WILLIAMS-SONOMA, INC.

SHINE

Be a better you

YOUR 2022-2023 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 2022–2023 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 Jan. 31, 2022. 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: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

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+: colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – MEDICAID

flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – MEDICAID AND CHIP

Medicaid
medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, press 1
CHIP
medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564-1162, press 2

INDIANA – MEDICAID

Healthy Indiana Plan
(for low-income adults 19-64)
in.gov/fssa/hip | 877.438.4479
All other Medicaid
in.gov/medicaid | 800.457.4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid
dhs.iowa.gov/ime/members
800.338.8366
Hawki
dhs.iowa.gov/Hawki | 800.257.8563
HIPP
dhs.state.ia.us/hipp | 888.346.9562

KANSAS – MEDICAID

kancare.ks.gov | 800.792.4884

KENTUCKY – MEDICAID AND CHIP

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
kidshealth.ky.gov/Pages/index.aspx
877.524.4718
Medicaid
chfs.ky.gov

LOUISIANA – MEDICAID

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

MAINE – MEDICAID

Enrollment
maine.gov/dhhs/ofi/applications-forms
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

MINNESOTA – MEDICAID

mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
800.657.3739

MISSOURI – MEDICAID

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

MONTANA – MEDICAID

dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
800.694.3084

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/oii/hipp.htm
800.852.3345, Ext. 5218 or 603.271.5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid
state.nj.us/humanservices/dmahs/clients/medicaid
609.631.2392
CHIP
njfamilycare.org/index.html
800.701.0710

NEW YORK – MEDICAID

health.ny.gov/health_care/medicaid
800.541.2831

NORTH CAROLINA – MEDICAID

medicaid.ncdhhs.gov | 919.855.4100

NORTH DAKOTA – MEDICAID

nd.gov/dhs/services/medicalserv/medicaid
844.854.4825

OKLAHOMA – MEDICAID AND CHIP

insureoklahoma.org | 888.365.3742

OREGON – MEDICAID

healthcare.oregon.gov/Pages/index.aspx
oregonhealthcare.gov/index-es.html
800.699.9075

PENNSYLVANIA – MEDICAID

dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
800.692.7462

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

gethipptexas.com | 800.440.0493

UTAH – MEDICAID AND CHIP

medicaid.utah.gov
health.utah.gov/chip
877.543.7669

VERMONT– MEDICAID

greenmountaincare.org
800.250.8427

VIRGINIA – MEDICAID AND CHIP

coverva.org/en/famis-select
coverva.org/hipp
800.432.5924 or 855.242.8282

WASHINGTON – MEDICAID

hca.wa.gov | 800.562.3022

WEST VIRGINIA – MEDICAID AND 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/p-10095.htm
800.362.3002

WYOMING – MEDICAID

health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
800.251.1269

To see if any other states have added a premium assistance program since Jan. 31, 2022, 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 1/31/2023)

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 lymph edemas

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 800.414.1444, 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 Service Center at 800.414.1444, 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 Service Center at 800.414.1444, option 1.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Federal privacy laws require employer-sponsored group health plans to develop privacy policies and disclose them to associates and retirees. You are receiving the enclosed notice because federal law requires associates and retirees to be informed about how their personal medical information may be used and disclosed in the course of administering group health plans.

The notice describes the WSI group health plans' (the "Plan") privacy policies concerning the use and safeguarding of your personal health information. The notice also addresses the Plan's compliance procedures and responsibilities, as well as your rights to view your protected health information and make necessary corrections. Please read this notice and keep it for your records.

WHY IS THIS NOTICE REQUIRED?

HIPAA requires the federal government to issue national standards to protect the privacy of personal health information. These standards allow the Plan to use and disclose your personal health information for purposes of treatment, payment and health care operations.

WHAT INFORMATION IS PROTECTED UNDER THE LAW?

Protected health information (PHI) is the information that the WSI health plans create and obtain in providing benefits to you. PHI may include information regarding your health status (including diagnosis, treatment and claims payment) or the fact that you are enrolled in or have participated in the WSI health plans.

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 whether you have or have had certain medical conditions (e.g., cancer, diabetes or heart disease), 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 the HRA and 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 Tatausha Webster at **twebster1@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.

2022 COVID-19 SUPPLEMENTAL PAID SICK LEAVE
Effective Feb. 19, 2022 (for California covered associates only)

Covered employees in the public or private sectors who work for employers in California with 26 or more employees are entitled to up to 80 hours of 2022 COVID-19 related paid sick leave from Jan. 1, 2022, through Sept. 30, 2022, immediately upon an oral or written request to their employer, with up to 40 of those hours available only when an employee or family member tests positive for COVID-19.

A full-time covered California associate may take up to 40 hours of leave *if the associate is unable to work or telework for any of the following reasons:*

- **Vaccine-Related:** The covered California associate is attending a vaccine or booster appointment for themselves or a family member*or cannot work or telework because they have vaccine related symptoms or are caring for a family member with vaccine-related symptoms. An employer may limit an employee to 24 hours or 3 days of leave for each vaccination or booster appointment and any consequent side effects, unless a health care provider verifies that more recovery time is needed.
- **Caring for Yourself:** The associate is subject to quarantine or isolation period related to COVID-19 as defined by an order or guidance of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local public health officer with jurisdiction over the workplace; has been advised by a health care provider to quarantine; or is experiencing COVID-19 symptoms and seeking a medical diagnosis.
- **Caring for a Family Member*:** The covered California associate is caring for a family member who is subject to a COVID-19 quarantine or isolation period or has been advised by a health care provider to quarantine due to COVID-19, or is caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises.

A full-time covered California associate may take up to an additional 40 hours of leave *if the associate is unable to work or telework for either of the following reasons:*

- The covered California associate tests positive for COVID-19
- The covered California associate is caring for a family member* who tested positive for COVID-19.

Part-Time Covered California Associates: Part-time covered California associates may take as leave up to the amount of hours they work over two weeks, with half of those hours available only when they or a family member* tests positive for COVID-19.

Payment: If California associate took leave for one of the reasons identified above between Jan. 1, 2022, and Feb. 19, 2022, and that leave was either unpaid or compensated at a rate less than the associate's regular rate of pay, the associate may also request a retroactive payment. Payment is at the associate's regular or usual rate of pay, not to exceed $511 per day and $5,110 in total.

Retaliation or discrimination against a covered California associate requesting or using COVID-19 supplemental paid sick leave is strictly prohibited. A covered California associate who experiences such retaliation or discrimination can file a claim with the Labor Commissioner's Office. Locate the nearest district office by looking at the directory on our website at **dir.ca.gov/dlse/DistrictOffices.htm** using the alphabetical listing of cities, locations and communities or by calling 833.526.4636.

2022 State of California, Department of Industrial Relations

* A family member includes a child, parent spouse, registered domestic partner, grandparent, grandchild or sibling.

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.

WILLIAMS-SONOMA, INC.

POTTERY BARN pottery barn kids POTTERY BARN | teen west elm

WILLIAMS SONOMA CALIFORNIA WILLIAMS SONOMA HOME REJUVENATION MARK & GRAHAM OUTWARD

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 2022