Your 2024–2025 Guide

Benefits for a Health-Full Life

WILLIAMS-SONOMA, INC.

6 Steps to a Stress-Free Enrollment

1 Prepare

Gather names, birth dates and Social Security numbers of everyone you plan to enroll or name as a beneficiary.

2 Consider

Check out benefits like Flexible Spending Accounts (FSAs), critical illness and accident insurance, and pet insurance.

3 Discover

Read this guide to learn about the benefits available to you and your family.

4 Enroll

Enroll online, by mobile app or phone. See instructions on page 2.

5 Compare

Use the Plan Comparison Tool on MyWSIBenefits.com.

6 Check

Are your beneficiaries up to date? View and update your beneficiary info at MyWSIBenefits.com.

Where To View SPDs and Legal Notices

Visit MyWSIBenefits.com/resources/resource-library to obtain a copy of the Legal Notices and the current Summary Plan Description (SPD) for the Cigna and Kaiser Permanente plans described in this guide. For the Williams-Sonoma, Inc. Health & Welfare Plan SPD, log in to the Benefits Portal at MyWSIBenefits.com (look for "Enroll or Check Your Benefits"). Then select "Library" and click on "Plan Summaries." If you would like to receive a paper copy of an SPD, please contact the WSI Benefits Department at benefitsdept@wsgc.com or call 415.616.8500. SPDs maintained at MyWSIBenefits.com are updated periodically. The Cigna and Kaiser Permanente SPDs effective for the plan year beginning July 1, 2024, should be available around September 1, 2024.

What's Inside

Start Here

You're In!

You are eligible for WSI benefits if you're a regular full-time associate scheduled for or normally working 30 or more hours per week.

Who You Can Cover

If you enroll for benefits, you can also cover:

- 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.
- Your dependent children up to age 26, including natural children, step-children, your domestic partner's children, legally adopted children and children for whom you or your spouse are the legal guardian.
- Disabled children of any age who are unable to take care of themselves. Proof of disability is required.

Dependent Verification

You will be required to provide dependent verification documents when you add your spouse, domestic partner and/or child(ren). Open Enrollment is a good time to review your personal data each year and make sure your dependent information is complete and up to date.

Do I Need To Enroll?

ANNUAL ENROLLMENT

Once a year in the spring, we offer a one-time opportunity for you to enroll, waive or make changes to your coverage, which includes adding or removing dependents.

- If you don't take action and actively enroll, most of your benefits will carry over for the next plan year.
- You will not be able to make any changes during the plan year unless you experience a qualifying life event, such as having a baby or getting married.
- If you want to contribute to a Health Care, Limited Purpose or Dependent Care Flexible Spending Account (FSA) or the Health Savings Account (HSA), you will need to elect your pre-tax contribution for the upcoming plan year – it does not carry over. You can change your HSA contribution any time during the plan year.

NEW HIRES

As an active, full-time, benefits-eligible associate, you have 31 days from your full-time date of hire to enroll in benefits. Your benefits will be effective the first day of the month following your date of hire or change to active full-time status. Short-term disability coverage is effective 90 days after your date of hire or change to active full-time status, if you do not waive this coverage.

After your 31st day, you won't be able to enroll in or make changes to your benefits until the next Open Enrollment, unless you experience a qualifying life event, like getting married or having a baby.

When Benefits End

Your benefits will terminate at the end of the month you no longer remain in a benefits-eligible status, e.g., termination of employment or status change.

3 Ways To Enroll

Enroll Now

MyWSIBenefits.com

Set Up Your Account

Visit MyWSIBenefits.com and click "Enroll" in the top right corner to access the WSI Benefits Portal.

1. Set up your username, password and security questions. The company key is "WSI."
2. Log in using your new credentials.
3. Choose your notification preference: work email, personal email or text.
4. Follow the steps to select and view your benefits.

Helpful tip: If you forget your username or password, click the link below the "Login" button to reset them at any time.

Need Help? Ask Sofia

Sofia is your personal benefits assistant who can help answer your benefit questions. Click on the Sofia icon in the WSI Benefits Portal.

1. Online

Go to MyWSIBenefits.com.

IF YOU ARE ON THE WSI NETWORK

Look for "Enroll or Check Your Benefits" at the bottom of the page. Then select "Benefits Portal."

IF YOU ARE NOT ON THE WSI NETWORK

Go to "Enroll or Check Your Benefits" at the bottom of the page. Then look for, "Outside the WSI network, click here."

STEPS TO ENROLL

- If you have not already, set up your username, password and security questions. The company key is "WSI."
- Log in using your new credentials.
- You will be directed to the Enrollment landing page.
- From there, click on "Start Here" to go through the enrollment process.
- Save a copy of your election summary for your records. Your confirmation statement will be mailed to your home address on file and will also be available in the WSI Benefits Portal.

2. Mobile App

Log in to the MyChoice benefits app and follow the prompts to make your elections.

- **From the WSI Benefits Portal:** Log in and select "Access the App" on the home page. You will be prompted to scan a QR code to download the app. (This code is unique to you. Do not share it, as it will log you into your account.)
- **From the App Store or Google Play:** Search for "MyChoice Benefits" and log in using the credentials you created when registering your account on the WSI Benefits Portal.

3. Phone

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.

For the Big Moments

When you experience a qualifying life event, you can make benefit changes outside the regular Open Enrollment period. Here's what you need to do to make sure your family has the coverage you want.

Qualifying Life Event Examples

- Marriage, legal separation or divorce
- The birth or adoption of a child
- Gain or loss of other benefits coverage
- A move from part-time to full-time employment
- Your spouse or child passes away

Make a Change

Go to **MyWSIBenefits.com** and select the Start Here section. Then click on "Enroll and Change Your Benefits."

Questions? Contact the WSI Benefits Resource Center at 800.413.1444 from 7 a.m. to 4 p.m. Pacific time, Monday through Friday, except on certain holidays.

Turn in the Paperwork

You'll need to provide documentation, such as a marriage license, birth certificate or divorce decree, along with an enrollment form, for verification. Documentation must be received within 31 days from the date that the change occurred. Eligibility requirements must be met and proof provided before coverage begins. Any changes you make must be consistent with your event, such as adding or removing dependents.

31 Days

That's how long you have to update your benefits when you experience a qualifying life event. If you miss the deadline, you won't be able to enroll in or change your benefits until the next Open Enrollment.

Medical — Cigna

You have choices when it comes to medical coverage:

HIGH DEDUCTIBLE HSA • STANDARD CARE • PREMIUM CARE

How are the Cigna plans alike?

The High Deductible HSA, Standard Care and Premium Care plans all:

- Are administered by Cigna
- Cover the same services, such as doctor visits, hospital stays and lab work
- Pay 100% of the costs for eligible in-network preventive care, such as flu shots, routine physicals, blood pressure and cholesterol tests, and cancer screenings
- Allow you to use any doctor, but offer savings when you use in-network providers

How are the Cigna plans different?

HIGH DEDUCTIBLE HSA

- Pay lower premiums and have higher deductibles and out-of-pocket maximums than the Standard Care and Premium Care plans
- WSI contributes to your Health Savings Account (HSA) to help you pay for care
- No copays – you pay 100% of the cost until you met your deductible (except for certain in-network preventive care); after that, you and the plan share costs (coinsurance)

STANDARD CARE AND PREMIUM CARE

- Pay higher premiums in exchange for a lower deductible and out-of-pocket maximum than the High Deductible HSA
- No Health Savings Account (HSA) is available with these plans
- Copays for some services and cost sharing (coinsurance) for other services

Starting a Family?

The Cigna and Kaiser Permanente HMO plans offer infertility benefits. For more details, refer to the Summary Plan Descriptions (SPDs) on **MyWSIBenefits.com**.

Find a Provider

Visit **Cigna.com** or call 855.273.3551.

Which network is right for me?

In certain ZIP code areas, your Cigna plan options may include both the Open Access Plus Network plan and a Local Plus Network plan option.

A Local Plus Network plan covers the same services and has the same deductibles, coinsurance and out-of-pocket maximums as the Open Access Plus Network plan option. So what's different?

- The Local Plus Network has a limited list of participating providers chosen for having met certain criteria, like lower hospital admission rates, fewer complications and treatments proven to show positive results.
- Premiums will be less than the Open Access Plus Network plan.

HOW TO CHOOSE YOUR NETWORK

The **Open Access Plus Network** plan may be a better fit if:

- Your current providers are not in the Local Plus Network and you prefer not to change providers.
- You have dependents who live elsewhere (like at college).
- You travel frequently.

A **Local Plus Network plan** may be a good choice if:

- You want to make the most of your health care dollars.
- Your current providers are in the network, or you're fine with changing providers.

Check Out This Help-Full Tool

The Plan Comparison Tool helps you compare your medical plan options and choose the plan that works best for you and your family.

To use the tool, visit MyWSIBenefits.com and log in to the Benefits Portal.

How the Cigna Plans Work

HIGH DEDUCTIBLE HSA

FIRST, SET UP YOUR HSA.

WSI contributes to your account: **$500 for individual coverage** or **$1,000 for family coverage**. You can contribute pre-tax money of your own, too. Please see pages 20 and 21 for more details about HSA contributions.

THEN, PAY TOWARD YOUR DEDUCTIBLE.

You pay 100% of the cost for medical care and prescription drugs (except for certain in-network preventive care) until you meet your deductible. If you elect family coverage, there's no individual deductible – you must meet the family deductible.

You can use your HSA to help pay for qualified expenses before you dip into your own pocket.

NEXT, SHARE COSTS WITH THE PLAN.

Once you meet your deductible, you'll share costs with the plan until you meet the out-of-pocket maximum. You can continue using money from your HSA for your portion.

FINALLY, THE PLAN PAYS THE REST.

If you reach your out-of-pocket maximum, the plan will pay 100% of your eligible expenses for the rest of the plan year. Each family member has an individual out-of-pocket maximum (the family out-of-pocket maximum is met by two or more individuals).

STANDARD CARE AND PREMIUM CARE

These plans don't have an HSA associated with them, so you don't receive any extra money from WSI.

FIRST, YOU PAY FOR CARE.

You pay copays (set amounts) for some services such as doctor's office visits. You don't have to meet the deductible for these services.

THEN, SHARE COSTS WITH THE PLAN.

For other services such as hospitalization, you must meet your deductible before the plan shares costs. Each family member has an individual deductible (the family deductible is met by two or more individuals).

FINALLY, THE PLAN PAYS THE REST.

If you reach your out-of-pocket maximum, the plan will pay 100% of your eligible expenses for the rest of the plan year. Each family member has an individual out-of-pocket maximum (the family out-of-pocket maximum is met by two or more individuals).

Take Full Advantage of 100%-Paid Preventive Care

Preventive care can help spot health problems before they become big issues. Our WSI medical plans cover in-network preventive care at 100%! Covered services include flu shots, routine physicals, well-woman exams, well-baby exams, blood pressure checks, cholesterol tests and cancer screenings.

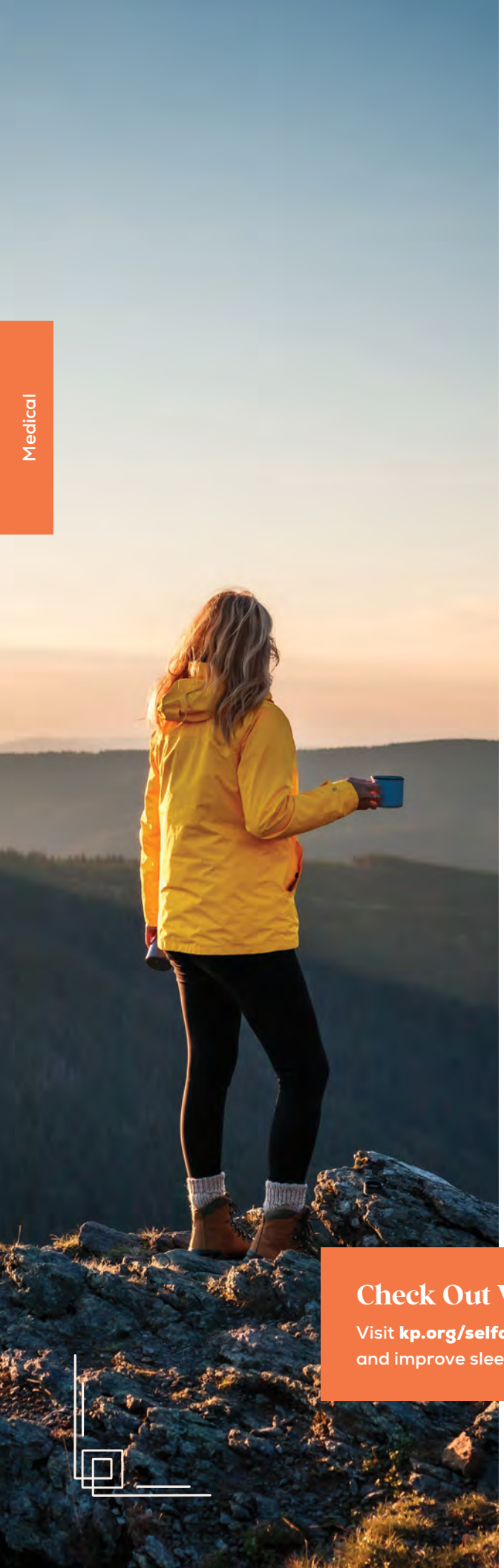
Cigna Medical Plans at a Glance

Here's a look at what you'll pay when you need care.

You will begin to contribute toward the plan deductibles and out-of-pocket limits on **July 1, 2024**, and will continue through **June 30, 2025**. There are separate in-network and out-of-network deductibles and out-of-pocket maximums, and they do not cross apply.

	HIGH DEDUCTIBLE HSA		STANDARD CARE		PREMIUM CARE	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
2024–2025 HSA Contribution from WSI (only if enrolled in High Deductible HSA)						
Individual	$500		No contribution		No contribution	
Family	$1,000					
Deductible (what you pay first for some services)						
Individual	$1,600	$4,200	$500	$2,250	$400	$1,500
Family	$3,200	$8,400	$1,000	$4,500	$800	$3,000
Out-of-Pocket Maximum[1] (the most you have to pay for eligible services)						
Individual	$4,000	$8,000	$3,500	$7,000	$3,000	$6,000
Family	$8,000	$16,000	$7,000	$14,000	$6,000	$12,000
Preventive Care						
Well-adult visits, well-child visits and immunizations	$0	40% after deductible	$0	40% after deductible	$0	30% after deductible
Office Visits/Telehealth						
PCP/specialist	20% after deductible	40% after deductible	$25/$50	40% after deductible	$20/$40	30% after deductible
Telehealth	20% after deductible	Not covered	$15	Not covered	$10	Not covered
Chiropractic care (up to 20 days per plan year)	20% after deductible	40% after deductible	$25	40% after deductible	$20	30% after deductible
Lab/X-ray						
Office, independent lab, outpatient and inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Emergency Services						
Ambulance[2]	20% after deductible		20% after deductible		10% after deductible	
Emergency room	20% after deductible		$150 copay, then 20% after deductible		$100 copay, then 10% after deductible	
Urgent care	20% after deductible	40% after deductible	$50	40% after deductible	$50	30% after deductible
Convenience care	20% after deductible	40% after deductible	$15	40% after deductible	$10	30% after deductible
Inpatient Services						
Hospital and physician services	20% after deductible	40% after deductible	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Mental Health/Substance Abuse						
Inpatient care	20% after deductible	40% after deductible	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Outpatient care	20% after deductible	40% after deductible	$25	40% after deductible	$20	30% after deductible

1 Out-of-pocket maximums include deductibles, copays (if applicable) and coinsurance.
2 Non-emergency ambulance transportation is not covered.



Medical — Kaiser Permanente

Depending on where you live, you may be able to choose Kaiser Permanente for your medical and prescription drug coverage. If available, you'll see this option when you log in to the Benefits Portal at MyWSIBenefits.com.

You must use providers and facilities in the Kaiser Permanente network. There's no out-of-network coverage, except for emergencies.

How Kaiser Permanente HMOs Work

FIRST, YOU PAY FOR CARE.

You pay copays (set amounts) for doctor's office visits and prescription drugs. You don't have to meet the deductible for these services.

THEN, SHARE COSTS WITH THE PLAN.

For other services such as hospitalization, you must meet your deductible before the plan shares costs. Each family member has an individual deductible (the family deductible is met by two or more individuals).

FINALLY, THE PLAN PAYS THE REST.

If you reach your out-of-pocket maximum, the plan will pay 100% of your eligible expenses for the rest of the plan year. Each family member has an individual out-of-pocket maximum (the family out-of-pocket maximum is met by two or more individuals).

Check Out Wellness Resources

Visit **kp.org/selfcare** for online programs to help manage depression, reduce stress and improve sleep. Plus, you can try the Calm and MyStrength apps at no cost.

Kaiser Permanente HMOs at a Glance

Here's a look at what you'll pay when you need care. Generally, there are no out-of-network benefits (you must use providers and facilities in the Kaiser Permanente network). However, emergency services are covered by any provider.

You will begin to contribute toward the plan deductibles and out-of-pocket limits on **July 1, 2024**, and will continue through **June 30, 2025**.

Note: Certain services – such as private duty nursing, physical therapy, massage therapy or acupuncture – may be covered differently or may not be covered. There are coverage variations from state to state. For more information about the Kaiser Permanente coverage available to you, please refer to the Summary of Benefits and Coverage (SBC) available at MyWSIBenefits.com.

Find a Provider

Visit **kp.org** and select Doctors & Locations. You can also call the phone number for your HMO, shown on the inside back cover of this guide.

	NORTHERN/SOUTHERN CALIFORNIA	COLORADO • GEORGIA MID-ATLANTIC STATES NORTHWEST • WASHINGTON
	IN-NETWORK	IN-NETWORK
Deductible (what you pay first for some services)		
Individual	$250	$250
Family	$500	$500
Out-of-Pocket Maximum[1] (the most you have to pay for eligible services)		
Individual	$1,000	$1,000
Family	$2,000	$2,000
Preventive Care		
Well-adult visits, well-child visits and immunizations	$0	$0
Office Visits/Telehealth		
PCP/specialist	$20/$40	$20/$40
Telehealth	$0	$0
Chiropractic care (up to 20 visits per plan year)	$15	$20
Lab/X-ray		
Office, independent lab, outpatient and inpatient	10% after deductible	10% after deductible
Emergency Services		
Ambulance[2]	10% after deductible	10% after deductible
Emergency room	10% after deductible	10% after deductible
Urgent care	$20	$40 (Washington only: $20)
Convenience care	$20	$40
Inpatient Services		
Hospital and physician services	10% after deductible	10% after deductible
Mental Health/Substance Abuse		
Inpatient care	10% after deductible	10% after deductible
Outpatient care	$20 copay for individual therapy visits $10 copay for group therapy visits	$20 copay for individual therapy visits $10 copay for group therapy visits (Washington only: $0 for group therapy visits)

Note: Vision services are not included. Please review vision benefits available through VSP on page 19.

1 Out-of-pocket maximums include deductibles, copays and coinsurance.
2 Non-emergency ambulance transportation is not covered.

Health Help

Take care of yourself with these programs and tools, available if you're enrolled in a Cigna medical plan. Once you are enrolled, you can take advantage of these programs by visiting myCigna.com or calling 855.273.3551.

First Things First

Register on myCigna.com. You'll be able to manage and track claims, view ID cards, find in-network doctors and review your coverage. You can also download the myCigna app from the App Store or Google Play.

HEALTH AND MONEY-SAVING RECOMMENDATIONS

Program: One Guide

How it helps: Navigating health care can be complex. Cigna One Guide can help make getting and staying healthy as easy as possible. You can:

- Get answers to health care questions and understand how your coverage works
- Find the right doctor, lab or urgent care center
- Connect to health coaches
- Find 1-on-1 support for complex health situations
- Avoid surprises by getting cost estimates
- Learn how to maximize your benefits

Get started: Visit myCigna.com or call 855.273.3551.

ANYTIME, ANYWHERE DOCTOR VISITS

Program: MDLIVE

How it helps: Video chat with or call a doctor 24/7. MDLIVE doctors can answer your questions, make a diagnosis and prescribe basic medications (subject to availability by state). This includes:

- **Primary care:** Preventive care, routine care and specialist referrals
- **Urgent care:** On-demand care for minor medical conditions
- **Dermatology:** Fast, customized care for skin, hair and nail conditions

Get started: Virtual care visits are convenient and easy. To schedule an appointment, access MDLIVE by logging in to myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

SECOND OPINIONS

Program: Second Opinion Service

How it helps: Cigna offers Virtual Second Opinions by Cleveland Clinic through a joint venture between the Cleveland Clinic and Amwell for members diagnosed with life-threatening and life-altering diagnoses. This program provides remote access to the expertise of Cleveland Clinic's top specialists and the ability to request a second opinion without the time and expense of travel.

The program offers:

- Concierge-like support from a nurse case manager
- The ability to interact directly with a provider – by phone or video
- Provider opinions delivered via video, phone or written report

Get started: Clinicians help eligible members access the website through myCigna.com, and health coaches refer eligible members to the program when appropriate.

OH BABY! HEALTHY PREGNANCY SUPPORT

Program: Healthy Pregnancy, Healthy Babies

How it helps: Get support and resources to help you have a healthy baby. When you enroll, you'll get:

- Helpful guidance and support on everything from infertility and preconception planning to post-delivery information
- A workbook to help you learn about pregnancy and babies, including topics like prenatal care, exercise, stress, depression and more
- 24/7 live telephone support from a maternity specialist
- Access to an audio library of health topics

You'll also have a wealth of information on the myCigna website from trusted sources like WebMD and Healthwise.

Get started: To enroll, visit myCigna.com or call 855.273.3551.

Enrolled in a Kaiser Permanente HMO?

Check out these programs from Kaiser Permanente to help you be at your healthiest. Visit kp.org for details.

- **Telehealth** – Meet face-to-face with a doctor by video or phone from the comfort of home.
- **Maternity care** – Adding to your family? You can choose a mix of in-person and virtual appointments for your prenatal and postpartum care. After you enroll, you'll receive an at-home toolkit to help you have a healthy pregnancy which includes a scale to track healthy weight gain, a blood pressure monitor, a fetal doppler to check your baby's heartbeat and an app to register your vital signs.
- **Health goals** – Kaiser Permanente offers a number of tools and resources to help you with your health goals, including wellness coaching and smoking cessation.

HEALTH DISCOUNTS

Program: Healthy Rewards

How it helps: Healthy Rewards is a discount program where you get discounts on the health products and programs you use every day for:

- Gyms and virtual workouts
- Mind/body programs and equipment
- Vision and hearing care
- Alternative medicine

Get started: Just use your Cigna medical ID card when you pay and let the savings begin. Learn more about the Healthy Rewards Program by logging in to myCigna.com and navigate to the Healthy Rewards Discount Program or call 800.870.3470.

Note: Some Healthy Rewards programs are not available in all states, and programs may be discontinued at any time. If your plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge.

PERSONALIZED HEALTH SUPPORT

Program: Lifestyle Management Programs

How it helps: A health coach can provide you with personalized support.

- **Stress Management** – Understand your stress signals and learn coping techniques.
- **WinFertility** – Get personalized guidance, education and emotional support on your family-building journey.
- **Treatment Decision Support** – Learn about treatment options for common health conditions.

HELP KICKING THE HABIT

Program: Smoking Cessation Program

How it helps: You've got a goal. And you've got what it takes to reach it. Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy (patch or gum).

Get started: To enroll over the phone, call 855.273.3551. Or, if you want to enroll online, visit myCigna.com to access an 84-day self-paced My Health Assistant program (powered by WebMD) that includes specific completion goals and criteria to help you quit today.

You've Got Health-Full Support!

Take full advantage of the health programs that WSI offers to help you manage your diabetes and lower your blood pressure. These programs are available at no cost for you and your dependents over age 18 who are enrolled in a WSI medical plan.

CIGNA MEDICAL PLANS

Omada is available beginning July 1, 2024.

When you join, you get:

- **Easy monitoring with smart devices and tools.** These may include a smart scale, blood pressure monitor, blood glucose meter and continuous glucose monitors (CGMs).* Devices are shipped to your home at no extra cost.
- **Personal support from a health coach and clinical specialist.** Your dedicated care team will help you create a plan based on your health needs, goals and lifestyle.
- **Online peer groups and communities.** Connect with others for added support and encouragement.

* Certain features and smart devices are only available if you meet program and clinical eligibility requirements. CGMs are only available if you qualify for the diabetes program. CGMs also require a prescription and a compatible smartphone. You will receive two CGM sensors–one after you enroll and the other at the six month follow-up.

Get Started

Beginning July 1, 2024, visit **omadahealth.com/williams-sonoma** to apply. It takes about 5–10 minutes. You'll receive an email within 48 hours letting you know if you're eligible for the program.

KAISER PERMANENTE HMOs

Kaiser Permanente offers comprehensive disease management programs.

Prediabetes

- In-person and virtual education classes
- Nutrition information
- 1-on-1 virtual wellness coaching

Diabetes

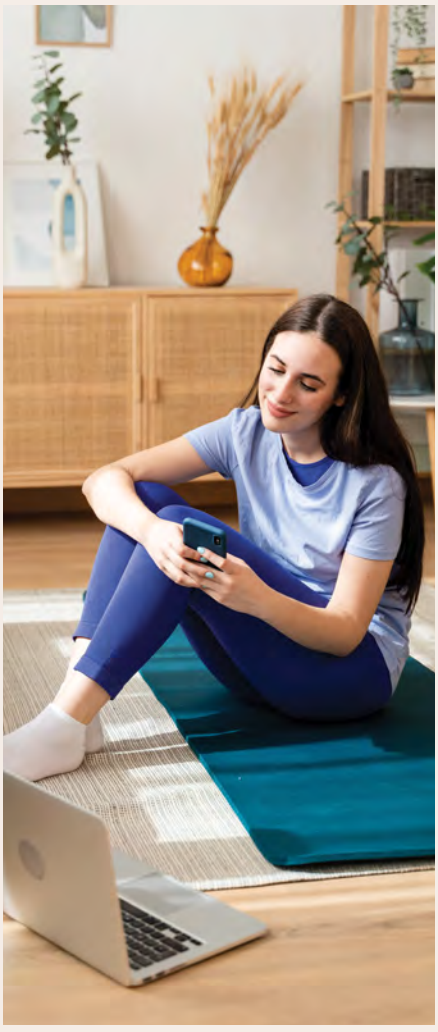
- In-person and virtual education classes
- Medication management
- Diabetic supplies
- Health coaching
- Access to registered dieticians and nutritionists

High Blood Pressure

- Remote data monitoring
- Drop-in blood pressure checks
- Healthy lifestyle programs

Get Started

You're automatically enrolled after you're diagnosed with pre-diabetes, diabetes or high blood pressure. Learn more at **kp.org**



Wellness

Get paid for taking steps toward better health! The Live Well program provides cash incentives when you complete wellness activities from **July 1, 2024–May 31, 2025**. Check and track your completed goals and earned incentives by logging in to myCigna.com (select "Wellness" or "View My Incentives").

Step 1: Complete Your Health Assessment

Remember, you must complete a Health Assessment before you start earning incentives. Go to myCigna.com (select "Wellness" and click on "Health Assessment"). Questions? Call 855.273.3551.

Step 2: Earn Incentives 7/1/2024–5/31/2025

WELLNESS PROGRAM INCENTIVES Note: Must be enrolled in a WSI medical plan to receive incentives.		
INCENTIVE ACTIVITY	AVAILABLE INCENTIVES (PRIMARY SUBSCRIBER)	AVAILABLE INCENTIVE (SPOUSES/SAME-GENDER DOMESTIC PARTNERS)
Participate in biometric screening; complete blood pressure, cholesterol and blood sugar, and body mass index (BMI) screening **Get the Incentive:** Complete a form, available at myCigna.com › Wellness › Wellness & Incentives › Incentive Spotlight. Then select "Let's Go" to download the form.	$75	$0
Preventive screening conducted by provider (annual physical, well-woman exam, mammogram, prostate screening, colon cancer screening) **Get the Incentive:** You'll need to self-report that you completed the screening. Go to myCigna.com › Wellness › Wellness & Incentives › Incentive Spotlight. Then select "Let's Go" to enter the date you completed your exam.	$100	$50
TOTAL MAXIMUM INCENTIVE PAYOUT	$175	$50

PREGNANCY WELLNESS INCENTIVES AVAILABLE

Enrolled in a Cigna medical plan? Start your journey to motherhood with the Cigna Healthy Pregnancies, Healthy Babies program. When you enroll during your first trimester and complete the program, including your postpartum check-in, you'll be eligible to receive a $150 incentive.

If you're a Kaiser Permanente member: You can earn an incentive of $150 by participating in the Kaiser Permanente Maternity Care/Pregnancy program during your first trimester and providing confirmation you completed one in-person or online maternity class.

Cigna and Kaiser Permanente members can also earn an additional $75 if you enroll and complete an in-person or online maternity class in your second trimester.

Get the Pregnancy Wellness Incentives

Cigna members: Call 855.273.3551 and speak to a maternity nurse. The Cigna nurse will update your record once complete.

Kaiser Permanente members: To receive your pregnancy wellness incentive, you will need to self-report your activity through myCigna.com › Wellness › View My Incentives.

Prescription Drug Benefits

When you enroll in a Cigna plan, you automatically get prescription drug benefits through Express Scripts. If you enroll in a Kaiser Permanente HMO, your prescription drug benefits will be provided through your Kaiser Permanente HMO.

How the Cigna Plans Work

HIGH DEDUCTIBLE HSA	STANDARD CARE AND PREMIUM CARE
If you haven't met your medical plan deductible, you pay 100% of the cost for prescription drugs (except for certain preventive drugs).	There's no deductible to meet.
After you meet the deductible, you pay coinsurance, with a minimum and a maximum. You can use your HSA to help pay for qualified expenses.	You pay coinsurance, with a minimum and a maximum.
If you reach your in-network medical out-of-pocket maximum, the plan will pay 100% of your eligible medical and prescription drug expenses for the rest of the plan year.	If you reach your in-network medical out-of-pocket maximum, the plan will pay 100% of your eligible medical and prescription drug expenses for the rest of the plan year.

Filling Your Prescriptions

SHORT-TERM PRESCRIPTIONS

You can fill short-term prescriptions through retail pharmacies. Find the nearest pharmacy by visiting myCigna.com or calling 855.273.3551.

LONG-TERM PRESCRIPTIONS

Maintenance drugs are drugs you take for long-term or chronic conditions, such as blood pressure medication. All WSI medical plans offer savings when you get 90-day supplies of these medications.

You have two ways to get your prescriptions:

- Take advantage of home delivery from the Express Scripts Pharmacy. Your medications will be delivered directly to you with free standard shipping. To get started, visit myCigna.com or call 855.273.3551.
- Pick up your prescriptions at a nearby preferred pharmacy.

Cigna Prescription Drug Benefits at a Glance

Here's a look at what you'll pay when you need a prescription filled.

	HIGH DEDUCTIBLE HSA		STANDARD CARE AND PREMIUM CARE	
	RETAIL AND SPECIALTY (UP TO A 30-DAY SUPPLY)	MAIL ORDER (UP TO A 90-DAY SUPPLY)	RETAIL AND SPECIALTY (UP TO A 30-DAY SUPPLY)	MAIL ORDER (UP TO A 90-DAY SUPPLY)
Deductible (what you pay first for some services)				
Individual/Family	Combined with medical: $1,600/$3,200		N/A	
Out-of-Pocket Maximum (the most you have to pay for eligible services)				
Individual/Family	Combined with medical		Combined with medical	
What You Pay				
Preventive drugs	15%, no deductible[1]	15%, no deductible[1]	N/A	N/A
Generic	15% after deductible ($4 minimum; $10 maximum)	15% after deductible ($10 minimum; $25 maximum)	$10	$25
Brand	15% after deductible ($15 minimum; $40 maximum)	15% after deductible ($35 minimum; $100 maximum)	25% ($20 minimum; $80 maximum)	25% ($50 minimum; $200 maximum)
Non-preferred brand	15% after deductible ($30 minimum; $60 maximum)	15% after deductible ($75 minimum; $150 maximum)	40% ($40 minimum; $100 maximum)	40% ($100 minimum; $250 maximum)

1 The High Deductible HSA includes a list of medications considered to be preventive by Cigna in accordance with the guidelines set by the IRS. This might include medication used to treat conditions such as high blood pressure, cholesterol and diabetes. For these preventive medications, you pay 15%, subject to the applicable minimum and maximum amounts. These medications do not accumulate toward the deductible, but do accumulate toward the out-of-pocket maximum. For more information, contact Cigna.

Get the GoodRx® Savings

If you're enrolled in a WSI medical plan through Cigna, you'll automatically get GoodRx savings. GoodRX pricing is available for many commonly used non-specialty generic medications (filled for a 30-day or 90-day supply) at any in-network retail pharmacy that accepts GoodRx discount cards. When you fill a prescription, the system compares the price available through your pharmacy benefit to the GoodRx price. You're charged whichever price is lower.

Help-Full Terms

The Cigna plans and Kaiser Permanente HMOs cover drugs according to their category. Here's what the categories mean.

- **Generic** – Generic drugs have the same active ingredients as brand-name drugs and must meet FDA standards for quality and purity. You usually save the most with generics.
- **Brand** – Certain brand-name drugs are listed on the plan's formulary (list of preferred prescription drugs). They have been chosen based on safety, quality and cost-effectiveness.
- **Non-preferred brand** – These drugs are not included on the plan's formulary. You will pay more for non-preferred drugs than for generic and brand drugs.

To see the formulary lists for the Cigna plans, visit myCigna.com. For the Kaiser Permanente HMOs, visit kp.org.

How the Kaiser Permanente HMOs Work

- No deductible to meet
- You pay set copays for prescriptions
- If you reach your in-network medical out-of-pocket maximum, the plan will pay 100% of your eligible medical and prescription drug expenses for the rest of the plan year

Kaiser Permanente HMO Prescription Drug Benefits at a Glance

Here's a look at what you'll pay when you need a prescription filled. For more information, visit kp.org. You can also call the phone number for your HMO, shown on the inside back cover of this guide.

	NORTHERN/SOUTHERN CALIFORNIA		COLORADO • GEORGIA MID-ATLANTIC STATES • NORTHWEST WASHINGTON	
	RETAIL AND SPECIALTY (UP TO A 30-DAY SUPPLY)	MAIL ORDER (UP TO A 100-DAY SUPPLY)	RETAIL AND SPECIALTY (UP TO A 30-DAY SUPPLY)	MAIL ORDER (UP TO A 90-DAY SUPPLY)
Deductible (what you pay first for some services)				
Individual/ Family	N/A		N/A	
Out-of-Pocket Maximum (the most you have to pay for eligible services)				
Individual/ Family	Combined with medical		Combined with medical	
What You Pay				
Preventive drugs	$0	$0	$0	$0
Generic	$10	$20	$10	$20
Brand	$50	$100	$50	$100
Non-preferred brand	$50	$100	$75	$150
Specialty	$150	N/A	$150	N/A

Save With Mail Order

If you take ongoing maintenance medications, using mail order can save you money. Plus, you get the convenience of having your prescriptions delivered right to your door.

Dental

Dental benefits are provided through Delta Dental of California. You have two options:

STANDARD PLAN • PREMIUM PLAN

How are the plans alike?

BOTH PLANS

- Allow you to use any dentist, but offer savings when you use a Delta Dental network provider
- Pay 100% for preventive care
- Provide coverage for preventive, basic and major care

How are the plans different?

STANDARD PLAN

- Pay lower premiums and have a higher deductible to meet
- Orthodontia is **not** covered

PREMIUM PLAN

- Pay higher premiums in return for a lower deductible and higher level of benefits coverage
- Orthodontia **is** covered

Dental Plans at a Glance

Here's a look at what you pay when you need dental care.

Out-of-network benefits are paid according to a "reasonable and customary" schedule. If you use an out-of-network dentist, you could receive an additional bill for the difference between what the plan pays and what the dentist charges.

	STANDARD PLAN	PREMIUM PLAN
Deductible (what you pay first for some services)		
Individual	$50	$25
Family	$150	$100
Annual Benefit Maximum (the most the plan will pay in a plan year)		
Per person	$1,500	$2,500
Orthodontia Lifetime Maximum (the most the plan will pay for orthodontia per lifetime)		
Per person	N/A (orthodontia not covered)	$2,500
What You Pay		
Preventive (exams, cleanings, X-rays; sealants and fluoride covered up to age 16)	$0, no deductible	$0, no deductible
Basic (fillings, oral surgery, denture repair)	20% after deductible	20% after deductible
Major (crowns, inlays, onlays, bridges, dentures, implants)	50% after deductible	50% after deductible
Orthodontia	Not covered	50% after deductible

Find a Provider

Find a Delta Dental provider by visiting **deltadentalins.com** or calling 800.397.4741.

You will not receive a dental ID card – you can print one from the Delta Dental website.

Vision

Vision coverage is offered through VSP. You can choose from two plans:

STANDARD PLAN • PREMIUM PLAN

How are the plans alike?

BOTH PLANS

- Allow you to use any provider, but offer savings when you use a VSP network provider
- Provide coverage for routine eye exams and eyeglasses or contacts

Both plans offer savings and discounts on certain glasses and contacts at eyeconic.com

How are the plans different?

PREMIUM PLAN

The **Premium Plan** offers some enhanced benefits, so your paycheck contributions are higher.

At the point of service, you can choose one of the following: a $250 frame allowance, progressive lenses, light-reactive lenses, anti-glare coating or a $250 elective contact lens allowance in lieu of glasses.

Each family member you cover can choose the upgrade that's right for them. Choose one upgrade every 12 months.

Vision Benefits at a Glance

Here's a look at what's covered and what you pay. If you use an out-of-network provider, you'll need to pay the cost up front and then submit a claim form to be reimbursed up to the out-of-network allowance.

	STANDARD PLAN AND PREMIUM PLAN[1]	
	IN-NETWORK	OUT-OF-NETWORK
What You Pay		
Eye Exam (once every plan year)		
WellVision exam	$10 copay (up to $39 copay for routine retinal screening)	All amounts over $45
Eyeglass Frames		
Frames (**Premium Plan:** once every year; **Standard Plan:** once every other year)	$25 copay for frames and lenses, then all amounts over $150 allowance[2]	All amounts over $70
Lenses[3] (once every plan year)		
Single vision	$25 copay for frames and lenses	All amounts over $30
Bifocal	$25 copay for frames and lenses	All amounts over $50
Trifocal	$25 copay for frames and lenses	All amounts over $65
Contact Lenses (once every plan year in lieu of glasses)		
Contact lens exam (fitting and evaluation)	Up to $60 copay	No reimbursement
Contacts	All amounts over $150	All amounts over $105

1 The Premium Plan offers some enhanced benefits. You can choose one of the following every 12 months: a $250 frame allowance, progressive lenses, light-reactive lenses, anti-glare coating or a $250 elective contact lens allowance in lieu of glasses.
2 You get an $80 Costco® frame allowance and a $170 allowance for featured frame brands. You get a 20% discount on all amounts over the plan allowance.
3 There is an additional charge for some lens enhancements, such as progressive lenses.

Find a Provider

Find a VSP provider by visiting **vsp.com** or calling 800.877.7195. In-network providers include Costco, Walmart® and Sam's Club®.

You will not receive a vision ID card. When you make your appointment, provide your name, date of birth and Social Security number, and the optometry office will verify your benefits.

Health Savings Account (HSA)

An HSA is a tax-advantaged account available to you if you enroll in the High Deductible HSA.* (This account is not available if you enroll in the Standard Care, Premium Care or Kaiser Permanente HMO plan.) Your HSA is managed by HealthEquity.

How the HSA Works

1

REGISTER YOUR ACCOUNT

Enrolling in the High Deductible HSA for the first time? Once HealthEquity receives your enrollment, they will send you a welcome kit. In order to receive all your WSI contributions, you must log in to my.healthequity.com and ensure any required documents are submitted in a timely manner as required by the US Patriot Act – Customer Identification Program (CIP). If you need help to complete the CIP process, contact HealthEquity at 866.346.5800. If you fail the CIP process, you will not be eligible to receive retroactive WSI contributions. If you currently have a BenefitWallet HSA, your account will transition to HealthEquity. You will still need to set up your username and password.

Name a Beneficiary!

Make sure you designate a beneficiary for your HSA.

2

START WITH MONEY FROM WSI

WSI will add money to your account: **$500** for individual coverage or **$1,000** for family coverage. You'll receive half of WSI's contribution during the first available pay cycle after the start of the plan year (July 1, 2024) or after your election is processed. You'll receive the remaining WSI contributions on a per-paycheck basis throughout the year. If you enroll in the High Deductible HSA after July 1, 2024, your remaining HSA deposits will be prorated based on the number of pay periods left in the plan year.

3

ADD MONEY OF YOUR OWN

You decide how much (if any) you want to contribute to your HSA. The annual HSA contribution limit is $4,150 for individual coverage and $8,300 for any level of family coverage. WSI's HSA contributions count towards this annual maximum. For example, if you elect individual coverage, you can contribute $3,650 to your HSA ($4,150 annual limit - $500 WSI contribution = $3,650 is your maximum contribution). If you'll be age 55 by December 31, 2024, you can contribute an additional $1,000 in HSA catch-up contributions. Please review your payroll elections carefully.

Your contributions are taken out of your paycheck before taxes. HSA payroll deductions will start with your first available pay cycle after July 1, 2024. Because your benefits coverage spans two calendar years, the amount you elect to contribute to your HSA this year will also carry over into the next calendar year.

Keep in mind you can change your contributions at any time during the year.

4

PAY FOR HEALTH CARE

HSA dollars can be used anytime – now or down the road. When you have an eligible expense, you can pay for it from your HSA with no taxes taken out. Or, you can pay out of pocket and leave your untaxed HSA dollars invested.

5

INVEST FOR THE FUTURE

Think of your HSA as a savings plan for health care. Once your HSA reaches a balance of $1,000, you can invest your funds in a wide variety of options, including mutual funds, stocks and bonds. There is no tax on HSA interest or investment growth. There are fees for investments or trades.

* You must meet all eligibility requirements for the HSA. No one can claim you as a dependent on their taxes, you can't be enrolled in Medicare or Tricare and you can't be enrolled in or covered by another person's general purpose Health Care Flexible Spending Account (FSA) or health coverage.

HSA Fast Facts

TAX ADVANTAGES X 3

1. Pre-tax savings
2. Tax-free earnings
3. Tax-free withdrawals for eligible expenses

PICK HOW TO PAY

- Use the debit card that you'll receive in the mail.
- Pay with the HealthEquity mobile app (available in the App Store or Google Play).
- Pay out of pocket and fill out a form to be reimbursed.

KNOW WHO'S COVERED

You can use your HSA to pay for eligible expenses for you, your spouse and your tax dependents (including your children up to age 19, or age 24 if a full-time student), even if they're not covered under your WSI medical plan. (While the WSI medical plans cover eligible children up to age 26, the IRS has different rules for HSAs.)

WHAT'S AN ELIGIBLE EXPENSE?

Eligible expenses include:

- Medical and dental deductibles and expenses
- Vision expenses, such as eye exams, glasses and contacts
- Prescription drug expenses
- Over-the-counter medications and medical supplies (like bandages, diabetic supplies and contact lens solution)

For a complete list of covered expenses, visit **irs.gov/publications/p502**.

Any money you spend on ineligible expenses is taxable, and you may pay a 20% tax penalty.

IT'S ALWAYS YOURS!

Any money left in your HSA rolls over from year to year – there's no "use it or lose it" rule. Plus, you can take it with you if you leave WSI.

USE THE TOOLS

At the HealthEquity Member Portal (**my.healthequity.com**), you'll find resources to help you understand and manage your HSA, including calculators, videos and articles.

CHECK YOUR BALANCE

You must have the funds available in your HSA before you can use them. If you pay out of pocket now, you can reimburse yourself from your HSA later, when the funds are available.

Flexible Spending Accounts (FSAs)

WSI offers FSAs, administered by HealthEquity, to help you save on taxes for health care and dependent care.

HEALTH CARE FSA OR LIMITED PURPOSE FSA • DEPENDENT CARE FSA

Note: If you're enrolled in an HSA, you can't participate in the Health Care FSA. You can contribute to the Limited Purpose FSA to be reimbursed for dental and vision expenses.

How These Accounts Work

1

DECIDE HOW MUCH TO CONTRIBUTE

Your contributions come out of your paycheck before taxes.

- **Health Care FSA or Limited Purpose FSA:** Up to $3,200 a year
- **Dependent Care FSA:** Up to $5,000 a year ($2,500 if you are married but file separate tax returns)*

2

PAY FOR ELIGIBLE EXPENSES

For the Health Care FSA or Limited Purpose FSA: Use your debit card, and the amount is automatically withdrawn from your account. You'll receive a card by mail. You have access to the full amount you contribute for the year up front.

For the Dependent Care FSA: Pay the expense up front and then file a claim for reimbursement. You must have the money in your account before you can receive reimbursement.

Make sure you keep your receipts in case you need to verify your purchase.

3

PLAN CAREFULLY!

If you don't use all of your **Health Care FSA or Limited Purpose FSA funds** by the end of the plan year, you'll be able to carry over $610 to the next plan year. Any remaining amount over $610 will be forfeited. There's no carryover with the **Dependent Care FSA**.

4

PAY ATTENTION TO DEADLINES

The deadline to use your FSA dollars is **June 30, 2025**. You have until **September 30, 2025**, to request reimbursement and file claims. Any remaining amount will be forfeited. (Remember, you can carry over $610 with the Health Care FSA and Limited Purpose FSA only.)

Know the Rules

- The accounts are separate. You can't transfer money between the accounts, or use the Dependent Care FSA to pay for health care expenses or vice versa.
- The money in your FSA does not earn interest.
- You can't take your FSA with you if you leave WSI.

* If you are a highly compensated employee (HCE), your Dependent Care FSA contribution may be limited to a lower maximum contribution amount.

FSAs at a Glance

	HEALTH CARE FSA	LIMITED PURPOSE FSA	DEPENDENT CARE FSA
Who can use it	Anyone not enrolled in an HSA	High Deductible HSA participants enrolled in an HSA	If you have dependent care expenses so you (and your spouse, if married) can work, look for work or attend school full time
How much you can add	Up to $3,200 a year	Up to $3,200 a year	Up to $5,000 a year ($2,500 if you are married but file separate tax returns)
Whose expenses are eligible	Yours, your spouse's and your tax dependents'	Yours, your spouse's and your tax dependents'	• Your children under age 13 who qualify as dependents on your federal tax return • Your spouse who is physically or mentally incapable of self-support and lives with you for more than half the year • An unmarried child of any age who is physically or mentally incapable of self-support • Other family members who are physically or mentally incapable of self-support, who live with you for more than half the year and who qualify as dependents on your federal tax return
What you can use it for	Eligible medical, prescription drug, dental and vision expenses	Eligible dental and vision expenses	Eligible dependent care expenses such as licensed nursery schools, licensed day care centers for children and disabled dependents, after-school care and services from a care provider (must be age 19 or older and not claimed as a dependent)

HSA + Limited Purpose FSA

Already have an HSA and wondering if you should consider the Limited Purpose FSA? This type of FSA might be right for you if:

- **You're already contributing up to the IRS limit in the HSA and want additional tax savings.**
- **You anticipate a large dental or vision expense during the plan year, such as orthodontia or LASIK.**

401(k) Plan

Your retirement goals matter to us, and WSI is committed to providing you with the tools and resources to help you achieve them.

How the Plan Works

Here's how the 401(k) plan works.

- **Decide how much to contribute.** The money is taken out of your account each paycheck and deposited into your Charles Schwab 401(k) account.
- **Get paid to save.** To encourage you to save, WSI matches your contributions. See "Company Contributions" for more details.
- **Choose your investments.** You can choose from a wide variety of investments that work best for your age, risk tolerance and how long you have until you retire. You can choose your own investment mix or have your account managed for you.
- **Make changes when you need to.** You can change your contribution rate or investments anytime during the year.
- **Let your money grow.** The earlier you start saving, the more time your money has to grow. When that interest starts earning interest (called compounding), your savings will get a big boost.
- **Name a beneficiary.** Your beneficiary is the person(s) who receives your retirement account balance in the event of your death. Not having a beneficiary on file can cause confusion and make things harder for your loved ones.

When You're Eligible

If you're 21 or older, you're eligible to participate in the 401(k) Plan any time after your hire date. There is no special enrollment window.

Full-y Automate Your Savings

With Annual Savings Adjustments, you can schedule slow and steady increases to your contribution rate. You decide when you want the increases to happen. For example, you might decide to save an additional 1% every January 1 until you're saving 15% of your pay.

Saving Basics

Your Contributions

You can save 1% to 75% of your eligible earnings up to IRS limits. You can make different types of contributions.

- **Pre-tax contributions** are deducted from your paycheck before income taxes are withheld. You pay taxes on these contributions and earnings when you withdraw the money from the plan.
- **Roth after-tax contributions** are deducted from your paycheck after income taxes are withheld. You will not pay taxes again on these contributions or on the earnings if you receive the money as a qualified distribution.*
- **Catch-up contributions** are for savers who will be age 50 or older in 2024. These contributions help you save more than the annual IRS limits as you near retirement.
- **Rollover contributions** that you move from a retirement plan account with a prior employer or a rollover IRA to the WSI Plan allow you to keep all of your retirement savings in one place and avoid paying tax penalties.

* A qualified distribution means you have your Roth account open for at least 5 years and you take your distribution after age 59½ or due to death or disability.

Company Contributions

WSI matches your contributions $.50 for every dollar you contribute up to 6%, for a total matching contribution of 3%. Save at least 6% to get the full 3% matching contribution.

The company matches both pre-tax and Roth after-tax contributions, and the match is paid on a pre-tax basis.

Match Details

For full-time associates, you're eligible for the match after one year of service. For all other associates (part-time associates, casual, seasonal and temporary), you're eligible for the match after one year of service and after you have worked 1,000 hours during your first year of service or during any calendar year thereafter.

- 401(k) contributions will be matched starting on the first day of each calendar quarter (January 1, April 1, July 1 and October 1) after you complete one year of service.
- The company match is deposited twice per year. The first matching contribution is deposited in August for associate contributions made from January 1–June 30. The second matching contribution is deposited in February of the following year for associate contributions made from July 1–December 31. You must be employed on the last day of each matching period to receive the company match.
- You become 100% vested in (you own) company matching contributions after one year of service.

How Much Can You Save?

For 2024, you can save up to the IRS limit of $23,000 (combined pre-tax and Roth after-tax limit). If you're eligible to make catch-up contributions, you can save an additional $7,500 for a total contribution of $30,500.

Investing

Through your Plan, you have access to a managed account service that, for a fee, includes ongoing account monitoring and automatic adjustments to your investments. Advice is provided by Morningstar Investment Management LLC, an independent registered investment adviser.

Prefer to manage your retirement plan account yourself? You can still get a personalized recommendation at no additional cost, without signing up for the managed account service.

3 Ways To Get Started

1. Go to **workplace.schwab.com**.

2. Download the Schwab Workplace Retirement App.

3. Call participant services at 800.724.7526.

When creating your account, you will need your Social Security number and date of birth. You will choose your contribution rate, make your investment elections and name your beneficiary.

Life and AD&D Insurance

To protect your family, WSI offers these benefits through MetLife:

BASIC LIFE • SUPPLEMENTAL LIFE • BASIC AD&D

Life Insurance

Life insurance pays a benefit if you or a covered family member dies.

- WSI pays 100% of the cost for Basic Life insurance.
- You can purchase Supplemental Life for yourself, your spouse/domestic partner and/or children.
- You pay the full cost of any Supplemental Life insurance you purchase through after-tax payroll deduction. Rates for yourself and your spouse/domestic partner will vary based on age. You will be able to see your cost when you enroll.

Note: An age reduction schedule will apply starting at age 70 and also at age 75. Please contact MetLife for further details.

AD&D Insurance

AD&D pays a benefit if you die or suffer a serious injury due to an accident. WSI pays 100% of the cost for Basic AD&D for you.

Important Reminders

A **beneficiary** is the person that you designate to receive your benefits.

Remember to complete or update your **Beneficiary Designation form**, located on the Benefits Portal.

Evidence of Insurability (EOI) is a statement of health that insurance companies may require before life insurance will be effective. See the chart on the next page.

Life and AD&D Benefits at a Glance

BENEFIT	AMOUNT	DETAILS
Basic Coverage (automatically enrolled; paid by WSI)		
Basic Life	1x your base earnings	$1 million maximum
Basic AD&D	1x your base earnings	$1 million maximum
Optional Coverage, in addition to Basic coverage (paid by you)[1]		
Supplemental Life for you	$10,000 to 5x your base earnings, in $5,000 increments	$1 million maximum
Supplemental Life for your spouse/domestic partner[2]	$10,000 to $100,000, in $5,000 increments	Can't exceed 100% of your associate life benefits
Supplemental Life for your children[3]	$5,000 or $10,000 per child	$1,000 benefit for birth to 6 months

1 If you and your spouse/domestic partner both work for WSI, you can each purchase associate supplemental life – spouse/domestic partner life insurance is not available. Only one of you can cover your dependent children.
2 In California only, you can enroll your same-sex and opposite-sex domestic partner as permitted by law.
3 Dependent children from birth to 26 years old are eligible for coverage. When you elect child life, all of your eligible children are covered.

When is EOI required?

Here's when you will need to provide EOI:

	FOR YOU	FOR YOUR SPOUSE/DOMESTIC PARTNER
As a new hire	Any amounts over $100,000	Any amounts over $25,000
During Open Enrollment or after a qualifying life event	Any coverage increase over $30,000 or any total coverage amount over $100,000	Any coverage increase over $5,000 or any total coverage amount over $25,000
If you did not enroll when first eligible	EOI required for any amount	EOI required for any amount

Simple Steps To Filing a Leave of Absence

Follow these steps if you need to take time off from work for medical or personal reasons.

1. Call or Use the Online Portal

Call TELUS Health at 833.467.0736 to initiate your leave claim or use the online portal at WSILOA.abilitiabsenceus.com.

Learn More

Get details about each leave type in the benefits section of Homefront. Visit **homefront.wsgc.com/content/homefront/people/health-welfare1/leave_of_absenceloa1.html.**

2. Complete

Complete and return the required information provided to you by your case manager at TELUS Health.

Workers' Compensation

If you become injured on the job, report the injury directly to your manager.

All injuries must be reported.

You and your manager will need to report the incident/injury to the Sedgwick NurseLine at 866.648.4749.

3. Contact

Stay in contact with your TELUS Health case manager with updates/changes to your leave.

Family Planning

Did you know that WSI has a Parental Leave Benefit?

- **Primary caregivers are eligible for up to 12 weeks of pay immediately following the birth or adoption of a child.***
- **Secondary caregivers are eligible for up to 4 weeks of pay within the first 4 months immediately following the birth or adoption of a child.**

For more information regarding the Parental Leave Benefit, visit HomeFront at homefront.wsgc.com/content/homefront/people/health-welfare1/leave_of_absenceloa1.html.

* Associates must be enrolled in the Company's Short-Term Disability Plan to receive 100% wage continuation and have met the Plan's 90-day waiting period.

Disability

If you are unable to work because of a non-work-related illness or injury, WSI's disability benefits replace part of your income. You have two types of disability coverage:

SHORT-TERM DISABILITY (STD) OR STATE DISABILITY INSURANCE (SDI) • LONG-TERM DISABILITY

Short-Term Disability (STD) or State Disability Insurance (SDI)

STD replaces part of your pay if a non-work-related illness or injury prevents you from working for a short period of time. You are automatically enrolled in this benefit. If you are a non-exempt associate who lives in California, you will be enrolled in SDI instead.

Long-Term Disability (LTD)

LTD replaces a portion of your pay if a non-work-related illness or injury prevents you from working for a long period of time.

Disability Benefits at a Glance

BENEFIT	COVERAGE
Short-Term Disability (STD) For new hires: Full-time non-exempt associates (excluding those who live in CA) are automatically enrolled after 90-day waiting period; you can waive coverage by calling the Benefits Resource Center at 800.413.1444, option 1, within the 90-day waiting period*	**Waiting period:** 90-day waiting period from full-time hire date **Benefits begin:** On 8th day of illness or first day of hospitalization **Plan pays:** 55% of your weekly base salary up to a $1,129 weekly benefit maximum **Benefits continue:** Up to 26 weeks or until you fully recover, whichever comes first **Coordination with other benefits:** STD coordinates with income from other sources (such as state disability income benefits in CA, NY, RI, NJ, HI and PR)
Short-Term Disability (STD) for Exempt Associates For new hires: Full-time exempt associates (including those who live in CA) are automatically enrolled after 90-day waiting period; you can waive coverage by calling the Benefits Resource Center at 800.413.1444, option 1, within the 90-day waiting period*	**Waiting period:** 90-day waiting period from full-time hire date **Benefits begin:** On 8th day of illness or first day of hospitalization **Plan pays:** 66 ⅔% of your weekly base salary up to $4,000 weekly maximum benefit **Benefits continue:** Up to 26 weeks or until you fully recover, whichever comes first **Coordination with other benefits:** STD coordinates with income from other sources (such as state disability income benefits in CA, NY, RI, NJ, HI and PR)
State Disability Insurance (SDI) Non-exempt associates who work in California are automatically enrolled	**Benefits begin:** On 8th day of disability **Plan pays:** 60% of your average base wages, up to $1,252 weekly benefit maximum **Benefits continue:** Up to 52 weeks or until you fully recover, whichever comes first
Voluntary Long-Term Disability (LTD) All non-exempt associates (excluding corporate) are eligible to enroll in this voluntary benefit	**Benefits begin:** On 181st consecutive day of disability **Plan pays:** Choose coverage of 40% or 60% of your monthly base salary; maximum benefit of $5,000 per month **Benefits continue:** Refer to the LTD Summary on the Resources tab at **MyWSIBenefits.com**. **Note:** LTD coordinates with other income sources (e.g., Social Security).
Company-Provided Basic Long-Term Disability (LTD) and Voluntary LTD All exempt and corporate non-exempt associates are automatically enrolled in the Basic LTD benefit; some associates may be eligible for additional Voluntary LTD	**Benefits begin:** On 181st consecutive day of disability **Plan pays:** Basic LTD benefit is 40% of monthly base salary; elect Voluntary LTD for additional 20% of your monthly base salary; combined monthly maximum benefit of up to $10,000 **Benefits continue:** Refer to the LTD Summary on the Resources tab at **MyWSIBenefits.com**. **Note:** LTD coordinates with other income sources (e.g., Social Security).

* If you waive STD coverage during your new hire enrollment opportunity, you will be required to provide Evidence of Insurability (EOI) if you want to elect coverage at a later date.

Critical Illness, Accident and Hospital Indemnity

Supplemental insurance coverage for illnesses, accidents and hospital stays provides an extra layer of protection for you and your family.

The plans have low weekly premiums that can help fill financial gaps where you may need extra coverage. These benefits are offered through MetLife. For more information, visit the Benefits Portal at MyWSIBenefits.com.

How the Plans Work

- You enroll for each of these benefits separately.
- You purchase coverage with after-tax payroll deductions, making benefits paid tax-free.
- If you leave the company or retire, you can continue this coverage.
- You can enroll yourself and your eligible family members.
- Benefits are paid directly to you.
- Make sure you name a beneficiary.
- You'll file a claim when you need to access these benefits. Go to MyWSIBenefits.com > Other Benefits > Critical Illness, Accident & Hospital Indemnity.

Know the Stats

Even with medical coverage, extra expenses can add up.

- **The average cost of an ER visit is $2,800.**
- **The average cost of a three-day hospital stay is $30,000.**

Critical Illness, Accident and Hospital Indemnity Benefits at a Glance

	CRITICAL ILLNESS INSURANCE	ACCIDENT INSURANCE	HOSPITAL INDEMNITY INSURANCE
How it helps	Pays a cash benefit directly to you if you're diagnosed with a covered critical illness. Use your cash benefit to help pay for treatment or everyday living expenses.	Pays a cash benefit directly to you to help with unexpected costs due to a covered accident. This includes expenses like ambulance rides, ER visits and physical therapy.	Pays a cash benefit directly to you during a covered hospitalization to help with related expenses. These expenses include things like transportation and meals for family members, help with child care or time away from work.
What it covers	More than 20 conditions, including cancer, heart attack, stroke and kidney failure.	A wide variety of accidental injuries, including broken bones, concussions, dislocations, and second-and third-degree burns.	The plan pays set benefits for hospital admissions, hospital confinements and inpatient rehabilitation.
Benefit options	$10,000, $20,000 or $30,000	Low Plan or High Plan	Low Plan or High Plan
Wellness benefits (available in certain states)	Receive up to $50 for getting a covered wellness screening and up to $200 for a mammogram	Receive up to $50 for getting a covered wellness screening	N/A

Live a Full Life

Our WSI programs are here to help you live your best life. Our Connect Employee Assistance Program (EAP), provided by Cigna, offers free confidential support for everyday challenges and for more serious problems. It's available to you and your household members, even if you're not enrolled in a WSI medical plan.

Get Help

LEGAL ASSISTANCE
FINANCIAL • PARENTING
ELDER CARE • PET CARE
IDENTITY THEFT

EAP Fast Facts

- Available 24/7
- Up to 7 free counseling sessions per issue for each household member each plan year
- Virtual or face-to-face support
- Help with everything from anxiety and depression to marriage and relationships to money management
- Online library of videos and articles

EAP

Get in Touch With the EAP

Call 877.505.4161 or visit myCigna.com.

If you're enrolled in a Cigna medical plan, you'll be able to access the EAP when you sign in to myCigna.com.

For those not enrolled in a Cigna plan and/or for household members, scan the QR code. If you haven't registered yet, click on "Register" to complete your registration (Employer ID: WSI).

Other Benefits

You can enroll in these additional benefits:

LEGAL • IDENTITY & FRAUD PROTECTION • COMMUTER BENEFITS • PET INSURANCE

ENROLL FOR LEGAL COVERAGE AND IDENTITY PROTECTION AT MYWSIBENEFITS.COM

Legal

You can purchase affordable legal coverage through MetLife Legal Plan. You'll be able to access a network of more than 18,000 credentialed attorneys who have an average of 25 years of experience.

Get help with personal legal matters like:

- Buying or selling a home
- Getting married
- Dealing with identity theft
- Starting a family
- Sending kids off to college

You can pay $15.87 per month. You can enroll or cancel coverage during your 31-day initial new hire enrollment period, Open Enrollment or a qualifying life event.

Plus, you have access to Family First benefits that help you navigate caregiving challenges. Get help with elder care, child and adolescent well-being, and navigating insurance and Medicare.

Learn more at info.legalplans.com (enter access code 6090209) or call 800.821.6400.

Identity & Fraud Protection

Identity & Fraud Protection (offered through Aura in partnership with MetLife) can help make your world a safer place.

Features include:

- Coverage for up to 10 additional adults (friends or family)
- $5 million identity theft insurance for each enrolled adult
- Digital vault to store and share sensitive data

To learn more, visit aura.com and go to Features, or call 844.931.2872.

ENROLL FOR COMMUTER BENEFITS AND PET INSURANCE ON THE PROVIDER WEBSITES LISTED IN EACH SECTION BELOW

Commuter Benefits

The Commuter Benefits account helps you save on eligible expenses related to your commute by allowing you to set aside tax-free dollars through payroll deductions. You can use your contributions to pay for expenses related to parking, ridesharing and mass transit. For 2024, you can contribute up to $315 per month pre-tax for transit and parking expenses. To enroll in Commuter Benefits, visit wageworks.com. You can register a new account or log in to your existing HealthEquity/WageWorks account. Place, change or cancel your monthly order by the 10th of the current month for use in the following month.

Pet Insurance

Protect your furry and feathered family members with pet insurance through MetLife that helps cover your pet's ongoing or unexpected veterinary costs. You can see any licensed vet or emergency clinic. You can even do telehealth visits!

Coverage is flexible and customizable, so you can choose the plan that works for you. Enroll or cancel coverage at any time by:

1. Going to metlife.com/getpetquote

or

2. Calling 800.GET.MET8 (800.438.6388) and mentioning you are employed by WSI.

Shop and Save With the Discount Program!

Save on thousands of brands with PerkSpot, WSI's online discount program. From travel to electronics, choose from over 25 categories to shop. All WSI associates, contractors, temporary associates and their friends and family members are eligible for a PerkSpot account. To get started, register for an account at wsi.perkspot.com using your WSI or personal email address. You'll receive a registration email containing login instructions.

Protect What Matters Most

Identity & Fraud Protection (offered through Aura in partnership with MetLife) helps safeguard the things that matter most to you: your identity, money and assets, family, reputation and privacy.

Features You'll Like

- Broad definition of "family" – cover up to 10 additional adults (family or friends) and an unlimited number of minors
- $5 million identity theft insurance for each enrolled adult
- Child monitoring tools and parental controls
- Connects with your MetLife Legal Plan for a seamless user experience

Learn More

Visit aura.com and go to Features, or call 844.931.2872.

Full Coverage

1. **Identity Theft Protection.** Get alerts if threats are detected to your identity, Social Security number and more. This coverage also helps protect your personal info from data brokers and reduce robocalls and spam.
2. **Financial Fraud Protection.** You'll receive alerts for new inquiries made to your credit, suspicious transactions and changes to your home or car title.
3. **Privacy & Device Protection.** Securely store and share sensitive data, digital files and passwords with military-grade encryption – all in one place.

Costs for Coverage

Your Monthly Paycheck Costs for Medical Coverage*

Your costs for coverage will depend upon which plan you select, your level of coverage and your salary.

Monthly costs shown below are Open Access Plus Network rates for non-tobacco users. If you are a tobacco user, your rates will be higher. Additional rates can be found at MyWSIBenefits.com.

	HIGH DEDUCTIBLE HSA	STANDARD CARE	PREMIUM CARE	KAISER PERMANENTE HMO (CERTAIN LOCATIONS ONLY)
If you make $50,000 or less				
Associate Only	$101.67	$150.90	$417.01	$139.13
Associate + Spouse/ Same-Gender Domestic Partner	$276.12	$407.76	$1,008.53	$381.00
Associate + Child(ren)	$226.89	$337.13	$854.41	$312.51
Associate + Family	$400.26	$595.05	$1,440.28	$561.87
If you make $50,000.01–$100,000				
Associate Only	$105.83	$157.08	$429.90	$144.83
Associate + Spouse/ Same-Gender Domestic Partner	$287.42	$424.46	$1,039.72	$396.60
Associate + Child(ren)	$236.17	$350.93	$880.84	$325.30
Associate + Family	$416.66	$619.41	$1,484.82	$584.88
If you make greater than $100,000				
Associate Only	$110.05	$163.35	$442.80	$150.60
Associate + Spouse/ Same-Gender Domestic Partner	$298.90	$441.39	$1,070.92	$412.42
Associate + Child(ren)	$245.61	$364.93	$907.26	$338.28
Associate + Family	$433.28	$644.12	$1,529.36	$608.21

* Rate determination will be based on the associate's annualized salary as of April 2024.

Your Monthly Paycheck Costs for Dental Coverage

Your monthly costs for coverage will depend upon which plan you select.

	STANDARD PLAN	PREMIUM PLAN
Associate Only	$9.84	$24.04
Associate + Spouse/Same-Gender Domestic Partner	$31.69	$62.28
Associate + Child(ren)	$26.22	$51.36
Associate + Family	$40.43	$87.42

Your Monthly Paycheck Costs for Vision Coverage

Your monthly costs for coverage will depend upon which plan you select.

	STANDARD PLAN	PREMIUM PLAN
Associate Only	$4.37	$6.56
Associate + Spouse/Same-Gender Domestic Partner	$8.74	$13.11
Associate + Child(ren)	$8.74	$13.11
Associate + Family	$13.11	$19.67

Benefits To Help You Live a Health-Full Life

Take advantage of all the benefits WSI offers.

GO TO MYCIGNA.COM › WELLNESS

LIVE WELL CASH INCENTIVES[1]

Earn cash for completing wellness activities such as preventive screenings and biometric screenings.

ACTIVE & FIT DISCOUNTS[2]

Get a $25-a-month fitness membership.

HEALTHY REWARDS[2]

Save on things like meal delivery, gyms and virtual workouts, and alternative medicine.

GO TO KP.ORG › HEALTH & WELLNESS › FITNESS & EXERCISE DEALS

WELLNESS DISCOUNTS AND RESOURCES[3]

Take advantage of programs like Active & Fit Discounts and ClassPass.

WELLNESS COACHING[1]

Work with a health coach to meet your personalized health goals.

SMOKING CESSATION[1]

Find support to kick your tobacco habit.

CONNECT EMPLOYEE ASSISTANCE PROGRAM (EAP)[4]

Get free confidential support for everyday challenges and more serious problems. Call 877.505.4161 or visit **myCigna.com**.

1 Available if you're enrolled in a WSI medical plan (Cigna or Kaiser Permanente)
2 Available if you're enrolled in a WSI medical plan through Cigna
3 Available if you're enrolled in a Kaiser Permanente HMO
4 Available to all WSI associates

Contacts

BENEFIT	CONTACT INFO
Benefits Enrollment	
Enrolling	MyWSIBenefits.com 800.413.1444, option 1 (Representatives are available Monday through Friday, 7 a.m. to 4 p.m. Pacific time, except on certain holidays)
Medical and Prescription Drugs	
Cigna (High Deductible HSA, Standard Care, Premium Care)	855.273.3551 myCigna.com
Kaiser Permanente	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
Dental	
Delta Dental of California	800.397.4741 deltadentalins.com
Vision	
VSP	800.877.7195 vsp.com
Health Savings Account (HSA) and Flexible Spending Accounts (FSAs)	
HealthEquity	866.346.5800 my.healthequity.com
Life and AD&D, Disability, Critical Illness, Accident, Hospital Indemnity	
MetLife	800.GET.MET8 (800.438.6388) mybenefits.metlife.com/wsi
Employee Assistance Program (EAP)	
Cigna	877.505.4161 myCigna.com; Employer ID: WSI
Legal	
MetLife Legal Plans	800.821.6400 info.legalplans.com Access code 6090209
Identity & Fraud Protection	
Aura in partnership with MetLife	844.931.2872 aura.com
Pet Insurance	
MetLife	800.GET.MET8 (800.438.6388) metlife.com/getpetquote
Commuter/Parking/Transit	
HealthEquity/WageWorks	877.924.3967 participant.wageworks.com
401(k) Plan	
Charles Schwab	800.724.7526 workplace.schwab.com

WILLIAMS-SONOMA, INC.

POTTERY BARN pottery barn kids POTTERY BARN | teen west elm GreenRow

WILLIAMS SONOMA WILLIAMS SONOMA HOME MARK & GRAHAM REJUVENATION

This document is intended for all regular full-time associates scheduled for or normally working 30 or more hours per week. This document excludes the following groups: Hawaii, Puerto Rico and International associates.

This 2024–2025 Benefits Guide for William-Sonoma, Inc. is a Summary of Material Modifications (SMM) to the Health & Welfare Plan Document and Summary Plan Description for Williams-Sonoma, Inc. associates. This SMM amends the most recent Summary Plan Descriptions (SPDs), available on MyWSIBenefits.com. Log in to the Benefits Portal at MyWSIBenefits.com (look for "Enroll or Check Your Benefits"). Then select "Library" and click on "Plan Summaries."

This guide is designed as a reference to help eligible associates enroll for benefits and answer many benefit questions. The legal documents and insurance contracts governing these plans will determine your benefits in the event of any omissions or discrepancies. Your participation in these plans is not a contract of employment and does not guarantee your future employment.

April 2024

WILLIAMS-SONOMA, INC.

Benefits for a

Health-Full Life

Where To View SPDs

Visit **MyWSIBenefits.com/resources/resource-library** to obtain a copy of the current Summary Plan Description (SPD) for the Cigna and Kaiser Permanente medical plans described in this guide. For the Williams-Sonoma, Inc. Health & Welfare Plan SPD, log in to the Benefits Portal at **MyWSIBenefits.com** (look for "Enroll or Check Your Benefits"). Then select "Library" and click on "Plan Summaries." If you would like to receive a paper copy of an SPD, please contact the WSI Benefits Department at **benefitsdept@wsgc.com** or call 415.616.8500. SPDs maintained at **MyWSIBenefits.com** are updated periodically. The Cigna and Kaiser Permanente SPDs effective for the plan year beginning July 1, 2024, should be available around September 1, 2024.

WILLIAMS-SONOMA, INC.

Benefits for a Health-Full Life

Your 2024-2025 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 2024–2025 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, 2024. 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/dpa/Pages/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
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/
flmedicaidtplrecovery.com/hipp/index.html
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

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
hhs.iowa.gov/programs/welcome-iowa-medicaid
800.338.8366
Hawki
dhs.iowa.gov/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
kidshealth.ky.gov/Pages/index.aspx
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/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
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

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 AND CHIP

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

PENNSYLVANIA – MEDICAID AND CHIP

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

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

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
800.432.5924

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/hipp.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, 2024, 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 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 800.413.1444, 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, 2024.

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 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.

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 GreenRow

WILLIAMS SONOMA WILLIAMS SONOMA HOME MARK & GRAHAM REJUVENATION

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 2024