THE MICHAELS COMPANIES

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Important Legal Information

Required Health Coverage Notices

The notices included in this brochure are being provided to you as required by federal law. This packet contains important benefits information, so please read it carefully and keep it where you can find it. If you have any questions regarding the notices, please use the contact information listed for that notice.

For Your Files

This brochure contains several legal notices that are required to be distributed to participants in group health plans sponsored by Michaels Stores, Inc.

The notices included in this brochure are:

- **Notice of Privacy Practices Regarding Your Medical Information –** explains how the Michaels health plans protect your personal medical information
- **Wellness Program and Reasonable Alternatives Notice –** this informs Team Members of what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential, as well as options for those who have a medical condition that makes wellness program participation difficult
- **Notice of Special Enrollment Rights** – explains when you can enroll in the plan due to special circumstances
- **60-Day Special Enrollment Period** – describes a special 60-day timeframe to elect or discontinue coverage
- **Newborn & Mothers Health Protection Notice –** describes federal laws that govern benefits for hospital stays for mothers following the birth of child
- **Women's Health and Cancer Rights Act –** summarizes the benefits available under Michaels health plans if you have had or are going to have a mastectomy
- **COBRA Rights Notice –** explains when you and your family may be able to temporarily continue coverage under Michaels health plan if coverage would otherwise end for you
- **Medicare Part D Notice** – provides information about how your current prescription drug coverage under Michaels Stores, Inc. health care plans is affected – and your options for coverage – when you become eligible for Medicare
- **Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP) –** provides information about how your state may help pay for medical coverage if you or your children are eligible for Medicaid or CHIP

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see page 10 for more details.

NOTICE OF PRIVACY PRACTICES REGARDING YOUR MEDICAL INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their protected health information ("PHI"). "PHI" means individually identifiable health information, including demographic and genetic information, that relates to your past, present, or future physical or mental health or condition; related health care services; and payment for health care services.

This document is intended to satisfy HIPAA's notice requirement with respect to PHI created, received, or maintained by the Medical, Prescription Drug, Dental, Vision, and/or Health Care Flexible Spending Account plans (collectively, the "Plans") sponsored by Michaels Stores, Inc. (the "Company").

The Plans need to create, receive, and maintain records that contain PHI for administration and to provide you with health care benefits. This notice tells you the ways the Plans may use and disclose PHI, describes your rights, and the obligations the Plans have regarding the use and disclosure of PHI. However, it does not address the privacy policies or practices of your health care providers.

This notice is a joint notice for the Plans listed above. Each plan agrees to abide by the terms of this notice with respect to your PHI. The Plans, other group health plans sponsored by the Company, and each of the insurance companies and HMOs that those group health plans may contract with, are part of an "organized health care arrangement" or "OHCA." Members of an OHCA may share PHI with each other to carry out treatment, payment, or health care operations relating to the OHCA.

Privacy Obligations of the Plans
The Plans are required by law to:

- Make sure that your PHI is kept private;
- Give you this notice of the Plans' legal duties and privacy practices with respect to PHI;
- Notify affected individuals after a breach of unsecured PHI;
- Follow the terms of the notice that is currently in effect; and
- Communicate to you any future changes to this notice.

Uses and Disclosures of PHI without Your Authorization
The following categories describe uses and disclosures of your PHI that may be made without your authorization. Not every use or disclosure in a category is listed. However, all the ways the Plans are permitted to use or disclose PHI will fall within one of the categories:

- **For Treatment.** The Plans do not provide medical treatment directly, but they may use or disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, if you are unable to provide your medical history as the result of an accident, the Plans may advise an emergency room physician about the types of prescription drugs you currently take.
- **For Payment.** The Plans may use or disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plans' terms. This includes activities the Plans undertake before approving or paying for the health care services recommended for you, such as determining eligibility for benefits, reviewing medical necessity, undertaking utilization review activities, and coordination of benefits with other coverage that you may have. For example, the Plans may receive and maintain information about surgery you received to enable the Plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf. The Plans may also disclose your PHI to a health care provider or another health plan for that provider or plan's payment activities.
- **For Health Care Operations.** The Plans may use or disclose your PHI for the Plans' operations, such as underwriting, conducting quality assessment and improvement activities, evaluating provider performance, and case management and care coordination. For example, the Plans may use your PHI to contact you or your doctor with information about treatment alternatives. In addition, the Plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plans will not use or disclose PHI that is genetic information for any purpose related to underwriting. Underwriting purposes includes eligibility for or determination of benefits under the Plans and coverage or cost changes in return for activities, such as completing a health risk assessment or participating in a wellness program. The Plans may also disclose your PHI to your health care provider or another health plan with which you have a relationship for certain health care operations (for example, quality assessment or case management) of that provider or plan.
- **To the Company.** The Plans may disclose your PHI to designated Company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Your PHI will not be used by the Company for any employment-related actions and decisions or in connection with any other Team Member benefit plan sponsored by the Company.
- **To Business Associates.** The Plans may disclose your PHI to certain third parties that provide services to the Plans, which are known as "business associates." For example, the Plans may input information about your health care treatment into an electronic claims processing system maintained by the Plans' business associate so your claim may be paid. In so doing, the Plans will disclose your PHI to their business associate so it can perform its claims payment function. However, the Plans will require their business associates, through contract, to appropriately safeguard your PHI.
- **To Individuals Involved in Your Care or Payment of Your Care.** The Plans may disclose limited PHI to your close friend or family member who is involved in or helps pay for your health care, unless you object or request a restriction as described in the "Right to Request Restrictions" paragraph below). The Plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death. If you are not present or able to agree to these disclosures, then, using professional judgment, the Plans may make this disclosure if it is in your best interests.

- **To You or Your Personal Representative.** The Plans will disclose to you or your personal representative most of your PHI when you request access to this information. The Plans will disclose your PHI to an individual who has been designated by you as your personal representative or who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plans must be given written documentation that supports and establishes the basis for the personal representation. The Plans may elect not to treat the person as your personal representative if the Plans have a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person or treating such person as your personal representative could endanger you, and the Plans determine, in the exercise of professional judgment, that it is not in your best interest to treat the person as your personal representative.
- **To the Secretary of the U.S. Department of Health and Human Services.** The Plans are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plans' compliance with the HIPAA privacy rule.
- **As Required by Law.** The Plans may use or 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.
- **Lawsuits and Disputes.** The Plans 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 Plans may disclose your PHI to a law enforcement official in response to a request that is made through a court order, subpoena, warrant, summons, or similar process. For example, the Plans may disclose PHI to a law enforcement official 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 Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.
- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plans may use or disclose your PHI as deemed necessary by military command authorities, provided that certain requirements are met.
- **To Avert Serious Threat to Health or Safety.** The Plans may use or 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 Plans may use or disclose PHI for public heath activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Abuse, Neglect, or Domestic Violence.** Except for reports of child abuse described under "Public Health Risks" above, the Plans may disclose PHI about an individual reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority if required by another law.
- **Health Oversight Activities.** The Plans 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 Plans may use or disclose your PHI for research purposes.
- **National Security, Intelligence Activities, and Protective Services.** The Plans may use or disclose your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** The Plans may disclose PHI 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 Funeral Directors.** The Plans may disclose 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 Plans may also disclose your PHI to a funeral director, as necessary, to carry out his/her duty.

Uses and Disclosures of PHI that Require Your Authorization
The following categories describe uses and disclosures of your PHI that require your authorization:

- **Psychotherapy Notes.** The Plans must obtain an authorization for any use or disclosure of your psychotherapy notes, except: (1) to carry out the following treatment, payment, or health care operations: use by the originator of the psychotherapy notes for treatment; use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual; and (2) a use or disclosure that is: required by the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plans' compliance with the HIPAA privacy rule; permitted by law; for health oversight with respect to the oversight of the originator of the psychotherapy notes; to a coroner or medical examiner for the purpose of identifying a decedent; or to avert a serious threat to health or safety.
- **Marketing.** The Plans must obtain an authorization for the use or disclosure of your PHI that is used for marketing purposes, unless the communication is face-to-face or is a small, promotional gift. If the marketing involves financial remuneration to the Plans from a third party, the authorization must state that such remuneration is involved.
- **Sale of PHI.** The Plans must obtain an authorization for any disclosure that is a sale of PHI. Such authorization must state that the disclosure will result in remuneration to the Plans.
- **Other Uses and Disclosures.** Other uses and disclosures of PHI not covered by this notice will be made only with your written authorization or that of your personal representative. If the Plans are authorized to use or disclose PHI about you, you or your personal representative may revoke that authorization, in writing, at any time, except to the extent that action has already been taken in reliance on the authorization.

Your Rights Regarding Your PHI
Your rights regarding the PHI the Plans maintain about you are as follows:

- **Right to Inspect and Copy.** In most cases, you have the right to inspect and copy your PHI that is in a "designated record set," which 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 Plans, submit your request in writing to the Contact Person described at the end of this notice. The Plans may charge a fee for the cost of

copying and/or mailing your request. In limited circumstances, the Plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to PHI, you may request a review of the denial.

- **Right to Amend.** If you feel that your PHI is incorrect or incomplete, you may ask the Plans to amend PHI that is in a "designated record set." You have the right to request an amendment for as long as the information is kept by or for the Plans. To request an amendment, send a detailed request in writing to the Contact Person described at the end of this notice. You must provide the reason(s) to support your request. The Plans may deny your request if you ask the Plans to amend PHI that is accurate and complete, not created by the Plans, not part of the health information kept by or for the Plans, 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 Plans have 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 Contact Person described at the end of this notice. 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 PHI the Plans use or disclosures about you for treatment, payment, or health care operations; and disclosures 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 Plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Contact Person described at the end of this notice. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. The Plans are not required to agree to your request unless the disclosure is for the Plans' payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service that has been paid for in full by you or another person (other than the Plans) on your behalf.
- **Right to Request Confidential Communications.** You have the right to request that the Plans communicate with you about PHI in a certain way or at a certain location. For example, you can ask that the Plans 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 Contact Person described at the end of this notice. Your request must specify how or where you wish to be contacted.
- **Right to be Notified of a Breach.** You have the right to be notified if we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice, even if you have previously agreed to receive the notice electronically. You may write to the Contact Person described at the end of this notice to request a written copy of this notice at any time.

Changes to this Notice

The Plans are required to abide by the terms of this notice currently in effect, however, the Plans reserve the right to change this notice at any time and to make the revised notice effective for PHI the Plans already have about you, as well as any information the Plans receive in the future. The Plans will post a copy of the current notice online at **www.MIKBenefits.com** at all times. You may receive a copy of any revised notice by mail or by email.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed below can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Contact Person

To exercise any of the rights described in this notice, to file a complaint, or if you have any questions about this notice, please contact:

Director of Benefits
Michaels Stores, Inc.
3939 W John Carpenter Fwy
Irving, TX 75063
The phone number is: (972) 409-1300

Notice Effective Date: July 1, 2023

Notice of Reasonable Alternatives to Wellness Program Participation

Michaels Stores, Inc.' Wellness Program is a voluntary wellness program available to all Full-Time Team Members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve Team Member health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the Wellness Program you will be asked to complete an age-appropriate routine physical examination and biometric screening with your primary care physician. The biometric screening will include a blood test for cholesterol and glucose levels. The results from your biometric screening and examination will help you understand your current health and potential risks and may also be used to offer you services through the Wellness Program.

You are not required to participate in the blood test or other medical examinations. However, Team Members and enrolled spouses/domestic partners who choose to participate and complete the required activities of the Wellness Program will avoid a medical plan contribution surcharge of $25 per person, per paycheck for the 2023/2024 plan year. Team Members can avoid a separate $25 per person, per paycheck surcharge in 2023 by being tobacco-free or completing a tobacco cessation program. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Team Member Services at 1-855-432-MIKE (6453).

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program and Michaels may use aggregate information to design a program based on identified health risks in the workplace, the Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your doctor, Aetna and USWellness in order to confirm your participation in the Wellness Program.

In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Michaels medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 60 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Michaels medical coverage as long as you request enrollment by contacting Team Member Services no more than60 days after the marriage, birth, adoption or placement for adoption. For more information, contact Team Member Services at 1-855- 432-MIKE (6453).

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery. ***However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).***

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Team Member Services at 1-855-432-MIKE (6453) or your medical plan administrator.

COBRA RIGHTS NOTICE

THIS NOTICE EXPLAINS COBRA CONTINUATION COVERAGE, WHEN IT MAY BECOME AVAILABLE TO YOU AND YOUR FAMILY AND WHAT YOU NEED TO DO TO PROTECT THE RIGHT TO RECEIVE IT.

You're receiving this notice because you have recently become eligible for coverage under Michaels Stores, Inc. group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Summary Plan Description or contact Team Member Services at 1-855-432-MIKE (6453).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group Plan coverage when coverage would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're a Team Member, you'll become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of a Team Member, you'll become a qualified beneficiary if you lost your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Team Member dies;
- The parent-Team Member's hours of employment are reduced;
- The parent-Team Member's employment ends for any reason other than his or her gross misconduct;
- The parent-Team Member becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event occurred.

Michaels will notify the COBRA Administrator of the following qualifying events:

- Your hours of employment are reduced;
- Your employment ends;
- Your death; or
- Your entitlement to Medicare benefits (under Part A, Part B or both).

You Must Give Notice of Some Qualifying Events

For the following qualifying events, you or a family member must notify Michaels within 60 days after the qualifying event occurs:

- Your divorce or legal separation; or
- Your dependent's loss of eligibility for coverage as a "dependent child."

You must notify Michaels of the qualifying event by calling Team Member Services at 1-855-432-MIKE (6453).

How Is COBRA Coverage Provided?

Once Michaels receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

- Your death;
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

When the qualifying event is your reduction in hours or your termination of employment and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare eight months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for you and your family up to a total of 29 months at a higher premium if:

- You, your covered spouse or your covered dependents (including newborn and newly adopted children) are determined to be disabled, as defined by the Social Security Act, prior to the qualifying event or during the first 60 days of COBRA coverage;
- The Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
- The disability lasts at least until the end of the 18-month period of continuation coverage; and
- The COBRA Administrator is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify the COBRA Administrator within the first 60 days of COBRA coverage.

You, your covered spouse or your covered dependents must notify the COBRA Administrator within 60 days of receipt of the disability determination and prior to the end of the initial 18- month continuation period in order to receive the coverage extension. To notify the COBRA Administrator of the disability determination, call 1-800-675-7341.

You, your covered spouse or your covered dependents must notify the COBRA Administrator within 30 days of the date the disability ends by calling 1-800-675-7341.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

You, your covered spouse or your covered dependents must notify the COBRA Administrator within 60 days after the event occurs in order to receive this

additional coverage. To notify the COBRA Administrator of the qualifying event, call 1-800-675-7341.

Events That May Change Continued Coverage

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules if you experience a qualified change in status. You, your covered spouse or your covered dependents must notify the COBRA Administrator within 60 days of the qualified change in status to change your COBRA coverage. See your Summary Plan Description for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered Team Member or placed for adoption with the covered Team Member during the 18-, 29- or 36-month continuation period. In such case, you must notify the COBRA Administrator within 60 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage

COBRA coverage will end automatically upon the expiration of the 18-, 29- or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

- Michaels stops providing group health benefits;
- Premiums are not paid within 30 days of the due date (except for the initial premium which is due within 45 days of your election date); or
- A person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable pre-existing condition clause) or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18-, 29- or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the Plan.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Date: July 2023
Name of Entity/Sender: Michaels Stores, Inc.
Contact: Team Member Services
Address: 3939 W John Carpenter Fwy, Irving, TX 75063
Phone: 1-855-432-MIKE (6453)

Important Notice from Michaels Stores, Inc.
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Michaels Stores, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Michaels Stores, Inc. has determined that the prescription drug coverage offered by Michaels Stores, Inc. Team Member Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Michaels coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Michaels coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Michaels and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage.

Contact the Benefits Department at the phone number shown below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Michaels Stores, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov,** or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	July 2023
Name of Entity/Sender:	Michaels Stores, Inc.
Contact/Office:	Benefits Department
Address:	3939 W John Carpenter Fwy, Irving, TX 75063
Phone Number:	(972) 409-1300

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)