card or print a temporary one. • Fill or refill a prescription. • Locate a participating pharmacy near you. • Obtain prescription medication information (such as side effects). • Learn about patient care. • Estimate costs for common treatments. **Mail-Order Prescription Drugs:** • Obtain prescription medication information (such as pricing and side effects). • Print a mail-order form or extra mail-order envelopes. • Send online member services inquiries. • Order claim forms. • Learn about patient care. • Link to other sites for information about diseases, diagnoses, prevention, and treatment.
Flexible Spending Accounts (FSAs)	**Alight Smart-Choice Accounts** **https://yourbenefitsresources.com/tapestry** **833-692-6387 (833-MYBNFTS)** Representatives are available between the hours of 9:00 a.m. and 6:00 p.m. ET, Monday through Friday.	• Verify your Health Care and/or Dependent Care FSA balance. • Ask about covered expenses. • Submit claims. • Check on the status of a claim.

Long-Term Disability ("LTD") Insurance	**Lincoln Financial Group** **http://www.mylincolnportal.com/** **855-832-9581**	• Obtain information about how the LTD Plan works. • Apply for LTD benefits. • Request or provide updated information about an LTD claim.
Group Term Life and Accidental Death and Dismemberment ("AD&D") Insurance	**The Hartford** **www.thehartfordatwork.com** **800-523-2233**	• Inquire about statements of health. • Inquire about claims.
Critical Illness Insurance*	**Allstate** **https://www.allstatevoluntary.com/tapestry/** **866-828-8067** 8:00 a.m. – 8:00 p.m. ET	• Ask questions about coverage or eligibility. • Submit claims.
Hospital Indemnity Insurance*	**Allstate** **https://www.allstatevoluntary.com/tapestry/** **866-828-8067** 8:00 a.m. – 8:00 p.m. ET	• Ask questions about coverage or eligibility.
Accident Insurance*	**Allstate** **https://www.allstatevoluntary.com/tapestry/** **866-828-8067** 8:00 a.m. – 8:00 p.m. ET	• Ask questions about coverage or eligibility.
COBRA	**https://yourbenefitsresources.com/tapestry** **833-692-6387 (833-MYBNFTS)** Representatives are available between the hours of 9:00 a.m. and 6:00 p.m. ET, Monday through Friday.	• Ask questions about coverage or eligibility. • Inquire about premium payments.
Aon Active Health Exchange Legal Services Plan*	**LegalEASE** **https://www.legaleaseplan.com/tapestry** **800-248-9000**	• Verify your eligibility and coverage. • Obtain plan services: — Office consultation or phone advice. — Small claims assistance. — Personal bankruptcy or debt collection defense. — Identity theft. — Tax audits. — Document preparation. — Separation or divorce. — Premarital agreements. — Wills and estate planning. — Real estate matters.
Aon Active Health Exchange Identity Theft Protection*	**NortonLifeLock** **www.lifelockbusinesssolutions.com/EmployeeBenefits/BenefitPremier** **800-607-9174**	• Ask questions about coverage or eligibility

Aon Active Health Exchange Auto & Homeowners Insurance*	**Liberty Mutual** **800-295-5059** **Farmers - MetLife** **866-441-0154** **Travelers** **888-434-5270**	• Ask questions about coverage or eligibility.
Aon Active Health Exchange Pet Insurance*	**Healthy Paws® Pet Insurance** **www.healthypawspetinsurance.com/aon** **855-898-8991**	• Enroll or change your covered pets. • Ask questions about coverage or eligibility.
International Vacation Medical*	**GeoBlue** **U.S.: 844-358-7278** **Outside U.S.: 610-254-8771**	• Ask questions about coverage or eligibility.
Bill Negotiation Services*	**MCA** **www.medicalcostadvocate.com/aon** **844-891-8981**	• Ask questions about coverage or eligibility.

Employee Assistance Program (EAP)	**ComPsych**
	guidanceresources.com
	866-365-0818
		• Employee Assistance Program is a resource that you and your family can use to solve a wide range of everyday issues 24 hours a day. Examples include:
		  • Relationship issues
		  • Stress management
		  • Depression
		  • Counseling

*These benefits are not considered ERISA-covered benefits under the Plan. Contact information is presented here for your convenience.		

Table of Contents

Introduction

SPD Overview

Tapestry, Inc. ("Tapestry") maintains the Tapestry, Inc. Welfare Benefit Plan (the "Plan") to provide certain welfare benefits to eligible employees, including medical (includes prescription drugs), dental, vision, group term life insurance, disability, business travel medical and accident, and accidental death and dismemberment.

Tapestry offers these welfare benefits through a private health exchange known as the "Aon Active Health Exchange." This health exchange is an innovative online marketplace that allows you to shop for coverage just as you would shop for other items online. You can choose from multiple coverage options and a variety of insurers, depending on where you live. Please note that the Aon Active Health Exchange is **not** the state governmental exchanges required under the Affordable Care Act, but the process of selecting coverage is similar.

An exchange creates a centralized and efficient way to deliver health care coverage and also encourages you to compare options and prices.

For medical, dental, and vision coverage, options are named by a metallic level: Platinum, Gold, Silver, and Bronze. A number of insurers are affiliated with each option. See the "Whom to Contact" chart for the list of insurers.

Tapestry offers you access to a Health Savings Account if you enroll in a Bronze Plus or Silver medical option that is a qualifying high deductible health plan. A Health Care Flexible Spending Account is available if you enroll in a Gold or Platinum medical option, and a Dependent Care Flexible Spending Account is also available under the Plan.

Although they are not part of the Plan, the following optional benefits are noted in this SPD for reference purposes only, to assist you in making your benefit decisions. Additional information about these benefits can be obtained directly from the insurer or third-party administrator or through the My Health Benefits enrollment website at https://yourbenefitsresources.com/tapestry:

- Supplemental medical plans (critical illness, hospital indemnity, accident)
- Group legal
- Identity theft protection
- Pet insurance
- Auto and home insurance
- International vacation medical insurance
- Bill negotiation services
- EAP

Benefits are provided under insurance and other contracts entered into between Tapestry and various insurance companies and administrators (each, an "Insurance Company" and collectively, the "Insurance Companies" and "Administrators").

Enrollment

- To begin your Plan participation, you have to affirmatively enroll yourself and your eligible spouse, domestic partner, and/or children, as described in the “Eligibility and Participation Requirements” section.
- If you decide to waive medical coverage, you must do so through the My Health Benefits enrollment website at https://yourbenefitsresources.com/tapestry.
- Benefits under the Plan are summarized in the Your Reference Guide and are described in greater detail in the materials issued by the Insurance Companies and Administrators, which are available online and upon request.

Hawaii Residents

- If you reside in Hawaii, there are some differences in eligibility and required contributions. For more details, log on to https://yourbenefitsresources.com/tapestry or contact the My Health Benefits Center at 833--692--6387 (833-MYBNFTS).

Purpose of SPD

- The purpose of this Tapestry SPD document is to provide you with an overview of the Plan and to discuss certain information that may not be addressed in the booklets or other materials provided to you by the Insurance Companies and Administrators. This document, together with the booklets provided to you by the Insurance Companies and Administrators (the “Booklets”), is the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA). This Tapestry document is not intended to provide benefits or other rights that are not already provided by the official plan document, the Booklets, or by the insurance and other contracts between Tapestry and the Insurance Companies and Administrators.

Eligibility and Participation Requirements

Eligibility Requirements

- To determine whether you are eligible to participate in any of the benefits provided under the Plan, please refer to Appendix A for employee eligibility and waiting periods. If you are eligible, you may also cover your eligible dependents. A dependent is defined as your:
  - Legally married same-sex or opposite-sex spouse
  - Children up to the end of the month in which they turn age 26
  - Same-sex or opposite-sex domestic partner
  - Children or domestic partner’s children (regardless of age) who are mentally or physically incapable of self-support
- An individual will be considered your domestic partner if they satisfy the requirements set forth in the Tapestry Inc. Affidavit of Domestic Partnership.
- To enroll in these benefits, you must enroll yourself, your spouse or domestic partner, and your other eligible family members through the My Health Benefits enrollment website at https://yourbenefitsresources.com/tapestry. You must enroll within 30 days of becoming eligible. If you have a life event (such as a marriage), you have 30 days to enroll your newly acquired spouse, domestic partner, or child; otherwise, enrollment is generally limited to the annual open enrollment period with coverage starting on the following January 1. A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan, regardless of whether a court or tax or regulatory authority determines that the person is an employee.

- By enrolling any person in coverage under the Plan, you state, represent, and agree to all of the following:
  - You understand the eligibility requirements set forth above and any additional requirement in the applicable benefit description Booklet.
  - The person you enroll meets the applicable eligibility requirements.
  - If the person ceases to meet the eligibility requirements, you will immediately notify https://yourbenefitsresources.com/tapestry.
  - You understand that the Plan Administrator reserves the right to require you, as a condition of eligibility and at any time, to submit proof of eligibility of any person you enroll, and you agree to provide the required proof within the time specified by the Plan Administrator.
  - You understand that meeting the eligibility requirements and providing required proof of eligibility are material conditions of enrollment and continued coverage under the Plan.
  - You understand that enrolling a person who does not meet the eligibility requirements, failing to notify the Plan Administrator immediately if a person ceases to meet the eligibility requirements, or refusing or failing to provide required proof of eligibility constitutes fraud or an intentional misrepresentation of material fact and is prohibited by the Plan.
  - If a person does not meet the eligibility requirements at the time of enrollment, the Plan Administrator will cancel that person's coverage.
  - If a person ceases to meet the eligibility requirements at a time after enrollment, the Plan Administrator will cancel that person's coverage.
  - If you refuse or fail to timely provide required proof of eligibility for a person, the Plan Administrator will cancel that person's coverage as of the date of enrollment or such other date as the Plan Administrator determines, in its sole discretion, to be appropriate.
  - If you enroll a person who does not meet the eligibility requirements, or if you fail to notify the Plan Administrator immediately if a person ceases to meet the eligibility requirements, or if you refuse or fail to timely provide required proof of eligibility for a person, you may be financially and legally responsible for all health care expenses incurred during the period of ineligibility, and you may be subject to disciplinary action, including but not limited to termination of your and your dependents' coverage under the Plan, and criminal charges.
  - In certain circumstances, you can enroll outside the open enrollment period, such as when you get married. See the "Qualifying Life Events" section of this SPD. This is also explained in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request. The Plan's Special Enrollment Notice (Appendix B) also contains important information about your Special Enrollment rights.

Required Premium Payments

- Tapestry employees share in the cost of the medical, dental, and vision benefits for themselves and eligible dependents through before-tax payroll deductions. Contributions for your domestic partner (or your domestic partner's children) are after-tax, unless they are your tax dependents*. The cost varies based on the level of coverage you elect and is subject to change if your family status changes. Your current plan year contribution rates are available on https://yourbenefitsresources.com/tapestry when you make your annual enrollment elections or when you need to change coverage due to a Qualifying Life Event.

*Note: If your domestic partner and/or their children are enrolled in the medical and dental benefits under the Plan, you will have imputed income on the portion of the coverage that is paid for by Tapestry unless that domestic partner is your tax dependent as defined under IRS rules.

- Tapestry offers two types of flexible spending accounts ("FSAs") under the Plan: A Health Care FSA (if you enroll in a Gold or Platinum medical option) and a Dependent Care FSA to allow you to pay for certain eligible health and dependent day care expenses with before-tax dollars. Tapestry also offers you access to a Health Savings Account (if you enroll in a Bronze Plus or Silver medical option) that permits you to contribute a portion of your pay (subject to IRS limits) to a separate account that is maintained by a trustee or custodian outside of the Plan. Funds in your account may be used to pay for IRS-approved health care expenses on a before-tax basis.

When Participation Begins

Coverage for full-time employees generally begins 30 days following your date of hire. Coverage for eligible part-time employees generally begins 90 days following your date of hire (or change in status date). Generally, coverage changes following a Qualifying Life Event (such as a marriage or an adoption) are effective on the date of that life event. For more information about when coverage begins, refer to the eligibility information contained in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request.

See Exhibit A for further details on when coverage begins for each benefit.

Termination of Participation

Your eligibility for medical, dental, and vision benefits terminates on the last day of the month in which you terminate your Tapestry employment. Your eligibility for all other Plan benefits terminates on the last day in which you work at Tapestry. Coverage will also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you engage in fraudulent activity (such as if you submit false claims), and for certain other reasons described in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request.

Coverage for your spouse or domestic partner and for your covered dependents ends when your coverage stops and for other reasons that are specified in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request (for example, divorce, dependents attaining age limit, and other reasons). Benefits will also end for employees, spouses, domestic partners, and children if and when the Plan terminates.

Qualifying Life Events

As a general rule, enrollment in the Plan is limited to when you first become eligible for benefits under the Plan and during the annual open enrollment period. In certain circumstances, however, you may be able to make changes or choose new benefits during the benefit plan year if you experience a Qualifying Life Event.

A Qualifying Life Event is a change in your personal situation that may permit you to make, change, or terminate an election under the Plan at a time other than annual enrollment. New elections made upon the occurrence of a Qualifying Life Event must be on account of and consistent with the event.

Qualifying Life Events include:

- Change in marital status, including marriage, divorce, death of spouse, annulment, or legal separation.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent.
- Change in employment (termination or commencement of employment) for you, your spouse, or your dependent.
- Change in residence or worksite for you, your spouse, or your dependent that results in a loss of coverage.
- Inability of your dependent to meet the Plan's coverage requirements due to a change in age or other conditions of eligibility.

- Your dependent becomes eligible for coverage under his or her employer's plan.
- Enrollment in Medicare or Medicaid by you, your spouse, or a dependent.
- Health Insurance Portability and Accountability Act (HIPAA) special enrollment event.
- The Booklet for a particular benefit under the Plan may contain additional rules regarding election changes for that benefit.
- Any change arising from a Qualifying Life Event will not be given effect unless it is made within 30 days following the event.
- For fully insured Plan benefits, the applicable insurance carrier may impose additional limitations on when you can make election changes. You should read the Booklet or other materials provided to you by the insurance carrier.

Continuation of Coverage

- If medical, dental, vision, and/or Health Care FSA coverage for you, your eligible spouse, or your eligible dependents ceases because of certain "qualifying events," then you, your eligible spouse, or your eligible dependents may have the right under a federal law called COBRA to pay for continuing coverage under the Plan for a limited period of time. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.
- **You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower monthly premium costs and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.
- COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this SPD. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The cost for COBRA continuation coverage is generally 102% of the full premium amount. In some cases, it is higher (see below).
- If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
  - Your hours of employment are reduced; or
  - Your employment ends for any reason other than your gross misconduct.
- If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
  - Your spouse dies;
  - Your spouse's hours of employment are reduced;
  - Your spouse's employment ends for any reason other than his or her gross misconduct;
  - Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
  - You become divorced or legally separated from your spouse.

- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
  - The parent-employee dies;
  - The parent-employee's hours of employment are reduced;
  - The parent-employee's employment ends for any reason other than his or her gross misconduct;
  - The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
  - The parents become divorced or legally separated; or
  - The child stops being eligible for coverage under the Plan as a "dependent child."

- The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.
- For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA administrator within 30 days after the qualifying event occurs. The current mailing address for the COBRA administrator is available on https://yourbenefitsresources.com/tapestry or by contacting the My Health Benefits Center at 833-692-6387 (833-MYBNFTS). Please provide the following required documentation if applicable to your qualifying event:
  - Divorce decree or court documentation of legal separation.
  - Current address of COBRA-eligible participants if different from your own.
- Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
- COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

  — If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA administrator in a timely fashion, you and your entire family may be entitled to received up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of COBRA continuation coverage. During the extension period, the cost for COBRA continuation coverage (assuming the disabled person is covered) is 150% of the full premium amount.

— If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

- COBRA continuation coverage for the Health Care FSA is only available until the end of the calendar year in which the qualifying event occurred, and no extensions are available.
- For more information about COBRA rights, see the "Continuation of Coverage" notice, a copy of which has been previously furnished to you and your spouse (assuming you are covered under the Plan). Please contact the My Health Benefits Center at 833-692-6387 (833-MYBNFTS) if you need another copy.
- Continuation and reinstatement rights may also be available if you are absent from employment at Coach because of your service in the armed forces pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994. More information about coverage available under USERRA is included in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request.
- COBRA coverage pays secondary to Medicare Parts A and B, which means that, with respect to Medicare-eligible individuals, the plan will pay as if Medicare has already made a payment, even if the Medicare-eligible individual did not actually enroll in Medicare. Accordingly, if you are eligible for Medicare Parts A and B but you choose to not enroll in Medicare Parts A and B, you may face potentially significant out-of-pocket expenses. Therefore, you should enroll in Medicare (Parts A and B) as soon as you are eligible when you have COBRA coverage.
- If your Medicare benefits (Parts A or B) become effective on or before the day you elect COBRA coverage, you can have COBRA and Medicare coverage. This is true even if your Part A benefits begin before you elect COBRA coverage but you don't sign up for Part B until later. If you become entitled to Medicare after you've signed up for COBRA coverage, your COBRA coverage may be terminated by your plan as of the day you enroll in Medicare. (But if COBRA covers your spouse and/or dependent children, their coverage may continue.)

Benefit Plan Summary

Benefits Provided

The Plan provides covered benefits to eligible employees and to eligible spouses and domestic partners and to their dependents. These benefits are provided under insurance or other contracts entered into between Tapestry and the various Insurance Companies and Administrators. A list of the benefits provided under the Plan is included in Appendix A. A detailed description of the benefits is contained in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request. You must refer to this information to understand your Plan benefits.

Qualified Medical Child Support Orders

The Plan will provide benefits to an employee's non-custodial child, as required by a qualified medical child support order (QMCSO), under Section 609(a) of ERISA. The Plan has separate procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain a copy of these procedures without charge by contacting the My Health Benefits Center at 833-692-6387 (833-MYBNFTS).

Circumstances That May Affect Benefits

Denial or Loss of Benefits

Your participation will end at the time and in the manner described above in the section called “Termination of Participation.”

Coverage Exclusions

Other circumstances that can result in the termination, reduction, loss, or denial of benefits are described in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request. Please read these Booklets carefully. As discussed above, the Plan’s Special Enrollment Notice contains important information about the special enrollment rights that you have.

How the Plan Is Administered

Plan Administration

The Plan is administered by a committee approved by the Vice President, Total Rewards and People Insights.(the “Committee”). The Committee has delegated certain responsibilities to the Benefits Director to act on behalf of the Plan Administrator. Tapestry has agreed to indemnify the Committee and the Benefits Director for any liability that they incur as a result of acting on behalf of the Plan Administrator, unless that liability is due to their gross negligence or misconduct. The Plan Administrator has delegated responsibility for making benefit claims determinations to the Insurance Companies and Administrators that insure and/or process benefit claims under the Plan. The role of each Insurance Company and Administrator is described in the Booklet for the benefit insured or administered by the Insurance Company or Administrator.

Power and Authority of Insurance Company

The following parts of this Plan are fully insured:

- All medical plan options (including Aetna Global Benefits and Triple-S);
- Dental;
- Vision;
- Accidental death and dismemberment;
- Basic, supplemental, and dependent group term life insurance;
- Business travel accident; and
- Short-term and long-term disability.

Benefits for these fully insured benefits are provided under group insurance contracts entered into between Tapestry and the respective Insurance Companies. The Insurance Companies, not Tapestry, are responsible for paying claims. The Insurance Companies also have the authority to require eligible individuals to furnish them with any information that they determine necessary for the proper administration of the Plan. The Health Care FSA and Dependent Care FSA benefits provided under the Plan are self-insured and are paid for by the Insurance Companies and Administrators out of Tapestry’s general assets.

The Insurance Companies and Administrators for the above-listed benefits are the Named Fiduciaries for benefit appeals and are responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan; and
- Administering the claims procedures to be followed and the claims forms to be used by eligible individuals

pursuant to the Plan.

Plan Amendment or Termination

Amendment or Termination

- Tapestry, as Plan Sponsor, has the right to amend or terminate the Plan at any time.
- The Plan may be amended or terminated by a written instrument signed by the Global HR Officer, who is authorized to take those actions and to enter into or amend contracts with the Insurance Companies and Administrators. In addition, termination of a contract entered into between Tapestry and one or more Insurance Companies or Administrators will not constitute termination of the Plan, unless Tapestry exercises its sole discretion to terminate the Plan.

No Contracts of Employment

No Contract of Employment

- The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Tapestry to imply that you will be employed for any specific period of time.

Claims Procedures

Benefit Claim

Each Insurance Company or Administrator is responsible for evaluating all benefit claims under the Plan. Each Insurance Company or Administrator will decide your claim in accordance with its own reasonable claims procedures, as required by ERISA. These claim procedures are described in more detail in the Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestry or upon request. These Booklets include details regarding the Insurance Companies' and Administrators' claims procedures and information about how to file a claim.

Appealing Denied Claim

You may appeal to the Insurance Company or Administrator for a review of your claim if it is denied. The Insurance Company or Administrator will decide your appeal in accordance with its reasonable appeal procedures, as required by ERISA.

Important Appeal Deadlines

- If you don't appeal on time, you may lose your right to file a lawsuit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally are a condition for bringing a lawsuit).
- The Booklets provided to you by the Insurance Companies and Administrators on https://yourbenefitsresources.com/tapestryor upon request include information about how to appeal a denied claim and details regarding the Plan's claims procedures.

Administrative Claims

- An Administrative Claim is a claim that relates to eligibility, enrollment, premium payment or other administrative issue under the Plan and is **not** for a particular benefit due to you under the Plan. For example, if you believe you are being charged too much for coverage or you believe that an individual is an eligible dependent under the Plan but has not been permitted to enroll, you must file

an Administrative Claim.

- Administrative Claims must be submitted to:

  Vice President, Total Rewards and People Insights
  Tapestry, Inc.
  10 Hudson Yards, 19th floor
  New York, NY 10001

- Administrative Claims must be submitted within 60 days from the date you know or should have known that there is an issue, dispute, problem, or other Administrative Claim with respect to the Plan. If a claim involves a Plan change or Amendment, you are considered to know about your claim when the change or Amendment is first communicated to participants in the Plan, and the 60-day period for filing a claim begins on the date the change is first communicated, whether or not the change or Amendment has become effective by that date.
- If you do not file an Administrative Claim by the applicable deadline, your claim will expire and it will be denied automatically if it is subsequently filed. The Plan Administrator (or its delegate) will provide a written response to your Administrative Claim within 90 days after it receives your Administrative Claim. The Plan Administrator may require a 90-day extension to respond to your Administrative Claim. If so, the Plan Administrator will notify you of the need for an extension in writing before the original due date.
- If your Administrative Claim is denied, you have the right to file an appeal by writing to the Plan Administrator at 10 Hudson Yards, 19th Floor, New York, NY 10001. You must file your appeal within 60 days after the date of the Administrative Claim denial letter. Be sure to explain why you think your Administrative Claim should be approved and provide all relevant information and any supporting documentation.
- The Plan Administrator will review your appeal of an Administrative Claim and provide you with a written response within 90 days after receiving your appeal. The Plan Administrator may require a 90-day extension to respond to your Administrative Claim. If so, the Plan Administrator will notify you of the need for an extension in writing before the original due date.
- If you do not file an appeal of an Administrative Claim by the applicable deadline with the necessary information and in the proper manner, your claim will expire and be denied automatically if it is subsequently filed.
- If your Administrative Claim and your appeal are denied and you are still not satisfied with the Plan's decision, you have the right to file a civil action under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA). With limited exceptions, you must exhaust these internal procedures, including filing an appeal, before filing a civil action for benefits under Section 502(a)(1)(B).

General Information About the Plan

Plan Name	The name of the Plan is the Tapestry, Inc. Welfare Benefit Plan.
Type of Plan	The Plan is a welfare benefit plan that is subject to the provisions of ERISA and other applicable laws and regulations.
Plan Year	The plan year is January 1 to December 31.
Plan Number	The plan number is #501.
Effective Date	The Plan was originally effective on July 1, 2001 and has been amended and restated several times since then.

Funding and Type of Plan Administration

The Plan includes both insured and self-insured benefits as described in the "How the Plan Is Administered" section.

Insurance premiums and other benefit expenses for Tapestry employees and their families are paid in part by Tapestry out of its general assets and in part by employees with before-tax and after-tax payroll deductions. Tapestry and its employees each pay part of the cost.

Employee payroll deductions shall be used in their entirety prior to using Tapestry contributions to pay for premiums and other benefit costs under this Plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under insurance or other contracts entered into between Tapestry and the Insurance Companies and Administrators shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Tapestry for premiums and other costs that it has paid.

Plan Sponsor

Tapestry, Inc.
10 Hudson Yards, 19th Floor
New York, NY 10001
(212) 946-8400

Employer Identification Number

Tapestry, Inc.'s employer identification numbers (EINs) for the employers participating in the Plan are 52-2242751 (for Tapestry, Inc.) and 36-4287289 (for Coach Stores Puerto Rico Inc.)

Insurance Companies

The following are the Insurance Companies and Administrators that are providing or administering benefits under the Plan, the related benefit(s) and whether the Insurance Company or Administrator is acting as an insurer (for insured benefits) or as a third-party administrator (TPA) for self-insured benefits:

- Aetna (Medical/Dental) – Insurer
- Cigna (Medical/Dental) – Insurer
- Dean / Prevea360 (Medical) – Insurer
- Empire BCBS (Medical)
- Geisinger (Medical) – Insurer
- Health Net (Medical) – Insurer
- Kaiser Permanente (Medical) – Insurer
- UnitedHealthcare (Medical/Dental/Vision) – Insurer
- Triple-S (Medical) – Insurer
- Delta Dental (Dental) – Insurer
- DeltaCare USA (Dental) – Insurer
- MetLife (Dental/Vision) – Insurer
- EyeMed (Vision) – Insurer
- VSP (Vision) – Insurer
- Aetna International (Aetna Global Benefits) – Insurer
- The Hartford (Life) – Insurer
- The Hartford (AD&D) – Insurer
- Lincoln Financial Group (Disability) – Insurer
- AXIS Insurance Company (Business Travel Accident) – Insurer
- Alight Smart-Choice Accounts (FSAs) – TPA

Plan Administrator and Named Fiduciary

Welfare Plan Administrative Committee
Tapestry, Inc.
10 Hudson Yards, 19th Floor
New York, NY 10001
(212) 946-8400

Named Claims Fiduciary (for benefit appeals)	• Medical/Dental – Aetna Life Insurance Company • Medical/Dental – Cigna • Medical – Dean / Prevea360 • Medical – Empire BCBS • Medical – Geisinger • Medical – Health Net • Medical – Kaiser Permanente • Medical/Dental/Vision – UnitedHealthcare • Medical – Triple-S (Puerto Rico residents only) • Medical/Dental/Vision – Aetna International • Dental – Delta Dental • Dental – DeltaCare USA • Dental/Vision – MetLife • Vision – EyeMed • Vision – VSP • Life – The Hartford • AD&D – The Hartford • Disability – Lincoln Financial Group • Business Travel Accident – AXIS Insurance Company • Flexible Spending Accounts – Alight Smart-Choice Accounts
Agent for Service of Legal Process	Service of legal process may also be made on the Plan Administrator.
HIPAA Privacy and Security	The Health Insurance Portability and Accountability Act (“HIPAA”) requires the Plan to safeguard the privacy and security of certain information that is known as “protected health information.” Your rights under HIPAA are described in a Notice of Privacy Practices that was provided to you by the Plan. If you need another copy of that notice, contact the My Health Benefits Center at 833-692-6387 (833-MYBNFTS).
Important Disclaimer	Plan benefits are described in an official plan document and Booklets and other materials provided by the Insurance Companies and Administrators online and upon your request. If the terms of this summary document conflict with the terms of the official plan document, or the insurance or other contracts, then the terms of those other documents will control, unless superseded by applicable law.

Statement of ERISA Rights

Your Rights

As a plan participant, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at Tapestry's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance and other contracts, and a copy of the latest annual report (Form 5500), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Upon written request to Tapestry Human Resources, obtain copies of documents governing plan operation, including insurance contracts and copies of the latest annual report (Form 5500) and an updated SPD. Tapestry may assess a reasonable charge for making and providing these copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Tapestry, as Plan Administrator, will furnish each participant with a copy of this summary annual report (called a "SAR").
- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your dependents may have to pay for this continuation coverage. You should review this SPD and the other documents governing the Plan to determine and understand the rules explaining your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of this Plan. These people, called plan "fiduciaries," have a duty to operate the Plan prudently and in the interest of you and other plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or otherwise exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within the required time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, and you 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 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claim procedures available to you under the Plan (discussed in the “Claims Procedures” section), 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 to be frivolous.

If You Need Further Assistance

Assistance with Your Questions

If you have any questions about your Plan, you should contact Tapestry. If you have any questions about this statement or about your rights under ERISA, HIPAA, or any other applicable law, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

Appendix A

The eligibility for types and levels of benefits may change from time to time at the sole discretion of the company. However, Tapestry will notify you of changes as soon as administratively possible. Following is the benefit eligibility chart in effect at the time of this SPD's printing:

	Full-Time	Part-Time Eligible (22.5–30 hrs/wk)*	Part-Time Ineligible (<22.5 hrs/wk)
Medical Plan	After 30 days	After 90 days (30 days for Hawaii residents)	
Dental Plan	After 30 days	After 90 days	N/A
Vision Plan	After 30 days	After 90 days	N/A
Basic Life Insurance and AD&D	After 30 days	After 90 days	N/A
Supplemental & Dependent Life Insurance	After 30 days	After 90 days	N/A
Short-Term Disability	Immediate	Immediate	Immediate
Long-Term Disability	After 30 days	N/A	N/A
Business Travel Accident	Immediate	N/A	N/A
Flexible Spending Accounts	After 30 days	After 90 days (30 days for Hawaii residents)	N/A
Critical Illness**	After 30 days	After 90 days	N/A
Group Accident**	After 30 days	After 90 days	N/A
Group Legal Plan**	After 30 days	After 90 days	N/A
Identity Theft**	After 30 days	After 90 days	N/A
Auto & Homeowners Insurance**	Immediate	Immediate	Immediate
Pet Insurance**	Immediate	Immediate	Immediate

International Vacation Medical**	Immediate	Immediate	Immediate
Bill Negotiation**	Immediate	Immediate	Immediate

*Part-time employees working in Hawaii are eligible if they work 20 hours or more per week.
**These benefits are not considered ERISA-covered benefits offered under the Plan.

Eligibility for Benefits

This SPD describes the benefit programs available to eligible employees of Tapestry, Inc.
You are generally eligible for benefits under the Plan if you are:

- Regularly scheduled to work at least 30 hours per week or a part-time employee working 22.5 to 30 hours (20 hours if you're an employee living in Hawaii) per week;
- Classified as "full-time" or "part-time" by the company; and
- Not an Excluded Employee (as defined below).

Different eligibility and participation requirements may be imposed by particular benefit programs. You must satisfy the eligibility requirements under a particular benefit program in order to receive benefits under that program. For purposes of clarity, expatriates are eligible for medical benefits under the expatriate health plan, provided such expatriates satisfy the eligibility and participation requirements set forth under the expatriate health plan.

Excluded Employees

An individual is an "Excluded Employee" if he or she is:

- Classified by the company's books as an independent contractor, a "Project Employee," or any employee regularly scheduled to work less than 20 hours per week;
- A member of a collective bargaining unit to which this Plan has not been extended; or
- A leased employee, as defined by federal tax law.

Appendix B

Notice of Special Enrollment
(From the HIPAA Regulations)

- If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Tapestry will also allow a special enrollment opportunity if you or your eligible dependents either:
  - Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible; or
  - Become eligible for a state's premium assistance program under Medicaid or CHIP.

  For these enrollment opportunities, you will have 60 days—instead of 30—from the date of the Medicaid/CHIP eligibility change to request enrollment in the Tapestry medical health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change. To request special enrollment or obtain more information, contact the My Health Benefits Center at 833-692-6387 (833-MYBNFTS).

Required Notice of Rights Under the Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information about WHCRA benefits, call the My Health Benefits Center at 833-692-6387 (833-MYBNFTS).

Required Notice under the Newborns' and Mothers' Health Protection Act

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