Flexible Spending Accounts

Summary Plan Description

JOANN

This summary plan description is the formal summary plan description as required by ERISA for the Healthcare Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan. This summary plan description, along with the Jo-Ann Stores, LLC Benefits Plan, also constitutes the formal plan document for these plans. In the event of a discrepancy between the benefits plan and this document, the terms of the summary plan description will control.

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A Flexible Spending Account (FSA) is a valued benefit that can increase the purchasing power of your income. By participating in an FSA, you are setting aside a pre-determined amount of money, on a pre-tax basis, that you can use to reimburse yourself for eligible expenses that you incur throughout the Plan Year. There are two types of FSAs -- a Healthcare FSA and a Dependent Care FSA. Examples of eligible expenses for a Healthcare FSA include:

- Your annual Medical, Prescription, Dental and Vision Plans' deductibles,
- Your out-of-pocket maximums,
- Your copays and/or coinsurance amounts,
- Your prescription drug costs, and
- Your pharmacy-related costs (non-prescription Healthcare items).

Eligible expenses for a Dependent Care FSA include expenses you incur for the care of your dependent to allow you to work outside the home.

Money that you set aside in these reimbursement accounts is not subject to Federal Income, State or Social Security Taxes.

BENEFITS RESOURCES & TOOLS

Benefit Plan	Carrier	Tool/Resource/Key Services	Contact Information
Flexible Spending Account (FSA)	**WEX Health, Inc.**	**Customer Service:** • Questions about the Healthcare and Dependent Care FSAs • Process claims **FSA Online Information:** • Print new claim form • Access detailed claims and payment history	WEX Health, Inc. P.O. Box 2926 Fargo, ND 58108 866-451-3399 Phone 866-451-3245 Fax www.wexinc.com
COBRA	**WEX Health, Inc.**	Continuing Healthcare Flexible Spending Account coverage after coverage would otherwise end	WEX Health, Inc. P.O. Box 2926 Fargo, ND 58108 866-451-3399 Phone 866-451-3245 Fax

Benefits Group Hotline

For questions about your JOANN Benefits, enrollment and coverage, contact the Benefits Department at 866-396-HR4U (4748) or joannstoresbendept@joann.com.

ELIGIBILITY

Your Eligibility

To participate in an FSA Plan, you must:

1. Be an active Team Member, and

2. Be classified as full-time, and

3. Have completed at least 30 days of full-time service.

Effective Date of Participation

If you satisfy the eligibility requirements described above, your participation under the FSA Plans is effective on the first day of the first full 14-day pay period following the 30-day waiting period, provided you enroll during the required timeframe, as explained in the "*Enrolling to Participate*" section below.

Rehires

If you terminate employment and are later rehired as a JOANN Team Member, your eligibility for coverage is as follows:

- If you are rehired as an eligible Team Member within 30 days of termination, your benefits will be reinstated to the bi-weekly deduction taken prior to termination, effective as of your rehire date. (Your annual election will be reduced by the deductions you missed during your absence. Note that expenses you incur during your absence are not eligible for reimbursement.) You must notify the Benefits Department within 14 days from your rehire date to reinstate coverage effective on your rehire date.
- If you are rehired as an eligible Team Member after more than 30 days of termination, you must satisfy the eligibility requirements again and make a new election. (That is, your participation generally begins after the 30-day waiting period and the effective date of participation will be on the first day of the first full 14-day pay period following the 30-day waiting period after your rehire date, if you timely enroll.)

Part-Time/Full-Time Changes

- If your status changes from part-time to full-time, your participation is effective on is effective on the first day of the first full 14-day pay period following the 30-day waiting period.
- If your status changes from full-time to part-time, your participation will end immediately (but you may be able to continue your benefits under COBRA, as explained later). If you return to full-time employment within 30 days of the part-time date, you must notify the Benefits Department within 14 days to reinstate participation effective as of the date you return to full-time status.
- If your status changes from full-time to part-time and then back to full-time after 30 days from the part-time date, your participation is effective on is effective on the first day of the first full 14-day pay period following the 30-day waiting period.

Team Members Not Eligible to Participate

Persons classified as part-time, Casual, or are employed by Jo-Ann Trading (Shanghai) Co., LTD are not eligible to participate in the FSAs. Persons classified as contract and/or leased Team Members are also not eligible to participate in the FSAs, even if they are determined by a court or governmental agency to be, or have been, common law Team Members of JOANN.

Layoffs

- If your employment as a full-time member ends due to your being laid off, your benefits will end on the last day of the month in which you are laid off.
- If you are recalled to active full-time status, your benefits will be reinstated effective with your recall date. Note: If you are reinstated after an enrollment period, you will be given the opportunity to make elections consistent with the enrollment offerings.
- If you are laid off and then recalled and have had coverage cancelled due to non-payment of premiums while on layoff, coverage will be reinstated effective with your recall date.

Note: If you are/were on a voluntary layoff, special arrangements may apply. Please refer to the Voluntary Layoff Leave Agreement.

ENROLLING TO PARTICIPATE

What Do You Need To Do?

All benefit enrollments for eligible Team Members are completed online through Ally. Ally is available 24/7 from the JOANN Gateway or by downloading the Workday app on your mobile device.

Plan Year Open Enrollment
Each year JOANN holds a Benefit Open Enrollment with respect to coverage for the following plan year (February 1 - January 31). If you are an eligible Team Member, you can re-enroll or change your plan elections during this time by accessing the Open Enrollment link through your Ally inbox. You will need to upload any proof of dependency forms or other required documentation. Elections you make during Open Enrollment are effective as of the following February 1st. Your deductions will be adjusted to reflect the cost of coverage for the next year.

New Hire
New enrollment is completed through Ally's New Hire Enrollment link. New enrollment must be completed within 14 days of your hire date for full-time Team Members. You will need to upload any proof of dependency forms or other required documentation. Provided you enroll for your coverage within 14 days of your hire date, coverage will begin on the first day of the first full 14-day pay period following the 30-day waiting period.

Full Time Enrollment
If your status changed from part-time to full-time, and you are not already eligible as a Team Member or an ACA Eligible Team Member, you will enroll for benefits through Ally's Full-Time Enrollment link within 14 days of your full-time status. You will need to upload any proof of dependency forms or other required documentation. Provided you enroll for coverage within 14 days, your coverage will begin is effective on the first day of the first full 14-day pay period following the 30-day waiting period day of full-time status.

Coverage Limitations
If you do not enroll when you are first eligible to participate in the Plan, you will not be able to enroll in the plan until the next plan year Open Enrollment period, unless you have a change in status (see below).

Changing Your Contribution

Because your contributions to the FSAs are made on a pre-tax basis, Federal laws generally require your elections to remain in effect for the entire Plan Year (February 1 - January 31). You may not change your elections mid-year unless you have a change in status (see below) and your election change is consistent with the event.

If you have one of the events described below, you need to complete the following action items within 31 days of the event:

- Contact the Benefits Department at 1-866-396-HR4U (4748)
- Submit required documentation

Provided you make your election change within 31 days of the event, your new election will be effective on the date of the event. If you don't meet the 31-day deadline, you can't make a coverage change until the next Plan Year enrollment period, unless you once again meet one of the conditions for changing your coverage during the year.

Note that, unless you are adding coverage on account of the birth, adoption, or fostering of a child, your premiums for any retroactive periods of coverage (i.e., the period from the date of your event to the date of your election change) will be paid on an after-tax basis.

Under any one of the following circumstances, you may enroll for/change your coverage during the year:

1. If you experience a "**Change in Status**" that affects your, your spouse/domestic partner's, or your dependent's eligibility (proof of lost or new coverage is required) such as:
   - You get married, divorced or legally separated or have your marriage annulled;
   - You have a baby, adopt, and have a child placed with you for adoption, fostering or your spouse/domestic partner or dependent dies;
   - You, your spouse/domestic partner, or your dependent starts or ends employment;
   - Your, your spouse/domestic partner's, or your dependent's work schedule changes (a switch from part-time to full-time employment and vice versa, a strike or lockout, or the start of or return from an unpaid leave of absence); or
   - Your, your spouse/domestic partner's, or your dependent's work location changes (this applies only if it affects the Healthcare FSA plan available to you).
2. If the Plan receives a court order, such as a **Qualified Medical Child Support Order (QMCSO)**;
3. For the Dependent Care FSA only, if there is a significant **change in cost** (as long as the provider is not related to you); or
4. For the Dependent Care FSA only, if the change is consistent with **another employer's plan** with a different annual enrollment period than this Plan.

Changes will be administered in accordance with IRS regulations and guidance.

COST FOR PARTICIPATION

The cost for FSA participation is paid entirely by you. Your contributions are paid with before-tax dollars that can reduce your taxable income because these contributions are not included in your taxable pay. That means you pay less in Federal income tax, Social Security, and, in some cases, state taxes, which may allow you to use the income reduction to pay for your out-of-pocket expenses. The amount of savings will differ for each Team Member, depending on family income, the amount of the contribution, tax rate, etc.

The chart below shows the tax implications of your Healthcare and Dependent Care FSAs.

Benefit	Pre-Tax Deduction	Exempt from Federal Tax	Exempt from FICA Tax	Exempt from Most State Tax
Healthcare FSA	Yes	Yes	Yes	Yes, except NJ
Dependent Care FSA	Yes	Yes	Yes	Yes, except NJ & PA

Annual Contributions

Annual Contribution Limits

Flexible Spending Accounts	Minimum Contribution	Maximum Contribution
Healthcare FSA	$250 per year	$3,050 per year
Dependent Care FSA	$250 per year	$5,000 per year*

*Highly compensated employees may be limited to a lesser amount per Plan Year.

Payroll Deductions

Your election through Ally authorizes a payroll deduction for the contribution amounts you elected. Your annual contribution will automatically be divided equally over the number of pay periods during the Plan Year.

Contributions While on Leave of Absence

While you are on any type of leave of absence, your contributions to the Plan will continue to be deducted from your pay or disability benefits for up to 26 weeks. This benefit will be cancelled after 26 weeks if the Team Member does not return to work. If you do not have sufficient payroll checks during your leave, you are on a workers' compensation leave of absence, are on a personal leave and/or reside in a state that provides a state benefit; you are responsible for continuing any contributions that would normally have come out of your payroll check. A letter will be sent to your address on file explaining how to make payments. If you do not make your contributions payments, your participation in the plan may be suspended and/or cancelled.

If you leave your job to enter military service, you may continue your participation in accordance with the provisions under the Uniformed Services Employment and Reemployment Rights Act, as amended. You may continue your coverage for the lesser of:

- 24 months from the date your civilian employment ended; or
- The end of the period allowed for you to apply for reemployment.

The actual length of time for measuring these periods may vary depending on when you entered military duty and the length of time you've been in service.

You may be responsible for paying up to 102% of the cost of participation under the plan. If your military service is less than 31 days, you'll only be responsible for the regular Team Member share of the cost. For more information on military leaves, contact the Disability Department at 866-396-HR4U (4748).

WHEN COVERAGE BEGINS

Generally, Plan coverage becomes effective on the date following:

- The first day of the month of the new Plan Year (typically February 1st) for the elections you made during the previous open enrollment period; or
- If you were hired after an open enrollment period, the first day of the 14-day pay period following the 30-day waiting period, provided you enroll in the required timeframe.

HOW THE FLEXIBLE SPENDING ACCOUNTS WORK

Your election to participate in an FSA is for the entire Plan Year and you cannot elect to increase/decrease contributions or discontinue your participation unless you have an event that permits a mid-year change, as explained in the *"Enrolling to Participate"* section in this Summary Plan Description. Once your enrollment in a Healthcare FSA has been processed, you will receive a Letter of Confirmation directly from the COBRA/FSA Administrator. This letter will verify your Plan election.

There are two options to choose from:

1. Healthcare Flexible Spending Account (Healthcare FSA)
2. Dependent Care Flexible Spending Account (Dependent Care FSA)

The annual amount that you elect to contribute is credited to a bookkeeping account designated for your use in submitting eligible expenses. Please note that the Healthcare FSA and the Dependent Care FSA are separate accounts, and you cannot reimburse dependent care expenses from the Healthcare FSA or medical expenses from the Dependent Care FSA.

The money you set aside for the FSA is reimbursed to you upon submission of proper documentation. Both the Healthcare FSA and the Dependent Care FSA are "use-it or lose-it" plans. This means that if you elect to contribute an amount in excess of the eligible charges you are able to claim, you forfeit those dollars. If you contribute dollars to a FSA and do not use all of the money, you will lose any remaining balance in the account at the end of the Plan Year.

Plan carefully and only contribute those dollars that you are confident you will use to pay for eligible expenses incurred during the Plan Year. You may not transfer funds from one FSA to the other FSA during the Plan Year.

Healthcare Flexible Spending Account

You may elect to set aside a minimum annual contribution amount of $250 or a maximum of $3,050, divided equally by the number of pay periods during the Plan Year. Once you begin to incur charges for you or your eligible dependents' health care needs (i.e., deductibles, coinsurance, hearing aids, contact lenses, etc.), you have three reimbursement methods available to you. Please see the Reimbursement Methods section for details.

You will be reimbursed under the Healthcare FSA for the total amount of an expense, even if you have not funded your account completely through payroll deduction. For example, you elect to participate in the Healthcare FSA for an annual contribution of $1,000. As of March 1st, you have only contributed $200 but your expense is $500. You will be reimbursed the entire $500. We will continue deducting the bi-weekly amount from your pay for the balance of the Plan Year.

Healthcare FSA Reimbursement

Under the Healthcare FSA, you are reimbursed for eligible expenses up to the total amount of your annual election at any time during the Plan Year. You do NOT need to wait until your annual contribution has been made in total before submitting receipts under the Healthcare FSA**.**

Eligible and Ineligible Expenses

Reimbursable expenses include those expenses incurred by you, your spouse/domestic partner or eligible dependents (as defined below) for any of the categories explained below. The items must be for medical care as defined under Section 213(d) of the Internal Revenue Code, and not merely to advance your good health. Receipts from a place of purchase must include evidence of the medicine and/or drug name.

Some examples of expenses not eligible for reimbursement through Healthcare FSA include toiletries, elective cosmetic surgery and your bi-weekly premiums for health care . To be eligible for reimbursement from your Healthcare FSA for a Plan Year, the expense must be incurred during that year. For purposes of this Plan, an expense is incurred when services are rendered or items purchased, not when you pay for the service or item.

For a comprehensive list of reimbursable expenses please visit the FSA Administrators website located on the Benefits Resources & Tools page at the beginning of this document.

Dependents

As noted above, you may also submit your eligible dependents' medical expenses for reimbursement.

For purposes of the Healthcare FSA, your eligible dependents include your:

- Legal spouse (provided you are not legally separated or divorced);
- Children under age 26 including:
  - Natural children;
  - Adopted children;
  - Foster children;
  - Stepchildren; and
  - Children for whom you are the legal guardian, provided they depend solely on you for their support and are living in your home;
- For information regarding domestic partner coverage refer to the Domestic Partner Supplement within the Ally Benefits icon.

Dependents are not eligible for participation if they:

- Are a common law spouse, unless added to the plan under the domestic partner provision; or
- Are serving active duty in the military or armed forces of any country; or
- Live outside the United States or Canada, unless a Qualified Medical Child Support Order (QMCSO) states otherwise; or
- Are covered under the Plan as Team Members.

Dependent Care Flexible Spending Account (Dependent Care FSA)

You may elect to set aside a minimum annual contribution amount of $250 or a maximum of $5,000*, divided equally by the number of pay periods in the Plan Year. Once you begin to incur charges for the care of your eligible dependents (i.e., childcare) you will need to submit a Dependent Care Verification Form and receipts to the plan Administrator located on their website. You will be reimbursed under the Dependent Care FSA, but only up to the amount that you have actually put into your account.

Under the Dependent Care FSA rules, a maximum limit of $2,500 is imposed for married participants filing separate IRS returns. If your spouse/domestic partner is a full-time student or incapacitated, the maximum annual election is $3,000 for one child or $6,000 for two or more children.

**Highly compensated employees may be limited to a lesser amount per Plan Year.*

Example:

- On February 1 you elect to participate in the Dependent Care FSA and wish to make an annual contribution of $1,200.
- Your child (under the age of 13) attends an after-school program for $75 per week.
- During the month of March you have paid out $300 in childcare costs.

- You may submit your receipts to the Plan. They will reimburse you $200 in March because that is how much you have funded in your account year to date.
- As you continue to have deductions withheld from your paycheck, the Plan will issue the reimbursements to you until you have been reimbursed for the $300 claim.

For purposes of a Dependent Care FSA, an eligible dependent means:

- Your dependent (as defined in Section 152(a)(1) of the Internal Revenue Code) under the age of 13; or
- Your dependent (as defined under Section 152 of the Code) or spouse/domestic partner who is physically or mentally incapable of caring for himself/herself and has the same principal place of residence as you for more than one-half of the taxable year.

Eligible and Ineligible Expenses

For purposes of the Dependent Care FSA, eligible expenses are those expenses that are incurred during the Plan Year which enable you and/or your spouse/domestic partner to work or to look for work.

- These services may be performed in your home or outside of your home for an eligible dependent or any other qualifying individual who resides at least eight hours per day in your home. If the expenses are incurred for services provided by a dependent care center (i.e., facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.
- If the expenses are incurred for services provided by an individual who is related to you, please contact the Plan Administrator PRIOR to making your contribution election regarding special Federal regulations that apply.

Some examples of eligible dependent care expenses include babysitters, day care centers, nanny, before and after school care or extended day programs, day camp, and elder care. Common expenses not eligible for reimbursement include overnight camp, kindergarten and school lunches, activity fees or travel expenses. For a comprehensive list of reimbursable expenses, please visit the FSA Administrators website found on the Benefits Resources & Tools page located at the beginning of this document.

Dependent Tax Credit

Some Team Members may qualify for the household and dependent care tax credit offered by the IRS. If you qualify, you will need to compare whether the Tax Credit or the Dependent Care FSA will give you the greater tax advantage. You cannot use both. To determine whether the household and dependent care tax credit or the Dependent Care FSA is better for you, consult a professional tax advisor.

Healthcare FSA/Dependent Care FSA Worksheet

Annual Healthcare Expenses	
Health Insurance Deductibles	**$**
Coinsurance costs	**$**
Vision Care (contacts, eyeglasses, contact solutions)	**$**
Prescription Drug Coinsurance Costs	**$**
Prescription Medicines	**$**
Medically Required Equipment	**$**
Dental Expenses	**$**
Total Healthcare FSA	**$**

Annual Dependent Care Expenses	
Babysitter, Day Care Center, After-School Care	**$**
Elder Care	**$**
Total Dependent Care FSA	**$**

REIMBURSEMENT METHODS

Receiving reimbursement under an FSA is easy. There are three methods by which you may receive reimbursement:

1. Pay Me Back: Submit a claim form for expenses already incurred by mail, fax, online or Smartphone
2. Pay by Benefits Debit Card: Use your card for swipe and go convenience at the time of expense, i.e. copays and eligible OTC expenses.
3. Pay My Provider: Make an online payment for an expense directly to a provider

Claims submitted for reimbursement must have been incurred during the plan year enrolled. For example, if your claim date of service is November 16, 2021 and you are not enrolled in an FSA for the plan year February 1, 2021 through January 31, 2022, you may not submit the claim for reimbursement in that plan year. Nor would it be eligible for reimbursement during any other plan year, even if you enrolled in an FSA for another plan year. Some exceptions exist for orthodontia and maternity. Regardless of the method used for reimbursement, as you or your eligible dependents incur services, retain a copy of the receipts or proof of services as these are required by the IRS.

Submit Your Claims by April 30

You will have 3 months following the end of the Plan Year (no later than April 30) to submit claims for services rendered.

Pay Me Back

You may submit a claim by using one of four methods: mail, fax, online, or Smartphone.

You may complete a Reimbursement Form and attach copies of your receipts, Explanation of Benefit (EOB) Statements or other documentation indicating date(s) of service and amount being claimed. This completed form should be sent to the address located at the end of this document under Administrative Information.
You may also fax your claim.

If you fax your claim, do not mail it. Before sending any information, make a copy for your records. After claim approval and processing, you will receive a check from the FSA Administrator. Your reimbursement check will reflect your current account activity, including payroll deposits, submitted claims and disbursements.

You may also file a claim online by logging onto the FSA Administrator website. Select and complete the online claim form, and scan receipts, EOBs and other supporting documentation by using the upload utility. Claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

The Plan Administrators mobile application may also be used to file a claim from your Smartphone.

Benefits Debit Card

You may use an electronic payment card to pay for eligible expenses through your Healthcare FSA or Dependent Care FSA at the point of service. Keep in mind that the following rules apply with respect to your use of the card:

Electronic Payment Card Terms of Usage:
The Electronic Payment Card allows you to pay for eligible expenses at the time that you incur the expense. Here is how the card works.

(a) You must make an election to use the card. In order to be eligible for the card, you must agree to abide by the terms and conditions of the program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. A Cardholder Agreement will be provided to you. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) The Card will be turned off when employment or coverage terminates. The Card will be turned off when you terminate employment or coverage under the Plan. You may not use the Card during any applicable COBRA continuation coverage period.

(c) You must certify proper use of the Card. As specified in the Cardholder Agreement, you certify during the applicable election period that the amounts in your Healthcare or Dependent Care FSA will only be used for eligible expenses, that you have not been reimbursed for the expense, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of Card use privileges.

(d) Reimbursement under the Card is limited to certain merchants. Use of the Card for eligible medical expenses is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. The Card will be administered in accordance with applicable IRS guidance.

(e) You swipe the Card at the merchant like you do any other credit or debit card. When you incur an eligible medical expense at an eligible merchant, such as a copayment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the available balance on the card. If the expense exceeds the available balance, the expense will not be processed. Every time you swipe the Card, you certify to the Plan that the expense for which payment under the Healthcare FSA is being made is an eligible medical expense, that you have not been reimbursed from any other source and you will not seek reimbursement from another source.

(f) You must obtain and retain a receipt/third party statement each time you swipe the Card. You must obtain a third party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the Card:

- The nature of the expense (e.g., what type of service or treatment was provided);
- If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred; and
- The amount of the expense.

You should retain this receipt for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the Card arrangement, a written third party statement is generally required to be submitted (except as otherwise set forth in the applicable law and/or related guidance). You will receive a letter from the Third Party Administrator that a third party statement is needed. You must provide the third party statement to the Third Party Administrator within 45 days (or such longer period provided in the letter from the Third Party Administrator) of the request. In accordance with applicable guidance, there may be situations in which the Third Party Administrator does not ask for substantiation related to a Card swipe.

(g) You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Third Party Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the Card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible

medical expenses. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement) or the remaining unpaid amount may be treated by the Employer as any other bad debt, which will result in additional gross income for you.

Pay My Provider

To pay a provider, log in to your FSA account. Click either the Healthcare or Dependent Care tab. Request "Pay My Provider" from the menu and follow the instructions. The Administrator of the FSA will send a check directly from your account. However, you must still provide documentation.

If you have any questions pertaining to your FSAs, please contact the Administrator of the plan listed on the Administrative Information sheet located at the end of this document.

If a Claim is Denied

When disagreements arise, every effort is made to resolve them quickly and informally. However, if that isn't possible, formal procedures have been developed so you can appeal the decision.

If your claim is denied, in whole or part, you are entitled to a review of the denial. Within 180 days of receiving the denial, you or your representative may:

- Submit a written request to the Plan Administrator for a review of the denial;
- Look at relevant documents; and
- Submit issues and comments in writing.

You have the right to designate a representative (e.g. your Physician) to file an appeal on your behalf and to represent you in the appeal. If your representative is seeking an appeal on your behalf, the Plan Administrator must obtain a signed Designation of Representation form from you before processing your appeal. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records and other information relevant to your appeal.

Your claim will be reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. You will receive notice of the decision on your appeal within 30 days after the Plan receives your request for an appeal. The notice will explain:

- The reasons for the denial;
- The Plan provisions on which it is based;
- Your right to bring an action under ERISA;
- If the determination is based on an internal rule, guideline, protocol or other similar criterion, either a copy of the specific internal rule, guideline, protocol or criterion will be provided or a statement will be included that says that the internal rule, guideline, protocol or criterion was relied on in making the determination and that a copy of the internal rule, guideline, protocol or criterion will be provided free of charge upon request; and

- If the determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, that applies the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request will be included.

If you are dissatisfied with the initial appeal decision, you may request that your claim be reviewed by a panel of the Administrator's staff members. Your request must be made within 60 days of the date you receive the determination on the initial appeal. You will receive notice of the decision of the panel on your appeal within 30 days after the Plan receives your request for an appeal. You must exhaust these claims and appeal procedures before you may file a lawsuit in court.

WHEN PARTICIPATION ENDS

Your participation in the FSAs will end at the earliest of:

- The last day you work as a JOANN Team Member;
- The date you are no longer eligible for coverage (if, for example, you become a part-time Team Member);
- The Effective Date of your election to drop coverage; (e.g., if you elect to cease coverage during open enrollment period, your coverage will end on January 31st.)
- The date you stop making required contributions;
- Your retirement date;
- The date the Plan ends;
- The Effective Date of any amendment affecting your eligibility for coverage;
- The date of your death;
- The last day of the month in which you are laid-off;
- At the expiration of 26 weeks on any approved leave of absence;
- The date you fail to timely return from any approved leave of absence or leave of absence permitted by law, or the date you give notice to JOANN that you do not intend to return from an approved leave of absence;
- End of Plan Year if you do not re-enroll in the FSA during the annual open enrollment (You will not be eligible to continue coverage through COBRA); or
- The date you or a family member makes any misrepresentation to the Plan or fraudulently submits a claim for benefits under the Plan. Or, if earlier, the date coverage would have ended or not given effect but for the misrepresentation.

In some cases, coverage may be continued as described in the "COBRA" section of this Summary Plan Description.

Note that if the last contribution withheld from your pay is for a payroll period extending after an above event (other than the last bullet), your coverage will extend to the end of that payroll period. This may occur, for example, where there are administrative delays in processing your termination of employment. If your participation ends, you may continue to submit claims for reimbursement for services rendered prior to the date your participation ends. You will have the same claim filing timeframe as an active participant. You must file any claims for reimbursement within 90 days of the end of the Plan Year in which your participation ends.

COBRA

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply only to the Healthcare FSA.

If you have any questions after reading this material, please contact the Benefits Department. COBRA continuation coverage is administered by the COBRA Administrator listed on the Administrative Information page at the end of this document.

When Coverage May Be Continued

If you are a participant in the Healthcare FSA, then you generally have a right to choose continuation coverage under the Healthcare FSA if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct)

If you are the spouse/domestic partner of a participant, then you generally have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of the participant;
- A voluntary or involuntary termination of the participant's employment (for reasons other than gross misconduct) or reduction in your spouse/domestic partner's hours of employment; or
- The divorce or legal separation from the participant.

In the case of a dependent child of a participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the participant;
- A voluntary or involuntary termination of the participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events." Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries." A child who is born to, or placed for adoption with, the participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Healthcare FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse/domestic partner) must notify the COBRA Administrator identified above in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse/domestic partner is treated as notice to any covered dependents who reside with the spouse/domestic partner. An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Healthcare FSA if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage as a result of a Qualifying Event or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified above. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Healthcare FSA until the end of the Plan Year in which the Qualifying Event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The first day of the month for which you failed to make a timely and complete premium payment (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan after you have elected COBRA continuation coverage;
- The date that you first become entitled to Medicare after you have elected COBRA continuation coverage; or
- The date the Employer no longer provides group health coverage to any of its employees.

Other COBRA Information

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) 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 the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy of any documentation that you send to the Plan Administrator.

ADMINISTRATIVE INFORMATION

General administrative information for the Company's FSA Plans can be found here.

Plan Sponsor and Administrator	The Plans described in this Summary Plan Description are sponsored by: Jo-Ann Stores, LLC 5555 Darrow Road Hudson, OH 44236 Attn: Human Resources 866-396-4748 Additional copies may be requested by the participant and/or beneficiaries by writing to the above address.
Affiliated Employers	Affiliated employers may also adopt these Plans with the consent of Jo-Ann Stores, LLC. A complete list of current affiliated employers adopting the Plans is available from the plan administrator.
Plan Type and Year	The official Plan names are the Jo-Ann Stores, LLC Healthcare Flexible Spending Account Plan and the Jo-Ann Stores, LLC Dependent Care Flexible Spending Account Plan. These are part of the Jo-Ann Stores, LLC Benefits Plan. **Plan Year:** Plan records are kept on a Plan Year basis, which is February 1 through January 31.
Claims Administrator	All FSA claims are administered by WEX. WEX Health, Inc. Claims P.O. Box 2926 Fargo, ND 58108 866-451-3399
Agent for Service of Legal Process	The agent for service of legal process is: Jo-Ann Stores, LLC 5555 Darrow Road Hudson, OH 44236 Attn: Manager, Benefits & Compensation 866-396-4748
ERISA Rights	As a participant in the Healthcare FSA, you have certain rights and protections. For more information on those rights and protections, refer to the "*Your ERISA Rights"* section of this Summary Plan Description.

YOUR ERISA RIGHTS

As a participant in certain benefits programs, like the Healthcare FSA (but not the Dependent Care FSA), 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 Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description(s). 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.

Continuation of Group Health Plan Coverage

Continuation of health care coverage for yourself, spouse/domestic partner and dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing 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, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and all 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 welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a

copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the administrator's control.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, then you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20220. You may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-275-7922.