Summary Plan Description

Payless ShoeSource, Inc.

Flexible Spending Account (FSA) Program

(Health Care and Dependent Care Flexible Spending Account Plans)

Effective: January 1, 2018

FLEXIBLE SPENDING ACCOUNT PROGRAM

Notice To Associates

This booklet describes the Employer-sponsored Flexible Spending Account Program of Payless ShoeSource, Inc. ("Plan") as of January 1, 2018.

The Flexible Spending Account Program permits you to establish an Account(s) from which your eligible Dependent Care and Health Care Expenses can be reimbursed on a pre-tax basis.

Payless ShoeSource, Inc. and its adopting affiliates ("Company") have entered into an arrangement with Alight Solutions LLC and its affiliates "Aon " under which Aon's Your Spending Account™ (YSA) will process reimbursements and provide certain other administrative services to the Plan.

Aon does not insure the benefits described in this booklet.

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IMPORTANT TERMS

Understanding the following words and phrases will help you to understand the Flexible Spending Account Program offering the Health FSA and Dependent Care FSA Plans.

"Associate" means any person employed by Payless ShoeSource, Inc. and its affiliates who is designated by the Company to participate in the Payless ShoeSource, Inc. Health and Dependent Care Flexible Spending Account Plans. Associate does not include independent contractors or leased employees.

"Benefit Year" means the period beginning on the first day of a Plan Year and ending on March 15th following the end of the Plan Year. With respect to a new Participant or a Participant who has had a Change in Status or other event justifying a mid-Plan Year election change, the "Benefit Year" commences on the date the Participant's election first becomes effective under the Flexible Spending Account Program and ends on the March 15th date referenced above.

"Dependent" *under the Dependent Care FSA Plan* means an individual for whom a Participant provides more than half of the individual's support for the Plan Year in question and who is either a child of the Participant under age 13 or a spouse, parent or other relative who qualifies under applicable tax rules contained in the Internal Revenue Code and described under the "Dependent Care Expenses" section of this summary.

"Dependent" *under the Health Care FSA Plan* means an individual who is a Participant's legal spouse, consistent with federal law, or a Dependent child of the Participant. The term child includes a natural child, a stepchild, a legally adopted child, a child placed for adoption, a child for whom legal guardianship has been awarded to the Participant or the Participant's spouse. The definition of Dependent is subject to the following conditions and limitations: (1) a Dependent includes any Dependent child under 26 years of age; (2) the child must be primarily dependent upon the Participant for support and maintenance; (3) a Dependent includes a Dependent age 26 or older who is primarily not able to be self-supporting because of mental retardation or physical handicap and depends mainly on the Participant for support. Proof of the Dependent's condition and dependence must be submitted to the FSA Administrator within 31 days after the date the Dependent ceases to qualify under this subset number 3. The FSA Administrator may, from time to time, but not more than once a year, require proof of the continuation of such condition and dependence. No one may be considered a Dependent of more than one Participant.

"Election Period" means all or part of the period designated as such by the Company during which elections are made under the Flexible Spending Account Program for a Plan Year. The yearly "Election Period" means the period designated by the Company preceding January 1, which is also referred to as the "Annual Enrollment" period. For all newly eligible Associates the Election Period is the first 31 days of employment. With respect to an Associate who has had a Family Status Change or other event justifying a mid-Plan Year election change, "Election Period" means the period commencing on the date of the Family Status Change or other event and ending on the earlier of the date the Associate enters a Compensation Reduction Agreement with the Company or the date which is 30 days after

the occurrence of the Family Status Change or other event giving rise to the election change. If an eligible Associate experiences a Change of Status which results from a change of employment status, the "Election Period" means a period of 31 days commencing on the date of the change of employment status.

"Employer" means Payless ShoeSource, Inc. its affiliates adopting the Plan.

"Full-time" Associate means the Associate is classified on the Employer's records as a Full-time employee. In many locations, this means the Associate is normally scheduled to work 30 or more hours per week. However, the Associate's classification on the Employer's records, and not the actual number of hours worked in any period, determines Full-time status.

"Participant" means an Associate who is eligible and who has elected to participate in the Plan.

"Part-time" Associate means the Associate is classified on the Employer's records as a Part-time employee. In many locations, this means the Associate is normally scheduled to work less than 30 hours per week. However, the Associate's classification on the Employer's records, and not the actual number of hours worked in any period, determines Part-time status.

"Plan Year" means the period commencing on January 1 and ending on December 31 each year.

PLAN HIGHLIGHTS

Under the Plan, you can elect to establish a Dependent Care and/or a Health Care Flexible Spending Account. These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses.

If you are a Qualified Reservist called to active duty, this Plan includes a special distribution rule to assist such reservists as described in Sections, *Health Care Spending Account - Qualified Reservist Distribution* and *Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Accounts*.

The **Health Care Flexible Spending Account ("HCFSA")** is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the ***Health Care Spending Account*** section), including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents as determined consistent with the terms of the Plan and in compliance with the Internal Revenue Code (IRC).

The **Dependent Care Flexible Spending Account ("DCFSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the ***Dependent Care Spending Account*** section), such as day care.

You can elect to participate in the HCFSA, the DCFSA, or both. Each Plan Year (January 1 through December 31) you can contribute to your HCFSA and/or DCFSA, and then, during the Benefit Year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, *Contributions*.

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

Dependent Care FSA Plan

To be eligible for the Dependent Care FSA Plan you must be a full-time Associate of the Company and complete 31 days of service (except for the Eastern Distribution Center and Store Associates). Store Associates and Associates of the Eastern Distribution Center must complete at least ninety (90) days of service. All Associates must be employed by an Employer of the Company who participates in the Dependent Care FSA Plan.

If you are married, your spouse must be working, looking for work, in school full-time, or physically or mentally unable to work. You must be incurring your Dependent Care Expenses (as defined later in this summary) so that you can work at the Company. If you are married and your spouse is physically and mentally able to work but does not, you cannot sign up for the Dependent Care FSA Plan.

If you are eligible to participate, enroll in the Dependent Care FSA Plan, and then later are no longer eligible to participate in the Plan because you no longer satisfy the eligibility

requirements, only eligible Dependent Care expenses incurred while you were eligible to participate in the Dependent Care FSA Plan will be eligible for reimbursement under the Plan during the Benefit Year.

Health Care FSA Plan

To be eligible for the Health Care FSA Plan you must be a full-time Associate of the Company and complete 31 days of service (except for the Eastern Distribution Center and Store Associates). For Store Associates and Associates of the Eastern Distribution Center you must complete at least ninety (90) days of service. All Associates must be employed by an Employer of the Company who participates in the Health Care FSA Plan.

If you are eligible to participate, enroll in the Health Care FSA Plan, and then later are no longer eligible to participate in the Plan because you no longer satisfy the eligibility requirements, only Health Care Expenses incurred while you were eligible to participate in the Health Care FSA Plan will be eligible for reimbursement under the Plan during the Benefit Year.

When You May Enroll

You may elect to participate in the Plan during your first 31 days of employment or during any subsequent annual enrollment period. If timely elected, the Plan will be effective on the first day of the pay period following completion of a 31 or 90 day waiting period, as applicable to you. If you do not elect to participate in the Plan during your initial enrollment period of the first 31 days of your employment, you must wait until the next Annual Enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (Refer to the Section, *Changing Your Contribution Amounts*.) Following your initial enrollment in the Plan, you will need to enroll every year you wish to continue participation.

How to Enroll

To enroll, an Associate must complete their election within the 31 days of their employment. If you do not enroll within the 31 day period, you will need to wait until the next Annual Enrollment period. Associates enroll by logging onto https://payless.benefitsnow.com and completing their enrollment online.

If you elect to participate in the Plan you must specify the amount of before-tax dollars you wish to contribute to the HCFSA, the DCFSA, or both.

Each year during Annual Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the HCFSA and/or the DCFSA. Any changes you make during Annual Enrollment will become effective the following January 1.

CONTRIBUTIONS

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCFSA and/or DCFSA, however, amounts contributed to one

account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses" because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan Year, including those unused funds remaining after the 2 ½ month grace period immediately following the end of the Plan Year.

For the Health Care Spending Account, you may elect to contribute between $100 and $2,650 a year.

For the Dependent Care Spending Account, if you are married filing jointly for federal income tax purposes, you may each elect to contribute between $100 and $5,000, with $5,000 being the maximum aggregate amount. If you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 a year. If you or your spouse's earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income.

FSA PLAN – General Provisions

Health Care Eligible Expenses incurred during the Benefit Year, January 1 through March 15 (14 ½ months), must be submitted to the FSA Administrator on or before April 30 following the close of the Benefit Year (March 15), or they will not be paid. If your employment terminates, no money will be paid into your HCFSA after your last paycheck. COBRA continuation coverage may be available to you under the rules described in this document. If you do not elect COBRA continuation, you may still obtain reimbursement for Eligible Expenses incurred prior to your termination date.

Dependent Care Eligible Expenses incurred within the Benefit Year (January 1 through March 15th) must be submitted to the FSA Administrator on or before April 30th following the close of the Benefit Year (March 15), or they will not be paid. If your employment terminates, no further contributions will be made into the DCFSA after your last paycheck. You can continue to request reimbursement for Eligible Expenses incurred during your employment until the earlier of the date your DCFSA balance is exhausted or the end of the Plan Year following your employment termination date.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan Year, unless you meet one of the following conditions:

A. With regard to both a HCFSA and a DCFSA, one of the following changes in status events occurs:
   - An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
   - An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.

- An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the HCFSA or DCFSA.

B. For individuals who participate in a HCFSA, the following additional events will enable you to change your election:
   - If you become entitled to Medicare or Medicaid, you may elect to revoke your HCFSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
   - If the FSA Plan Sponsor and/or the Company receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator and/or the Company may:
     - ♦ Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the HCFSA, or
     - ♦ Permit you to cancel your child's coverage under the HCFSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in a DCFSA, the following events, in addition to those in (A.) above will enable you to change your election:
   - A change in your dependent care provider.
   - A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify the Company within 31 days of above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your HCFSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Changes in contribution amounts, including your new election, made during the Plan Year are effective the first day of the pay period following the date of your timely election due to the change of status or as soon thereafter as administratively feasible.

HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses

To be eligible for reimbursement from your HCFSA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- Incurred during the Plan Year or through March 15 immediately following the end of the Plan Year.
- Incurred while you are participating in the HCFSA. If you decide not to re-enroll in the Plan, you are still eligible for reimbursement through March 15 immediately following the end of the Plan Year as long as you were enrolled in the HCFSA on the last day of the Plan Year; and there is still a balance in your HCFSA.

Please note
Any reimbursement you receive through your HCFSA can not be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCFSA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts. Further limitations apply for your limited use FSA if you are enrolled in a high deductible health plan/Health Savings Account. Refer to the Section below titled "Limited Use FSA" for more information.

A more comprehensive list of Eligible Expenses and some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website **www.irs.gov** or by phone at 1-800-TAX-FORM (1-800-829-3676).

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Drug abuse treatment centers;
- Vaccinations;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, Coinsurance and Deductible amounts;
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer sponsored medical, dental or vision plan, health expenses reimbursed through your HCFSA cannot be claimed as deductions on your income tax return.

Limited Use FSA

If you participate in a high deductible health plan or health saving arrangement, eligible medical expenses are limited to your eligible vision and dental expenses until the deductible has been met under your high deductible health plan. You are responsible for monitoring the limits applicable to you.

Qualified Reservist Distribution

In accordance with the "Heroes Earning Assistance and Relief Tax Act of 2008" ("HEART Act") a qualified reservist distribution (QRD) is permitted of all or part of any unused HCFSA amounts if you are a reservist called to active duty provided that: (1) you are called up for a period of 180 days or more or for an indefinite period of time, and (2) the request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the HCFSA for that Plan Year.

To receive a QRD of all or part of any unused HCFSA amounts, you must give notice to the Company by contacting the Benefits Department as soon as you receive your orders or are called to active duty. For additional details on how to request a qualified distribution, refer to Section, *Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Account.*

DEPENDENT CARE SPENDING ACCOUNT

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCFSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCFSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some associates may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCFSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a DCFSA. In other words, you cannot use expenses reimbursed through the DCFSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each Associate's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCFSA.

Your Spending account™ Visa card (YSA Visa Card)

You will be provided with a YSA Visa card that may be used to pay for certain Eligible Expenses directly from your HCFSA. The YSA Visa card allows for direct payment to

qualified locations and providers and can be used at any approved location that accepts Visa®. Use of the YSA Visa Card is voluntary.

Receiving Your YSA Visa Card®

You will automatically receive your YSA Visa Card® in a welcome kit within approximately 7-10 business days once your enrollment has been processed. Read the terms and conditions found on the card insert and sign the back of your card. You may call the YSA Visa Card® customer service number or access the YSA website to order additional cards.

Activating Your YSA Visa Card® For use with the HCFSA

If you choose to activate your YSA Visa Card® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. You will be required to establish a Personal Identification Number, (PIN) as part of the activation process. The card will be ready to use with funds available immediately following activation of the card within the first Plan Year (If the card is activated prior to the Plan Year begin date the funds are not available until the effective date of the Plan Year even in the first year). However, for future Plan Years the funds will not be available for use until the effective date of the future Plan Year. If you continue to participate in the HCFSA you will continue to use the same YSA Visa Card® year after year until it expires. Once the card expires a new one will automatically be sent to you at no cost. Your YSA Visa Card will remain active for three years.

If you decide not to activate the YSA Visa Card®, simply destroy and discard the card. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from the YSA website found by logging onto https://payless.benefitsnow.com and as described under Section, *Requesting a Reimbursement or Qualified Distribution from Your Flexible Spending Account* or by filing an online claim or a filing a claim through the YSA mobile application

Please note
If you activate your card prior to the Plan effective date, you cannot use your card until the Plan effective date.

Using the YSA Visa® Card - Qualified Locations and Providers

The YSA Visa® Card may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts Visa Card® or your YSA Visa Card® number can be entered online or on an order form, similar to using a credit card number. You can even use your YSA Visa Card® to pay for a bill you receive in the mail if the merchant or provider accepts Visa®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, retail pharmacy counters.. (The card is not available for use with the DCFSA).You may also choose to use your YSA Visa Card® for **eligible** over-the-counter (OTC) products by going to a participating pharmacy, including an online pharmacy approved for use of the card. Please check with YSA for such approved pharmacies before making any purchase. While over the counter items generally

are allowable, such claims may require a Statement of Medical Necessity from a physician. This form can be found at the YSA website.

Your FSA and YSA Visa® card are regulated by the IRS, therefore you should retain all itemized receipts generated from the card, because certain payments must be verified. YSA may request your receipts from time to time to ensure that payments made using the YSA Visa® Card were made for qualified health care expenses. *Please note:* You may be able to use your YSA Visa® card to pay for prescribed OTC medicines if you take your OTC prescription to a pharmacist to be filled and have a prescription number assigned. Or you may purchase prescribed OTC medicines using another form of payment, such as cash or a personal credit card. If it is an Eligible Expense under your Plan, you can manually submit the claim, along with the prescription script for reimbursement. Non prescribed OTC medicines are not an Eligible Expense subject to reimbursement.

Retailers with Inventory Information Approval System (IIAS)

IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate Eligible Health Care Expenses, per Section 213(d) of the Internal Revenue Code. The IIAS allows you to use your YSA Visa® Card to pay for 213(d) Eligible Health Care Expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your HCFSA. Additionally, IIAS compatibility allows the retailer to distinguish between Eligible and Ineligible Health Care Expenses on the same transaction. Eligible Health Care Expenses will be approved via the YSA Visa® Card and remaining Ineligible Expenses may be paid using another form of payment. When you use your card at participating retailers, Eligible Health Care Expenses will be identified and noted on your receipt. You generally will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your YSA Visa® Card. IRS guidelines still require you to save your itemized receipts as part of your tax records, however, and YSA may require you to submit your receipts from time to time to validate your proper use of the card. You can see a full list of participating retailers at http://www.sig-is.org. If you go to a non-Participating retailer you can still buy Eligible Health Care Expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described under the Section, *Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Account.*

Account Balance and Yearly Statement

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you may access your account at any time by logging on at https://payless.benefitsnow.com. YSA will send you a statement during the fourth quarter of the calendar year advising you of your remaining account balance. If you note a discrepancy on your account, please call YSA at 1-855-564-6152 Monday through Friday between 8 am and 8 pm Eastern to resolve the issue.

Getting help is easy.
Simply go onto https://payless.benefitsnow.com anytime, or call the Payless Benefits Center at 1-855-564-6152 Monday – Friday from 8 am – 8 pm Eastern time.

REQUESTING A REIMBURSEMENT OR QUALIFIED DISTRIBUTION FROM YOUR FLEXIBLE SPENDING ACCOUNT

If you do not activate your YSA Visa® Card or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your HCFSA and/or DCFSA for the Eligible Expenses that have been incurred. A request for a reimbursement form is available at https://payless.benefitsnow.com.

When submitting a paper claim form for reimbursement from your HCFSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any medical/dental/vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from your DCFSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider. All dependent care expenses have to have been incurred before payment can be issued.

To receive a qualified reservist distribution (QRD), you must give notice to the Company by contacting the Benefits Department as soon as you receive your orders or are called to active duty and request a QRD.

The amount available as a QRD will be the amount contributed to the HCFSA as of the date of the QRD request, less any HCFSA reimbursements received as of that date.

Once your Plan Administrator has determined your eligibility for a QRD, you will see your qualified distribution included as part of your paycheck, subject to taxation, within 60 days of the request.

You should call the Plan Administrator if you have questions about your rights to receive a QRD under the Plan and for additional information about the procedures to apply for a qualified reservist distribution.

Only expenses which are incurred while you are a participant in the Plan including the 2 ½ month grace period immediately following the end of the Plan Year may be reimbursed from a Flexible Spending Account. For the DCFSA, if your employment terminates Eligible Dependent Care Expenses incurred prior to your termination can be reimbursed until the earlier of the date your DCFSA balance is exhausted or the end of the Plan Year following your employment termination date against what is in your DCFSA balance at the time of termination. The dates of service must fall within the Plan Year in which the DCFSA

account termed. In addition, expenses which are incurred during one Plan Year, with the exception of expenses incurred through March 15 immediately following the end of the Plan Year, cannot be reimbursed from funds contributed to your HCFSA or DCFSA during another Plan Year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

If you have established a HCFSA, your total annual contribution amount is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCFSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

HCFSA and DCFSA requests for withdrawal will be accepted and processed through April 30 of the following year for expenses incurred during the Plan Year and through March 15 immediately following the end of the Plan Year. For the DCFSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCFSA balance is exhausted or the end of the Plan Year following your employment termination date against what is in your DCFSA balance at the time of termination. The dates of service must fall within the Plan Year in which the DCFSA account termed. Any such Eligible Dependent Care Expenses must be submitted on or before April 30 of the Plan Year following your termination.

For the HCFSA, you may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of employment termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before April 30 of the next Plan Year.

In accordance with IRS regulations, amounts contributed to your HCFSA or DCFSA during the Plan Year but remaining in your account at the end of the processing period (April 30 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited.

Extension for Incurring Expenses

If you remain active in the plan, and you have unused contributions in your HCFSA or DCFSA at the end of the current Plan Year you can continue to incur expenses through March 15 immediately following the end of the Plan Year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through April 30. After April 30 funds remaining in your account for the current Plan Year will be forfeited. Unused benefits relating to a particular qualified benefit (e.g. HCFSA, DCFSA) may only be used to pay expenses incurred with respect to that particular benefit and can not be transferred to another account.

If you elect coverage under this Plan for the next Plan Year and there are still funds available in your account from the current Plan Year, expenses incurred between the end of the

current Plan Year and March 15 of the next Plan Year will be reimbursed from the funds in your current Plan Year's account until they are depleted.

A Qualified Reservist Distribution will be distributed in accordance with any Plan Year grace period.

CLAIMS PROCEDURES

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call YSA at 855-564-6212 to request a formal appeal. YSA will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

Your Spending Account ™ Claims & Appeals Management
P.O. Box 64030
The Woodlands, TX 77387-4030

Review of an Appeal

YSA will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and

Once the review is complete, if YSA upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from YSA within 60 days from receipt of the first level appeal. YSA must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments.

UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

The table below describes the time frames in an easy to read format which you and YSA are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, YSA must notify you within:	**30 days**
You must then provide completed claim information to YSA within:	**45 days** after receiving an extension notice*
If YSA denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
YSA must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
YSA must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*YSA may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible Associate.
- The date you fail to make a required contribution under the terms of the Plan.

Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of employment termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before April 30 of the next Plan Year.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the HCFSA. You should call the Company to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

Optional Continuation Coverage Under Your Health Care Spending Account (COBRA)

This optional continuation coverage only applies if it has been made available by the Company. The Company may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask the Company to find out if and how this continuation coverage and continuation coverage under USERRA described below applies.

In no event will YSA be obligated to provide continuation coverage to a participant if the Company or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying YSA in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's HCFSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan Year in which the qualifying event occurs and coverage cannot be continued beyond such date. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by the Company on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

Uniformed Services Employment and Reemployment Rights Act

An Associate who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Associate and the Associate's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Associates may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the HCFSA. If an Associate 's Military Service is for a period of time less than 31 days, the Associate may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the HCFSA.

An Associate may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Associate's absence from work; or
- the day after the date on which the Associate fails to apply for, or return to, a position of employment.

Regardless of whether an Associate continues the HCFSA, if the Associate returns to a position of employment, the Associate's HCFSA and that of the Associate's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Associate or the Associate's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue the HCFSA under USERRA.

YSA is not the Company's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred until the earlier of the date your DCFSA balance is exhausted or the end of the Plan Year following your employment termination date, against what is in your DCFSA balance at the time of termination. Any such claims must be submitted on or before April 30 of the next Plan Year.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Please note
The DCFSA is not subject to ERISA. Only the HCFSA is subject to ERISA and the terms described below.

Plan Sponsor and Administrator
The Company is the Plan Sponsor and Plan Administrator of the Company's FSA Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – FSA Plan
Payless ShoeSource, Inc.
Corporate Benefits Department
3231 S. E. 6th Avenue
Topeka, KS 66607-2207
(785) 233-5171

Claims Administrator
YSA, an affiliate of Alight Solutions LLC, is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at 855-564-6152 or in writing at:
Your Spending Account ™ Claims & Appeals Management
P.O. Box 64030
The Woodlands, TX 77387-4030

Agent for Service of Legal Process
Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - FSA Plan
Payless ShoeSource, Inc.
Corporate Benefits Department
3231 S. E. 6th Avenue
Topeka, KS 66607-2207
(785) 233-5171

Legal process may also be served on the Plan Administrator.

Other Administrative Information
This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Names:	Payless ShoeSource, Inc. Dependent Care Flexible Spending Account Plan Payless ShoeSource, Inc. Health Care Flexible Spending Account Plan
Plan Numbers:	Dependent Care Flexible Spending Account Plan: 560 Health Care Flexible Spending Account Plan: (under Plan Number 551)
Employer ID:	48-0674097
Plan Type:	Welfare benefits plan
Plan Year:	January 1, 2018 – December 31, 2018
Benefit year:	January 1, 2018 – March 15, 2019
Plan Administration:	Self-Insured
Source of Plan Contributions and Funding:	The Plans are funded out of the general assets of the Plan Sponsor based on the salary reduction elections made by participating Associates

Your ERISA Rights
As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all documents governing the HCFSA – including pertinent insurance contracts, trust agreements, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 series) filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all documents that govern the operations of the HCFSA and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual reports (Form 5500), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

- You can continue HCFSA benefits 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 to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan Benefit under the HCFSA is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or the latest annual report 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 for 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, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's 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.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to 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 at (866) 444-3272.

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