WILLIAMS-SONOMA, INC.

Benefits for a

Health-Full Life

Your 2025-2026 Benefits

Legal Notices

This insert contains several notices that are required to be distributed annually to participants in the Group Health Plans sponsored by Williams-Sonoma, Inc. (WSI). Please refer to your 2025–2026 Benefits Guide and Summary Plan Descriptions (SPDs) for more information about your benefits, including other required notices.

For Your Files

Please keep these notices with your other information. If you have any questions about the notices, contact the WSI Benefits Resource Center at 800.413.1444, option 1, Monday through Friday, 7 a.m. to 4 p.m. Pacific time, except on certain holidays.

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 are not eligible for Medicaid or CHIP, you will not 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 on the following pages, 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 **877.KIDSNOW** or visit **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 **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 March 17, 2025. Contact your state for more information on eligibility.

ALABAMA – MEDICAID

myalhipp.com | 855.692.5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
myakhipp.com | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: health.alaska.gov/en/services/division-of-public-assistance-services/apply-for-medicaid/

ARKANSAS – MEDICAID

myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
dhcs.ca.gov/hipp | 916.445.8322
hipp@dhcs.ca.gov | Fax: 916-440-5676

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

healthfirstcolorado.com
Health First Colorado Member Contact Center:
800.221.3943/ State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 800.359.1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): mycohibi.com/
HIBI Customer Service: 855.692.6442

FLORIDA – MEDICAID

flmedicaidtplrecovery.com/
877.357.3268

GEORGIA – MEDICAID

HIPP
medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, press 1
CHIPRA
medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, press 2

INDIANA – MEDICAID

HIPP/All other Medicaid
in.gov/medicaid/
800-457-4584
Family and Social Services Administration
in.gov/fssa/dfr/
800-403-0864

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid
hhs.iowa.gov/programs/welcome-iowa-medicaid | 800.338.8366
Hawki
hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
800.257.8563
HIPP
hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp | 888.346.9562

KANSAS – MEDICAID

kancare.ks.gov | 800.792.4884
HIPP: 800.967.4660

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328
KIHIPP.PROGRAM@ky.gov
KCHIP
kynect.ky.gov
877.524.4718
Medicaid
chfs.ky.gov/agencies/dms/Pages/default.aspx

LOUISIANA – MEDICAID

medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or
855.618.5488 (LaHIPP)

MAINE – MEDICAID

Enrollment
mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine Relay 711
Private Health Insurance Premium
maine.gov/dhhs/ofi/applications-forms
800.977.6740 | TTY: Maine Relay 711

MASSACHUSETTS – MEDICAID AND CHIP

mass.gov/masshealth/pa
800.862.4840 TTY: 711
masspremassistance@accenture.com

MINNESOTA – MEDICAID

mn.gov/dhs/health-care-coverage/
800.657.3672

MISSOURI – MEDICAID

dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – MEDICAID

dphhs.mt.gov/
MontanaHealthcarePrograms/HIPP
800.694.3084 | HHSHIPPProgram@mt.gov

NEBRASKA – MEDICAID

ACCESSNebraska.ne.gov | 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – MEDICAID

dhcfp.nv.gov | 800.992.0900

NEW HAMPSHIRE – MEDICAID

dhhs.nh.gov/programs-services/medicaid/
health-insurance-premium-program
800.852.3345, Ext. 5218 or 603.271.5218
DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – MEDICAID AND CHIP

Medicaid
state.nj.us/humanservices/dmahs/clients/
medicaid | 800.356.1561
CHIP Premium Assistance
609.631.2392
CHIP
njfamilycare.org/index.html
800.701.0710 TTY: 711

NEW YORK – MEDICAID

health.ny.gov/health_care/medicaid
800.541.2831

NORTH CAROLINA – MEDICAID

medicaid.ncdhhs.gov | 919.855.4100

NORTH DAKOTA – MEDICAID

hhs.nd.gov/healthcare | 866.614.6005

OKLAHOMA – MEDICAID AND CHIP

insureoklahoma.org | 888.365.3742

OREGON – MEDICAID AND CHIP

healthcare.oregon.gov/Pages/index.aspx
800.699.9075

PENNSYLVANIA – MEDICAID & CHIP

Medicaid
pa.gov/en/services/dhs/apply-for-
medicaid-health-insurance-premium-
payment-program-hipp.html
800.692.7462
CHIP
dhs.pa.gov/CHIP/Pages/CHIP.aspx
800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP

eohhs.ri.gov | 855.697.4347 or
401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

scdhhs.gov | 888.549.0820

SOUTH DAKOTA – MEDICAID

dss.sd.gov | 888.828.0059

TEXAS – MEDICAID

hhs.texas.gov/services/financial/health-
insurance-premium-payment-hipp-
program | 800.440.0493

UTAH – MEDICAID AND CHIP

UPP
medicaid.utah.gov/upp/
Email: upp@utah.gov | 888-222-2542
Adult Expansion
medicaid.utah.gov/expansion/
Medicaid Buyout
medicaid.utah.gov/buyout-program/
CHIP
chip.utah.gov

VERMONT – MEDICAID

dvha.vermont.gov/members/medicaid/
hipp-program | 800.250.8427

VIRGINIA – MEDICAID AND CHIP

coverva.dmas.virginia.gov/learn/premium-
assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-
assistance/health-insurance-premium-
payment-hipp-programs | 833.522.5582

WASHINGTON – MEDICAID

hca.wa.gov | 800.562.3022

WEST VIRGINIA – MEDICAID & CHIP

Medicaid
dhhr.wv.gov/bms | 304-558-1700
CHIP
mywvhipp.com | 855.MyWVHIPP
(855.699.8447)

WISCONSIN – MEDICAID AND CHIP

dhs.wisconsin.gov/badgercareplus/index.htm
800.362.3002

WYOMING – MEDICAID

health.wyo.gov/healthcarefin/medicaid/
programs-and-eligibility
307.777.7531

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
cms.hhs.gov
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)

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. The WSI Medical Care Program provides coverage for certain breast reconstructive benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis
- Physical complication at all stages of mastectomies, including lymphedema

Such coverage is subject to all of the terms of the plans, including relevant deductible and coinsurance provisions. If you would like more information on WSI benefits, call the WSI Benefits Resource Center at 800.413.1444, option 1.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, 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 section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WSI MEDICAL CARE PROGRAM

When an inpatient admission is precertified, a length of stay is assigned. The Medical Care Program is required to provide a minimum length of stay in a hospital facility for the following:

Maternity Care

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by C-section

If you require a longer stay than was first precertified, your provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Mental Health Parity and Addiction Equity Act of 2008

In accordance with the Mental Health Parity and Addiction Equity Act of 2008, mental health care coverage provided by the WSI medical plans is generally comparable to coverage available for other medical care. Deductibles, copays, out-of-pocket maximums, and treatment limitations for mental health or substance use disorders must be no more restrictive than the same requirements or benefits offered for other medical care.

Upon request, the insurance company will explain the criteria used to make medical necessity determinations regarding mental health or substance abuse disorder benefits. In the event a claim for mental health or substance abuse disorder benefits is denied, you will receive an explanation for the denial from the insurance company. If you have questions, contact the WSI Benefits Resource Center at 800.413.1444, option 1.

Notice of Special Enrollment Rights

If you decline enrollment in WSI's medical coverage for you or your dependents (including your spouse/same gender domestic partner or common-law spouse as defined by state law; in California only, your opposite sex domestic partner is also eligible) because you already have other coverage, you may in the future be able to enroll yourself or your dependents in the WSI Group Health Plan as long as you request enrollment no more than 31 days after your other coverage ends. 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 the WSI Group Health Plan as long as you request enrollment by contacting the WSI Benefits Resource Center at 800.413.1444, option 1, no more than 31 days after the marriage, birth, adoption or placement for adoption.

You may also be able to enroll yourself and your dependents in the WSI Group Health Plan if (1) you or your dependents lose coverage under a state Medicaid or Children's Health Insurance Program (CHIP), or (2) you or your dependents become eligible for premium assistance under state Medicaid or CHIP, as long as you request enrollment no more than 60 days from the date of the Medicaid/CHIP event. For more information, contact the WSI Benefits Resource Center at 800.413.1444, option 1.

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

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.

1. WSI'S GROUP HEALTH PLAN

This Notice describes the privacy practices of the WSI Group Health Plan (the "Plan"). The Plan provides health benefits to eligible associates of WSI and their eligible dependents.

2. OUR PLEDGE REGARDING MEDICAL INFORMATION

WSI has always been committed to keeping our associates' personal information confidential. The Plan is required by federal and applicable state law to protect the privacy of individually identifiable health information (including genetic information) about you that the Plan creates or receives (your "Protected Health Information") and to provide you with this Notice of its legal duties and privacy practices. When the Plan uses or discloses your Protected Health Information, it is required to abide by the terms of this Notice (or any other notice in effect at the time of the use or disclosure).

3. USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

The Plan may use and disclose to others your Protected Health Information without your written authorization for the following purposes. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes.

A. Treatment. The Plan may disclose your Protected Health Information to your health care provider for its provision, coordination or management of your health care and related services – for example, for managing your health care with the Plan or for referring you to another provider for care.

B. Payment. The Plan may use and disclose your Protected Health Information to obtain payment for your coverage and to determine and fulfill the Plan's responsibility to provide health benefits – for example, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. The Plan also may disclose your Protected Health Information to another health plan or a health care provider for its payment activities – for example, for the other health plan to determine your eligibility or coverage or for the health care provider to obtain payment for health care services provided to you.

C. Health Care Operations. The Plan may use and disclose your Protected Health Information for its health care operations – for example, disease management, medical review, quality assessment and improvement activities. The Plan also may disclose your Protected Health Information to another health plan or a health care provider that has or had a relationship with you for it to conduct quality assessment and improvement activities; accreditation, certification, licensing, or credentialing activities; or for the purpose of health care fraud and abuse detection or compliance – for example, for the other health plan to perform case management or evaluate health care provider performance, or for the health care provider to evaluate the outcomes of treatments or conduct training programs to improve health care skills. As part of WSI's Wellness Program, Plan vendors share health information. These disclosures are permitted under HIPAA as health care operations. Notwithstanding the foregoing, the Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

D. To Comply with the Law. The Plan may use and disclose your Protected Health Information to the extent required to comply with applicable law.

E. Disclosures to WSI. The Plan may disclose your Protected Health Information to certain associates or other individuals under the control of WSI as necessary for it to carry out WSI's responsibilities to administer Plan payment and health care operations activities. The Plan documents identify by position the specific associates or other individuals under the control of WSI who are authorized to have access to or receive your Protected Health Information for the purpose of administering the Plan. WSI cannot use your Protected Health Information obtained from the Plan for any employment-related actions without your authorization. However, health information derived from other sources, for example, in connection with an application for disability benefits, workers' compensation, life insurance, and accidental death and dismemberment insurance, or a leave qualifying under the Family and Medical Leave Act, is not protected by HIPAA. If WSI obtains your health information in a way that is unrelated to the Plan, this Notice will not apply to that health information, but WSI will safeguard that information in accordance with other applicable laws and WSI policies.

F. Business Associates. The Plan contracts with various service providers, called business associates, to perform plan administration functions on its behalf. The Plan's business associates will receive, create, use and disclose your Protected Health Information, but only after the business associates have agreed in writing to appropriately safeguard and keep confidential your Protected Health Information.

G. Marketing Communications. The Plan may use and disclose your Protected Health Information to communicate face-to-face with you to encourage you to purchase or use a product or service that is not part of the health benefits provided by the Plan, or to provide a promotional gift of nominal value to you. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you.

H. Public Health Activities. The Plan may disclose your Protected Health Information for the following public health activities and purposes: (1) to report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury, or disability; (2) to report child abuse or neglect to a government authority that is authorized by law to receive such reports; (3) to report information about a product or activity under the jurisdiction of the U.S. Food and Drug Administration to a person who has responsibility for activities related to the quality, safety, or effectiveness of such FDA-regulated product or activity; and (4) to alert a person who may have been exposed to a communicable disease if the Plan is authorized by law to give such notice.

I. Health Oversight Activities. The Plan may disclose your Protected Health Information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs for which health information is necessary for determining compliance.

J. Judicial and Administrative Proceedings. The Plan may disclose your Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

K. Law Enforcement Officials. The Plan may disclose your Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order or other process authorized by law.

L. Health or Safety. The Plan may disclose your Protected Health Information to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.

M. Specialized Government Functions. The Plan may disclose your Protected Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

N. Workers' Compensation. The Plan may disclose your Protected Health Information as necessary to comply with workers' compensation laws.

O. Disclosures to Family Members and Friends. The Plan may disclose Protected Health Information to your family members, close friends or other persons involved in your health care if you are present and do not object to the disclosure (or if it can be inferred that you do not object), or, if you are not present or are unable to object due to incapacity or emergency, and the disclosure is in your best interest. Disclosure will be limited to Protected Health Information that is directly relevant to the person's involvement in your health care.

4. USES AND DISCLOSURES WITH YOUR WRITTEN AUTHORIZATION

The Plan may use or disclose to others your Protected Health Information for a purpose other than the purposes described in Section 3 above, only when you give the Plan your authorization on the Plan's authorization form. Most uses and disclosures of psychotherapy notes, uses and disclosures of your Protected Health Information for marketing purposes and disclosures that constitute a sale of your Protected Health Information require your authorization under the HIPAA privacy rules. You may revoke your authorization, except to the extent the Plan has taken action in reliance on it, by delivering a written revocation statement to the Plan's Privacy Officer identified below.

5. YOUR INDIVIDUAL RIGHTS

A. Right to Request Additional Restrictions. You may request restrictions on the Plan's use and disclosure of your Protected Health Information for payment and health care operations in addition to those explained in this Notice. While the Plan will consider all requests for additional restrictions carefully, it is not required to agree to a requested restriction. If a participant requests a restriction on the disclosure of their Protected Health Information to another health plan, the Plan is required to approve the request if (1) the disclosure is being made for payment or health care operations reasons and (2) the restricted Protected Health Information pertains solely to a health care item or service provided by a health care provider who has been paid out-of-pocket in full (in other words, the Plan has not paid for any part of the item or service). If a participant wants to request additional restrictions, please obtain a request form from the Privacy Officer and submit the completed form to the Privacy Officer. You will be given a written response.

B. Right to Receive Confidential Communications. The Plan will accommodate any reasonable request for you to receive your Protected Health Information by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. Please note that in certain situations, such as eligibility and enrollment information, the Plan is obliged to communicate directly with the associate rather than a dependent unless the request clearly states that disclosure of that information to the associate could endanger you.

C. Right to Inspect and Copy Your Protected Health Information. You may request access to the Plan's records that contain your Protected Health Information in order to inspect and request copies of the records. To the extent that Protected Health Information is maintained in an electronic health record, participants may request that the Plan provide a copy to the participant or to a person or entity designated by the participant in an electronic format. Under limited circumstances, the Plan may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Officer and submit the completed form to the Privacy Officer. If you request copies, the Plan will charge you applicable copying and mailing costs.

D. Right to Amend Your Records. You have the right to request that the Plan amend your Protected Health Information maintained in the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Plan and any other records used by or for the Plan to make decisions about individuals. To make such a request, please obtain an amendment request form from the Privacy Officer and submit the completed form to the Privacy Officer. The Plan will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

   The Plan may deny your request for an amendment if it does not include a reason to support the request or if the Plan believes that the information is accurate as is. In addition, the Plan may deny your request if you ask to amend information that was created by another health care organization, but the Plan will inform you of the source of that information if known.

E. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by the Plan, excluding disclosures made earlier than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, the Plan will charge you a reasonable fee for the second and any subsequent accounting statements. The accounting will not include disclosures of your Protected Health Information made in accordance with federal law; to carry out treatment, payment or health care operations activities; to you; pursuant to your written authorization; for national security or intelligence purposes; or to correctional institutions or law enforcement officials.

F. Right to Receive a Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such Notice electronically.

G. Personal Representatives. You may exercise your rights through a personal representative who will be required by the Plan to produce evidence of their authority to act on your behalf. Proof of authority may be made, for example, by a notarized power of attorney or a court order of appointment of the person as your legal guardian or conservator. The Plan reserves the right to deny access to your personal representative.

H. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that the Plan has violated your privacy rights or disagree with a decision that the Plan made about access to your Protected Health Information, you may contact the Plan's Privacy Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you if you file a complaint.

6. EFFECTIVE DATE AND DURATION OF THIS NOTICE

A. Effective Date: This Notice is effective on April 1, 2025.

B. Right to Change Terms of this Notice. WSI may change the terms of this Notice at any time. If WSI changes this Notice, the new notice will be effective for all of your Protected Health Information that it maintains, including any information created or received prior to issuing the new notice. If WSI changes this Notice, a new notice will be sent to you if you are covered by the Plan. You also may obtain any new notice by contacting the Privacy Officer.

C. Limitation on Application of Notice. This Notice does not apply to information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the Plan may use or disclose "summary health information" to WSI for its purposes of obtaining premium bids or modifying, amending or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses or types of claims experienced by individuals for whom WSI provides benefits under the Plan and from which the individual identifying information, except for five-digit ZIP codes, has been deleted. The Plan and WSI also may use or disclose eligibility and enrollment information without your authorization.

7. KEEP THE PLAN INFORMED OF ADDRESS CHANGES

A participant should keep the Plan informed of any changes in their address and the addresses of their covered family members. In the event that a participant's Protected Health Information has been breached, the Plan will notify the participant at their address on record.

8. PRIVACY OFFICER

You may contact the Privacy Officer at:

Privacy Officer
Teresa Joyce
VP, Technology
William-Sonoma, Inc.
100 North Point
San Francisco, CA 94133
tjoyce3@wsgc.com

Patient Protection Disclosure

The Kaiser Permanente HMO offered by WSI generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the selected network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, Kaiser will designate one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, refer to the plan issuer contact information below.

You do not need prior authorization from Kaiser or any person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the selected network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to the plan issuer contact information below.

KAISER PERMANENTE HMO

800.464.4000 (California)
800.632.9700 (Colorado)
888.865.5813 (Georgia)
800.777.7902 (Mid Atlantic States)
800.813.2000 (Northwest)
888.901.4636 (Washington)
kp.org

ADA Notice Regarding Wellness Program

The Williams-Sonoma, Inc., Wellness Program is a voluntary wellness program available to all benefits-eligible associates, spouses/same-sex domestic partners or in California only, same-sex and opposite-sex domestic partners (as required by law) enrolled in Williams-Sonoma, Inc. sponsored medical coverage. This program is administered according to federal rules permitting such employer-sponsored programs, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA) and the Health Insurance Portability and Accountability Act (HIPAA), among others.

If you choose to participate in the Williams-Sonoma, Inc., Wellness Program, you will be asked to complete two voluntary activities that generate confidential information:

- A health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and
- A biometric screening, which includes a blood test for total cholesterol, HDL, LDL, triglycerides, TC/HDL ratio, and glucose, and testing for blood pressure, height and weight to calculate body mass index (BMI) and waist circumference.

You are not required to complete these steps. However, only associates enrolled in Williams-Sonoma, Inc. sponsored medical coverage will receive an incentive of up to $75 for completion of a biometric screening.

Additional incentives of up to $100 may be available for associates enrolled in Williams-Sonoma, Inc. sponsored medical coverage that complete a preventive screening conducted by the provider. Spouses/partners (as required by law) enrolled in Williams-Sonoma, Inc. sponsored medical coverage will receive $50 for a preventive screening.

Under the ADA, 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 such an accommodation by contacting the WSI Benefits Resource Center at 800.413.1444, option 1.

You will receive a confidential report based on your HRA and biometric screening results that will help you understand your current health and potential risks. We are required by law to maintain the privacy and security of your personally identifiable health information.

Williams-Sonoma, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace. Williams-Sonoma, Inc.'s Wellness Program will never disclose any of your personal information, either publicly or to the employer, except as necessary to respond to your request for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Your health information will never be used to make discriminatory 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. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in this program or receiving an incentive. The entities who will receive your personally identifiable health information include Cigna, Kaiser Permanente, Delta Dental, VSP, HMSA and MCS. All these organizations will provide you with services under the wellness program to help you improve your health and/or prevent disease. Our wellness providers who receive your information also will abide by the same confidentiality requirements.

In addition, all medical information obtained through this program will be maintained separate from your personnel records, electronic information will be encrypted and no information you provide as part of a wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach. Should a data breach involving information you provide in connection with the wellness program occur, we will notify you immediately. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, contact the WSI Benefits Department at **benefitsdept@wsgc.com**.

DEPENDING ON THE NATURE OF YOUR QUESTION, CONTACT ONE OF THE FOLLOWING PARTIES:

- Call your health plan or your health care provider (i.e., hospital, physician) for questions about your medical history or claims.
- Call the WSI Benefits Resource Center at 800.413.1444, option 1. Representatives are available Monday through Friday, 7 a.m. to 4 p.m. Pacific time, except on certain holidays.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

California law generally protects consumers from surprise medical bills when they go to an in-network health facility and receive care from an out-of-network provider without their consent. The law is intended to make sure consumers only have to pay their in-network cost-sharing in that circumstance. In covered situations, medical providers cannot send consumers out-of-network bills when the consumer followed their health insurer's requirements and went to an in-network facility. The law generally applies to consumers in plans regulated by the state of California.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out of network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out of network. You can choose a provider or facility in your plan's network.

California law generally protects consumers from surprise medical bills when they go to an in-network health facility and receive care from an out-of-network provider without their consent. The law is intended to make sure consumers only have to pay their in-network cost-sharing in that circumstance. In covered situations, medical providers cannot send consumers out-of-network bills when the consumer followed their health insurer's requirements and went to an in-network facility. The law generally applies to consumers in plans regulated by the state of California.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, please contact Cigna or Kaiser Permanente at the phone number listed on your ID card. You may also contact the federal Department of Health and Human Services' No Surprises Help Desk by calling 800.985.3059 or by visiting **cms.gov/nosurprises/consumers** for federal surprise billing protections, or the California Department of Managed Healthcare by calling 888.466.2219 or by visiting **HealthHelp.ca.gov** for state surprise billing protections.

Visit **cms.gov/nosurprises/consumers** for more information about your rights under federal law.

Visit **HealthHelp.ca.gov** for more information about your rights under California state law.

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This brochure presents a brief summary of federal laws that may affect your health care coverage under the WSI Group Health Plan. It is not intended as a complete description of these laws or as a description of your benefits. Although every effort has been made to ensure that information in this brochure is accurate, the provisions of the legal documents that describe the benefits will govern in the case of any discrepancy.

APRIL 2025