Williams-Sonoma, Inc.

HEALTH & WELFARE PLAN

Summary Plan Description

Effective: July 1, 2023 to June 30, 2024

SECTION 1 – INTRODUCTION

Williams-Sonoma, Inc. ("WSI" or "Company") maintains the **Williams-Sonoma, Inc. Health & Welfare Plan** (Plan) to provide health and other benefits to eligible associates of Williams-Sonoma, Inc. and of Participating Employers, their spouse or domestic partner, and eligible dependents (as those terms are defined herein). See the chart below at Section 15 for a list of Participating Employers.

This Summary Plan Description (SPD or Summary) describes the health (medical, prescription drug, dental vision, EAP, and health care flexible spending account) benefits, dependent care flexible spending account, life insurance, disability benefits, as well as certain supplemental benefits offered under the Plan as in effect on July 1, 2023. Please note, certain benefits described in this Summary (for example, the dependent care flexible spending account and the health savings account) are not subject to the Employee Retirement Income Security Act (ERISA) and not part of the Plan but are described in this Summary. The Summary will identify those benefits as "Voluntary" or Non-ERISA benefits throughout.

The Open Enrollment materials and the benefit materials published by the insurers and third-party administrators provide additional information about the benefits under the Plan. These materials are referred to as "benefit materials" in this Summary.

If there is any conflict between this Summary and the official Plan document, the Plan document will control. If there is any conflict between this Summary and benefit materials published by insurers and third-party administrators, this Summary will control with respect to non-benefit issues, such as eligibility, and the benefit materials will control with respect to benefit issues. This Summary cannot otherwise modify any benefits described in the benefit materials.

SECTION 2 – ASSOCIATE ELIGIBILITY

A. Associate Eligibility. You are generally eligible to participate in the Plan if you are a regular full-time associate (including reduced hours associate) who is scheduled for or normally working 30 hours a week and you have completed the required eligibility period described below (but see discussion below on eligibility for temporary, part-time or reduced hour associates). Associates who otherwise satisfy the Plan's eligibility requirements, but who are on FMLA (or other full benefits-eligible leave in accordance with the Company's leave policies), shall remain eligible for benefits during such leave.

Required Eligibility Period. New hires who satisfy the eligibility requirements for a Plan benefit must complete enrollment within 31 days of hire. Subject to completing the enrollment requirement, Plan benefits (excluding short-term disability (STD) are effective the first of the month following such new hire's first day of employment. New hires will be eligible for STD on the 90th day following such new hire's first day of employment. Short-term disability coverage may be waived by calling the Benefits Resource Center at (800) 413-1444, option 1 within the 90-day waiting period.

If your employment status changes from non-benefits eligible to benefits eligible so that you first become eligible for benefits within the first 31-days of your date of hire, you will be eligible for benefits at the time described above. If your employment status changes so that

you become eligible for benefits more than 31-days from your date of hire, you will be eligible for benefits on the date of your change in employment status (subject to the 90-day waiting period described above for STD).

ACA Coverage Eligible. The Company may also extend coverage to those temporary, part-time or reduced hours associates who are not otherwise eligible for coverage as a regular full-time associate, but who have worked sufficient hours during the prior year (or other measurement period) to be eligible for coverage in accordance with the Company's Affordable Care Act (ACA) coverage policies. You will be notified by the Company if you have become ACA coverage eligible. Your participation in the Plan will be limited to the following:

- Medical (including Health Savings Account (HSA))
- Healthcare Flexible Spending Account

Leaves of Absence; Partial Benefits Eligible Coverage. If you are an associate on a leave of absence that is partially benefits eligible (as determined by the Company in accordance with its leave policies), you will be eligible to participate in the following coverages:

- Medical (including HSA)
- Basic Life
- Supplemental Life

Additional Eligibility Requirements. Some benefits offered under the Plan may have additional eligibility requirements, and you must meet the specific eligibility requirements for each benefit. These requirements, if any, are set out in the benefit materials.

B. Exclusions. You are not eligible to participate in the Plan(s) if any of the following apply:

- You do not meet the eligibility requirements described in Section 2.A.
- You are classified by the Company as a part-time, temporary, seasonal or casual employee (and you have not satisfied the requirements in 2.A. above to be ACA coverage eligible).
- You are classified by the Company as an independent contractor.
- You are not paid through US payroll.
- You perform services pursuant to a collective bargaining agreement that does not expressly provide for participation in the Plan.
- You perform services pursuant to a staffing agency agreement or employee leasing agreement that does not expressly provide for your participation in the Plan.

- You are otherwise classified by the Company as not benefits eligible.

Expat Medical Coverage. Team members on international assignment are eligible to participate in the Plan, provided they are only eligible for the Expat Medical Coverage described below. The expat medical coverage includes dental. These team members are also not eligible to make HSA and FSA contributions for the period they are not on US payroll.

SECTION 3 – DEPENDENT & DOMESTIC PARTNER ELIGIBILITY

A. Dependent & Domestic Partner Eligibility. If you are an associate who is eligible to participate in the Plan, you may elect to cover your spouse or domestic partner and eligible dependents under certain benefits offered under the Plan, (collectively, called "dependents," "spouse" or "domestic partner" in this Summary). Generally, you must be enrolled for coverage to enroll your spouse, domestic partner, and dependents.

For purposes of the Plan:

- **Your spouse**. Your spouse means the individual to whom you are legally married as determined under applicable state or foreign law.

  "Common Law" spouses are eligible for coverage, pursuant to the state laws in which associate resides (Refer to your state laws for guidance.) An Affidavit of Common Law Marriage form would need to be filled out and returned to add a new Common Law Spouse to coverage.

- **Your domestic partner**. Your domestic partner includes a same-gender individual (and for associates in California, a same gender individual and an opposite gender individual) with whom you have entered into a domestic partner relationship or civil union. To cover your domestic partner, you and your partner must:

  - complete an Affidavit of Domestic Partner's form when adding a new domestic partner to coverage,

  - be each other's sole spousal equivalent and intend to remain so indefinitely, not be legally married to, or the Domestic Partner of, another person under either statutory or common law,

  - be at least 18 years old and mentally competent to consent to contract,

  - not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside,

  - have resided together in the same permanent residence for at least six months and intend to do so indefinitely, and

  - be jointly responsible for each other's common welfare and financial obligations or your domestic partner is dependent on you for financial assistance.

- **Your dependents**. Your dependents include your eligible children or the eligible children of your spouse or domestic partner. Generally, eligible children include children who are:

    - Your biological children or the biological children of your spouse or domestic partner;

    - Children who have been adopted, or placed for adoption, with you or your spouse or domestic partner;

    - Your stepchildren or the stepchildren of your spouse or domestic partner;

    - Children for whom you or your spouse or domestic partner have legal guardianship (provided you claim the dependent on your federal income tax return);

    - A child for whom you are serving as a foster parent; and

    - Children for whom you are legally responsible to provide health coverage under the terms of a Qualified Medical Child Support.

    Children are eligible for coverage regardless of their student status, marital status, financial support or whether they live with you. Except as otherwise provided, children may be covered:

    - Through the end of the month in which the child reaches age 26,

    - Any age, if they are disabled (as determined by the claims administrator) and incapable of earning a living, provided the disability began before age 26 and they are unmarried

Ineligible Dependents

With the exception of certain benefits that may be provided under the Health Care and Dependent Care Spending Accounts or the Employee Assistance program, the following are not eligible for coverage as family members under the Plan benefit:

- Ex-spouses

- Parents or grandparents

- Siblings

- Grandchildren, unless legal dependents by legal adoption

- Brother-in-law or sister-in-law

- Aunts, uncles, cousins, nieces, or nephews

- Opposite gender domestic partner (except in California)

B. Dual Coverage.

- Medical/Dental/Vision/Accident/Critical Illness/Hospital Indemnity – An associate may not be enrolled under his/her own coverage and also be enrolled as the dependent of another associate for the same benefit. Dependent children may only be covered under one associate for each benefit.

- Life Insurance – An associate can be insured under only one plan-sponsored life insurance plan in addition to basic life insurance. This means an associate cannot cover themselves under Supplemental Life and also have coverage as a dependent under Spouse Life or Child Life.

C. Verification. As part of Williams-Sonoma, Inc. dependent eligibility verification process, you will be required to provide documentation for each of your covered dependents to establish their current eligibility for benefit coverage. Examples of valid documentation are your marriage certificate and proof of marriage for your spouse or a birth certificate or adoption certificate for your child. You must submit an Affidavit of Domestic Partnership Relationship to cover your domestic partner and his or her children. You may also be required to submit document(s) to substantiate that your marriage or domestic partnership is current.

You must submit verification within 45 days of your date of hire (or date of eligibility, if later), Open Enrollment or life event that allows for your dependent to be added to your benefits. If you fail to provide documentation, benefits for your dependents will be terminated. Questions about the dependent eligibility verification program may be directed to the *WSI Benefits Resource Center* at 800.413.1444. Representatives are available Monday through Friday, 7 a.m. to 4 p.m. PT, except on certain holidays.

D. Effective Date. Dependent coverage is effective the first day of the month following your date of hire (or date of eligibility, if later) or life event (except in the event of the birth or adoption of a child, in which case the benefits are effective immediately). Coverage of dependents that you add after your coverage begins will become effective as described in Section 4.

E. Domestic Partners and Children of Domestic Partners. Domestic partners and children of domestic partners may or may not qualify as dependents under applicable tax law. See Section 5 B below for a discussion of the tax consequences associated with covering domestic partners and children of domestic partners.

SECTION 4 –BENEFIT ELECTIONS AND ENROLLMENT

A. Enrollment. Any benefits that require an associate contribution will not begin until you have elected and enrolled in the benefits. These benefits are called "elective" benefits.

If you are a *newly eligible* associate, you must enroll in benefits within 31 days of when you first become eligible to participate in the Plan(s). If you enroll in a timely manner, your coverage will be effective the first day of the month following your date of hire or change to eligible status.

Dependent coverage is effective the first day of the month following your date of hire, change to eligible status or life event (except in the event of the birth or adoption of a child, in which case the benefits are effective immediately).

You may also enroll or change your benefit elections during the annual Open Enrollment period. Elections made during the Open Enrollment period will be effective on the first day of the next plan year. You will be provided with the procedures for enrolling in annual Open Enrollment materials.

To enroll, visit *MyWSIBenefits.com*;

- If you are on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the "Benefit Portal" icon, you will be directed to the Open Enrollment landing page. Then, click the "Enroll Now" button and follow the steps to make your elections.

- If you are not on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the option indicating that you are not on the WSI Network, located under the "Benefit Portal" icon. Then you will have an option to login using your Associate ID. If you do not have a password, select "Forgot My Password" to reset it. If you are a first-time user you will need to register. Once you have successfully logged in, click the "Enroll Now" button and follow the steps to make your elections.

- Contact the *WSI Benefits Resource Center* at 800.413.1444.

After you complete your enrollment, save a copy of your election summary for your records. Your confirmation statement will be available at *MyWSIBenefits.com*.

You are responsible for reviewing the confirmation statement and confirming that it is correct. If you determine that the confirmation statement is not correct, you must notify the *WSI Benefits Resource Center* at 800.413.1444 within the time specified in the enrollment materials. If you fail to do so, the elections stated on the confirmation statement will apply for the plan year to which the elections relate (e.g., the entire Plan year or remaining portion of the Plan year with respect to mid-year enrollment).

You may also be required to complete and submit additional enrollment forms provided by the insurance companies or third-party administrators for some of the benefits. If you select a benefit that requires completion of additional enrollment forms, you will be provided such forms by the insurer or third-party administrator.

B. If You Do Not Enroll in Benefits. If you do not enroll in benefits by the applicable deadline, you'll receive some benefits automatically, while you'll need to enroll in others. 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 have a Qualifying Life Event, like getting married or having a baby.

C. Re-hired Associates. If your employment terminates, your participation in the Plan terminates as described in Section 9, "*When Coverage Ends*." If you return to work for Williams-Sonoma, Inc. or Participating Employer in an eligible position within 31 days of

your termination, and during the same Plan Year, your prior elections, other than FSA elections, will be automatically reinstated. New FSA elections will be required, if you are rehired more than 31 days after your employment ended, or in a subsequent plan year, you must make new elections.

D. Special Enrollment Rights — Medical Coverage. You may be able to enroll for medical coverage outside of normal enrollment periods if you experience a "special enrollment event."

- ***New Dependents***. If you acquire a new dependent during the Plan Year because of marriage, birth, adoption, or placement for adoption, you may be able to enroll that dependent and yourself in the medical coverage during the Plan Year. However, you must request enrollment within the time allowed under the plan after the marriage, birth, adoption, or placement for adoption. Following a birth, adoption or placement, you have 60 days to make a change in your coverage. If you gain a new dependent through marriage, you have 31 days following the event to change your coverage. Benefits are effective the first day of the month following the date of the event, except in the event of the birth, adoption or placement of a child, in which case the benefits are effective back to the date of the event, as long as you notify the *WSI Benefits Resource Center* in a timely manner.

  If you fail to request enrollment within this time frame, you must wait until the following annual Open Enrollment period to elect coverage for the new dependent.

- ***Loss of Other Medical Coverage***. If you declined medical coverage under the Plan for yourself or your dependents because you (or they) were covered under another medical plan at the time, and that other coverage terminates, you may elect medical coverage for your dependents, or yourself if you were not previously enrolled and one of the three following requirements is met:

  - The other coverage was COBRA continuation coverage that terminated due to exhaustion of the maximum COBRA coverage period.

  - The other coverage terminated because you or your dependents are no longer eligible under the terms of the other plan for any reason other than your or your dependent's failure to pay premiums on a timely basis or the termination of coverage for cause.

  - The other coverage terminated due to the termination of employer contributions.

  You must request enrollment by notifying the *WSI Benefits Resource Center* within 31 days of the termination of the other coverage. To enroll, visit *MyWSIBenefits.com*;

  - If you are on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the "Benefit Portal" icon, you will be directed to the Open Enrollment landing page. Then, click the "Enroll Now" button and follow the steps to make your elections.

- If you are not on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the option indicating that you are not on the WSI Network, located under the "Benefit Portal" icon. Then you will have an option to login using your Associate ID. If you do not have a password, select "Forgot My Password" to reset it. If you are a first-time user you will need to register. Once you have successfully logged in, click the "Enroll Now" button and follow the steps to make your elections.

- Contact the *WSI Benefits Resource Center* at 800.413.1444.

If you make a timely request, coverage under this Plan may be effective as soon as practicable following the request for coverage and satisfaction of the applicable plan entry rules.

- ***Eligibility for Medicaid or State Children Health Insurance Program***.

  - If you or your dependents are eligible for, but not enrolled in, medical coverage, you may enroll for medical coverage if you are covered under a Medicaid plan or a State children health insurance plan and coverage is terminated as a result of loss of eligibility for such coverage. You must request coverage under this Plan within 60 days after the date of termination of the other coverage. You can make this request by contacting the *WSI Benefits Resource Center* at 800.413.1444 or logging online and visiting *MyWSIBenefits.com*. Scroll down and select the "Benefit Portal" icon, you will be directed to the Open Enrollment landing page. Then, click the "Enroll Now" button and follow the steps to make your elections.

  - If you or your dependents become eligible for premium assistance with respect to coverage under this Plan under a Medicaid plan or a State children health insurance plan, you or your dependents may enroll for coverage in this Plan. You must request coverage under this Plan within 60 days after the date you or your dependents become eligible for assistance. You can make this request by contacting the *WSI Benefits Resource Center* at 800.413.1444 or logging online and visiting *MyWSIBenefits.com*. Scroll down and select the "Benefit Portal" icon, you will be directed to the Open Enrollment landing page. Then, click the "Enroll Now" button and follow the steps to make your elections.

  - Coverage will be effective as soon as practicable following your request for enrollment and satisfaction of the applicable plan entry rules.

E. Changes in Elections. Generally, you cannot change your benefit elections during the Plan Year. There are several important exceptions to this general rule. You may change or revoke your benefit elections during a Plan Year if you experience any of the following events:

- *Change in Status*. You may revoke a benefit election during a Plan Year and make a new election with respect to the remainder of the Plan Year provided that both the revocation and new election are on account of and consistent with a change in status that affects eligibility for coverage under the Plan. The revocation and new election will be

considered consistent if the election change is necessary or appropriate as a result of the change in status event. A change in status includes:

- A change in your marital status due to marriage, divorce, legal separation, annulment, or death of your spouse;
- A change in the number of your dependents due to the death of your dependent or the birth, adoption, or placement for adoption of your dependent child;
- A change in your employment status or the employment status of your dependent that affects eligibility for coverage under this Plan or other associate benefit plan;
- A change that causes a dependent to satisfy or to cease satisfying eligibility requirements under the Plan due to age, student status, marriage or similar circumstance; and
- A change in the place of your or your dependent's residence or worksite that affects eligibility or coverage in the Plan.

- *Court Order*. If the Plan receives an order requiring you to provide health coverage for your child, you may change your election in a manner consistent with the change in your responsibility to provide health coverage to the child. See Section 12 C "Qualified Medical Child Support Order" for more information.

- *Medicaid or Medicare Coverage*. If you or your dependent become covered under Medicare or Medicaid, you may drop medical coverage for the affected individual prospectively. If you or your dependent lose eligibility for Medicare, you may commence or increase coverage prospectively for yourself or your dependent, as applicable. Loss of eligibility for Medicaid is a special enrollment event as described above.

- *Family and Medical Leave*. If you take an unpaid leave under the Family and Medical Leave Act and you are required to make contributions during the leave, you may revoke your elections. See section 10 B, "Family and Medical Leave Act" for more information.

- *Changes to Other Coverage*. If another employer plan: (1) permits participants to make an election change permitted under IRS regulations, or (2) has a period of coverage that is different from the period of coverage under this Plan (for example, it has a different plan year), this Plan may permit you to make a prospective election change that is on account of or corresponds with a change made under the other plan.

- *Cost Changes*. If the cost of a benefit increases or decreases during a Plan Year, the Plan may automatically increase or decrease, as applicable, on a reasonable and consistent basis, all affected participants' pre-tax contributions for such benefit. If the cost of a benefit increases significantly, you may either: (a) make a corresponding change in your pre-tax contributions, or (b) revoke your election and instead elect similar coverage on a prospective basis under another benefit package option providing similar coverage.

- *Coverage Changes*. If coverage is significantly curtailed or ceases during a Plan Year, you may revoke your election and, instead elect similar coverage on a prospective basis under another benefit package option providing similar coverage. If there is no option providing similar coverage, you may be permitted to drop coverage on a prospective basis. For health coverage, coverage is considered significantly curtailed only if there is an overall reduction in coverage provided to all participants under the Plan. The fact that your physician may no longer participate in your plan's network does not constitute a "significant curtailment."

- *Enrollment in Marketplace Coverage*. If you are eligible for a special enrollment period to enroll in a qualified health plan through a public marketplace or want to enroll in a qualified health plan during a marketplace's annual Open Enrollment period, you may drop medical coverage for yourself and your dependents provided you enroll in Marketplace coverage that is effective no later than the day immediately after the last day of your coverage under this Plan.

- *Reduction in Hours of Service*. If your employment status changes from one in which you were reasonably expected to average at least 30 hours of service per week to one in which you will reasonably be expected to average less than 30 hours of service per week, you may drop medical coverage for yourself and your dependents. The revocation of the election of medical coverage must correspond with the intended enrollment of yourself and your dependents in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date your original coverage is revoked.

  If you experience one of the events described above and you wish to change your election, you must notify the *WSI Benefits Resource Center* at 800.413.1444 of a qualified status change within 31-days of the event in order to change your election:

  - If you are on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the "Benefit Portal" icon, you will be directed to the Portal landing page. Click the *Report a Life Event* button and follow the steps to update your elections.

  - If you are not on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the option indicating that you are not on the WSI Network, located under the "Benefit Portal" icon. Then you will have an option to login using your Associate ID. If you do not have a password, select "Forgot My Password" to reset it. If you are a first-time user you will need to register. Once you have successfully logged in, click the Report a Life Event button and follow the steps to update your elections.

  - Contact the *WSI Benefits Resource Center* at 800.413.1444.

  If you fail to provide timely notice, you will need to wait until the following Open Enrollment period to make a change for the following plan year.

  Any new election(s) are generally effective the first day of the month following the date of the event, except in the event of the birth or adoption of a child, in which case the

benefits are effective the date of the event, after the change in election is submitted to the *WSI Benefit Resource Center*. Changes in benefit program coverage are subject to the terms of each benefit program and to the approval of each insurer or third-party administrator.

- *Involuntary Mid-Year Election Changes*. *Changes to Satisfy Nondiscrimination Rules*. At any time, the Plan Administrator may require some or all participants to modify their benefit elections under the Health Care and Dependent Care FSA if the Plan Administrator determines that such modifications are necessary to preserve the tax-preferred status of the Plan. For example, such modifications may be required to enable any flexible benefit option available under the Plan to satisfy the nondiscrimination requirements of applicable provisions of the Code and the Plan Administrator may reduce or cancel the compensation reduction of one or more participants (e.g. highly compensated associates or key associates) to satisfy these limitations.

2023-2024 Benefits and Coverage Levels

The Chart below provides a summary of each of the types of benefits offered under the Plan, including a brief description of the coverage. In some cases, the benefit is provided as voluntary coverage. Please see the explanation below regarding voluntary coverage.

BENEFIT AREA	VENDOR OR PLAN NAME	COVERAGE LEVELS
Medical	Cigna	If you enroll in medical, dental and/or vision coverage, you must choose from one of these coverage tiers/categories for each type of coverage: • Employee only • Employee and spouse or registered domestic partner • Employee and one or more children • Family
	Kaiser	
Dental	Delta Dental	
Prescriptions **Automatically included when a medical plan is elected (note, if Kaiser is elected, prescription coverage will be through Kaiser)*	Express Scripts	
Vision	VSP	
Health Savings Account & Flexible Spending Accounts • **Health Care Flexible Spending Account (HCFSA)** • **Limited Purpose Flexible Spending Account (LPFSA)** • **Dependent Care Flexible Spending Account (DCFSA)** Voluntary Non-ERISA Coverage*	BenefitWallet	Associates have the option to select: • I don't wish to contribute. They will just receive the Employer Contribution • I wish to contribute. They will receive Employer Contribution + Associate Contribution
Employee Assistance Program (EAP)	CONNECT EAP by Cigna	Upon hire, you are automatically enrolled in the employee assistance program which covers

BENEFIT AREA	VENDOR OR PLAN NAME	COVERAGE LEVELS
		yourself, spouse or domestic partner and dependent child(ren).
Critical Illness Insurance *Voluntary Non-ERISA Coverage**	MetLife	Associates may purchase Critical Illness insurance for themselves, spouse, and dependent child(ren). Coverage Levels: • $10,000 Non-Tobacco • $20,000 Non-Tobacco • $30,000 Non-Tobacco • $10,000 Tobacco • $20,000 Tobacco • $30,000 Tobacco Associates who elect this coverage must choose from one of these coverage tiers/categories for each type of coverage elected: • Associate Only • Associate + Spouse • Associate + Child(ren) • Associate + Family
Supplemental Accident Insurance *Voluntary Non-ERISA Coverage**	MetLife	Associates may purchase Supplemental Accident Insurance themselves, spouse, and dependent child(ren). Coverage levels: • High Plan • Low Plan Associates who elect this coverage must choose from one of these coverage tiers/categories for each type of coverage elected: • Associate Only • Associate + Spouse • Associate + Child(ren)

BENEFIT AREA	VENDOR OR PLAN NAME	COVERAGE LEVELS
		• Associate + Family
Hospital Indemnity Insurance *Voluntary Non-ERISA Coverage**	MetLife	Associates may purchase Hospital Indemnity insurance for themselves, spouse, and dependent child(ren). 2 coverage levels: • High Plan • Low Plan Associates who elect this coverage must choose from one of these coverage tiers/categories for each type of coverage elected: • Associate Only • Associate + Spouse • Associate + Child(ren) • Associate + Family
Basic Life Insurance	MetLife	Upon hire, associates are automatically enrolled in Basic Term Life insurance, which covers associates only. See Basic Life, Supplemental and AD&D summary for coverage levels.
Basic Accidental Death and Dismemberment Insurance	MetLife	Upon hire, associates are automatically enrolled in Basic Accidental Death and Dismemberment Insurance, which covers associates only. See Basic Life, Supplemental and AD&D benefit summary for coverage levels.
Supplemental Life Insurance	MetLife	See Basic Life, Supplemental and AD&D benefit summary for coverage levels.
Spouse/Domestic Partner Life Insurance	MetLife	See Basic Life, Supplemental and AD&D benefit summary for coverage levels.
Child Life Insurance *Voluntary Non-ERISA Coverage**	MetLife	See Basic Life, Supplemental and AD&D benefit summary for coverage levels.

BENEFIT AREA	VENDOR OR PLAN NAME	COVERAGE LEVELS
Short-Term Disability	MetLife	Upon hire and satisfying the applicable waiting period, associates have the option to enroll in Short-Term Disability, which covers associates only. Associates may call the WSI Benefits Resources Center and opt out if they do not wish to have the coverage. Note: associates outside the state of California are defaulted into STD coverage after they have met the 90-day waiting period.
Long-Term Disability	MetLife	Upon hire, associates are automatically enrolled in Long-Term Disability, which covers associates only.
Supplemental Long-Term Disability *Voluntary Non-ERISA Coverage**	MetLife	Associates have the option to enroll in Supplemental Long-Term Disability, which covers associates only.
Identity Theft *Voluntary Non-ERISA Coverage**	Allstate	Associates have the option to enroll in Identity Theft and, if they select this coverage, must choose from one of these coverage tiers/categories for each type of coverage: Coverage Levels: • Associate Only Associate + Family
Legal *Voluntary Non-ERISA Coverage**	MetLife Legal	Associates have the option to enroll in the Legal Plan providing coverage for the associate and eligible dependents.
Wellness	Cigna	Eligible associates who have elected medical are eligible for this benefit. • Eligible to Participate Associate Only • Eligible to Participate Associate + Spouse, Domestic Partner or Dependents
Tobacco cessation program	Cigna	Tobacco user – Associate, Spouse, Domestic Partner, or Dependents

BENEFIT AREA	VENDOR OR PLAN NAME	COVERAGE LEVELS
Pet insurance *Voluntary Non-ERISA Coverage**	MetLife	Upon hire, eligible associates;
Commuter/parking/transit *Voluntary Non-ERISA Coverage**	WageWorks	Upon hire, eligible associates. See commuter program description for details.

SECTION 5 – BENEFITS AND FUNDING

A. Benefits. The benefits currently available under the Plan are as described in Sections 4, 6, 7 and 8 of this document and Appendix B and Appendix C. Appendix B includes descriptions of the Plan's prescription drug benefits. Appendix C includes descriptions of other benefits provided under the Plan other than medical, dental and vision benefits. Appendix D refers to the benefit materials prepared by the various claim's administrators and insurers.

B. Funding. Both you and Williams-Sonoma, Inc. share in the cost of coverage. The chart below describes which benefits are paid entirely by Williams-Sonoma, those benefits paid in part by Williams-Sonoma, Inc. and in part by associates and which benefits are paid entirely by associates.

Prior to the beginning of each Plan Year, Williams-Sonoma, Inc. will announce the cost to you (if any) of each of the benefit options offered under the Plan. You generally will pay your portion of the cost of benefits with pre-tax dollars. However, you may pay for some benefits with after-tax dollars. The chart below describes whether the coverage is paid for on a before-tax or after-tax basis. In addition, as a general matter, coverage for domestic partners and children of domestic partners will generally be paid on an after-tax basis. Your contributions are automatically withheld in equal amounts from your paychecks throughout the year.

The pre-tax contribution payment feature of the Plan can help you reduce your taxes and increase your spendable income. Pre-tax dollars are not subject to withholding for federal income or FICA taxes. Consequently, the amount withheld from your pay for taxes is reduced. This means a higher take-home pay for you than if you purchased benefits with after-tax dollars. Because your taxes are reduced, your Social Security benefits may be reduced upon retirement or disability. The reduction will most likely be small.

C. Voluntary Coverage; Non-ERISA*. The benefits above that are described as voluntary coverage are not sponsored by WSI and are not subject to the Employee Retirement Income Security Act ("ERISA") (see information below over your rights under ERISA). While WSI facilitates providing information about these voluntary benefits and assists in collecting the premium for this coverage, the coverage is provided through and administered by the applicable carrier or service provider. The obligation for providing the coverage and determining your rights to benefits under the coverage will be determined by the applicable carrier or service provider. This summary includes a description of several programs that are described as Non-ERISA benefits. These programs are described in this SPD to provide you a complete description of the benefits and programs WSI provides to associates. However, these programs are not subject to ERISA, including any of the ERISA claims procedure requirements or other requirements.

Plan Type	Claims Administrator	Fully-Insured or Self-Insured	Plan Source of Funding and Type of Funding
Medical • **Premium Care (Open Access Network + Local Plus Network)** • **Standard Care (Open Access Network + Local Plus Network)** • **Care Plus HSA (Open Access Network + Local Plus Network)** • **Prescription Drug**	Cigna	Self-insured.	WSI and participating associates share the cost of coverage. Participant contributions toward the cost of coverage is generally pre-tax for active associates.
Medical - HMO • **Northern CA** • **Southern CA** • **Northwest** • **Colorado** • **Georgia** • **Mid-Atlantic States**	Kaiser	Fully-insured.	WSI and participating associates share the cost of coverage. Participant contributions toward the cost of coverage is generally pre-tax for active associates.

Plan Type	Claims Administrator	Fully-Insured or Self-Insured	Plan Source of Funding and Type of Funding
• **Washington**			
Expat Medical Coverage	Global UHC	Fully-insured.	WSI and participating associates share the cost of coverage. Participant contributions toward the cost of coverage is generally pre-tax for active associates.
Medical	Hawaii Medical (HMSA)	Fully-insured.	WSI and participating associates share the cost of coverage. Participant contributions toward the cost of coverage is generally pre-tax for active associates.
Medical Coverage for Puerto Rico	MCS (Puerto Rico)	Fully-insured.	WSI and participating associates share the cost of coverage. Participant contributions toward the cost of coverage is generally pre-tax for active associates.
Dental • **Standard** • **Premium**	Delta Dental	Self-insured.	WSI and participating associates share the cost of coverage. Participant contributions toward the cost of coverage is generally pre-tax for active associates.
Prescriptions	Express Scripts	Self-insured.	* Prescription coverage is automatic when a participating associate elects medical coverage.
Spending Accounts • **Health Care Flexible Spending Accounts** • ***Dependent Care FSA (non-ERISA plan)***	BenefitWallet	Self-Funded	WSI and participating associates share costs of the program. FSA, HSA deductions are pre-tax.

Plan Type	Claims Administrator	Fully-Insured or Self-Insured	Plan Source of Funding and Type of Funding
• ***Health Saving Account (non-ERISA plan)***			
Employee Assistance Program (EAP)	CONNECT EAP by Cigna Employer ID: WSI	Fully-insured	WSI pays for the full cost of the program.
Vision	VSP	Self-insured	Participating associates pay for the full cost of the program. Participant contributions toward the cost of coverage is generally pre-tax for active associates.
Basic Life Insurance • **1x Annual Pay** • **2x Annual Pay**	MetLife	Fully-insured	WSI pays the full cost of coverage.
• **Supplemental Life Insurance (16) (non-ERISA plan)** • **Spouse/Domestic Partner Life Insurance (07) (non-ERISA plan)** • **Child Life Insurance (08) (non-ERISA plan)**	MetLife	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Basic Accidental Death and Dismemberment • **1x Annual Pay** • **2x Annual Pay**	MetLife	Fully-insured	WSI pays the full cost of coverage.

Plan Type	Claims Administrator	Fully-Insured or Self-Insured	Plan Source of Funding and Type of Funding
Short-Term Disability	MetLife	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Long Term Disability • **Company Paid Long-Term Disability**	MetLife	Fully-insured	WSI pays the cost of coverage.
Supplemental Long-Term Disability (non-ERISA plan)	MetLife	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Critical illness Insurance (non-ERISA plan)	MetLife	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Supplemental Accident Insurance (non-ERISA plan)	MetLife	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Hospital indemnity Insurance (non-ERISA plan)	MetLife mybenefits.metlife.com/wsi	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Identify protection (non-ERISA plan)	Allstate myaip.com	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Legal (non-ERISA plan)	MetLife info.legalplans.com Access code 6090209	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Pet insurance (non-ERISA plan)	MetLife metlife.com/getpetquote	Fully-insured	Participating associates pay the full cost of coverage and deductions are after-tax.
Commuter/ parking/ transit (non-ERISA plan)	WageWorks participant.wageworks.com	N/A	Participating associates pay the cost of coverage on an after-tax basis
Wellness	Cigna	N/A	WSI pays the cost of coverage.

Plan Type	Claims Administrator	Fully-Insured or Self-Insured	Plan Source of Funding and Type of Funding
Tobacco cessation program	Cigna	N/A	WSI pays the cost of coverage.
Note: coverage for domestic partners and children of domestic partners generally does not qualify for pre-tax contributions.			

SECTION 6 – HEALTH SAVINGS ACCOUNTS

A. Eligibility. Associates who meet the following requirements on the first day of a month are eligible to establish and contribute to an HSA during that month:

- Enrolled in an HSA-compatible high deductible health plan (HDHP) on the first day of the month
- Not eligible to be claimed as a dependent on another person's tax return
- Not covered under another medical plan that is not a HDHP (e.g., coverage under a spouse's general-purpose health care flexible spending account)
- Not Enrolled in Medicare

Note that if you were enrolled in a general purpose health care flexible spending account in the prior plan year and you had a balance on the last day of that plan year, your plan allows for up to $500 of unused funds to rollover to the new plan year. If you enroll in a plan that is HSA qualified in the new plan year your funds will rollover to a limited purpose FSA. A limited purpose FSA only allows reimbursement for dental and vision expenses and is compliant to allow you to fund an HSA.

B. Associate Contributions. The annual amount that may be contributed to your HSA for a calendar year is limited by law and depends on whether you are enrolled in self-only or family coverage and the number of months during the year that you were enrolled in that coverage. Individuals who are age 55 or older as of the end of the calendar year may make an additional "catch-up" contribution of up to $1,000. The maximum annual contribution you may make will be reduced by any contributions made on your behalf by Williams-Sonoma, Inc.

Note that although you may establish an HSA with the provider of your choice, you will only be permitted to make pre-tax contributions to an HSA opened with BenefitWallet.

C. Company Contributions. If you open an HSA with BenefitWallet, you may also receive contributions from Williams-Sonoma, Inc. Note that while you may have an HSA elsewhere, the Williams-Sonoma, Inc. will fund only the HSA administered by BenefitWallet. Williams-Sonoma, Inc. will contribute $500 for associates enrolled in self-only coverage

under the Williams-Sonoma, Inc.'s HDHP and $1,000 for associates enrolled in family-coverage. WSI pays ½ of the contribution amount up front and the other ½ by payroll contributions over the course of the plan year.

Williams-Sonoma, Inc.'s HSA contribution is pro-rated for HSA opened as the result of a life event or new hire. Williams-Sonoma, Inc. may change the amount of the contribution or eliminate it entirely in the future.

D. Changes to HSA Contribution Elections. You may increase or decrease your HSA contribution election prospectively at any time during the Plan Year. Any change will be made as soon as administratively possible.

E. Distributions from your HSA. Distributions from your HSA are tax-free at the Federal level (note, CA and NJ do not recognize the HSA as tax free) as long as they are used for qualified medical expenses incurred after you have established your HSA. If you withdraw funds for non-qualified expenses, the withdrawal will be subject to federal taxes and penalties (note that although the distribution is still taxable, there is no penalty if you are at least age 65).

Qualified medical expenses generally are health care expenses incurred by you, your spouse, or your dependent children you can claim on your tax return, with some exceptions. Note that the definition of dependent child is different for HSA purposes than it is for health FSA purposes—generally you can only be reimbursed for your child's expenses until he or she is age 18 (age 24 if a full-time student). If you have questions, please contact your tax advisor. For more information on qualified medical expenses, refer to IRS Publication 502. Expenses incurred for menstrual care products as well as over-the-counter drugs obtained without a prescription are eligible to be qualified medical expenses.

F. If You Leave the Company. Your HSA balance is portable and yours to keep. If you don't enroll in another high deductible health plan, you will no longer be able to contribute to an HSA, but you will still be able to use your HSA account for qualified medical expenses.

G. Status of HSA Account. HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax basis. Terms and conditions of coverage and benefits will be provided by and are set out in the HSA documents. The HSA is not intended to be an ERISA benefit plan sponsored or maintained by Williams-Sonoma, Inc.

SECTION 7 – HEALTHCARE FLEXIBLE SPENDING ACCOUNTS

- **In General**. Each year you may elect to contribute a portion of your compensation to a healthcare flexible spending account. The amount of your election will be deducted from your pay on a pre-tax basis. The annual amount you elect will be available to reimburse you for eligible health care expenses not reimbursed by any other health program.

- **The Health Care Flexible Spending Account (HCFSA)** is available to all benefits-eligible associates who aren't enrolled in the HDHP. You can use your HCFSA to pay for eligible medical, dental, vision, and drug expenses, such as deductibles, coinsurance, copays, and certain over-the-counter drugs prescribed by a health care provider.

- **The Limited Purpose Flexible Spending Account (LPFSA)** is available to HDHP participants. The LPFSA can be used only for dental and vision expenses before you meet the medical plan deductible. Once the medical plan deductible is satisfied, you can use the LPFSA for all health expenses, including medical and drug expenses.

  Participants will need to work with the FSA administrator, BenefitWallet to change your LPFSA to a Post Deductible account once the medical plan deductible is satisfied.

A. Eligible and Ineligible Expenses. To be eligible for reimbursement under either flexible spending account, an expense must meet all of the following general requirements:

- It must qualify for the medical care deduction as described under Code Section 213; however, you may not claim the expense as a deduction on your federal income tax return.

- It must be incurred by you or your eligible dependents while you are a participant in the Plan. Your eligible dependents include your spouse and any other individual who qualifies as a tax dependent under Code Section 105(b), including your child through the end of the year in which he or she turns age 26.

- It must have been incurred during the Plan Year. An expense is considered incurred on the date on when the services giving rise to the eligible expenses are performed, and not on the date that the services are billed by the service provider or paid by you.

- The expense may not be covered by other health insurance or reimbursed by any other means.

  The following chart provides a partial list of eligible and ineligible expenses.

  Insulin is an eligible expense. Over-the-counter (OTC) drugs and medicines as well as supplies and equipment, including first-aid kits and diabetic management supplies are eligible for reimbursement without a prescription. A more complete list of eligible expenses is available in IRS Publication 502, available at www.irs.gov/pub/irs-pdf/p502.pdf.

  While Publication 502 provides guidelines for eligible and ineligible expenses under the HCFSA, there are some exceptions. Contact BenefitWallet if you have questions about what is and isn't eligible for reimbursement under the HCFSA.

Examples of Eligible Health Care Expenses	
Acupuncture	Laboratory fees
Alcoholism/drug addiction treatment	Menstrual care products

Birth control pills/devices (if prescribed)	OTC medications such as pain, allergy and cold medications with or without a physician's prescription
Braces (orthotic devices)	Physical examinations
Chiropractor	Physical therapy
Contact lenses, solutions and supplies	Physician-directed smoking cessation programs
Dental expenses (including orthodontia)	Physician's recommended/monitored weight-loss program
Hearing devices and batteries	Prescribed drugs, including smoking-cessation medications
Hospital bills	Prescription eyeglasses, including sunglasses
Insulin	Speech therapy

Examples of Ineligible Health Care Expenses	
Advanced payments made for lifetime care paid to a retirement home	Maternity clothes
Cosmetic surgery, except when necessary to correct a congenital deformity or accidental injury	Health club dues
Hair transplants or electrolysis, unless medically necessary	OTC vitamins and dietary supplements unless prescribed by a physician

B. Contributions. Williams-Sonoma, Inc. may establish minimum and maximum dollar limits on the amount that you may contribute to your healthcare flexible spending account during a Plan Year. The limits for a specific Plan Year will be announced in enrollment materials for that year. The amount that you elect will be withheld automatically from your pay in equal installments.

Generally, your contribution election for a Plan Year is irrevocable unless you have a change in status event as described in Section 4.

C. Submission of claims. The full amount of your healthcare flexible spending account coverage election (reduced by prior reimbursements made for the same Plan Year) will be available to reimburse your eligible health care expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim. You may submit a claim form along with the invoice or receipt for such expense.

How to Submit a Paper Claim for Your Health Care FSA Account

BEFORE YOU SUBMIT: Documentation to substantiate purchases made with your debit card must be submitted with a copy of your "Receipt Reminder".

Step 1: Account Holder Information

- Update the form to include your personal information for the purpose of identifying your account.

Step 2: Reimbursement Information

- Plan Type: Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- Did You File Online: If a claim for the expense was already filed online at www.mybenefitwallet.com, mark "Y" for yes; if not, mark "N" for no.
- Date(s) of Service: Provide the date services were rendered, or the date eligible products were purchased. If you are combining multiple expenses on one line, provide the range of dates during which expenses were incurred.
- Service Provider Name: Provide the name of the merchant or provider of service where the expense was incurred.
- Name of Person Receiving Product/Service: Provide your name or the name of the tax-qualified dependent for which the service was provided or the product was purchased.
- Claim Amount: Provide the total amount requested for the specified expense.
- Total Reimbursement Requested: Add all of the amounts in the "Claim Amount" boxes and provide the total here.

Step 3: Account Holder Certification

- Sign and date the form after reading the Account Holder Certification.

Step 4: Submit

- Submit the completed form with the supporting documentation to BenefitWallet as specified in step 4.

Health Care Reimbursement Account Claim Form

Option 1: Go Paperless!

You won't need to complete paper forms anymore. Just submit claims online at www.mybenefitwallet.com.

Option 2: Submit your claim using this form

Step 1: Fill out the form

- Please print in capital letters with the letters centered in the boxes as shown:
- Complete a separate line for each individual expense.
- Use page 4 if you exceed the number of lines available on page 3.

Step 2: Attach Supporting Documentation

- See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.
- Do not send original receipts or original supporting documentation.
- Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.

Step 3: Certify

- Read the Certification and then sign and date the form.

Step 4: Submit

- FAX the form and supporting documentation to 1-877-841-1152.
- Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.
- Alternatively, you may also mail your claims to: BenefitWallet, P.O. BOX 18009 Suite A, Norfolk, VA 23501

To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember

- Keep a copy of the form and all original receipts for your records.

D. Debit Card. If you enroll in a healthcare flexible spending account option, you will receive a debit card. It will allow you to pay out-of-pocket costs incurred at certain health care providers or pharmacies that have implemented certain standards required by the IRS, up to your plan year account election. The debit card is only accepted at retail locations that are known to provide health care items or services.

This debit card is for your convenience. The primary advantage of the card is that it allows you to access your FSA funds at the point of service without paying out-of-pocket up front and waiting for reimbursement; however, you don't have to use it. You can pay your expenses out-of-pocket and submit claims for reimbursement. You can file a claim online, by fax, or by mail.

You may receive a Request for Documentation letter. This means you need to verify that a card purchase is eligible. It is your responsibility to verify the expenses that need to be substantiated and to submit the required documentation by the deadline.

Note: If you don't respond to the request, your card may be suspended until you either send in the requested documentation or pay back the account. If you have unsubstantiated transactions, the IRS will consider those amounts as taxable.

E. Claims Denial. If your claim is denied in whole or in part, you will receive a notice that will provide the following information:

- The specific reason or reasons for the denial.
- The specific plan provisions on which the denial is based.
- Any additional material or information necessary to substantiate the claim and an explanation of why such material or information is necessary.
- An explanation of the plan's claim review procedure.

You may appeal a denial as set out in Section 11, *Claims and Appeals Procedures*.

F. Claims Submission Deadline and Forfeiture of Benefits. The Health Care Flexible Spending Account allows up to $500 of unused contributions to be carried over to the next plan year. The plan allows for a 90 day Runout period (September 30) after the end of the plan year during which the participant can submit eligible Health FSA or Dependent Day Care FSA claims incurred during the preceding plan year for reimbursement. For the Health FSA any amount over $500 remaining at the end of the applicable Plan Runout period will be forfeited. You must submit all claims for reimbursement no later than 90 days following the plan year end date. Any funds over $500 remaining in your Account after the applicable claims submission deadline will be forfeited.

If you terminate employment during the Plan Year and do not continue coverage through COBRA, only claims incurred prior to your termination of employment will be eligible for reimbursement. You must submit all claims for reimbursement no later than 90 days

following the plan year end date. Any funds remaining in your Account after the applicable claims submission deadline will be forfeited.

G. Continuation of Coverage under COBRA. A Healthcare Flexible Spending Account is subject to COBRA (See Section 10, *Continuation of Coverage*). However, COBRA continuation coverage under a Healthcare Flexible Spending Account only continues through the end of the Plan Year (and any associated Runout Period) in which the qualifying event occurred.

H. Leaves and Spending Accounts. If you go on an approved leave of absence:

- You may continue to make contributions to your healthcare flexible spending account and while you are on leave.
- If you choose to stop contributions to your healthcare flexible spending account while you are on leave, you will have the following options when you return to work:
  - You may choose not to participate for the remainder of the plan year.
  - You may reinstate the salary reduction amount of your prior elections, in which the amount of your salary reduction contributions will remain the same, but the total amount of your election (reduced by any prior reimbursements) will be prorated.
  - You may reinstate the dollar amount of your prior elections in which case the amount of your salary reduction will be increased, and the total amount of your election will remain unchanged.
  - You may make new elections consistent with a change in status that occurred while you were leave.
- If you revoked your healthcare flexible spending account election while you were on leave, any expenses incurred during the lapse in coverage will not be eligible for reimbursement.

SECTION 8 – DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A. In General. You may elect to contribute a portion of your compensation to a dependent care flexible spending account and that amount will be deducted from your pay on a pre-tax basis. The amount in your account will be available to reimburse you for employment related dependent care expenses.

B. Eligible and Ineligible Expenses. Employment related dependent care expenses are expenses you incur to permit you (and your spouse) to be gainfully employed and must be for the care of your dependents who are:

- Under the age of 13; or

- Physically or mentally incapable of self-care and who live with you for more than half of the year. If services are provided outside of your home, the dependent must spend at least eight hours per day in your home (therefore, full-time care for a dependent parent in a nursing facility will not qualify).

The following rules apply:

- The expense must be incurred while you are a participant in the Dependent Care Flexible Spending Account and during the Plan Year. A dependent care expense is incurred when the service that causes the expense is provided, not when the expense is billed or paid for.

- If the expense is incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any.

- Employment-related expenses will not include amounts paid to your child who is under the age of 19 or to an individual who is your or your spouse's dependent.

  The following chart lists the most common eligible and ineligible dependent care expenses. A more complete list of eligible expenses is available in IRS Publication 503, or on the IRS website at: www.irs.gov/pub/irs-pdf/p503.pdf.

  This list of eligible expenses may be modified at any time, without prior notice.

Eligible DCFSA Expenses	
In-home services provided by a babysitter, nursing aide or attendant[1]	Practical nursing care for an adult, in or outside the home[1]
Care provided outside your home (if your eligible dependent is over age 13, he or she must be disabled and spend at least eight hours per day in your home)	Services provided by a housekeeper or maid, if that person is responsible for the daytime care of an eligible dependent
Services provided by a day care facility for children or adults (the facility must be licensed if it provides care for more than six individuals who do not normally live there)	Any taxes you pay as the employer of a dependent care provider
Before- and after-school care for children under age 13	Day camps, including camps that specialize in a specific activity such as sports

[1] Any medical expenses incurred through utilization of a nurse or nursing home facility are not eligible.

Ineligible DCFSA Expenses	
Care provided by your spouse, your child under age 19 or anyone else you claim as a dependent on your federal tax return	Transportation to and from the place where care is provided
Any amounts paid to provide food, clothing or education (certain exceptions may apply)	Tuition expenses for dependent children in kindergarten or above; however, charges for before-school and after-school programs are eligible
Services outside your home at a camp where your child, disabled spouse or dependent stays overnight	

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the dependent care flexible spending account.

If you are married and your spouse does not work, you generally are not entitled to dependent care reimbursement, unless your spouse is a full-time student or incapable of self-care.

C. Contributions. The maximum amount that you may contribute to your dependent care flexible spending account for the year cannot exceed the least of: (1) $5,000 ($2,500 if you are married and file a separate return), (2) your earned income, or (3) your spouse's earned income. A spouse who is a full-time student or incapable of self-care will be treated as gainfully employed and deemed to have earned income of $250 per month (if you have one dependent), or $500 per month (if you have two or more dependents).

The amount that you elect to put into your dependent care flexible spending account will be automatically withheld from your pay in equal installments.

Generally, your contribution election for a Plan Year is irrevocable. However, you may change your election during the Plan Year if:

- Your dependent care costs change. You may change your dependent care flexible spending account election to reflect an increase or decrease in cost if you change dependent care providers. If the cost changes but you did not change dependent care providers, you may increase or decrease your dependent care flexible spending account election only if your dependent care provider is not a relative.

- Your need for dependent care changes. You may increase your dependent care flexible spending account election if your need for dependent care increases (e.g., your spouse changes from part-time to full-time employment). You may decrease your dependent care flexible spending account election if your need for dependent care decreases (e.g., your child starts kindergarten).

D. Leaves of Absence. If you go on an approved leave of absence:

- You may continue to make contributions to your dependent care flexible spending account and while you are on leave

- If you choose to stop contributions to your dependent care flexible spending account while you are on leave, you will have the following options when you return to work:

  - You may choose not to participate for the remainder of the plan year.

  - You may reinstate the salary reduction amount of your prior elections, in which the amount of your salary reduction contributions will remain the same, but the total amount of your election (reduced by any prior reimbursements) will be prorated.

  - You may reinstate the dollar amount of your prior elections in which case the amount of your salary reduction will be increased, and the total amount of your election will remain unchanged.

  - You may make new elections consistent with a change in status that occurred while you were leave.

- If you revoked your dependent care flexible spending account election while you were on leave, any expenses incurred during the lapse in coverage will not be eligible for reimbursement.

E. Submission of Claims. You may submit a claim form along with the invoice or receipt for such expense.

- **<u>How to Submit a Paper Claim for Dependent Care FSA Account</u>**

  BEFORE YOU SUBMIT: Documentation to substantiate purchases made with your debit card must be submitted with a copy of your "Receipt Reminder".

  Step 1: Account Holder Information

  - Update the form to include your personal information for the purpose of identifying your account.

  Step 2: Reimbursement Information

  - Plan Type: Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.

- Did You File Online: If a claim for the expense was already filed online at www.mybenefitwallet.com, mark "Y" for yes; if not, mark "N" for no.

- Date(s) of Service: Provide the date services were rendered, or the date eligible products were purchased. If you are combining multiple expenses on one line, provide the range of dates during which expenses were incurred.

- Service Provider Name: Provide the name of the merchant or provider of service where the expense was incurred.

- Name of Person Receiving Product/Service: Provide your name or the name of the tax-qualified dependent for which the service was provided or the product was purchased.

- Claim Amount: Provide the total amount requested for the specified expense.

- Total Reimbursement Requested: Add all of the amounts in the "Claim Amount" boxes and provide the total here.

Step 3: Account Holder Certification

- Sign and date the form after reading the Account Holder Certification.

Step 4: Submit

- Submit the completed form with the supporting documentation to BenefitWallet as specified in step 4.

- **Dependent Care Reimbursement Account Claim Form**

  - **Option 1: Go Paperless!**

    You won't need to complete paper forms anymore. Just submit claims online at www.mybenefitwallet.com.

  - **Option 2: Submit your claim using this form**

Step 1: Fill out the form

- Please print in capital letters with the letters centered in the boxes as shown:

- Complete a separate line for each individual expense.

- Use page 4 if you exceed the number of lines available on page 3.

Step 2: Attach Supporting Documentation

- See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.

- Do not send original receipts or original supporting documentation.
- Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.

Step 3: Certify

- Read the Certification and then sign and date the form.

Step 4: Submit

- FAX the form and supporting documentation to 1-877-841-1152.
- Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.
- Alternatively, you may also mail your claims to: BenefitWallet, P.O. BOX 18009 Suite A, Norfolk, VA 23501

  To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember

- Keep a copy of the form and all original receipts for your records.

F. Payment of Claims. The claims administrator will decide your claim for benefits within a reasonable time, but not later than 30 days after it is received. This period may be extended for an additional 15 days when necessary due to matters beyond the control of the Plan or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30 day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to such notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

G. Insufficient Funds. Your dependent care flexible spending account cannot reimburse you for more money than has been credited to your account on the date you make a claim. If there are insufficient funds in the account to pay the full amount of your claim, you will receive a partial payment and the unpaid amount will be held until there are sufficient funds in the account.

H. Claims Denial. If you claim is denied in whole or in part, you will receive a notice that will provide the following information:

- The specific reason or reasons for the denial.
- The specific plan provisions on which the denial is based.
- Any additional material or information necessary in order for you to substantiate the claim and an explanation of why such material or information is necessary.
- An explanation of the plan's claim review procedure.

You may appeal a denial as set out in Section 11, *Claims and Appeals Procedures*.

I. Forfeiture of Benefits. You must use the full amount of money in your Dependent Care Flexible Spending Account for eligible expenses incurred during the applicable Plan Year. Generally, your request for reimbursement must be filed by September 30 after the end of the Plan Year in which funds are allocated to your Dependent Care Flexible Spending Account.

If you terminate employment during the Plan Year, you must submit all claims for reimbursement no later than 90 days after then plan year end date. Only claims incurred prior to your termination of employment are eligible for reimbursement. Any funds remaining in your Account after the applicable claims submission deadline will be forfeited.

J. Dependent Care Tax Credit. Expenses that are eligible for reimbursement by the Dependent Care Flexible Spending Account may also be eligible for a tax credit under federal tax laws. The amount of federal income taxes you owe may be reduced by a percentage of the money you have spent on eligible dependent care expenses. The percentage varies depending on the combined income of you and your spouse. The total amount of expense eligible for the credit is $3,000 per year for one child and $6,000 per year for two or more children. You are not permitted to use both the tax credit and the dependent care flexible spending account for the same expenses. You should consult with your tax advisor to determine if you should participate in the dependent care flexible spending account or take the tax credit on your federal income tax return.

K. IRS Filing. The IRS requires you to provide certain information about your dependent care provider on your federal tax return, Form 2441, available at www.irs.gov/formspubs/index.html. If you don't provide this information, the money you receive from your DCFSA will become taxable income.

The amount of your DCFSA contribution will be reported to the IRS, as required by law, and will appear on your W-2 Form.

The following information must be included on your federal tax return for each year you participate in a DCFSA:

- The provider's name and address
- For care provided by an:
    - Individual, their Social Security number

- Organization or care center, its tax identification number

SECTION 9 – WHEN COVERAGE ENDS

A. Termination of Associate Coverage. Except as described below or as described in the benefit materials for the specific programs, your coverage under the Plan will end on the earliest of the following dates:

- The date on which you cease to satisfy the eligibility requirements for participation in the Plan due to termination of employment, reduction in hours, reclassification, death or any other reason.
  - For flexible spending accounts, on the last day of the period covered by your contributions;
  - The day on which you are no longer eligible for an approved leave of absence and you don't return to work;
  - The day in which your benefit election is no longer in effect;
  - The end of the period for which the last required contributions has been paid, if the contribution for the next period is not paid when due;
  - The day the Plan, or any benefit offered under the Plan (or insurance contract funding a benefit of the Plan), is terminated; or
  - The date the Plan Administrator terminates your coverage for cause.

  There may be other termination provisions applicable to specific coverage. Refer to the appropriate section of this SPD for complete details.

B. Termination of Dependent Coverage. Except as described below or as described in the benefit materials for the specific programs, your dependent's coverage under the Plan will end on the earliest of the following to occur:

- The day that you lose coverage;
- The date your dependent no longer meets the eligibility requirements for participation under the Plan, except that for medical, dental and vision coverage, coverage will end on the last day of the month of dependent child's 26th birthday;
- The day on which your election of dependent coverage is no longer in effect;
- The end of the period for which the last required contributions has been paid, if the contribution for the next period is not paid when due;
- The day the Plan, or dependent coverage under the Plan, is terminated; or

- The date the Plan Administrator terminates your dependent's coverage for cause.

  You are responsible for notifying the WSI Benefits Resource Center when a dependent is no longer eligible for coverage. This includes notifying the WSI Benefits Resource Center of a divorce, dissolution of a domestic partnership, death or a child reaching the age limit.

C. Fraud and Misrepresentation. If you commit a fraudulent act or intentionally misrepresent a material fact related to the Plan (including submission of a fraudulent claim or misrepresentation of citizenship or immigration status in obtaining or maintaining employment), benefits may be terminated retroactive to the date of the fraudulent act or misrepresentation. When you enroll a dependent in the Plan, you represent that the individual is eligible under the terms of the Plan. Further, you understand that the Plan is relying on your representation of eligibility in accepting the enrollment of your dependent and that your failure to notify WSI Benefits Resource Center of a dependent's loss of eligibility or failure to provide evidence of eligibility is considered a misrepresentation of a material fact. WSI Benefits Resource Center will provide at least 30 days advance written notice prior to the retroactive termination. However, if you do fail to make your contributions towards the cost of coverage in a timely manner, coverage may be terminated retroactively without advance notice.

SECTION 10 – CONTINUATION OF COVERAGE

A. COBRA Continuation Coverage. You and your covered dependents may be offered COBRA continuation coverage when your health coverage (e.g., medical, dental, vision, prescription drug, employee assistance and FSA coverage) under the Plan would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage generally consists of the coverage under the Plan that you and your family members had immediately before the qualifying event. Individuals who lose coverage because of a qualifying event are referred to as "qualified beneficiaries".

Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other similarly situated participants or beneficiaries covered by the Plan who did not have a qualifying event. This includes the right to add dependents if they qualify for a HIPAA special enrollment period. If the Plan changes benefits, premiums, etc., continuation coverage changes accordingly. During Open Enrollment, each qualified beneficiary will have the same options available under COBRA coverage as active associates covered under the Plan.

- **When COBRA Continuation Coverage Is Available**. The specific qualifying events that trigger the right to elect COBRA continuation coverage are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse, your domestic partner[1] or your dependent

[1] Under federal law, domestic partners cannot be qualified beneficiaries. However, the Plan will treat domestic partners the same way as spouses for COBRA continuation coverage purposes.

children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced to a benefits-ineligible status, or
- Your employment ends.

If you have coverage under the Plan as the ***spouse or domestic partner*** of an associate, you will become a qualified beneficiary if you lose that coverage Plan because any of the following qualifying events occurs:

- The associate dies;
- The associate's hours of employment are reduced to a benefits-ineligible status;
- The associate's employment ends;
- The associate becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from the associate, or you and the associate dissolve your domestic partnership.

An individual who has coverage under the Plan as a ***dependent child*** of an associate will become a qualified beneficiary if he or she loses that coverage because any of the following qualifying events occurs:

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

Qualified beneficiaries will be offered COBRA continuation coverage only after the *WSI Benefits Resource Center* has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, death of the associate or the associate's becoming entitled to Medicare

benefits (under Part A, Part B, or both) Conduent, the COBRA administrator, will be informed of the qualifying event within 31 days of the event.

- **You Must Give Notice of Some Qualifying Events**. For the other qualifying events (divorce of the associate and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the WSI Benefits Resource Center of a qualified status change within 31-days of the event in order to change your election:

  - If you are on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the "Benefit Portal" icon, you will be directed to the Portal landing page. Click the Report a Life Event button and follow the steps to update your elections.

  - If you are not on the WSI Network, please go to *MyWSIBenefits.com*, scroll down and select the option indicating that you are not on the WSI Network, located under the "Benefit Portal" icon. Then you will have an option to login using your employee ID. If you do not have a password, select "Forgot My Password" to reset it. If you are a first time user you will need to register. Once you have successfully logged in, click the Report a Life Event button and follow the steps to update your elections.

  - Contact the *WSI Benefits Resource Center* at 800.413.1444.

- ***If notice is not provided within 60 days of the later of the event or loss of coverage, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage***.

- **Duration of COBRA Coverage**. COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

  - When the loss of coverage is because of the death of the associate, the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, dissolution of a domestic partnership or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage for the associate's spouse and/or dependent child may last for up to a total of 36 months.

  - When the loss of coverage is because of the associate's termination of employment or reduction of hours of employment, COBRA continuation coverage for the associate and his or her spouse, domestic partner and/or dependent children generally may last for up to a total of 18 months.

    A special rule applies if the associate becomes entitled to Medicare benefits less than 18 months before the end of employment or reduction in hours. In that situation, the associate is still entitled to up to 18 months of COBRA continuation coverage under the general rule described above. However, COBRA continuation coverage for qualified beneficiaries other than the associate may last up to 36 months after the date of the associate's Medicare entitlement. For example, if a covered associate becomes entitled to Medicare 8 months before the date on which his employment terminates,

COBRA continuation coverage for his or her spouse, domestic partner and children can last up to 36 months after the date of Medicare entitlement. Thus, their COBRA continuation coverage may continue for up to 28 months after the date of the qualifying event (36 months minus 8 months).

If the associate becomes entitled to Medicare more than 18 months prior to the end of employment or reduction of hours, the general rules apply.

- **Extension of the 18-Month Period of Continuation Coverage**. There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

  - **Disability extension**. If the Social Security Administration (SSA) determines that you or a family member covered under the Plan is disabled and COBRA Administrator receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. In order for the extension to be available, you must notify COBRA Administrator in writing of the disability determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event or (iii) the date coverage would end on account of the qualifying event.

    The notice must be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. It must include the associate's name, the name of the disabled individual as well as a copy of the Social Security Administration disability determination.

    A notice mailed to COBRA Administrator will be considered provided on the date of mailing.

    If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.

    The disability extension is available only for as long as the family member remains disabled. COBRA Administrator must be notified if the Social Security Administration makes a final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than 31 days after the date of the determination.

  - **Second qualifying event**. If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and/or dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage. This extension may be available if the associate or former associate dies, is divorced, or if a child no longer qualifies as a dependent child under the terms of the Plan, but

only if the event would have caused the spouse, domestic partner, or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to COBRA Administrator no more than 60 days of the later of the event or loss of coverage.

This notice should be sent to COBRA Administrator at the address specified in the section *How to Contact COBRA Administrator*. The notice must include the associate's name, the name of the spouse, domestic partner, and/or dependent child, the nature of the second qualifying event (e.g., divorce or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or the date the dependent child lost dependent status (e.g., reached the Plan's limiting age). If you are notifying the WSI Benefits Resource Center about a divorce, you should provide a copy of the divorce decree.

A notice mailed to COBRA Administrator will be considered provided on the date of mailing.

If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period.

- **Electing COBRA Continuation Coverage**. Once COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or your spouse, domestic partner, and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

  - The date coverage would end because of the qualifying event, or
  - The date the COBRA administrator, Conduent provides notice of the right to elect COBRA.

  A COBRA election mailed to COBRA Administrator will be considered made on the date of mailing.

  If COBRA continuation coverage is not elected during this 60-day election period, the right to elect continuation coverage will be lost.

  You and/or your spouse, domestic partner and dependent children may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation coverage. Thus, both you and your spouse or domestic partner may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

- **Paying for COBRA Continuation Coverage**. You must pay the full cost of COBRA continuation coverage. Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45-day period,

Conduent, the COBRA Administrator will terminate coverage retroactively to the beginning of the maximum coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. A premium payment that is mailed will be considered made on the date of mailing. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

The amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost to the group health plan (including both employer and associate contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will increase to 150 percent of the cost of coverage.

- **When COBRA Continuation Coverage Ends**. A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

  - The premium for coverage is not paid in a timely manner,

  - After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have,

  - After electing COBRA continuation coverage, the qualified beneficiary enrolls for Medicare,

  - If coverage is extended because of disability, the Social Security Administration makes a determination that the individual is no longer disabled, or

  - Your employer no longer provides group health coverage to any of its associates.

    Continuation coverage also may be terminated for any reason that the Plan Administrator would terminate coverage of a participant or beneficiary not receiving continuation coverage, such as termination for cause; however the Plan Administrator may only retroactively terminate a qualified beneficiary's COBRA coverage for any purpose that is not considered a "rescission" under the Patient Protection and Affordable Care Act or any regulations or other guidance issued with respect to such Act.

- **Options Other than COBRA Continuation Coverage**. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

  Keep the Plan Informed of Address Changes. To protect your family's rights, you should keep Williams-Sonoma, Inc. informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the WSI Benefits Resource Center or Conduent, COBRA Administrator for your records.

  How to Contact COBRA Administrator. Additional information about continued coverage is available from Conduent, the COBRA Administrator. You may contact the *WSI Benefits Resource Center* at 800.413.1444.

  For any period in which the US Department of Labor determines that the COBRA notice, election or premium payment requirements for plans subject to ERISA are suspended or tolled, the Plan will be administered in accordance with such suspension or tolling requirements. Williams-Sonoma, Inc. will communicate to participants any applicable changes to the such deadlines as soon as administratively practicable.

B. Family and Medical Leave Act. If you are on a leave of absence covered by the Family and Medical Leave Act (FMLA), you may continue to participate in the benefits during your FMLA leave.

- You must continue to make any associate contributions that you would have paid if you had been working. If your leave is *paid*, your payments will be made by the method normally used during any paid leave. If your leave is *unpaid*, you may make arrangements with the WSI Benefits Resource Center to:

  - Pay your share of the cost of coverage on the same schedule as if you were not on leave on an after-tax basis; or

  - Pre-pay your share of the cost of coverage on a pre-tax basis if your earnings allow.

  The *WSI Benefits Resource Center* will provide you with advance written notice of the terms and conditions under which these payments will be made.

- If you fail to pay your share of the cost within 31 days of the due date, your coverage will terminate retroactive to the first day of the coverage period for which payment is unpaid. The WSI Benefits Resource Center will notify you of nonpayment at least 15 days before the expiration of the 31 day grace period. Williams-Sonoma, Inc. may choose to pay your share instead of discontinuing your coverage; in this case, Williams-Sonoma, Inc. will be entitled to collect unpaid amounts from you after you return from leave.

- If you do not continue health benefits during your leave, your coverage will be reinstated upon your return. If you do not continue your health flexible spending account during your leave, your options when you return from leave will be as described in Section 7 H.

- Your right to continue coverage during the leave will terminate if your employment relationship would have terminated if you had not taken FMLA leave, if you inform Williams-Sonoma, Inc. of your intent not to return from leave, or if you fail to return from leave or continue on leave after exhausting your FMLA period. You will be eligible to elect COBRA at the termination of the FMLA leave if you do not return to work.

- If you do not return to work from FMLA leave for any reason other than an event that would otherwise entitle you to FMLA leave, or other circumstances beyond your control, Williams-Sonoma, Inc. may recover any Company contribution paid to the Plan to maintain your coverage during your leave

C. Military Leaves of Absence. You may continue your health coverage for yourself and your dependents for up to 24 months during an authorized leave for military service. If you elect to continue coverage, you must pay for that coverage. If your military leave period is shorter than 31 days, the cost will be the same amount that is charged for active associates for that period of coverage. If you don't elect to continue coverage, your coverage will be reinstated when you return to work at the end of the authorized leave period, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

D. Continuation of Coverage during Other Leaves of Absence.

- Other Paid Leaves of Absence. If you are on a non-FMLA paid leave of absence, you may continue your health coverage for yourself and your dependents. You will continue to be obligated to pay your share of the costs of coverage during your paid leave. You will be eligible to elect COBRA at the termination of your leave if you do not return to work.

- Unpaid Leaves of Absence. If you are on a non-FMLA unpaid leave of absence, you will be eligible to participate in the Plan during the leave if the terms of the leave provides for continued participation. If you are on a benefits-eligible non-FMLA leave, the maximum period of health coverage is 90 days. You must continue paying your share of the cost of benefits and will be obligated to reimburse the Company for any amount of premium you do not pay during your unpaid leave period. You will be eligible to elect COBRA at the termination of your leave if you do not return to work.

E. All Leaves. Unless otherwise stated above, all periods of approved leave, including FMLA leave will run concurrently. Your participation in the Plan will cease at the end of the period of continuation, if any, or the cessation of the condition for which the leave was granted, whichever occurs first.

SECTION 11 – CLAIMS AND APPEALS PROCEDURES

A. In General. Williams-Sonoma, Inc. is the Plan Administrator and has the responsibility and sole discretionary authority for interpreting the terms of the Plan, except as provided below. All decisions and interpretations of the Plan Administrator, or its designee, made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the Plan's claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious. Only benefits subject to ERISA are subject to the Plan's claims procedures (see explanation above regarding voluntary coverage and non-ERISA benefits described in this summary). Notwithstanding the following sections, Williams-Sonoma, Inc. has the sole discretion to determine whether an individual satisfies the requirements for eligibility under the Plan.

B. Insured Benefits. Williams-Sonoma, Inc. may provide some benefits through the purchase of insurance policies for which it makes contributions. Each insurance company is responsible for determining eligibility for, and the amount of, any benefit payable under its policy and for prescribing claims procedures to be followed. All claims for benefits and appeals are filed directly with the applicable insurance company. The procedures for submitting claims and appealing denied claims for insured benefits are described in the applicable benefit materials published by the insurer.

Each insurance company is a "fiduciary" under the Plan with respect to the insured benefit provided by that carrier. The insurers have sole and complete discretion to interpret and administer all claims and appeals for insured benefits under the Plan and such decisions will be conclusive and binding.

C. Self-Insured Benefits Other than Spending Accounts. Williams-Sonoma, Inc. provides some benefits on a self-insured basis, meaning that claims are paid from its general assets. Williams-Sonoma, Inc. has hired a third-party administrator to administer those claims. The third-party administrator is responsible for determining eligibility for and the amount of any benefit payable and for prescribing the claims procedures to be followed. The specific procedures for submitting claims and appealing denied claims for self-insured benefits are described in the applicable benefit materials published by the third-party administrator.

D. Spending Accounts. If your claim is denied in whole or in part, you or your duly authorized representative may:

- Request a review of the denial by filing written application for review with Benefit Wallet within 180 days after you receive such denial.

- Review documents pertinent to the claims at such reasonable time and location as shall be mutually agreeable to you and Benefit Wallet.

- Submit your appeal and any comments in writing to:

  Claims Appeal Department
  BenefitWallet
  PO Box 18011
  Suite C
  Norfolk, VA 23501

  A decision on the review will be made within 30 days after receiving your request. If special circumstances require an extension of time for processing, you will be notified within 30 days. A decision will be made as soon as possible, but no later than 60 days after you first make the request for review. The decision will be in writing and will include specific references to the pertinent plan provision on which it is based. All decisions by Benefit Wallet will be final.

  Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.

- You may request and receive any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination, as well as other relevant documents, records and other information that pertains to the claim.

- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision.

  The Plan Administrator and third-party administrator have the authority and discretion to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD.

  For any period in which the US Department of Labor determines that the claims and appeals timing requirements for plans subject to ERISA are suspended or tolled, the Plan will be administered in accordance with such suspension or tolling requirements. Williams-Sonoma, Inc. will communicate to participants any applicable changes to such deadlines as soon as administratively practicable.

SECTION 12 – SPECIAL RULES AND NOTICES

A. Maternity and Newborn Coverage. Generally, federal law provides that the minimum length for any hospital stay in connection with childbirth for the mother or the newborn is 48 hours following a normal delivery and 96 hours following a caesarian section delivery. The attending provider, however, after consulting with the mother, may discharge the mother or her newborn earlier. If the hospital stay does not exceed the preceding minimums, the provider is not required to obtain authorization for the hospital stay.

B. Post-mastectomy Coverage. If you receive benefits under the Plan in connection with a mastectomy and elect breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Coverage is subject to the same deductibles and coinsurance limitations that apply to the mastectomy treatment.

C. Qualified Medical Child Support Order. Health coverage will be extended to your children pursuant to a "qualified medical child support order" or a national medical support order.

The *WSI Benefits Resource Center* will follow these procedures upon receipt of a "qualified medical child support order":

- The *WSI Benefits Resource Center* will promptly notify the associate and each alternate recipient of the receipt of such order and provide a copy of these procedures.

- The *WSI Benefits Resource Center* will determine whether the order is a "qualified medical child support order" as described in ERISA Section 609(a) within a reasonable period of time after receipt of the order and notify the associate and each alternate recipient of its determination.

- If the *WSI Benefits Resource Center* determines that the order is "qualified," the Plan will provide coverage effective as of the later of the date specified in the order, the date the associate satisfies any applicable waiting periods, or as soon as practicable after the *WSI Benefits Resource Center* determines that the order is "qualified."

- If the order is a national medical support notice, the WSI Benefits Resource Center will comply with the notice by the due date specified and will:

    - Notify the parties that it has received the notice; and

    - Provide the information requested in the notice to the issuing agency.

  If the terms of the order or the national medical support notice require it, the *WSI Benefits Resource Center* will revoke the associate's previous election and enroll each alternate recipient in the health care program specified in the order or notice. Your compensation and deductions will be adjusted in the same manner as similarly situated associates who

elect dependent coverage at the same level required by the order or the notice. The adjustment will be effective beginning with the next payroll period after the *WSI Benefits Resource Center* determines that the order is a qualified medical child support order and the child is enrolled in coverage. If the alternate recipient is eligible for more than one coverage option under the Plan, and the order does not specify the coverage level, the alternate recipient will be enrolled in the least expensive coverage option.

D. Privacy Rules. The privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to the health care provisions of the Plan but not to those provisions addressing non-health benefits, such as disability or life insurance. Williams-Sonoma, Inc. will provide you with a separate Notice of Privacy Practices describing in detail the manner in which Williams-Sonoma, Inc. and the Plan use and disclose protected health information, your rights to inspect, copy and correct medical records concerning you, and the procedure for filing complaints if you think your privacy rights have been violated will be provided to you. If benefits are insured, the Notice of Privacy Practices will be provided by the insurer.

E. Coordination of Benefits. Certain benefits offered under the Plan will be coordinated with benefits from other plans. Coordination of benefits applies whenever an associate or any family member is covered by this Plan and is also covered by any other plan(s). Your benefit materials describe the coordination of benefit provisions. Please refer to the benefit materials for further information.

F. Subrogation and Reimbursement

- **Subrogation and Reimbursement**. The Plan may take over a participant's or dependent's ("covered person's") right to receive payments from a third-party whose act or omission resulted in the covered person's need to incur medical expenses. This is known as the Plan's subrogation right. The Plan's right of subrogation allows the Plan to pursue any claim that the covered person may have, regardless of whether the covered person chooses to pursue that claim. Therefore, the Plan may intervene in any claim or action against a third-party and also may assert its own claim or start its own lawsuit to recover the amount of benefits advanced.

  Further, each covered person agrees to reimburse the Plan from any monies or other property recovered from any third-party, in an amount equal to any amount the Plan paid. This is known as the Plan's right to reimbursement. By accepting benefits under the Plan, each covered person agrees to this subrogation right and right to reimbursement (in addition to any subrogation and reimbursement rights provided in the benefit materials).

  The Plan is entitled to subrogation and reimbursement on a first-dollar basis. The Plan's right to subrogation and reimbursement applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical charges, attorney fees, or other costs and expenses. Further, the Plan's right is without regard to equitable defenses. Specifically, the Plan is entitled to subrogation and reimbursement even if the covered person is not "made whole" (i.e., the covered person is not fully compensated for all claims or damages) through the

recovery he or she receives, and the Plan's rights will not be subject to reduction under any common fund or similar claim or theory.

In addition, the subrogation and reimbursement rights apply regardless of how the third-party recovery is characterized or the application of any rule or state law that would limit or preclude subrogation.

The Plan Administrator reserves the right to negotiate a return of less than the full amount on a participant-by-participant basis based on the facts and circumstances.

- **Equitable Lien and other Equitable Remedies**. The Plan will have an equitable lien upon any recovery, whether by settlement, judgment, mediation or arbitration, or otherwise, that the covered person receives or is entitled to receive from any third-party. This lien will not exceed the amount of benefits paid by the Plan for the illness or injury, plus the amount of all future benefits which may become payable under the plan that are due to the same illness or injury or the amount that the covered person recovers from the third-party.

  This equitable lien will also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery. The Plan will also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds.

- **Obligations of Covered Person**. The covered person must cooperate fully with the Plan in asserting its subrogation and reimbursement rights. The covered person must, upon the Plan's request, provide all information and sign and return all documents necessary for the Plan to exercise its rights under this Section.

- **Notification**. The covered person has a duty to notify the Plan within 10 days of the date when any notice is given to any party (including an insurance company or attorney) of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition for which the Plan has paid benefits or has agreed to pay benefits. The covered person must also provide notice to the Plan of any recovery the covered person (or the covered person's agent) obtains prior to receipt of such recovery or within five days if no notice was given prior to receipt. Further, the covered person agrees to provide notice prior to any disbursement of settlement or any other recovery funds obtained.

- **Failure to Comply with This Section**. If a covered person makes a recovery from a third person and does not reimburse the Plan for benefits that arise from the illness or injury, the covered person will be personally liable to the Plan for the amount of benefits paid under the Plan, and the Plan may reduce future benefits payable for any illness or injury by the amount of the payment that the covered person received from the third-party.

G. Mistaken Payments. If the Plan mistakenly pays benefits for which you are not entitled, you must reimburse the benefits paid in error. An equitable lien will automatically be created on any such excess payment and the excess payment will be held in trust for the benefit of the Plan. The reimbursement is due and payable as soon as the Plan notifies you and requests reimbursement. If reimbursement is not made in a timely manner, future benefits may be offset.

SECTION 13 – YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). The following statement is provided in accordance with federal regulations.

- **Participant Rights**. ERISA provides that as a Plan participant, you are entitled to:
    - Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
    - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
    - Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
    - Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- **Prudent Actions by Plan Fiduciaries**. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the welfare benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including Williams-Sonoma, Inc. or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- **Claim for Benefits**. If you make a claim for a welfare benefit which is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- **Enforce Your Rights**. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 31 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions**. If you have any questions about your Plan, you should contact the *WSI Benefits Resource Center* at 800.413.1444. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the *WSI Benefits Resource Center*, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 14 – OTHER IMPORTANT INFORMATION

A. Amendment and Termination of Plan. All Williams-Sonoma, Inc. associate benefit plans and benefits are subject to alteration, amendment, or termination in whole or in part, at any time. Generally, if the Plan is terminated, you will be entitled to receive payment for covered expenses incurred before the Plan was terminated, but you will not have any further rights under the Plan.

B. Company's Rights. The Plan is not intended to create, nor is it to be construed to constitute, a contract of employment between Williams-Sonoma, Inc. and any of its associates. Williams-Sonoma, Inc. retains its rights to discipline or discharge associates or to exercise its rights as to incidents and tenure of employment. You continue to have the right to terminate your employment at any time and for any reason, or no reason at all, and Williams-Sonoma, Inc. retains similar rights with respect to terminating your employment.

SECTION 15 – ADMINISTRATIVE INFORMATION

<table>
<tr><td>Name of Plan</td><td>Williams-Sonoma, Inc. Health & Welfare Plan</td></tr>
<tr><td>Plan Sponsor</td><td>Williams-Sonoma, Inc.
3250 Van Ness Avenue
San Francisco, CA 94109</td></tr>
<tr><td>Plan Administrator</td><td>Williams-Sonoma, Inc.</td></tr>
<tr><td>Third-Party Administrator</td><td>Conduent</td></tr>
<tr><td>Claims Fiduciary</td><td>For insured plans, see insured plan certificate of coverage.

For plans administered by Cigna, the Plan has contracted with Cigna as the claims fiduciary. Please follows the claims procedures by working with these claims fiduciaries any submitting claims at the address below for your specific plan. Contact information is provided below.</td></tr>
<tr><td>Participating Employers
Employer Identification Number (EIN)

Plan Number</td><td>
<table>
<tr><td>94-2203880</td><td>Williams-Sonoma, Inc.</td></tr>
<tr><td>94-2949896</td><td>Williams-Sonoma Stores, Inc.</td></tr>
<tr><td>94-3379130</td><td>Williams-Sonoma DTC, Inc.</td></tr>
<tr><td>94-2203880</td><td>Williams-Sonoma Direct, Inc.</td></tr>
<tr><td>94-2203880</td><td>Williams-Sonoma Retail Services, Inc.</td></tr>
<tr><td>26-1081999</td><td>Sutter Street Manufacturing, Inc.</td></tr>
<tr><td>45-2822658</td><td>Williams-Sonoma Advertising, Inc.</td></tr>
<tr><td>27-5323949</td><td>Williams-Sonoma DTC Texas, Inc.</td></tr>
<tr><td>93-0803457</td><td>Rejuvenation, Inc.</td></tr>
<tr><td>46-0987660</td><td>Outward, Inc.</td></tr>
</table>
</td></tr>
</table>

ERISA Plan Number	502 (All Benefits Other than Disability) 505 For Disability
Agent for Service of Process	General Counsel Williams-Sonoma, Inc. 3250 Van Ness Avenue San Francisco, CA 94109
Plan Year	July 1 through June 30
Type of Plan	Welfare benefit plan Some benefits under the Plan are insured, meaning that benefits are guaranteed under a policy of insurance issued by an insurance company, and the insurance company is responsible for the payment of claims. Some benefits under the Plan are self-insured, meaning that Williams-Sonoma, Inc. pays claims for expenses and hires a third-party administrator to administer the claims. Because Williams-Sonoma, Inc pays these amounts, they are not guaranteed by a contract or policy with an insurance company, even if an insurance company is serving as the claims administrator. There is no special fund or trust from which self-insured benefits are paid. The insurance companies and third-party administrators are listed in Appendix A.

Appendix A – Other Administrative Information

Coverage/Plan Type	**Claims Administrator or Insurance Carrier**	**Financing Arrangement** (Plan Source of Funding and Type of Funding)
Benefits Administrator	WSI Benefits Resource Center at 800.413.1444.	
Medical Coverage		
Premium Care Plan-PPO (Open Access Network + Local Plus Network)	Cigna - Claims Cigna Medical PO Box 182223	Self-insured. Williams-Sonoma, Inc. and participants share the cost of coverage.

Coverage/Plan Type	Claims Administrator or Insurance Carrier	Financing Arrangement (Plan Source of Funding and Type of Funding)
Standard Care Plan-PPO (Open Access Network + Local Plus Network) **Care Plus HSA (Open Access Network + Local Plus Network)** **Prescription Drug- Automatically included when medical plan is elected**	Chattanooga, TN 37422 Phone# 1-855-820-6604 Cigna – Appeals Cigna Healthcare Inc. National Appeals Unit (NAO) PO Box 188011 Chattanooga, TN 37422 Express Scripts Express Scripts Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711 Phone# 1-800-282-2881 Fax# 608-741-5475 Specialty Medications: Accredo Phone# 1-877-222-7336	Express Scripts is Self-Funded
Kaiser Permanente for Northern California Region (Medical and Prescription Drug)	Kaiser Permanente Urgent/Emergent P.O. Box 12923 Oakland, CA 94612 (866) 752-4735	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.
Kaiser Permanente for Southern California Region (Medical and Prescription Drug)	Kaiser Permanente P.O. Box 7004 Downey, CA 90242-0361 (866) 752-4735	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.
Kaiser Permanente for Mid-Atlantic Region (Medical and Prescription Drug)	Kaiser Permanente National Claims Administration – Mid-Atlantic States P.O. Box 371860 Denver, CO 80237-9998 (877) 514-5114	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.
Kaiser Permanente for Colorado Region (Medical and Prescription Drug)	Kaiser Permanente National Claims Administration – Colorado P.O. Box 373150	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.

Coverage/Plan Type	Claims Administrator or Insurance Carrier	Financing Arrangement (Plan Source of Funding and Type of Funding)
	Denver, CO 80237-9998 (303) 306-227	
Kaiser Permanente for Northwest Region (Medical and Prescription Drug)	Kaiser Permanente National Claims Administration – Northwest P.O. Box 370050 Denver, CO 80237-9998 (503) 735-2727	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.
Kaiser Permanente for Washington (Medical and Prescription Drug)	Kaiser Permanente National Claims Administration – Washington P.O. Box 30766 Salt Lake City, UT 84130-0766 (800) 833-6388	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.
Kaiser Permanente for Georgia Region (Medical and Prescription Drug)	Kaiser Permanente National Claims Administration – Georgia P.O. Box 370010 Denver, CO 80237-9998 (404) 261-2825	Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage.

<table>
<tr><th>Coverage/Plan Type</th><th>Claims Administrator or Insurance Carrier</th><th>Financing Arrangement (Plan Source of Funding and Type of Funding)</th></tr>
<tr><td>MCS Puerto Rico</td><td>Claim/Appeals address:
MEDICAL CARD SYSTEM
MCS PLAZA
255 PONCE DE LEÓN AVENUE
SUITE 105
SAN JUAN, PR 00917-1919
787-758-2500</td><td>Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage</td></tr>
<tr><td>HMSA (Hawaii)
(Medical/Dental/Prescription Drug)
<table><tr><td>Coverage Code</td><td>Plan Description</td></tr><tr><td>730</td><td>COMPMED</td></tr><tr><td>762 (ppo)</td><td>PPP</td></tr><tr><td>E-V (hmo)</td><td>HPH</td></tr><tr><td>972</td><td>Drug</td></tr><tr><td>973</td><td>Drug</td></tr><tr><td>0DU</td><td>Vision</td></tr><tr><td>0DV</td><td>Vision</td></tr></table></td><td>HMSA - Claims Administration
8/CA
P.O. Box 860
Honolulu, HI 96808-0860</td><td>Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage</td></tr>
<tr><td>UHC Global
(Medical/Dental/Prescription Drug)</td><td>UnitedHealthcare Global Insurance
P.O. Box 740111
Atlanta, GA 30374-0111
1.877.844.0280</td><td>Fully insured. Williams-Sonoma, Inc. and participants share the cost of coverage</td></tr>
<tr><td>Dental coverage</td><td>Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330</td><td>Self-Insured</td></tr>
<tr><td>Vision coverage</td><td>VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195</td><td>Self-Insured</td></tr>
</table>

Coverage/Plan Type	Claims Administrator or Insurance Carrier	Financing Arrangement (Plan Source of Funding and Type of Funding)
	www.vsp.com	
Healthcare Flexible Spending Account coverage **Limited Purpose Flexible Spending Account coverage**	BenefitWallet PO Box 18009, Suite A Norfolk, VA 23501 855-214-9793 www.mybenefitwallet.com	Self-insured. Associates pay the full cost of their elections through pre-tax contributions.
Dependent Care Flexible Spending Account coverage (not part of ERISA plan)	Benefit Wallet PO Box 18009, Suite A Norfolk, VA 23501 855-214-9793 www.mybenefitwallet.com	Self-insured. Associates pay the full cost of their elections through pre-tax contributions.
Health Savings Account (not part of ERISA plan)	BenefitWallet PO Box 18009, Suite A Norfolk, VA 23501 855-214-9793 www.mybenefitwallet.com	Self-insured. Associates pay the full cost of their elections through pre-tax contributions.
Life Insurance, Accidental Death & Dismemberment **Supplemental Life (Employee, Spouse/Domestic Partner, Child(ren) (not part of ERISA plan)**	MetLife mybenefits.metlife.com/wsi 800.638.6420	Basic: Fully Insured. Company provided benefit. Supplemental: Fully Insured
Disability and Leave of Absence	MetLife mybenefits.metlife.com/wsi 800.638.6420	STD: Company paid benefit. AF%, UL% groups can purchase on an after-tax basis. Associate pays after-tax. LTD: Company paid benefit. Supplemental LTD: Associate pays after-tax for supplemental LTD.
Employee Assistance Program	Cigna 877.505.4161 Employer ID: WSI	Company provided benefit.

Coverage/Plan Type	Claims Administrator or Insurance Carrier	Financing Arrangement (Plan Source of Funding and Type of Funding)
Supplemental Benefits: Critical Illness, Accident Insurance, Hospital Indemnity Insurance (not part of ERISA plan)	MetLife mybenefits.metlife.com/wsi 800.638.6420	Associate deductions are after tax.
Group Legal Benefits (not part of ERISA plan)	MetLife mybenefits.metlife.com/wsi 800.638.6420	Associate deductions are after tax.

Appendix B – Prescription Drug Coverage for Cigna Medical Benefit Options

When you enroll in a medical plan option through Cigna, you automatically receive prescription drug coverage through Express Scripts (the prescription benefit manager); with a separate prescription benefit ID card.

The Plan provides coverage whether you choose Express Scripts network pharmacies or pharmacies that are not part of the Express Scripts pharmacy (known as "out-of-network pharmacies"), but you save money when you use a network pharmacy. You may purchase up to a 30-day supply of prescription medicine at retail pharmacies. For maintenance medications that are taken over an extended period of time for chronic conditions, you can use Express Scripts' mail order service or you can obtain a 90-day supply at a network retail pharmacy. To find a retail pharmacy near you that participates in the network, visit www.cigna.com and click "Locate a Pharmacy." You may also call 855-273-3551.

Here is a summary of how prescription drug coverage works:

- If you are enrolled in one of the three Health Savings Account (HSA) qualified plan you must meet the combined medical and pharmacy plan deductible prior to paying the plan's coinsurance. Medications on the Express Scripts HSA preventive drug list will bypass the deductible and be paid for by the Plan. Only the amounts that you pay count toward the deductible.

- For most medicines you pay a portion of the cost in either the form of a "copay" or "coinsurance," and the Plan pays the remainder of the expense. A "coinsurance" is a percentage of the cost. Your coinsurance percentage depends on whether your prescription is for generic, preferred brand or non-preferred brand medicine.

- Your coinsurance is lowest when you purchase generic drugs and highest when you purchase non-preferred brand medicine. Coinsurance amounts are shown in the Pharmacy Schedule of Benefits. Prescription drug expenses generally will count toward the out-of-pocket maximum under all plans. But see the discussion about rules regarding

generics below. Only the amounts that you pay count toward the out-of-pocket maximum.

- There are minimum and maximum limits on the amount you pay with coinsurance, which are shown in the Pharmacy Schedule of Benefits. The minimums and maximums vary depending on whether you fill your prescription with generics, preferred brand or non-preferred brand-name drugs.

- Use a retail pharmacy for medicine you take on a short-term basis, such as antibiotics, where you need only up to a 30-day supply. There are advantages to filling your prescription at a network pharmacy.

    - You save money. At a network pharmacy your cost will be based on the network price for covered expenses, which is usually less than the cost at an out-of-network pharmacy. If you visit an out-of-network pharmacy, your cost will be based on the out-of-network price. You pay your copay/coinsurance plus any difference between the in-network contracted rate and the amount charged by the out-of-network pharmacy.

    - It's more convenient. When you use an out-of-network pharmacy, you have to pay the full price of the prescription out of pocket at the time of purchase and then complete a paper claim for reimbursement. You don't need claim forms at a network pharmacy.

    - Always use your ID card at your network pharmacy. If you submit a paper claim, you pay your copay/coinsurance plus any difference between the network price and the amount charged by the pharmacy.

- There are two rules about generics:

    - If you choose to purchase a brand-name drug when a generic equivalent is available, you will pay your share of the cost of the generic version of the drug plus the difference in price between the generic drug and the brand-name drug you purchased, out-of-pocket. However, if your doctor requests that you should have the brand-name drug (writes DAW1 for dispense as written) on your prescription, you'll pay your share of cost of the brand-name drug, and this penalty will not apply. The difference in price that you pay WILL NOT count towards the Plan's out-of-pocket maximum.

    - You must try a generic first before the Plan will cover certain brand-name drugs. See "Generic Step Therapy".

- Only eligible prescription drugs will be covered. The Plan will not pay benefits for ineligible prescription drugs that are not covered.

  Not covered drugs include but are not limited to:

    - Non-medical substances regardless of intended use.

- Any over-the-counter medicine, unless specified otherwise.
- Compounding bulk ingredients
- Any nutritional supplements, unless specified otherwise.
- Insulin pumps, insulin pump supplies
- Continuous blood glucose monitors
- Allergy immunotherapy medications
- Respiratory therapy supplies
- Cosmetic drugs
- Blood serum (i.e., albumin, plasma)
- Experimental medicines do not have NDC numbers and therefore, are not covered.
- Topical Analgesics, Convenience Multi-product Kits, Scar Products, Otic Analgesics and Combinations etc.
- Unapproved Products- Exclusion of all new to market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act. Coverage will remain for select unapproved products that are legally marketed or deemed clinically necessary (e.g., because no alternatives exist).

About the Express Scripts Formulary

- The prescription drugs included on the list of formulary drugs covered by the Plan is decided by the Claims Administrator's Pharmacy and Therapeutics Committee which is comprised of independent physicians and pharmacists. The Pharmacy and Therapeutics Committee meets quarterly and decides on changes to make in the formulary drug list based on recommendations from the Claims Administrator and a review of relevant information, including current medical literature. The Claims Administrator may exclude drugs from coverage.

- The Express Scripts Formulary includes a list of medications that will not be covered without a prior authorization for medical necessity. For more information on the Express Scripts Formulary please visit www.cigna.com or you can call Cigna Member Services at 855-273-3551.

- The Express Scripts Performance Drug List (PDL) includes preferred brand-name drugs that are selected based on their ability to meet patient needs at a reasonable cost. Ask your doctor to consider prescribing a brand-name drug on the PDL when there is no

generic available or when more than one brand name drug is available. Note that the PDL may change from time to time. For the most up-to-date PDL, visit **www.cigna.com**.

- Infertility medications have a $5,000 lifetime maximum allowable benefit. Once the plan has paid $5,000 toward an individual's claims the plan will no longer cover infertility claims.

Pharmacy Schedule of Benefits

PRESCRIPTION DRUG PPO PLANS	
Retail and Specialty Pharmacy **Up to a 30-day supply**	You Pay
Generic	$10
Preferred Brand Participant minimum Participant maximum	25% $20 $80
Non-Preferred Brand Participant minimum Participant maximum	40% $40 $100
Mail **Up to a 90-day supply**	You Pay
Generic	$25
Preferred Brand Participant minimum Participant maximum	25% $50 $200
Non-Preferred Brand Participant minimum Participant maximum	40% $100 $250

PRESCRIPTION DRUG HSA PLAN	
Retail and Specialty Pharmacy **Up to a 30-day supply**	After the Deductible is Satisfied You Pay
Generic Participant minimum Participant maximum	15% $4 $10
Preferred Brand Participant minimum Participant maximum	15% $15 $40
Non-Preferred Brand Participant minimum Participant maximum	15% $30 $60
Mail **Up to a 90-day supply**	You Pay
Generic Participant minimum Participant maximum	15% $10 $25
Preferred Brand Participant minimum Participant maximum	15% $35 $100
Non-Preferred Brand Participant minimum Participant maximum	15% $75 $150

Specialty Drugs

Specialty drugs are the result of breakthroughs in biotechnology that have changed the way many doctors treat patients with rare and complex conditions, such as hemophilia, cancer, and multiple sclerosis, to name a few. This type of drug therapy helps many patients enjoy an improved quality of life with fewer disease symptoms. Specialty drug pharmacy services are included in the prescription drug benefit administered by Express Scripts through its specialty pharmacy,

Accredo. To obtain specialty drugs, please visit cigna.com. You may also call 855-273-3551. Specialty drugs are generally limited to a 30-day supply, HIV and transplant specialty drugs may be filled up to a 90-day supply. You are required to fill your specialty medications through Accredo.

Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Member shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

The Specialty Guideline Management

The Specialty Guideline Management program supports safe, clinically appropriate and cost-effective use of specialty medications. Programs are based on FDA-approved labeling, compendia use, current medical literature, and nationally recognized guidelines. The Accredo clinical team proactively works with the physician's office to obtain the required clinical information. If the participant meets the guidelines, Accredo will approve the case and notify the prescribing physician of the approval as well as ship the medication to the participant. If the participant does not meet the guidelines, Accredo will send a denial letter to the prescribing physician and participant.

Preventive Drugs

Due to the Affordable Care Act (ACA), certain FDA-approved medications on the Express Scripts defined drug list are covered at 100% (and without payment of a deductible, where applicable). You must have a prescription to obtain these, even if they are available over the counter. The chart below provides a summary (please note this list is subject to change):

WOMEN'S CONTRACEPTIVES DRUG/DEVICE CATEGORY
Barrier contraceptive methods (diaphragms and cervical caps), limited to one per 300 days
Emergency contraceptive methods
Implantable devices • Diaphragms, cervical caps, sub-dermal rods and IUDs are limited to one per 300 days • Vaginal rings are limited to one per month, 13 rings per 300 days
Injectable contraceptives, limited to 4 injections per 300 days • Generics • Brand (only if generic is unavailable)
Oral contraceptives

• Generics • Brand (only if generic is unavailable)
Over-the-counter spermicides, female condoms (prescription required)
Transdermal patches

Other preventive drugs that are covered at 100% per ACA requirements include (*please note this list is subject to change*):

DRUG/DEVICE CATEGORY
Aspirin, for individuals at age 45 and older (prescription required) • Generic • OTC (prescription required) • Limited to 100 units per fill
Fluoride Supplements; for children age 6 years and younger • Brand and Generic • Prescription only
Folic Acid; for individual age 55 and younger • Generics • OTC (prescription required) • Limited to 100 units per fill
Statins; for men and women ages 40 through 75 years old • Low to moderate dose statins, generics only
Tobacco cessation products • Generics • OTC (requires prescription) • Limit of 168 day supply per calendar year for nicotine replacement products and prescription drugs.
Immunization Vaccines • For children and adults

Vitamin D; for individuals age 65 or older • OTC only, requires prescription
Bowel Preparation Medicines; for individuals ages 50 through 74 years • Brands payable until they become available generically
Breast Cancer Prevention in women 35 years of age and older, who are at an increased risk • Generic oral tablets of the below medications • Raloxifene HCl tablet 60 mg • Tamoxifen citrate tablet 10 mg and 20 mg
Medication Assisted Treatment (MAT) for Substance Use Disorder • buprenorphine sublingual tab 2mg, 8mg • buprenorphine-naloxone sublingual tab 2 mg-0.5 mg, 8 mg-2 mg • naltrexone tablet 50 mg

Drug Coverage Management Programs

The Plan utilizes coverage management programs to help control rising drug costs and provide you with the coverage you need. Coverage management determines how the Plan will cover certain medications. Each program is administered by Express Scripts.

Some medications are not covered unless you receive pre-approval or prior authorization. Even if you are currently taking one of the medications when you join the Plan, you will still be required to satisfy the requirements below. Coverage management programs make use of three authorization processes that medications may fall under:

- Quantity Limitations
- Prior Authorization
- Step Therapy

Quantity Limitations

For some medications, the Plan may cover a limited quantity within a specified period of time. A coverage review may be necessary to have additional quantities of these medications covered by the Plan. For more information on medication coverage or limitations, please visit www.cigna.com or, you can call Cigna Member Services at 855-273-3551. For your prescription drugs that need special authorization, your doctor, or your pharmacist may initiate the review process by calling Cigna at 855-273-3551.

Prior Authorization

Prior Authorization requires that you obtain pre-approval through a coverage review. The review will determine whether the Plan covers your prescribed medication based on a confidential, clinical review to determine whether coverage is appropriate. This review is based on clinical guidelines for best medical practices. Below are examples of common medications that may require pre-approval. (Please note that this list is not all inclusive.) For more information on medication coverage or limitations, please visit www.cigna.com or you can call Cigna Member Services at 855-273-3551.

- ADHD /Narcolepsy
- Narcolepsy
- Anabolic Steroids
- Androgens (e.g., Androderm, Androgel, etc.)
- Topical Acne Medications (e.g., Retin-A, Differin, Tazorac) for those age 35 and older
- Incretin Memetics (Victoza, Bydureon)

Step Therapy and Generic Step Therapy

Step Therapy requires you to try a lower cost medication before a higher cost medication to help lower your out-of-pocket prescription costs. Generic Step Therapy requires first-line therapy failure before second- and third- line therapies are covered. For more information on medication coverage or limitations, please visit www.cigna.com or, you can call Cigna Member Services at 855-273-3551.

Prescription Drug Claims and Appeal Process

Definitions

The following terms are used herein to describe the claims and appeals review services provided by Express Scripts:

Adverse Benefit Determination (Does Not Include Adverse Coverage Determinations as defined below):

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise

provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Adverse Coverage Determination:

An Adverse Coverage Determination is based solely on the terms of the Plan and does not involve a determination that the requested drug is experimental or investigational or not medically necessary.

Claim:

A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims. Please note that a pharmacy transaction does not qualify as a claim in accordance with a Plan's procedures for filing benefit claims.

Medically Necessary (Medical Necessity):

Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service or product meets clinically appropriate criteria in accordance with U.S. Food and Drug Administration (FDA)-approved labeling or nationally recognized compendia (such as American Hospital Formulary Service [AHFS] or Micromedex) or evidence-based practice guidelines;

Post-Service Claim:

A claim which is not a Pre-Service Claim, as defined below; essentially, a Claim for a Plan benefit for which the medical care has already been provided.

Pre-Authorization:

Express Scripts' pre-service review of a member's initial request for a particular medication. Express Scripts will apply a set of pre-defined medical criteria to determine whether there is need for the requested medication.

Pre-Service Claim:

Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Urgent Care Claim:

A Claim for a medication, service, or product where a delay in processing the Claim (i) could seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product. Express Scripts will defer to the

member's attending health care provider as to whether or not the member's Claim constitutes an Urgent Care Claim.

The Express Scripts Claims and Appeals Process

Express Scripts' standard claims and appeals process complies with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), the Affordable Care Act (ACA) and their implementing regulations. You will be accorded all rights granted to them under ERISA, ACA and any related laws and regulations. The claims and appeals process will also comply with applicable law, as indicated by the Plan Sponsor.

Express Scripts will provide the following claims and appeals review services:

- Pre-Authorization Claim Review Services;
- Coverage Determination Claim Review Services;
- Post-Service Claim Review Services;
- Pre-Service Appeal Review Services;
- Coverage Determination Appeal Review Services; and
- Post-Service Appeal Review Services.

For any period in which the US Department of Labor determines that the claims and appeals timing requirements for plans subject to ERISA are suspended or tolled, the Plan will be administered in accordance with such suspension or tolling requirements. Williams-Sonoma, Inc. will communicate to participants any applicable changes to such deadlines as soon as administratively practicable.

Timing of Review (Claims)

Pre-Authorization Review – Express Scripts will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, Express Scripts will make a decision on the Claim as soon as possible, but not later than 72 hours.

Coverage Determination Review – Express Scripts will make a decision on a Coverage Determination within 15 days after it receives such a request. If the member is requesting the Coverage Determination of an Urgent Care Claim, a decision on such request will be made as soon as possible, but not later than 72 hours

Post-Service Review – Express Scripts will make a decision on a Post-Service Claim within 30 days after it receives such a request.

Notice of Adverse Benefit Determination or Adverse Coverage Determination

Following the review of your Claim, Express Scripts will notify you of any Adverse Benefit Determination or Adverse Coverage Determination in writing, in a culturally and linguistically appropriate manner. This notice will include:

- The specific reason or reasons for the determination in easily-understood language;
- Reference to pertinent Plan provision on which the determination was based;
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request;
- If the Adverse Benefit Determination is based on a Medical Necessity, either the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request;
- A statement of the member's right to bring action under ERISA Section 502(a), if applicable;
- A description of the available internal appeals processes and external review process, including information on how to file an appeal; and
- Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review.

Appeal of Adverse Benefit Determinations or Adverse Coverage Determinations

If an Adverse Benefit Determination or Adverse Coverage Determination is rendered on your Claim, you have the right to appeal the Adverse Benefit Determination (claim denial) or Adverse Coverage Determination. You or your authorized representative must file your appeal in writing within 180 days after receiving notification of an Adverse Benefit Determination or Adverse Coverage Determination. To initiate an appeal please contact:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Phone# 1-800-753-2851
Fax# 1-877-852-4070

Your appeal should include the following information:

- A clear statement that the communication is intended to appeal an Adverse Benefit Determination or Adverse Coverage Determination;
- Name of the person for whom the appeal is being filed. The member or prescriber may file an appeal. The member may also have a relative, friend, advocate, or anyone else (including an attorney) act on their behalf as their authorized representative;
- Express Scripts identification number;
- Date of birth;
- A statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Comments, documents, records, relevant clinical information or other information relating to the Claim.

Express Scripts' review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination. You can call customer care at the number on your member identification card, for information about how to appeal. It is recommended to have your doctor submit a letter of medical necessity on your behalf. Express Scripts will contact you and your doctor by phone or letter confirming whether or not coverage has been approved.

If the Adverse Benefit Determination or Adverse Coverage Determination is rendered with respect to an Urgent Care Claim, the member and/or the member's authorized representative may submit an appeal by calling, faxing or mailing the request to Express Scripts.

Timing of Review (Appeals)

Pre-Service Claim Appeal – Express Scripts will make a decision on the appeal of an Adverse Benefit Determination or Adverse Coverage Determination rendered on a Pre-Service Claim within 30 days after it receives the member's appeal. If you are appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made as soon as possible, but not later than 72 hours after the request for appeal is received.

Post-Service Claim Appeal – Express Scripts will make a decision on an appeal of a Post-Service Claim within 60 days after it receives such an appeal.

Second Level Appeal

If an Adverse Benefit Determination or Adverse Coverage Determination is rendered on your Appeal, you have the right to file a second level appeal. You or your authorized representative must file your appeal in writing within 180 days after receiving notification of the level one appeal. Your second level appeal should include the following information:

- Your name
- Member ID
- Letter of medical necessity from your treating physician
- Any additional information that may be relevant to your appeal

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for non-urgent pre-service claims or 72 hours for urgent pre-service claims.

If coverage is approved, you simply pay your normal co-payment for the medication. If coverage is not approved, you will be responsible for the full cost of the medication or there may be an alternative drug that would be covered.

External Review Procedures

Express Scripts has contracted with independent external review organizations (IROs) to conduct independent specialist physician reviews of denials of authorization of benefits when the member or beneficiary is entitled to obtain such a review.

For such appeals, the following will occur:

- Express Scripts will forward or cause to have forwarded to the IRO applicable medical records, documentation, plan language and specific criteria
- The independent specialist selected by the IRO to conduct the review will review documentation received with the case. If the physician reviewer considers additional information necessary or potentially useful in the review, the physician reviewer may contact you or the provider to request such information
- The independent specialist selected by the IRO will review available medical records and any additional information obtained from the provider, and current medical literature, and will write an independent rationale in support of his or her final decision

Appendix C – Additional Benefits

Employee Assistance Program

The Employee Assistance Program (EAP) provided through CONNECT Employer Assistance Program by Cigna offers support, resources and information for personal and work-life issues.

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. CONNECT EAP is **confidential** and provided at no charge to you and your dependents.

Employees and their family members can call 877-505-4161, 24 hours a day, or go online myCigna.com (Employer ID: WSI) every day of the year for an initial assessment and consultation and will be directed to confidential counseling, financial or legal representatives or work-life specialists.

Confidential Counseling

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by highly trained masters and doctoral level clinicians who will provide unlimited phone support and listen to your concerns regarding matters such as the following:

- Stress, anxiety and depression
- Job pressures
- Relationship/marital conflicts
- Grief and loss
- Problems with children
- Substance abuse

Your counselor can also refer you to virtual or in-person counseling which includes up to seven counseling sessions a year per issue to help you resolve the issue you are dealing with. (California state law may impact visit limits–contact Cigna for more information.) Face-to-face or virtual counseling is provided on a per-issue basis. For example, if you need help coping with grief from a death in the family and you are going through a stressful separation or divorce, these are separate issues. You could receive seven counseling sessions for help with the divorce, and five sessions for help with grief. If you or an eligible family member require treatment beyond the initial seven sessions or more extensive treatment anytime during those seven sessions, your counselor can assist you in locating an appropriate resource for further counseling. You will need to check with your medical plan administrator to understand whether treatment is covered under your plan and any costs that you may incur for treatment.

Work-Life Solutions

Work-life specialists will do the research for you, providing qualified referrals and customized resources for topics, such as:

- Child and elder care
- Moving and relocation

- Making major purchases
- College planning
- Pet care
- Home repair
- Event planning
- Vacation planning

You can contact an EAP counselor by calling Cigna at 877-505-4161, 24 hours a day, or go online to myCigna.com (Employer ID: WSI). On the website, you can access timely articles, tutorials, streaming videos and self-assessments.

Tobacco Cessation Program

To help tobacco users quit for good, Williams-Sonoma, Inc. encourages you to take advantage of the Smoking Cessation Program. The Smoking Cessation Program, brought to you by Cigna, is a leading tobacco cessation program. the Smoking Cessation Program employs an evidence-based combination of physical, psychological and behavioral strategies to enable you to take responsibility for and overcome your addiction to tobacco. Participation is free, voluntary and confidential.

If you enroll in this program, you will receive a Quit Guide in the mail, and a Quit Coach will contact you to help you develop a personalized quit plan. The Quit Coach will also determine whether nicotine patches, gum or prescription medication will be helpful for you during the quit process. If you choose to incorporate the nicotine patch or gum into your quit plan, up to an eight-week supply of the medication will be mailed directly to your home. Prescription medication will need to be discussed with your doctor.

As a participant, you will receive up to five calls from your Quit Coach to help you stay on track and prevent a relapse. You can also contact a Quit Coach at any time. If you like, you can sign up for text messages to provide encouragement and help you manage the transition from tobacco user to non-tobacco use and track your progress. Participants will also have access to Web Coach, the Smoking Cessation Program's interactive website, where you can:

- Track your progress along your personalized quit plan,
- Interact with others who are trying to quit and with Quit Coach Moderators on the discussion forums — peer support is a key factor in success, and
- Receive coaching emails between calls with tips on quitting and reminders to help you stay on track.

For additional information you can contact the Smoking Cessation Program at **1-855-273-3551** or visit quitnow.net to get started and a registration specialist will verify your eligibility to enroll and transfer you to a Quit Coach.

Medical Plan Resources

When you participate in the Williams-Sonoma, Inc. medical plan, your medical plan administrator offers you and your covered family members a number of wellness programs and resources designed to encourage health improvement. These confidential programs are available at no cost to you. Services may differ by medical plan administrator; contact your assigned carrier for more information.

Utilization and Case Management

Utilization management services support the precertification process for both inpatient and outpatient care, determinations of medical necessity, ongoing concurrent review and authorization of inpatient stays and discharge planning, including pre-admission and post discharge calls with medical policy review. The goal of utilization management is to encourage the highest quality, cost-effective care, in the most appropriate setting, from the most appropriate provider, so that services are neither over-used nor under-used.

All medical plan administrators also have case management programs designed to support you and your family when you have an injury, acute illness or complex care needs, such as a high-risk pregnancy, cancer treatment or a transplant. You may be identified for the case management program based on your diagnosis, pattern of using medical services that suggest a high health or cost risk, insurance claims, activities during a hospital or rehabilitation stay, or if you or your doctor ask for help.

Maternity Management

Maternity management provides the resources of an experienced maternity nurse who can offer advice and answer your questions so you can have a healthy pregnancy. You'll receive support through every stage of pregnancy and delivery.

Nurseline

When you need health care advice but your doctor's office is unavailable, Nurseline can help. With Nurseline, you can speak with experienced, registered nurses toll free any time, 24 hours a day, seven days a week. For example, you can get answers to questions like these:

- My baby has a 102ºF fever and it's midnight. What should I do?
- How can you tell the difference between a sprained ankle and a broken one?
- What kind of side effects should I expect from the medication I'm taking?

During a confidential conversation, you may be given information on self-care, referred to your physician, or advised to go to an urgent care center or emergency room.

Telemedicine

Telemedicine provides 24-hour access to physicians, including pediatricians, internal medicine physicians and other specialists who are available to consult with you by phone, email or video chat (varies by state). You can usually schedule these appointments at your convenience, and at a fraction of the cost of a regular office visit. Typical telemedicine services include:

- Primary care or specialist referrals
- Specialized health advice
- Medical education

Make use of telecommunication and technology to access clinical health care at a distance. You can gain access to a doctor to help you find treatment for minor, non-emergency conditions, and they may even be able to write you a prescription (varies by state). This is a cost-saving, efficient alternative to a traditional office visit.

Disease Management

Health management programs and chronic condition support, also known as disease management, supplement your doctor's care for health conditions such as asthma, COPD, diabetes and heart disease, which require special care and attention. Experienced registered nurses can help you prepare for physician visits, answer questions about your condition and reduce the barriers that may interfere with your health. Call your medical plan administrator's member services number to learn more about these programs and enroll.

Appendix D – Benefit Materials

Benefit	Administrator or Insurer	Option Name (if applicable)	Administrator/Insurer Document Title
Medical	Cigna		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Dental	Delta Dental		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Medical	Kaiser California		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Medical	Kaiser Colorado		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Medical	Kaiser GA		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Medical	Kaiser Mid-Atlantic States		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Medical	Kaiser Northwest		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Medical	Kaiser Washington		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Vision	VSP		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Accident	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents
Critical illness	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents

Hospital Indemnity	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents
Life Insurance and AD&D	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Short Term Disability	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Long Term Disability	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* or the Williams-Sonoma, Inc. Health & Welfare Plan Document for a list of specific benefit documents
Employee Assistance Program	CONNECT EAP by Cigna		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents
Identity Protection	Allstate		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents
Legal	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents
Pet Insurance	MetLife		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents
Commuter Benefits	WageWorks		See the "Benefit Portal" at *MyWSIBenefits.com* for a list of specific benefit documents