Michaels®

# *EyeMed Vision Care*

## Summary Plan Description

**July 1, 2021**

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This booklet contains general information about the Michaels Companies, Inc. Vision Plan. You must be in active, full-time status to be eligible for the benefits described in this booklet. The benefits described in this booklet are reviewed annually and are intended to be continued. However, as the Plan Sponsor, Michaels Companies, Inc. reserves the right at any time and at its discretion to amend, modify, reduce, discontinue, or terminate the plan. Participation in the plan does not constitute an employment contract. This information is a general overview only and is qualified in its entirety by plan documents. A Copy of the Plan Document is available in the office of the Plan Administrator for your inspection during regular business hours. You may also contact Human Resources to request a copy of the Plan Document. You will be charged a reasonable fee for copying costs.

# INTRODUCTION

Do you and your family need glasses or contacts? If so, then consider enrolling in the Michaels Companies, Inc. Vision Plan. This plan covers eye exams, frames, lenses, and contact lenses. And, it gives you a choice to use a provider in the EyeMed network or one outside the network. Of course, you have the option to waive vision coverage, too.

If you have any questions about the Vision Plan after reading this booklet, you may call EyeMed toll-free at 1-866-723-0513 or visit their web site at www.eyemed.com.

# ELIGIBILITY

**Full-Time Team Members**
If you are a full-time Team Member, you are eligible for coverage on the 1st of the month following 30 days. If you change from Part-Time to Full-Time status and have 30 days of service, coverage will begin on the 1st of the next month.

You become eligible for the Vision Plan once you have completed your applicable waiting period. Your waiting period will begin from your most recent full-time hire date.

**Part-Time Team Members**
Part-time Team Members are not eligible for the Vision Plan benefits.

**Eligible Dependents**

You may also enroll your eligible dependents for vision plan coverage. "Dependent" means one or more of the following:

- **A** Team Member**'s child under age 26.** "Child" means your biological child; legally adopted child (including a child who has been placed with you for adoption); a stepchild, or a foster child who is your or your Spouse's legal ward; a child placed in the custody or under the guardianship of you or your Spouse by court order. "Child" also includes a child of your Domestic Partner who is a participant in the Plan and whose child meets the definition of Dependent as defined herein. Such child may not participate in the Plan without the participation of the Domestic Partner.
- A Team Member's child age 26 or older who is incapable of self-care and who is:
    a. Unmarried; and
    b. mentally or physically incapable of sustaining his or her own living; and
    c. primarily dependent upon the Team Member for financial support.

  Such child or children must have been mentally or physically incapable of earning their own living prior to attaining the limiting age. The Plan Administrator may require written proof satisfactory to the Plan Administrator of the child's continued incapacity, andfinancial dependence.
- Your legal spouse;
- Your Domestic Partner of the same or opposite sex who:

(a) is at least age 18; and
(b) has a close personal relationship with you and are responsible for each other's welfare; and
(c) is your only Domestic Partner and intend to remain so indefinitely; and
(d) shares the same legal residence in an exclusive relationship with you for at least twelve (12) months; and
(e) is not related to you by blood, or affinity in a way that would disqualify either person from marriage under the laws of the state in which you reside; and
(f) is not married or in a domestic partnership with any other individual; and
(g) is legally competent to enter into a legal contract; and
(h) shares sufficient financial and legal obligations.

## HOW TO ENROLL

You must enroll in or decline vision coverage prior to your benefit effective date (please see *Eligibility* Section on the previous page for additional clarification). When you enroll, you choose whether to cover your spouse and/or children (your dependents). You may choose one of the following coverage levels:

- Employee only
- Employee + spouse
- Employee + child(ren)
- Employee + family

If you decline coverage for yourself or your dependents during your initial enrollment, you may enroll for coverage during a later annual enrollment period. You may also add coverage if you have a change in family status, and the addition of coverage reflects your new family situation.

As long as you enroll your new dependents within 31 days after they first become eligible, they are covered as soon as they meet the definition of "dependent." Otherwise, you must wait until the next annual enrollment period to enroll new dependents.

**If You Don't Enroll When First Eligible**
If you don't enroll or decline coverage by your enrollment deadline after you begin working as a full-time Team Member, you will have no vision coverage for the rest of that plan year. You can enroll for coverage during the next annual enrollment period.

## WHEN COVERAGE BEGINS

If you are a regular, full-time Team Member and enroll when first eligible, coverage can begin on the first of the month following your applicable waiting period (please see *Eligibility* Section on the previous page for additional clarification).

# ANNUAL ENROLLMENT PERIOD

During the annual enrollment period, you may change your vision plan elections to be effective July 1. Shortly before the annual enrollment period, you'll receive information about the coverage options being offered. Review these materials carefully and ask questions before you enroll.

Remember, once you enroll, you must keep that coverage until the next annual enrollment period, unless you experience a qualifying status change.

# MAKING CHANGES TO YOUR COVERAGE

Your benefit elections generally remain in effect for the entire plan year (July 1 – June 30). However, if you have a qualifying status change, you may be allowed to change some of your benefit choices. Any change you make must be consistent with your status change.

If you have a qualifying change in status and want to change your benefit coverage, you must notify the Michaels Benefits Department online or by completing an enrollment/change form within 60 days of the date you experience the change.

**Status Change Events**
The events that may be considered a qualifying status change include:

- Change in your legal **marital status** (such as marriage, legal separation, annulment, divorce, or death of your spouse);
- Change in the **number of dependents** (such as the birth of a child, adoption or placement for adoption, or death of a dependent);
- Change in your **employment status**, or a change in the employment status of your spouse, that affects Vision Plan eligibility (such as termination or commencement of employment, switching between part-time and full-time status, or having a reduction or increase in work hours);
- Change in your **dependent's eligibility** for benefits due to age, student status, marital status, or similar circumstance.

**Other Events**
You also can change certain coverage elections during the year for other events:

- Issue of a Qualified Medical Child Support Order that requires the addition or removal of coverage for a dependent child;
- Enrollment in (or loss of eligibility for) Medicaid or CHIP.

**Special Enrollment**
An eligible person and / or dependent may also be able to enroll during a special enrollment period. A special enrollment period applies to an eligible person and any dependents when one of the following events occurs:

- Birth;
- Legal adoption or guardianship;

- Placement for adoption;
- Marriage;
- Court or administrative order.

A special enrollment period also applies for an eligible person and / or dependent who did not enroll during the initial enrollment period or open enrollment period if the following are true:

- The eligible person and / or dependent had health coverage under another plan at the time they had an opportunity to enroll; and
- Coverage under the prior plan ends because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death);
    - The employer stopped paying contributions;
    - In the case of COBRA continuation coverage, the coverage was exhausted;
    - Loss of coverage through spouse.

A special enrollment period is **not** available to an eligible person and his or her dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

**Effective Date of Change**

- Birth or legal adoption: Coverage begins on the date of the event, provided the Plan Administrator receives the completed enrollment form and any required contribution within 60 days of the event.
- Other events, including marriage and loss of coverage under another group health plan: Coverage begins on the later of the date of the event or the first pay period beginning after the enrollment form is completed and returned to the Plan Administrator.

**Removing Dependents From Coverage**
It is your responsibility to notify the Plan Administrator as soon as possible but no later than 60 days after a spouse or dependent becomes ineligible. Until you do, your cost of coverage will stay the same. This means that deductions will still be taken from your pay, but your dependents will not have coverage because they are ineligible. Deductions will not be refunded.

# COST OF COVERAGE

You pay for your vision coverage with before-tax dollars. Before-tax dollars are deducted from your pay before federal income and Social Security taxes are withheld. When your taxable pay is less, so is your overall tax bill. State and local income taxes also may be reduced.

# WHEN COVERAGE ENDS

**Team Member Coverage**
Team Member coverage will end on the earliest of these dates

1. The date of the covered Team Member's termination of employment;
2. The date this Plan is terminated;

3. The date on which the covered Team Member ceases to be eligible under this Plan. This includes death or termination of employment of the covered Team Member.
4. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Except in certain circumstances, a covered Team Member and his/her enrolled family members may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, refer to the section entitled *Continuation of Coverage (COBRA)*.

**If You Take an Unpaid Leave of Absence**

You may continue your Vision Plan coverage during an unpaid leave of absence. To continue your coverage while out on any approved, unpaid leave of absence, you must pay the necessary funds to maintain your coverage during your absence. Upon your return to a regular pay status, automatic payroll deductions will resume for your portion of the cost.

The maximum duration of each leave of absence and the compensation and benefits you receive (if any) will be determined by Michaels. If you have completed the maximum duration of your leave of absence, you will be eligible to continue your benefit coverage through COBRA. See Section titled *Continuation of Coverage (COBRA)* for details on COBRA continuation.

**Dependent Coverage**

A dependent's coverage will terminate on the earliest of these dates:

1. The date this Plan or dependent coverage under this Plan is terminated;
2. The date the Team Member's coverage under this Plan terminates for any reason including death;
3. The date a covered spouse loses coverage due to loss of dependent status;
4. On the day that a dependent child ceases to be a dependent as defined by this Plan, unless otherwise stated;
5. The end of the period for which the required contribution has been paid.

Except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, refer to the section entitled Continuation of Coverage (COBRA).

## VISION PLAN OVERVIEW

If you enroll in the Vision Plan, you choose how you want to receive your vision care:

- You can use an Eyemed Access network provider.
- You can use a provider who does not participate in the EyeMed network.
- You can use a combination of the two.

**Vision Plan Information**
Our vision coverage is underwritten by Fidelity Security Life Insurance Company and administered by EyeMed.

To locate network providers or for more information about plan features, go to **www.eyemed.com**

Although the plan allows you to use other providers, you get the greatest benefit from using a provider who is a member of the EyeMed Access network. When they join the network, eye care practitioners agree to perform services at a reduced rate. If you use a non-EyeMed provider, you pay the full cost for any services and/or supplies you receive. You then submit a claim for reimbursement to EyeMed. You are reimbursed up to the Plan's allowed amount for the service or supply.

## HOW THE VISION PLAN WORKS

When you are ready to receive vision care – from an EyeMed network provider or other provider – here are the steps:

| | If You Use an EyeMed Network Provider | If You Use an Out-of-Network Provider |
|---|---|---|
| **Step 1** | Choose a doctor from the list of network doctors and make an appointment. Make sure you identify yourself as an EyeMed member. | Make an appointment with a doctor of your choice. You may receive services from any licensed optometrist, ophthalmologist, and/or dispensing optician. |
| **Step 2** | The EyeMed doctor contacts EyeMed to verify your eligibility and plan coverage. The EyeMed network doctor also obtains authorization so you can receive services and materials. | Pay all costs for your eye exam, eyeglasses, or contact lenses. |
| **Step 3** | Keep your appointment with the network doctor. After your eye examination, the doctor determines if eyewear is necessary. If so, the doctor can coordinate your prescription and dispense your eyewear. | To request reimbursement, complete and submit an out of network claim form, along with your itemized receipts to EyeMed. You must include your name, address, date of birth, Social Security number and group number. If the claim is for your dependent, you must also include the dependent's date of birth. |

# COVERED EXPENSES

Plan benefits vary, depending on whether you use an EyeMed network doctor or a non-EyeMed doctor. Through the network, providers are reimbursed for covered treatments at agreed-upon fees. If you use a non-EyeMed doctor, the plan reimburses only a certain amount of the costs for eye examinations and eyewear.

Covered expenses for an annual routine vision examination include:

- A determination of the need for vision correction.
- A prescription for lenses if necessary.
- Confirmation of the appropriateness of eyeglasses obtained under the prescription.
- Patient history.
- Testing the sharpness of your vision and the health and performance of your eyes through various types of examinations and measurements.

**Diabetic Eye Care Benefit**

The Vision Plan includes a special benefit for members with diabetes. Eligible members can obtain a vision evaluation every six months to detect or monitor signs of diabetic complications. Diagnostic testing, including retinal imaging, extended ophthalmoscopy, gonioscopy, and laser scanning, is available, subject to provider determination. Frequency limits may apply.

While EyeMed offers a wide choice of frames, you must ask your doctor if the frames are covered in full by the plan. You pay the difference for frames that cost more than the plan coverage or that are not offered through the plan.

# VISION PLAN HIGHLIGHTS

| Service | In-Network Benefit (You Pay) | Out-of-Network Benefit (Plan Reimburses You) |
|---|---|---|
| **Eye Exam w/ dilation as necessary** | $15 copay | Up to $40 |
| **Contact Lens Fitting & Follow-up*** | | |
| Standard# | $0 copay, paid in full fit and two follow-up visits | Up to $40 |
| Premium# | $0 copay, 10% off retail price, then $55 allowance | Up to $40 |
| **Standard Plastic Lenses** | | |
| Single Vision | $20 copay | Up to $25 |
| Bifocal | $20 copay | Up to $40 |
| Trifocal | $20 copay | Up to $65 |
| Standard Progressive | $20 copay | Up to $55 |
| Premium Progressive Lens | $20 copay plus (80% of charge less $120 allowance) | Up to $55 |
| **Frames** | $0 copay; $130 Allowance, | |
| Any Available Frame in Dispensary | 20% off balance over $130 | Up to $65 |
| **Lens Options** | | |
| UV Coating | $0 copay | $8 |
| Tint (Solid and Gradient) | $0 copay | $8 |
| Scratch-Resistance | $0 copay | $8 |
| Basic Polycarbonate - Adults | $0 copay | Up to $20 |
| Basic Polycarbonate – Kids under 19 | $0 copay | Up to $20 |
| Standard Anti-Reflective | $45 copay | N/A |
| Polarized | 20% off U&C charges | N/A |
| Other Add-Ons & Services | 20% off U&C charges | N/A |
| **Contact Lenses** | | |
| Conventional | $0 Copay; $130 allowance; 85% of retail price over $130 | Up to $104 |
| Disposables | $0 Copay; $130 allowance; 100% of retail price over $130 | Up to $104 |
| Medically Necessary | Paid in full | Up to $200 |
| **Frequency** | | |
| Examination | Once every 12 months | |
| Frames | Once every 12 months | |
| Lenses/Contact Lenses | Once every 12 months | |
| **LASIK/PRK Procedures** | 15% discount on U&C fees at LCA Vision locations or 5% discount on promotional pricing, whichever is greater | |

* Contact lens fit and two follow-up visits are available once a comprehensive exam has been completed
#" Standard Contact Lens" refers to spherical, clear lenses used in conventional wear and planned replacement. "Premium Contact Lens" refers to toric, multi-focal and other specialty fittings or lens designs.

Discount is not available on those frames where the manufacturer prohibits a discount.

Member is responsible for applicable taxes.

# PLAN LIMITATIONS AND EXCLUSIONS

Benefits are not provided for services or materials arising from:

- Orthoptic or vision training
- Subnormal vision aids and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment
- Safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any -governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses and/or contact lenses
- Non-prescription sunglasses
- Two pair of glasses in lieu of bifocals
- Services or materials provided by any other group benefit plan providing vision care Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
- Discounts not applicable to certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
- Benefits may not be combined with any discount, promotional offering, or other group benefit plans.

# CLAIMS AND APPEALS

In general, network providers handle the claims process for you. If you receive services and/or materials out-of-network, however, you will have to pay the provider and submit a claim for reimbursement.

You may authorize someone else to file and pursue a claim for benefits or an appeal on your behalf. If you do so, you must notify EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to act on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

Claims must be filed no later than 12 months from the date of service. Claims will generally be paid within 30 days of receipt. For reimbursement for out-of-network services, you must submit your claim information either online at www.eyemed.com, or to EyeMed's Claims department via mail to:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim can be completed online. Please click here. You may also print a claim form and email it to Eyemed at oonclaims@eyemed.com or call the EyeMed's Customer Care Center at **1-866-939-3633.**

Receipts for services received together must be submitted together. Receipts for services and materials purchased on different dates must be submitted together. Original copies of itemized bills may be required as proof of the claim. Canceled checks and payment receipts are not acceptable.

Separate claim forms must be submitted for each person filing a claim. All claim forms must be signed by you (the employee) and the patient if the patient is not a minor. To obtain claim forms, please go to www.eyemed.com.

Your itemized provider's bill must include:

- Your name (as the covered employee) and the name of the patient.
- The provider's name, address, Social Security or tax ID number, and telephone number.
- Codes for the diagnosis and complete description of services.
- Charges for the services received.
- The day, month, and year the service was received.

**Time Frames for Processing Claims**

Claims will be decided within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If additional time is needed to decide a claim, you will receive a written notice of the extension, which will not exceed 15 days. If additional information is needed from you to decide the claim, you will receive a written notice explaining the information needed. You

will have 45 days to provide the information. If your claim is denied, in whole or in part, you will be informed of the denial in writing.

**Expenses For Which A Third Party May Be Liable**
This plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to an injury or sickness. If anyone who receives benefits from this plan is injured and entitled to receive money from any other source, then this plan's benefits are secondary. This means that benefits will be paid only if the covered person fully cooperates with the terms and conditions of this plan.

**Payment of Benefits**
The plan generally pays all benefits to you. However, a plan may pay all or any part of any benefits directly to the person or institution on whose charge the claim is based.

The plan will pay benefits when it receives due proof that services and/or supplies have been received by a covered person.

If the plan makes an overpayment, it will have the right at any time to recover that overpayment from the person to whom it was made or offset the amount of that overpayment from a future claim payment.

**Complaint Procedure**

Although it does not happen often, occasionally disagreements about benefits arise. In most cases, they are resolved quickly and informally.

If you are dissatisfied with an EyeMed provider's quality of care, services, materials or facility or with Plan administration, you should first call EyeMed's Customer Care Center at 866-723-0513 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at

EyeMed Vision Care,
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

You may also include written comments or supporting documentation. The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

**Procedures for Appealing Claims – First Level**

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do

not receive an Explanation of Benefits (EOB) within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's first-level appeal, such as documents, records, questions or comments.

Appeals should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal and notify you in writing of its decision. Any documents that are created or received by the plan during the appeals process are available upon request. You are entitled to review all documents relevant to your appeal, including any protocols the decision-maker relied upon in denying the claim.

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# CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, requires the continuation of health benefits in certain situations where coverage would otherwise be lost.

**Who Is Eligible**

*Team Members*

If you are a Michaels Team Member, you have a right to elect COBRA coverage if you lose your group health coverage (including vision coverage) because of a loss of eligibility due to a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct.

*Dependents*

If you are covered as a spouse or child of a Team Member, you may elect COBRA for yourself if you lose your coverage because of:

- The death of the employee;
- A reduction in the employee's work hours or termination of the employee's employment for reasons other than gross misconduct;
- Divorce or legal separation; or
- The employee becoming entitled to Medicare.

In addition, a dependent child who stops being eligible as a "dependent" may be eligible for COBRA coverage.

A child born to (or placed for adoption with) the covered employee during a period of continuation coverage is also a qualified beneficiary eligible for COBRA coverage.

*Separate Elections*

Each person who is eligible for continuation of coverage has an independent right to elect. This means a spouse or dependent child may choose COBRA coverage even if you do not.

**Electing COBRA Coverage**

It is your (or your family member's) responsibility to inform Human Resources of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the event.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator. If you don't choose to continue coverage within this time period, your vision coverage will end as described in the *When Coverage Ends* Section of this Summary Plan Description without an opportunity for plan reinstatement.

Your coverage under COBRA will be identical to the coverage provided under the plan to employees or their covered dependents. This also means that if the coverage changes for employees or their covered dependents, your coverage under COBRA will also be modified.

**The Taben Group**
P.O. Box 7330
Shawnee Mission, KS, 66207

*Customer Service Contact Information:*
Access to online accounts, please visit https://taben2.webcobra.com
Telephone: 800-675-7341 8:00am to 5:00pm (Central Time)

*Written Correspondence is to be sent to:*
The Taben Group
P.O. Box 7330
Shawnee Mission, KS 66207

**How Long Coverage Will Continue**
You may continue coverage for yourself or your dependents for up to 18 months if you lose Vision Plan coverage because of a termination of employment or reduction in hours. If your dependents lose coverage because of your death, divorce, or legal separation, or you are becoming entitled to Medicare, they may continue coverage for up to 36 months.

*Additional Qualifying Event*
If an additional qualifying event (such as a death, divorce, Medicare entitlement) occurs while your COBRA coverage is in effect, the 18-month continuation period may be extended to 36 months. In no event will coverage extend beyond 36 months from the initial qualifying event. You should notify the COBRA administrator if a second qualifying event occurs during your COBRA continuation coverage period.

*Special Rules for Disability*
If you or a covered family member is disabled at any time during the first 60 days of continuation coverage, the continuation coverage period is 29 months for all family members, even those who are not disabled. "Disabled" means disabled under the Social Security Act.

To be eligible for extended COBRA coverage, you must notify the COBRA administrator within 60 days of receiving a determination of disability from the Social Security Administration or by the end of the 18-month continuation period. You must have been determined disabled within 60 days of the date of your COBRA qualifying event to be eligible for the 11-month extension.

However, if another qualifying event occurs within 18 months after termination of employment or reduction in hours, the continuation of coverage period for any covered dependent may be extended until 36 months after the termination of employment or reduction in hours.

**Cost of Continued Coverage Under COBRA**
The cost that you or your covered dependents will pay for this coverage will be the full cost to Michaels of the plan coverage you elect, plus 2% for administrative fees.

If you or a dependent is disabled when your employment ends or your hours are reduced, the cost of continued coverage is:

- The cost of the premium plus 2% during the first 18 months of coverage; and

- The cost of the premium plus 50% during the next 11 to 18 months of coverage.

The COBRA administrator must receive payments within 45 days of the date the election form is signed.

**When Coverage Under COBRA Ends**
There are certain circumstances under which this continuation coverage will end automatically. This will happen if premiums for continued COBRA coverage aren't paid in a timely manner. All payments due must be received within 45 days of the date the election form is signed. Subsequent payments are due on the first of each month and must be received within 30 days of the due date. It is the covered person's responsibility to make the payments in a timely manner.

Continued COBRA coverage ends automatically if:

- Michaels stops providing group health benefits;
- Monthly payments are not received within 30 days of the due date (or for the first payment, within 45 days of the initial election);
- The person receiving continued coverage becomes covered under another group health plan (medical, dental or vision) that doesn't exclude or limit coverage for preexisting conditions;
- The person receiving continued coverage becomes entitled to Medicare;
- The coverage has been extended for up to 29 months due to disability; or
- There has been a final determination that the individual is no longer disabled and has had 36 months of COBRA continued coverage.

# ABOUT YOUR HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify you about its policies and practices to protect the confidentiality of your health information. This section is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Michaels Vision Plan.

The plan needs to create, receive, and maintain records that contain health information about you to administer the plan and provide you with vision benefits. This section tells you the ways the plan may use and disclose health information about you, describes your rights, and the obligations the plan has regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

The plan's privacy policy and practices protect confidential health information that identifies you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

**Privacy Obligations of the Plan**
The plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the plan's legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

**How the Plan May Use and Disclose Health Information About You**
The following are the different ways the plan may use and disclose your PHI:

- **For Treatment.** The plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plan may advise an emergency room physician about the types of prescription drugs you currently take.
- **For Payment.** The plan may use and disclose your PHI so claims for health care treatment may be paid. For example, the plan may receive and maintain information about surgery you received so that the plan can process the hospital's claim for reimbursement of your surgical expenses.
- **For Health Care Operations.** The plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plan's participants receive their benefits. For example, the plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plan may also combine health information about many plan participants and disclose it to Michaels in summary fashion so it can decide what coverages the plan should provide. The plan may remove information that identifies you from health information disclosed to Michaels so it may be used without Michaels learning who the specific participants are.

- **To Michaels.** The plan may disclose your PHI to designated Michaels personnel so they can carry out their plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Plan Administrator and/or the members of the Michaels Benefits Department. These individuals will protect the privacy of your health information and ensure it is used only as described here or as permitted by law. Unless authorized by you in writing, your health information:
  - may not be disclosed by the plan to any other Michaels Team Member or department; and
  - will not be used by the Michaels for any employment-related actions and decisions, or in connection with any other employee benefit plan sponsored by Michaels.
- **To a Business Associate.** Certain services are provided to the plan by third party administrators known as "business associates." For example, the plan may input information about your health care treatment into an electronic claims processing system maintained by the plan's business associate so your claim may be paid. In so doing, the plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the plan will require its business associates, through contract, to appropriately safeguard your health information.
- **Treatment Alternatives.** The plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** The plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **Individual Involved in Your Care or Payment of Your Care**. The plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital) or death.
- **As Required By Law**. The plan will disclose your PHI when required to do so by federal, state, or local law – including those that require the reporting of certain types of wounds or physical injuries.

**Special Use and Disclosure Situations**

The plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
- **Law Enforcement.** The plan may release your PHI if asked to do so by a law enforcement official. For example, they may use this information to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description or location of the person who committed the crime.
- **Workers' Compensation.** The plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and/or other similar programs.
- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the plan may release medical information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety**. The plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- **Public Health Risks.** The plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medication or problems with medical products; or notifying people of recalls of products they have been using.
- **Health Oversight Activities.** The plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research.** Under certain circumstances, the plan may use and disclose your PHI for medical research purposes.
- **National Security, Intelligence Activities, and Protective Services**. The plan may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. It can also be released to enable federal officials to provide protection to the members of the U.S. government, foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** If you are an organ donor, the plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funerals Directors**. The plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

**Your Rights Regarding Health Information About You**
Your rights regarding the health information the plan maintains about you are as follows:

- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

  To inspect and copy health information maintained by the plan, submit your request in writing to the Plan Administrator. The plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- **Right to Amend.** If you feel that health information the plan has about you is incorrect or incomplete, you may ask the plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the plan.

  To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide reasons to support your request. The Plan Administrator may deny your request if you ask to amend health information that was not created by the plan, not part of the health information kept by the plan, or not information that you would be permitted to inspect and copy.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the plan has made to others, except for those necessary to carry out health care treatment, payment or operations; disclosures made to you; or in certain other situations.

  To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the plan not use or disclose information about a surgery you had.

  Make your request for restrictions in writing to the Plan Administrator. You must state what information you want to limit, to whom you want the limits to apply, and whether you want to limit the plan's use, disclosure or both.

  **Note:** ***The plan is not required to agree to your request.***

- **Right to Request Confidential Communications**. You have the right to request that the plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

  To request confidential communications, make your request in writing to the Plan Administrator. The plan will attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Changes to This Notice**
The plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the plan already has about you, as well as any information the plan receives in the future. The plan will post a copy of the current notice on your company provided intranet system.

**Complaints**
If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

***Note: You will not be penalized or retaliated against for filing a complaint.***

**Other Uses and Disclosures of Health Information**
Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plan will be made only with your written authorization. If you authorize the plan to use or disclose your PHI, you may revoke the authorization in writing at any time. If you revoke your authorization, the plan will no longer use or disclosure your PHI for the reasons covered by your written authorization. However, the plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

**Contact Information**
If you have any questions about this notice, please contact:

Michaels Companies, Inc.
Director of Benefits
3939 W John Carpenter Fwy
Irving, TX 75063
972-409-1300

# ADMINISTRATIVE INFORMATION

**Plan Legal Document**
The Vision Plan described in this booklet is governed by a legal plan document. If the wording in this booklet and the wording of the legal documents disagree, the legal document will control in all instances. Also, you and your beneficiaries should not rely on any oral description of the plan, because the written terms of the plan will always govern.

You may obtain a copy of the plan document upon written request to:

Michaels Companies, Inc.
Director of Benefits
3939 W John Carpenter Fwy
Irving, TX 75063
972-409-1300

**Plan Sponsor, Administrator, and Agent for Service of Legal Process**
Michaels sponsors the Vision Plan. You may contact Human Resources or EyeMed with any questions you may have about this plan.

Legal process may be served at this address:

Michaels Companies, Inc.
Director of Benefits
3939 W John Carpenter Fwy
Irving, TX 75063
972-409-1300

**Changes to the Plan**
Although Michaels intends to continue the Vision Plan described in this booklet indefinitely, Michaels reserves the sole and absolute right to alter, amend, suspend, or terminate the plan at any time and for any reason.

If material changes are made to the plan, you will be notified about them in the time and manner as required by federal law. In the unlikely event that Michaels suspends or terminates the plan, you will receive more information about your rights.

**Interpreting the Plans**
The Plan Administrator and EyeMed have the sole and absolute discretionary authority to interpret and construe the plan's provisions. This authority includes the responsibility to determine all discretionary matters that arise in the operation and administration of the plan. Any action or decision taken on any matter within the jurisdiction of the Plan Administrator or EyeMed is final, conclusive, and binding on all parties.

**Plan Identification Information and Funding**

*Plan Name*
Michaels Companies Inc. Employee Benefit Plan

*Michaels Employer Tax Identification Number*
75-1943604

*Plan Number*
501

*Plan Year*
July 1 – June 31

*Plan Type*
Group health plan

*Plan Funding*
Fully insured

*Claims Administrator*
EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

# YOUR RIGHTS UNDER ERISA

As a participant in the Vision Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

**Receive Information About Your Plan and Benefits**
You are entitled to:

- Examine, without charge, all documents governing the plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor. The Form 5500 may also be obtained from the Public Disclosure Room of the Pension and Welfare Benefit Administration. You are entitled to examine these documents at the Plan Administrator's office and at other specified locations, such as worksites and union halls.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan. These include insurance contracts, the latest annual report (Form 5500), and the updated summary plan description. The 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 with a copy of this summary annual report.

**Continue Group Health Plan Coverage**
You are entitled to:

- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. It is important to review this summary plan description and the documents governing the plan regarding the rules for exercising 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 employee benefit plan. The people who operate your plan are called "fiduciaries," and they 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 benefit or exercising your rights under ERISA.

**Enforce Your Rights**
If your claim for a benefit is denied or ignored, you are entitled to:

- Know why this was done,
- Obtain copies of documents relating to the decision without charge, and

- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps that you can take to enforce your rights. For example, you may file suit in Federal court if:

- You request a copy of plan documents or the latest annual report (Form 5500) and do not receive them within 30 days. 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 they were not sent for reasons beyond the control of the administrator.
- You have a claim for benefits which is denied or ignored, in whole or in part. You may also file suit in state court.
- You disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order.
- The plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. For example, 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. This could occur if the court finds your claim 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 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, which is listed in your telephone directory.

You may also contact:

Division of Technical Assistance & Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210.
1-866-444-EBSA (3272)

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For electronic inquiries, you may write to the Employee Benefits Security Administration at http://www.askebsa.dol.gov