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MICHAELS STORES, INC.

EMPLOYEE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective July 1, 2023

NOTE: THIS BOOKLET MERELY SUMMARIZES KEY PLAN FEATURES AND DOES NOT REPLACE THE LEGAL PLAN DOCUMENT WHICH GOVERNS IN CASE OF ANY DIFFERENCES.

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INTRODUCTION

Michaels Stores, Inc. ("**Michaels**") sponsors the Michaels Stores, Inc. Employee Benefit Plan (the "**Plan**") for you and your fellow employees. Certain employers that are affiliated with Michaels ("**Affiliates**") may adopt the Plan for the purpose of providing benefits for their employees and their beneficiaries. The term "**Employer**" used in this document refers to Michaels and each Affiliate that offers participation in the Plan to its otherwise eligible employees. A list of Michaels Affiliates that are participating Employers in the Plan is contained in the section titled "**Important Information Regarding the Plan**."

This document and the separate booklets describing each of the benefits offered under the Plan (the "**Component Programs**") comprise the summary plan description ("**SPD**") for the Plan. This SPD is intended to provide you with a general description of your benefits under the Plan. Complete details of the Plan can be found in the official Plan documents (which are available on MIKBenefits.com) that legally govern all aspects of the Plan. **If there is a conflict between the official Plan documents and this document, the Plan documents will govern**.

BENEFITS INCLUDED IN THE PLAN

As described in greater detail in this document, Michaels sponsors the following Component Programs some of which you share in the cost as noted below. The cost of the Component Programs is determined each year and your portion of the cost, if any, depends on the Component Program and, if applicable, coverage category that you choose. The cost is communicated as part of the Open Enrollment process.

COMPONENT PROGRAM	ELIGIBLE EMPLOYEES SHARE IN ALL OR A PORTION OF PREMIUM COSTS?	EMPLOYEE PREMIUMS PAID ON A PRE-TAX BASIS?
Medical Benefits (including Prescription Drug Benefits)	Yes	Yes
Dental Benefits	Yes	Yes
Vision Benefits	Yes	Yes
Basic Life Insurance Coverage	No**	N/A
Basic Accidental Death and Dismemberment Coverage	No	No
Supplemental Life Insurance Coverage*	Yes	No
Supplemental Accidental Death and Dismemberment Coverage	Yes	No
Long-Term Disability Coverage for Hourly Benefits Eligible Employees	Yes	No

COMPONENT PROGRAM	ELIGIBLE EMPLOYEES SHARE IN ALL OR A PORTION OF PREMIUM COSTS?	EMPLOYEE PREMIUMS PAID ON A PRE-TAX BASIS?
Long-Term Disability Coverage for Salaried Benefits Eligible Employees	No	No
Short-Term Disability Benefits for Hourly Full-Time Employees	Yes	No
Short-Term Disability Benefits for Salaried Full-Time Employees	No	No
Health Care Flexible Spending Account ("**Health FSA**")**	Yes	Yes
Dependent Care Flexible Spending Account ("**Dependent Care FSA**")	Yes	Yes
Employee Assistance Program ("**EAP**")	No	N/A
Critical Illness Program	Yes	No
Telehealth for Part-Time Employees***	No	No
Health Savings Accounts ("**HSAs**") Established by HSA Eligible Participants****	Yes	Yes

*Please note that the premium cost for additional coverage above $50,000 is taxable to you.

**Each year you will be permitted to carryover to the next plan year, for use in the next plan year, a specific amount of your unused Health FSA balance. The carryover amount is set annually by the Internal Revenue Service.

***Telehealth benefits are described in a separate SPD, a copy of which may be obtained from the Plan Administrator.

****Michaels does not sponsor the HSA. Rather, through the Plan, Michaels provides a vehicle under which you can make pre-tax contributions to an HSA that belongs to you. You may change your HSA contributions on a prospective basis during the Plan Year.

Besides premium and contribution amounts that are deducted from your salary, you also pay the cost for deductibles, co-payments, services that are not reasonable and customary, and other services that are not covered by the Plan.

Michaels may revise the Component Programs and coverage options offered under each Component Program from time to time.

ELIGIBILITY

You are eligible to enroll in each of the Component Programs in which you share in the cost of coverage, in full or in part, on your date of hire if you are a regular full-time employee scheduled to work at least 30 hours per week. In order to contribute to the Dependent Care FSA, you must

also be actively employed. Part-time employees scheduled to work less than 30 hours per week are eligible for Telehealth benefits on their date of hire.

In addition, if you are eligible for (and enrolled in) coverage under the Plan, you may also elect to enroll or cover certain of your family members under some of the Component Programs, as follows:

Component Program	Family Members Eligible for Coverage*
Healthcare Programs • Medical Benefits • Dental Benefits • Vision Benefits	• Your legal spouse or domestic partner • Your child** who is younger than age 26 • Your unmarried child who is older than age 26, if the child is disabled***
Health Care Related Accounts • Health FSA • HSAs	• All family members listed above who qualify as your dependent for income tax purposes • These family members are not actually enrolled, but you may use your account to pay for their eligible medical expenses
Dependent Care FSA	• Your dependent children under the age of 13, who reside with you and who you claim on your federal income tax return • Spouse or tax dependents who are physically or mentally incapable of caring for themselves and who spend at least eight hours a day in your home • These family members are not actually enrolled, but you may use your account to pay for their eligible dependent care expenses
Disability Coverage • Short-Term Disability Benefits • Long-Term Disability Coverage	• Only eligible employees are eligible to receive disability coverage
Other Protection Programs for Employees Only • Life Insurance Coverage • Accidental Death and Dismemberment Insurance	• Only eligible employees are eligible to receive basic life insurance and accidental death and dismemberment coverage. Supplemental coverage is available for eligible family members

Component Program	Family Members Eligible for Coverage*
Other Protection Programs and Benefits • EAP • Critical Illness Benefits • Telehealth	• Your legal spouse or domestic partner and dependents who are eligible for Medical Benefits coverage are automatically eligible to receive benefits offered under the EAP upon your hire as an eligible employee • Your legal spouse or domestic partner and dependents who are eligible for Medical Benefits coverage are eligible for Critical Illness Benefits • Part-time employees and their legal spouse or domestic partner and dependent children younger than age 26 or unmarried children who are older than age 26, if the child is disabled are eligible for Telehealth benefits

*No Employee may be covered as a family member (spouse or child) of another Employee.

**Unless provided otherwise in an applicable Component Program document, your "child" includes your natural child, legally adopted child, child for whom adoption proceedings have begun, child for whom you are a legal guardian, foster child, or stepchild.

***Your disabled child must be reported as a dependent on your current federal income tax return and be unable to earn a living due to mental retardation or a physical disability in order to be enrolled in the Plan based on these provisions. You will be required to provide documentation of the disability and of the child's dependency on you within 30 days after the date of the child's birthday when he/she reaches the age limit for coverage. If your child reaches the age limited is not disabled, but later becomes disabled and financially dependent, you may not restart coverage.

ENROLLMENT

You may not enroll your dependents in a Component Program that you are not eligible to participate in, or for which you have not elected to receive coverage. The children of married Michaels employees, if any, can be covered as a dependent of either employee, but not both; provided, that such children are not employees of Michaels.

Each year or at the time you become eligible you have the option to elect or decline coverage under the Component Programs in which you share in the cost of coverage, in full or in part. Failure to timely elect coverage under those Component Programs will result in you waiving coverage for that Plan Year until the next annual open enrollment period unless you experience a Change in Status or HIPAA Special Enrollment Event described below.

You and your eligible family members, if applicable, will be automatically enrolled in the Component Programs which are paid for entirely by the Company.

Enrolling When You are First Eligible: Generally, you are required to make your initial enrollment elections (or change such elections) during the first 30 calendar days after you become eligible, unless provided otherwise by a Component Program. Coverage is effective the first day of the month after you complete 30 days of employment. Once the initial enrollment period has ended, your participation elections for both you and your eligible dependents, if any, will stay in effect for the rest of the calendar year, unless you experience a Change in Status or HIPAA Special Enrollment Event described below.

Enrolling During Open Enrollment: Each year, during the Plan's annual open enrollment period ("**Open Enrollment**"), you will have an opportunity to elect, change, or cancel your existing

elections for yourself and any of your eligible dependents. All changes that you make to your elections during Open Enrollment will take effect on the following July 1. If you do not renew coverage that you or any of your dependents are enrolled in under a Component Program, you (and such dependents) will lose coverage under that Component Program as of June 30.

Declining Coverage: If you have other benefits coverage (for example, through your spouse's employer), you may choose to waive any or all benefits coverage available to you under the Plan. However, please note that if your benefit needs change during the year, you will not be able to change your coverage elections unless you experience a Change in Status or HIPAA Special Enrollment Event described below.

Change in Status: You will be allowed to make benefit changes (i.e., add, change or cancel coverages) if you experience a Change in Status that results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. In order to make an election change on account of a Change in Status, your election change must be consistent with that change. **You must contact the Benefits Department within 30 calendar days of the Change in Status to change your benefits election and must provide documentation of the event, such as a marriage, birth, or death certificate. If you fail to make your election change within this 30-day period, you will not be able to change your benefit elections until the next Open Enrollment period (unless you experience another Change in Status or HIPAA Special Enrollment Event during the Plan Year)**.

A "**Change in Status**" includes:

- A change in your legal marital status (*i.e.*, your marriage, divorce, legal separation, or annulment, or the death of your spouse),
- A change in the number of your dependents through birth, adoption, placement for adoption or death of a dependent,
- A change in employment status by you, your spouse, or your dependent,
- A change in the work schedule of you, your spouse, or your dependent, including a switch between part-time and full-time status, a strike or lockout, or a commencement or return from an unpaid leave of absence,
- An election change made by your spouse, former spouse, or dependent under another employer-sponsored plan, including an annual enrollment election or a permissible change in status election under such plan that results in a gain or loss of coverage under that plan,
- A change in the place of residence or worksite of you, your spouse, or your dependent, that causes the impacted individual(s) to become or cease to be eligible for benefits under an employee benefit plan,
- An event that causes your dependent(s) to satisfy or cease to satisfy the requirements for coverage (*e.g.*, due to age or student status), with respect to your dependent's eligibility to enroll or elect out of coverage under a Component Program,

- A change in your dependent care expenses that are eligible for reimbursement under the Dependent Care FSA, with respect to your contribution elections under the Dependent Care FSA,

- Certain cost or coverage changes that occur with respect to a Component Program (*i.e.*, if your share of the cost of participating in a Component Program or the coverage provided under a Component Program changes);

- You or your spouse's or dependents' entitlement to, or loss of eligibility for, Medicare or Medicaid; or

- With respect to your Medical Benefits, health coverage under the insurance market place exchange becomes available if you have a reduction in hours below 30 hours per week and you elect such coverage to become effective no later than the first day of the month following the month that your Medical Benefits coverage is revoked, or you enroll in health coverage through the health insurance market place exchange during an annual or special enrollment period and such coverage becomes effective the day immediately following the day your Medical Benefits coverage is revoked.

Generally, your new election for Change in Status involving a birth, adoption, or placement for adoption will be retroactive to the actual date the event occurred.

You must notify the Benefits Department that a family member is no longer eligible for coverage within 30 calendar days of an applicable Change in Status. If you fail to provide this notice within the 30-day period, coverage will still be cancelled retroactively, but due to Internal Revenue Service ("**IRS**") rules you will not be permitted to change your contribution elections so you could end up paying for coverage that is no longer effective.

Spending Account Contribution Changes: If you change your contribution elections under the Health FSA or Dependent Care FSA as a result of a Change in Status (such as your marriage or the birth of a child), the following occurs:

- If you increase your contribution election, the amount of the increase is prorated throughout the remaining calendar year.

- If you decrease your contribution, your new per-pay-period contribution, if any, is calculated by taking any contributions already deducted from your paycheck and subtracting those from your new annual amount, then dividing that difference by the remaining pay periods in the year.

You may not decrease your existing contribution election to an amount that is less than what you have already contributed to a Spending Account for the year.

Special Enrollment Events Under HIPAA: You may be eligible to make mid-year changes (including enrolling if you previously declined coverage) to your Medical Benefits, Dental Benefits and Vision Benefits enrollment elections if you or one of your dependents experiences a HIPAA Special Enrollment Event. However, you can only change your benefit elections for those individuals who are impacted by the HIPAA Special Enrollment Event.

Generally, a "**HIPAA Special Enrollment Event**" includes any of the following events:

- *A loss of health insurance coverage* – you, your spouse or your eligible dependents with health insurance coverage under another plan lose that coverage.

- *Acquisition of a new dependent* - you acquire a new dependent through marriage, birth, adoption, or placement for adoption. Coverage may be elected retroactively to the date of birth, adoption or placement for adoption. In the event that this type of HIPAA Special Enrollment Event occurs, you may also elect to enroll your spouse in the applicable Component Program at the time that you enroll your new dependent, as applicable, even if you previously declined to enroll your spouse in such Component Program.

- *Gain or Loss of SCHIP Status* – you, your spouse or your eligible dependent (i) become eligible for a premium subsidy under Medicaid or a state children's health insurance program ("**SCHIP**") or (ii) lose eligibility for benefits under Medicaid or a SCHIP. For purposes of this rule, a "premium subsidy" is a subsidy offered by certain states that helps individuals who are eligible for Medicaid or benefits coverage under a SCHIP to cover the costs of enrolling in Medical Benefits. Please note that the Employer has not elected to receive premium subsidies directly from a state at this time. Therefore, the only way you can pay for your Plan benefits if you choose to take advantage of any rights you have under these rules is to pay for your elected coverages through payroll deductions.

You must elect to enroll yourself or your eligible dependents in the applicable Component Program within 30 days (60 days for a Gain or Loss of SCHIP Status) of the applicable event. If you are not currently enrolled in a Component Program, you will be required to enroll to elect coverage for yourself in order to enroll your spouse or dependent(s) in that Component Program.

Leaves of absence: If you take an approved Family and Medical Leave Act ("**FMLA**") leave of absence from the Employer or a military leave of absence, you will generally have the right to continue your coverage under certain of the Component Programs that you are enrolled in. You will be advised of these options at the time of your leave of absence.

Qualified Medical Child Support Orders ("QMCSO"): The Plan will comply with any QMCSO issued by a court or other administrative body that requires the Plan to provide medical, dental or vision coverage to one of your eligible children. In addition, you may be eligible to enroll or increase your contributions to the Health FSA or the HSA based on medical, dental or vision coverage changes required under a QMCSO.

You must be enrolled in Medical Benefits, Dental Benefits, or Vision Benefits, as applicable, in order for your otherwise eligible child to receive coverage under any of these Component Programs based on a QMCSO. Accordingly, you may be required to enroll in the applicable Component Program in order for the Plan to honor the terms of the order. In addition, you are responsible for covering any additional premium costs resulting from the Plan's provision of coverage to both yourself and your eligible children who are covered by a QMCSO.

Documentation Requirements: In all cases, the Plan may require you to provide certain documentation and information as proof of your eligibility (or your dependent's eligibility) to participate in a Component Program and as a prerequisite to enrolling in the Plan or a Component Program and your coverage may be delayed or suspended until you provide this information.

WHEN WILL MY COVERAGE END?

Generally, your coverage under each Component Program ends as of the earliest to occur of any of the following events:

- The date of your termination of employment (for purposes of Medical Benefits, Dental Benefits, and Vision Benefits your coverage will generally end on the date of your termination of employment),
- The date you become ineligible for coverage under such Component Program for any reason, including a change in your employment status or a Plan amendment,
- For your spouse and child(ren), the date such spouse or child(ren) no longer satisfy the eligibility requirements for participation in such Component Program,
- The date you fail to make required premium contributions,
- The date the Plan is terminated, or
- The date of your death.

Coverage for your spouse and covered children ends when your coverage ends or, if earlier, when they cease to be considered eligible dependents under the applicable Component Program. Your elections with respect to participation in the Component Programs, for both yourself, your spouse and covered children, will automatically terminate each year unless you renew your coverage during the annual Open Enrollment period. The Plan Administrator may permit you to carry over your enrollment elections from year-to-year in which case you will be advised accordingly during the annual Open Enrollment period.

COBRA RIGHTS

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**"), you and your spouse and children may elect to continue your Medical Benefits, Dental Benefits and/or Vision Benefits (collectively "**Health Care Component benefits**") if these benefits would otherwise end due to a "qualifying event" described below. If you terminate employment with the Employer, your contribution election with respect to the Health FSA will end. You will only be entitled to reimbursement for qualifying health care expenses that you incurred while you were an active participant in the Plan during the current calendar year, and your maximum reimbursement will not exceed the amount you had elected to contribute to the Health FSA for the calendar year, less any amounts you have already received as reimbursements from the Health FSA during the year in which you terminated employment. **If at the time you terminate, the maximum amount you could receive as reimbursements under the Health FSA exceeds your remaining contributions for the year, you may elect to continue your Health FSA coverage pursuant to COBRA for the remainder of the calendar year.**

Qualified Beneficiaries and Qualifying Events. A "qualifying event" includes:

- A reduction in your hours of employment
- Your termination of employment for any reason other than gross misconduct
- Your death
- Your enrollment in Medicare (Part A, Part B, or both)
- Your divorce or legal separation
- Your child's loss of dependent status

A "qualifying beneficiary" is your or your spouse or children who would otherwise lose coverage on account of a "qualifying event." In addition, a child born to you or who is adopted by or placed for adoption with you, during your period of COBRA coverage, is also a qualified beneficiary.

Notice Requirements. You must advise the Benefits Department in writing within 30 days of a qualifying event, which is your divorce or legal separation or your child's loss of dependent status. If you fail to provide this notice, your right (or your otherwise eligible dependents' rights) to receive COBRA coverage will be lost. The notice should describe the qualifying event and the date that it occurred. You do not need to provide anyone with notice of the other types of qualifying events.

Duration of COBRA Coverage. COBRA coverage begins on the date that coverage would otherwise have been lost. When the qualifying event is your death, enrollment in Medicare (Part A, Part B, or both), your divorce or legal separation, or a child's loss of dependent status, COBRA coverage may last for up to 36 months. When the qualifying event is the end of your employment or a reduction in your hours of employment, COBRA coverage may last for up to 18 months. The 18-month period of COBRA coverage can be extended if:

- you or anyone in your family covered under a Health Care Component (i.e., spouse or child) is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage and the COBRA Administrator is notified in writing within 60 days of the date of the determination and within the 18 month COBRA continuation period, you and all other members of the family (who were covered by the applicable Health Care Component at the time of the qualifying event) can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The notice should be sent, in writing, to the COBRA Administrator's address listed in the chart in the "***Important Information Regarding the Plan***" section below.

- Your spouse and dependent children may purchase up to an additional 18 months of COBRA period (for a total of 36 months) if during the initial 18-month period of COBRA coverage you die, enroll in Medicare (Part A, Part B, or both; provided that your enrollment in Medicare would have triggered a loss of coverage had it been the initial qualifying event), or get divorced or legally separated from your spouse or your child loses dependent status. You or your spouse or children must notify the COBRA Administrator in writing within 60 days of the second qualifying event or any right to additional COBRA continuation coverage will be lost. This notice should be sent, in writing, to the COBRA Administrator's address.

Early Termination Of COBRA Coverage. COBRA coverage will continue for the period described above, unless:

- In the case of 29 months of COBRA coverage (due to your or another person's disability), the Social Security Administration determines that such individual is no longer disabled, in which case extended COBRA coverage will end on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination,

- A qualified beneficiary after electing COBRA first becomes entitled to Medicare,

- Any premium for COBRA coverage is not paid in a timely manner,

- A qualified beneficiary first becomes, after the date of the COBRA coverage election, covered under another group health plan that does not contain any exclusion or limitation that applies to a beneficiary,

- The Employer ceases to provide any group health plan to any of its employees,

- A qualified beneficiary elects to drop COBRA continuation coverage, or

- Such COBRA coverage is terminated for cause, on the same basis that the Plan terminates the coverage of similarly situated non-COBRA participants.

In the event that either of the first two situations described above occur, the qualified beneficiary must make sure that the Plan Administrator is notified of the event within 30 days of the applicable event. This notice should be sent, in writing, to the COBRA Administrator's address.

Application and Payment Procedures. To continue coverage under COBRA, you must complete and return all required information to the COBRA Administrator within 60 days from the later of the date your COBRA notice is sent to you or the date your coverage under the Health Care Components would otherwise terminate. This is the maximum period allowed to elect COBRA. **If COBRA coverage is not elected within this period, then all rights to continue coverage under COBRA will end**.

Qualified beneficiaries must make their contributions on a monthly basis. In addition, there will be a maximum grace period of 30 days (45 days with respect to the initial payment) for the regularly scheduled monthly contributions. Each qualified beneficiary may be required to pay the entire cost of continuation coverage, which is generally equal to 102% of the group cost. However, the cost for the additional 11 months of coverage on account of disability is 150% of the group cost.

Questions concerning COBRA should be addressed to the COBRA Administrator.

POTENTIAL LIMITATIONS ON PLAN BENEFITS

Limitations on Obtaining Medical, Dental, and Vision Benefits: The Plan may cover a larger percentage of your medical, dental and vision expenses if you receive covered services from a network provider (versus a non-network provider). You should carefully review the schedule of benefits and other documents for a particular Component Program to avoid incurring expenses that will not be covered by the Plan. All coverage is subject to the terms, conditions, exclusions, and limitations set forth in the Component Program documents.

If you have questions regarding specific coverage, you may also contact the applicable Claims Administrator. **Failure to verify that expenses will be covered in advance may result in you having to pay all or a portion of such expenses out of your own pocket.** You may be required to request advance approval to obtain otherwise covered services or to advance the money required to obtain such services and file a claim for reimbursement with the Claims Administrator for the applicable Component Program.

Coordination of Benefits ("COB"): COB provisions apply under certain Component Programs that offer health care benefits when an individual has health care coverage through more than one plan. The purpose of the provisions is to ensure that you or your covered dependents receive all of the coverage for which you are entitled, but no more than the actual cost for the care received. The specific COB provisions applicable to a Component Program, if any, are set forth in the benefits booklet, insurance certificate, or other documents applicable to such Component Program. Please see the applicable Component Program documents for more information regarding COB requirements and exclusions.

Reimbursement and Subrogation: In certain cases, the Plan may be entitled to reimbursement of claims it paid if you or a covered family member received payment for those services from another source and the total payments exceed the amount you are entitled to receive from the Plan. Where you or your family member receives or is entitled to receive compensation for an illness or injury for which the plan has reimbursement rights, the Plan will be deemed to have a "constructive trust" on such compensation to the extent of the benefits paid by this Plan. The constructive trust is imposed upon the person or entity then in possession of the compensation. The Plan is also subrogated to the extent of any monies paid or payable by reason of you or your family member's injury or illness for which another person or organization is obligated to pay. The Plan's subrogation rights will exist regardless of whether the covered person is "made whole" by payments received from any other plan or person. You and your family members are obligated to cooperate with the Employer in enforcing its reimbursement or subrogation rights. You may obtain additional information regarding the Plan's reimbursement and subrogation rights from the Claims Administrator of the applicable Component Program.

COVID-19 or Related Protections. Please note that, although this SPD reflects updates made to the *Plan* as of July 1, 2023, there may be adjustments made to *Plan* coverage or administrative requirements, such as applicable election rules or deadlines during the COVID-19 pandemic, most of which ended July 10, 2023, or during other times of crisis. Michaels intends for the *Plan* to comply with all applicable legal requirements, as they may be amended from time to time. If you have questions regarding current adjustments that may be in effect, please contact the Plan Administrator.

CLAIMS

Two types of claims may be filed under the Plan by you, your covered dependent or an authorized representative (collectively referred to as "**you**" in this section) (i) "**eligibility claims**" which are a request to participate in the Plan or a Component Program or to receive a benefit not otherwise covered by the Plan or Component Program or (ii) "**benefit claims**" which are a request for a Plan or Component Program benefit. Claims must be submitted to the applicable Claims Administrator in the manner and within the time period required under the terms of the Component Program. The "**Claims Administrator**" for benefit claims under each Component Program is identified in the chart in the "***Important Information Regarding the Plan***" section below.

The Medical Benefits, Dental Benefits, Vision Benefits, Critical Illness Benefits, Short-Term Disability Benefits, Long-Term Disability Coverage, Accidental Death and Dismemberment Insurance and Life Insurance Component Programs have their own claims procedures which are described in the applicable benefit booklets. **The following claims procedures apply to eligibility claims and claims for EAP benefits, Health FSA benefits, Dependent Care FSA benefits (collectively "Other Benefits").**

The HSA is not an employee welfare benefit plan established or maintained by the Employer. Therefore, reimbursement from your HSA will be governed by the processes and procedures established in your agreement with the applicable HSA Administrator.

Claims Procedures for Eligibility Claims and Claims for Other Benefits

You may file an eligibility claim or claim for Other Benefits with the Claims Administrator in writing. Your claim should state the name of the employee, the name of the individual making the claim, and the name of the applicable Component Program to which the claim applies. Eligibility claims and claims for Other Benefits must be filed within three months after the end of the Plan Year in which the claim occurs.

Initial Claim Decision

If your eligibility claim or claim for Other Benefits is denied, in whole, or in part, the Claims Administrator will provide you notice of the denial in writing within 90 days. This 90-day period may be extended for an additional 90-days for reasons beyond the Claims Administrator's control and you will be advised of any extension before the end of the initial 90-day period. The notice will include the following information:

- The specific reason or reasons for the denial,
- Reference to the specific Component Program provisions on which the determination is based,
- If applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed, and
- An explanation of the appeal procedures, the time limits that apply, and a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on final appeal.

Appealing the Denial

If you disagree with the initial claim decision, you may appeal the decision. You must submit your appeal within 60 days after you receive the denial notice. In connection with your appeal, you can submit written comments, documents, records, and other information relating to your claim.

Additionally, you may access (upon request and free of charge) copies of all documents, records, and other information relevant to your claim. Your appeal will be reviewed, and the appeal will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was submitted or considered in

the initial benefit determination. Someone other than the person who made the first decision on your claim must make this review.

Your appeal must be in writing and must include the following information:

- Name of the employee;
- Name of the individual claiming benefits;
- Name of the Component Program;
- Reference to the initial decision; and
- Explanation of why the initial decision is being appealed.

The Claims Administrator will notify you of the decision on appeal in writing within a reasonable period of time, but not later than 60 days of receipt of the appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing your appeal. In such a case, the Claims Administrator will provide you written notice of these special circumstances and the date the Claims Administrator expects to issue its decision before the end of the initial 60-day period, The extension will not exceed a period of 60 days from the end of the initial 60-day period.

If your appeal is denied, in whole or in part, the Claims Administrator's written notice will include:

- The specific reason(s) for the denial;
- Specific reference to pertinent plan provisions on which the denial is based, if applicable;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement of your right to bring a civil action under Section 502 of ERISA and the time period for bringing that action.

Civil Action under ERISA

The determination of the Claims Administrator regarding your claim will be final and binding unless you prevail in a lawsuit validly filed pursuant to ERISA. Any such lawsuit must be filed within two years of the date on which the Claims Administrator issues its final decision on appeal. Otherwise, you will waive your right to bring such a lawsuit.

Exhaustion of the claims procedure is a mandatory precondition to bringing a lawsuit regarding denial of a claim.

ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the "Plan Administrator's" (as defined in the chart below) office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series), and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant in the Plan with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about 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 Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

IMPORTANT INFORMATION REGARDING THE PLAN

Plan Name	Michaels Stores Inc., Employee Benefit Plan
Plan Number	501
Plan Sponsor	Michaels Stores, Inc. Attn: Benefits Department 3939 West John Carpenter Freeway, Irving, TX 75063 (972) 409-1300
Employer Identification Number	75-1943604
Participating Employers	• Artistree, Inc. • Michaels Stores Procurement Company, Inc. • Michaels Product Development, LLC • Mi-Kraft, LLC (effective January 1, 2024)
Type of Plan	The Plan is a welfare benefit plan providing medical and other benefits.
Plan Administrator	Michael' Stores, Inc. is the Plan Administrator, but has appointed the Benefits Administrative Committee to act on its behalf as the "**Plan Administrator**." The Administrative Committee also has authority to

	amend the Plan. In addition, Michaels, Inc. has delegated certain administrative responsibilities under the Plan to its Benefits Department and to one or more outside administrative services providers, and has delegated the authority to make claims determinations to certain insurers or other service providers designated as the "**Claims Administrator**" with respect to each Component Program below. The Plan Administrator has full discretionary authority to construe and interpret the Plan and make final determinations of questions concerning the interpretation or administration of the Plan, including without limitation, all questions relating to eligibility for and the grant or denial of any Plan benefit.
Claims Administrator	The "**Claims Administrator**" for each Component Program is as follows: **Eligibility Claims** Michaels Benefits Administrative Committee Attn: Benefits Department 3939 West John Carpenter Freeway, Irving, TX 75063 **Medical Benefits** 1-866-410-8649 **Blue Cross Blue Shield of Texas** https://www.bcbstx.com/michaels 1-877-269-1180 **MDLive** https://members.mdlive.com/bcbstx 1-888-680-8646 **2nd.MD** https://www.2nd.md/michaels 1-866-841-2545 **Mental Health/Chemical Dependency** https://www.bcbstx.com/michaels 1-800-528-7264 **Kaiser HRA (CA Only)** https://healthy.kaiserpermanente.org/southern-california/front-door 1-800-464-4000 TTY 711 **Prescription Drug** **Prime Therapeutics** https://www.bcbstx.com/michaels

	1-877-269-1180 **Dental Benefits** **CIGNA Dental** https://my.cigna.com/web/public/guest 1-888-336-8258 **Vision Benefits** **Eyemed Vision** EyeMed Vision Care LLC https://eyemed.com/en-us 1-866-723-0513 **Short-Term Disability and Long-Term Disability** **Matrix Absence** https://www.matrixabsence.com/login/ 1-888-288-1354 **Life Insurance, Accidental Death and Dismemberment and Critical Illness** **Reliance Standard** https://www.rslclaims.com/ 1-855-RSL-CLAIM (775-2524) **Employee Assistance Program** **Aetna Resource for Living** https://www.resourcesforliving.com/login 1-800-283-5645 **Spending Accounts** **Health Equity** https://healthequity.com/ 1-877-924-3967 **Telehealth** Cirrus MD **my.cirrusmd.com/sign-in** Each Claims Administrator will have discretionary authority to make claims determinations with respect to the applicable Component Program(s) noted above. **The COBRA Administrator is:** Taben Group https://taben2.webcobra.com/

	1-800-675-7341 **The Administrator of the HSAs is:** **HealthEquity** https://healthequity.com/ 1-844-351-6849
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan Contributions	The responsibility of the Employer and the responsibility of eligible employees to pay for the cost of Plan coverage is discussed under the "***Benefits Included under the Plan***" section. Employees will be advised when there is a change in required employee contributions for coverage.
Type of Funding	Benefits are funded through the Employer's assets and provided through one or more insurance contracts purchased with contributions from the Employer and with specified employee contributions, as applicable.
Plan Year	July 1st through June 30th provided, however, that effective January 1, 2024, the Spending Accounts and HSA will have a January 1 to December 31 Plan Year, following a short Plan Year beginning July 1, 2023, and ending December 31, 2023
Plan Changes	Michaels reserves the right to amend or terminate the Plan and/or any individual Component Program offered under the Plan and to discontinue offering the Plan and/or any individual Component Program to a specific group or class of employees at any time. Neither your eligibility for, nor participation in, the Plan constitutes a contract of employment with Michaels. Your participation in the Plan does not provide you with any right to continued employment, nor does Michaels sponsorship of the Plan interfere with Michaels right to discharge any employee.