

STRONG COVERAGE, HEALTHY YOU



2026 BENEFIT GUIDE
DCU

WHAT'S INSIDE



- 3 Welcome to Your Big 5 Benefits!
- 3 What's Changing in 2026?
- 4 Eligibility
- 4 Enrolling & Making Changes
- 5 Before You Enroll
- 6 Employee Assistance Program (EAP)
- 7 Where to Go for Care
- 7 Self-Service Resources
- 8 What Makes Your HMO Unique?
- 9 Medical Plan
- 10 Dental Coverage
- 10 Vision Coverage
- 11 Cost for Coverage
- 12 Life & Disability Insurance
- 13 Pet Insurance
- 13 COBRA
- 14 Benefit Terms & Definitions
- 15 Your Benefit Contacts
- 16 Legal Notices



This guide provides an overview of the benefits program. It is not intended to be a complete description of the benefits or official summary plan descriptions for these programs. If there is a conflict between this guide and the official plan documents, the plan documents will govern. Big 5 reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not a guarantee of current or future employment or benefits. For information about the specific plans available to you, please contact Human Resources.



WELCOME TO YOUR BIG 5 BENEFITS!

At Big 5, we're committed to supporting your total well-being—physically, mentally, and financially. Each year, we review our benefits to ensure they continue to meet your needs and remain competitive in a changing health care landscape.

While there are some updates to the plan design this year, our focus remains the same: giving you access to high-quality, affordable care, and tools that help you take charge of your health. We're proud to offer a benefits package that delivers value to you and your family all year. From preventive care and mental health resources to specialty programs and support services, we have you covered.

Please take time to review this guide and explore your options. Making informed choices now will help you get the most out of your benefits in the year ahead.

WHAT'S CHANGING IN 2026?

MEDICAL PLAN UPDATES

- Medical plan has been updated to align with industry standards and rising health care costs.

ELIGIBILITY

YOU

As an active, full-time employee working at least 40 hours per week, you are eligible for benefits on the first of the month, following 60 days of employment.

“Eligible employee” refers to an employee who is regularly scheduled to work 40 hours per week and is not classified by the employer as a temporary or seasonal employee. It may also refer to an employee who meets minimum levels of eligibility as defined by applicable federal, state, or local legislation.

YOUR DEPENDENTS

You may enroll your eligible dependents in the same plans you choose for yourself. You will need to provide documentation when adding new dependents to your plans. Eligible dependents include:

- Your legal spouse or registered domestic partner
- Your biological, adopted, or stepchildren, up to age 26, or your unmarried children of any age, if incapable of self-support due to mental or physical disability

ENROLLING & MAKING CHANGES

The benefit choices you make when you first become eligible are in effect for the remainder of the plan year. It's important to review your benefit options and choose the best coverage for you and your family. If you are a newly, eligible employee, have transferred from part-time to full-time status, or are an eligible part-time employee, you will receive benefits enrollment information.

You have three opportunities to enroll in or make changes to your benefits:

1	Within 60 days of your eligibility date
2	During the annual open enrollment period
3	Within 60 days of a qualifying life event

QUALIFYING LIFE EVENT EXAMPLES

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a dependent
- Loss or gain of other health coverage for you and/or dependents
- Change in employment status
- Change in Medicaid/Medicare eligibility for you or a dependent
- Receipt of a Qualified Medical Child Support Order



BEFORE YOU ENROLL

Follow these steps to enroll in your benefits:

1 EVALUATE YOUR NEEDS

To ensure you enroll in the plan that is best for you and your family, ask yourself the following questions:

- **Who should I cover?** Evaluate your coverage options for all dependents who meet eligibility requirements.
- **How much did I spend on health care last year?** Consider your past expenses to help you plan for your future needs.
- **Do I need more, or less, health coverage?** Are you having a baby? Considering surgery? Currently in treatment for a chronic condition? Estimate the level of health care you may need in the upcoming year.

2 REVIEW YOUR OPTIONS

- Review this benefit guide to compare your options and evaluate plan costs and potential savings.
- For pre-enrollment support and benefits questions, contact the Benefits Team at **800.367.2445** or email **benefits@big5corp.com**.

3 ENROLL ONLINE

- Visit **big5employeeportal.com** and log in to enroll.
- Click the *Myself* icon.
- Choose *Benefits* from the drop-down menu.
- Select *Manage My Benefits*.
- Submit your elections.
- If applicable, submit all required dependent verification forms to the Benefits Department at **benefits@big5corp.com**. If enrolling online, dependent forms will be uploaded directly to the site.

4 CONFIRM ELECTIONS

Even if you're not making changes, review your elections carefully and make sure your benefits, dependent, and beneficiary information is correct.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

When you need help with work, home, personal, or family issues, the EAP, through Lincoln Financial EmployeeConnect™, offers beneficial programs and services, available 24/7 at **no cost to you**.

WHO'S ELIGIBLE	SUPPORT INCLUDED	TOPICS	CONTACT
▪ You ▪ Your household family members	▪ Unlimited phone consultations ▪ In-person or virtual counseling sessions (limits may apply)	▪ Anxiety, depression, stress ▪ Child and elder care referrals ▪ Family challenges ▪ Financial counseling ▪ Legal resources ▪ Workplace issues	Lincoln Financial EmployeeConnect™ 888.628.4824 lincoln4benefits.com guidanceresources.com Username: LFGsupport Password: LFGsupport1



WHERE TO GO FOR CARE

VIRTUAL VISIT	PRIMARY CARE PROVIDER (PCP)
Time: Low Cost: \$	Time: Low Cost: \$
Benefit: - Lower cost - Speak to a doctor from anywhere - Reduced waiting room time Reasons to go: - Treatment of minor injuries and illnesses - Limits exposure to contagious diseases - May receive specialist referrals or prescriptions	Benefit: - Reasonable price in-network - In-person examination - Familiarity with health history Reasons to go: - Preventive care - Treatment of chronic illnesses - Follow-up visits and referrals
URGENT CARE CENTER	EMERGENCY ROOM
Time: Mid-range Cost: \$\$	Time: High Cost: \$\$\$\$
Benefit: - Lower cost than an ER visit - Same-day visits are often available Reasons to go: - Medical conditions that need prompt attention - Treatment of minor injuries or illnesses - May offer lab tests and X-rays onsite	Benefit: - Necessary for life-threatening conditions - Open 24/7/365 Reasons to go: - Sudden onset of severe medical conditions - Treatment of severe injuries or illnesses - Treatment after an accident

SELF-SERVICE RESOURCES

MY HEALTH MANAGER Kaiser Plan Members Only

If you are enrolled in the Kaiser medical plan, you have access to My Health Manager, a **FREE** online resource that allows you to:

- Find a provider.
- Email your doctor.
- View test results.
- Manage prescriptions.
- Request or cancel an appointment.
- Explore your medical plan details.
- And more!

Visit kp.org to get started.

WHAT MAKES YOUR HMO UNIQUE?

At Big 5, we understand the importance of good health as the foundation for a productive life, at home and at work. That is why we offer a comprehensive medical plan through Kaiser Permanente to support you and your family.

HMOs are a unique type of medical plan with many great perks, which is why Big 5 offers the Kaiser HMO plan to all DC Union employees. Through this plan, you have access to a Primary Care Physician (PCP) who is your go-to for all your needs. They can direct you to an in-network specialist if necessary.

The Kaiser HMO offers low deductibles and copays making it a more cost-effective choice for members seeking comprehensive coverage with reduced out-of-pocket expenses. However, in some cases, you may also be responsible for coinsurance, depending on the specific services provided.

The one potential downside of an HMO is that all coverage must be in-network. There is no coverage for out-of-network providers. However, the HMO offers everything you need in-network. You have access to all the same types of care as if you had out-of-network coverage.



MEDICAL PLAN COMPARISON

Plan Features	Kaiser HMO*
	In-Network Only
Annual Deductible Individual/Family	\$750 / \$1,500
Annual OOPM Individual/Family	\$3,400 / \$6,800
	You pay:
Preventive Care Visit	Covered in full
Telemedicine/Virtual Visit	Covered in full
Primary Care Visit	\$20 copay
Specialist Visit	\$30 copay
Lab & X-ray	\$10 copay
Urgent Care	CA: \$20 copay Other States: \$30 copay
Emergency Room (copay waived if admitted)	20%**
Outpatient Hospital Services	20%**
Inpatient Hospital Services	20%**
Outpatient Mental Health Services	20%**
Chiropractic (20 visits per year)	20%**
Acupuncture (visit limitations vary)	20%**
Prescription Drugs: Retail (up to a 30-day supply)	
Generic	\$10 copay
Formulary Brand	\$30 copay
Non-Formulary Brand	N/A
Specialty	20% up to \$250 max
Prescription Drugs: Mail Order (up to a 100-day supply)	
Generic	\$20 copay
Formulary Brand	\$60 copay
Non-Formulary Brand	20% up to \$250 max

*Plan available in 4 states: CA, OR, WA, CO.

**After deductible.

NEED TO MAKE AN APPOINTMENT?

You can make an appointment online by visiting kp.org or by downloading the Kaiser app.

DENTAL COVERAGE

Did you know good dental care improves your overall health? Our dental plans help you maintain a healthy smile through regular preventive dental care and offer coverage to fix problems when they occur. To find an in-network provider near you, visit [aetna.com](https://www.aetna.com).

Plan Features	Aetna DMO Plan	Aetna DPO Plan	
	In-Network Only	In-Network	Out-of-Network*
Calendar Year Benefit Maximum	None	\$1,500 per person	
Orthodontia Lifetime Maximum (adults & children)	\$2,000 per person	\$1,500 per person	
	You pay:	You pay:	
Annual Deductible (waived for preventive services) Individual/Family	None	\$50 / \$150	
Diagnostic & Preventive Services (e.g., x-rays, cleanings, exams)	Covered in full	Covered in full	Covered in full
Basic & Restorative Services (e.g., fillings, extractions, root canals)	Copay varies (refer to plan summary)	20%	20%
Major Services (e.g., dentures, crowns, bridges)	Copay varies (refer to plan summary)	50%	50%

*For out-of-network services, members pay applicable coinsurance plus any amount exceeding the usual, customary, and reasonable charge.

VISION COVERAGE

Regular eye exams help keep your vision clear and your eyes in good health. The vision plan offers an extensive network of optometrists and vision care specialists. Remember, you'll save money by visiting in-network providers. To find an in-network provider near you, visit [vsp.com](https://www.vsp.com).

Plan Features	VSP	
	In-Network	Out-of-Network
	You pay:	Plan reimburses you:
Exam every 12 months	\$5 copay	Up to \$45
Frames every 24 months	20% off any amount above the \$130 allowance	Up to \$70
Lenses every 12 months Single Vision Bifocal Trifocal Lenticular	Combined with eye exam copay	Up to \$45 Up to \$65 Up to \$85 Up to \$85
Contact Lenses every 12 months (in lieu of lenses & frames)	Amount above the \$130 allowance	Up to \$105
Laser Vision Correction	15% off retail price or 5% off promotional price for Lasik or PRK from U.S. Laser Network	N/A



COST FOR COVERAGE

Your bi-weekly payroll deductions for medical, dental, and vision premiums are shown in the table below. However, premium amounts are calculated based on a monthly coverage period.

Benefit Plan	Employee Only	Employee + 1	Family
Medical			
Kaiser HMO	\$285.00	\$285.00	\$285.00
Dental			
Aetna DMO	Dental coverage is included with the medical costs shown above.		
Aetna DPO	Dental coverage is included with the medical costs shown above.		
Vision			
VSP	Vision coverage is included with the medical costs shown above.		

LIFE & DISABILITY INSURANCE

Life and Disability insurance, through Lincoln Financial, provides financial security to you and your family if you pass away or become unable to work.

BASIC LIFE INSURANCE

As an eligible employee, you receive Basic Life insurance equal to 1.5 times your annual earnings, to a maximum of \$1,000,000. Basic Life is provided by the company, at **no cost to you**.

VOLUNTARY LIFE INSURANCE

In addition to your Basic Life coverage, you may buy Voluntary Life coverage at discounted rates. The chart describes the amounts of coverage you can buy for yourself, your spouse, and your child(ren).

Benefit Features	Voluntary Life Options*		
	Employee	Spouse	Dependent Child(ren)
Coverage Options	\$10,000 increments	\$50,000	14 days – 6 months: \$250 6 months – 26 years: \$10,000
Maximum	5x annual earnings rounded to the nearest \$10,000 up to \$750,000	\$250,000 (cannot exceed 50% of employee coverage)	
Guaranteed Issue Amount	\$300,000	\$50,000	
Guaranteed Issue Period	Within 30 days of benefits eligibility		

**Evidence of Insurability (EOI) may be required beyond the guaranteed issue amount or outside of your initial benefits eligibility period. See [page 14](#) for more information on EOI.*

HOW MUCH VOLUNTARY LIFE AND DISABILITY INSURANCE SHOULD I BUY?

When deciding how much Voluntary Life and Disability coverage to buy, consider the following:

1. How much will your dependents need to pay debts, such as a mortgage, car loan, or credit card balances?
2. How much do your dependents need to maintain their current standard of living?
3. What kind of future would you like to provide for your dependents or others who depend on you for financial support?

BENEFICIARY BASICS

The person(s) you select as your beneficiary(ies) will receive your coverage amount, in the event of your death.

- Choose your beneficiary at big5employeeportal.com.
- Review your beneficiary designation periodically to ensure it reflects your current wishes.
- Change your beneficiary anytime at big5employeeportal.com or call **844.396.5948**.
- Beneficiaries should be over the age of 18.

PET INSURANCE

Your pets can receive coverage to help them stay healthy, too. With Wishbone Pet Insurance, you can save on unexpected veterinary expenses, such as illnesses, accidents, hereditary conditions, surgery, prescription medications, and more. For more information, or to enroll in the plan, visit wishboneinsurance.com/big5sportinggoods.

COBRA CONTINUING YOUR BENEFITS AFTER TERMINATION

Coverage ends on the day you and/or your dependents are no longer eligible. This includes being on a Leave of Absence, for any reason, longer than a one-year period (unless precluded by State or Federal statute). COBRA benefits allow employees covered under the Big 5 benefits plans the option of continuing coverage in the event that benefits would normally be lost. Such qualifying events include:

- Termination of employment
- A reduction in hours, resulting in loss of benefits eligibility for the Big 5 plans

Additionally, covered dependents can elect COBRA and continue benefits at their own expense, in the following qualifying events:

- The covered employee passes away
- The covered dependent turns 26
- Divorce or legal separation from covered spouse
- The covered employee becomes eligible for Medicare

When electing COBRA benefits, the full cost of benefits becomes the sole responsibility of the covered employee. You will have a 60-day window from the qualifying event to elect COBRA coverage.

COBRA COVERAGE

For more information about COBRA coverage, please contact WageWorks at mybenefits.wageworks.com or 888.678.4881.



BENEFIT TERMS & DEFINITIONS

BALANCE BILL

When a health care provider bills a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

COINSURANCE

The percentage paid for a covered service, shared by you and the plan. Coinsurance can vary by plan and provider network. Review the plans carefully to understand your responsibility. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

COPAY

A fixed dollar amount you pay the provider at the time of service; for example, a \$25 copay for an office visit or a \$10 copay for a generic prescription.

DEDUCTIBLE

The amount you pay each calendar year before the plan begins paying benefits. Not all covered services are subject to the deductible; for example, the deductible does not apply to preventive care services.

EMERGENCY ROOM CARE

Care received at a hospital emergency room for life-threatening conditions.

EVIDENCE OF INSURABILITY

The process of providing health information to qualify for certain types of insurance coverage. You may be required to submit a health questionnaire that will be reviewed by the carrier, and you will be notified of their decision directly.

IN-NETWORK CARE

Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

OUT-OF-NETWORK CARE

Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase and services may be subject to balance billing.

OUT-OF-POCKET MAXIMUM

The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

PREMIUM

The complete cost of your plans. You share this cost with Big 5 and pay your portion through regular paycheck deductions.

PREVENTIVE CARE

Routine health care including annual physicals and screenings to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

URGENT CARE

Care provided at an urgent care center for sudden illnesses or injuries that are not life-threatening. Urgent Care Centers are helpful when care is needed quickly to avoid developing more serious pain or problem.

BENEFIT ACRONYMS

EAP	EOI	HMO	OOPM
Employee Assistance Program	Evidence of Insurability	Health Maintenance Organization	Out-of-Pocket Maximum

YOUR BENEFIT CONTACTS

Coverage	Contact/Policy Number	Phone	Website/Email
HR Department	Big 5	Call: 310.536.0611 Fax: 310.297.7628	benefits@big5corp.com
Medical	Kaiser Permanente #231485	800.464.4000	kp.org
Dental	Aetna #469718	877.238.6200	aetna.com
Vision	VSP #12164038	800.3877.7195	vsp.com
Employee Assistance Program (EAP)	Guidance Resources	888.628.4824	lincoln4benefits.com or guidanceresources.com User: LFGsupport; Password: LFGsupport1
Voluntary Pet Insurance	Wishbone	800.891.2565	wishboneinsurance.com/big5sportinggoods customer care@petbenefits.com

This communication highlights some of your Big 5 benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. Big 5 reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

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LEGAL NOTICES

Big 5 Corp 2026 Benefits Program Required Legal Notices

As part of Big 5 Corp's compliance obligations Big 5 Corp must provide certain legal notices to its U.S. benefit eligible employees. The required disclosure notices included within this packet are:

- Medicare Part D Notice
- General Notice of COBRA Continuation Coverage Rights
- Notice of Privacy Practices
- HIPAA Special Enrollment Notice
- Newborns and Mothers Health Protection Act
- Women's Health and Cancer Rights Act (WHCRA)
- Patient Protection Disclosure

Medicare Part D Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Big 5 Corp and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Big 5 Corp has determined that the prescription drug coverage offered by the Aetna and Kaiser health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Big 5 Corp coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Big 5 Corp coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Big 5 Corp and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information Aetna at 888-792-3862 or Kaiser at www.kp.org NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Big 5 Corp changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact--Position/Office: Wendell Albin
Address: 2525 El Segundo Blvd., El Segundo, CA 90245
Phone Number: 310-536-0611

Model General Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Big 5 Corp's Benefits Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

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 your Plan informed of address changes

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Contact--Position/Office: Wendell Albin
Address: 2525 El Segundo Blvd., El Segundo, CA 90245
Phone Number: 310-536-0611

Notice of Privacy Practices

Notice of Big 5 Corp Group Benefit Plan Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of **Big 5 Corp** Health Information Privacy Practices (the “Notice”) is January 1, 2026, revised as of August 1, 2025.

Big 5 Corp Group Benefit Plan (the “Plan”) provides health benefits to eligible employees of **Big 5 Corp** (the “Company”) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words “you,” “your,” and “yours” refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your “Protected Health Information” (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan’s duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates, and any of their subcontractors without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request. However, if you, or a third party requests a copy of your PHI, the fee limitations set out in the rules will apply only to your individual request for access to your own records but these fee limitations will not apply to an individual's request to transmit records to a third party.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information The Plan has designated Wendell Albin, Benefits Manager as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: **2525 El Segundo Blvd., El Segundo, CA 90245**, benefits@Big5corp.com.

Reviewed: June 2023

WTW is not a law firm and therefore cannot provide legal or tax advice. This document was prepared for information purposes only and it should not be considered a substitute for specific professional advice. In particular, the contents of this document are not intended by WTW to be construed as the provision of specific legal, tax or other professional advice

or recommendations of any kind. The issues presented here have legal implications, and we recommend discussing this matter with your legal counsel prior to choosing a course of action. Before distributing to employees, be sure to review and update to ensure the document accurately reflects your company and plan details. As the plan sponsor, you are ultimately responsible for accuracy, timely distribution, and ensuring the appropriate notices are sent. We assume no duty in contract, tort, or otherwise in connection with this document and expressly disclaim, to the fullest extent permitted by law, any liability in connection with this document. This document is based on information available to WTW as of the date of issue and does not account for subsequent developments after that date. This document may not be reproduced or distributed to any other party, whether in whole or in part, without WTW's prior written permission.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact:

Contact--Position/Office:	Wendell Albin
Address:	2525 El Segundo Blvd., El Segundo, CA 90245
Phone Number:	310-536-0611

The Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Group health plans that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier.

Many states have enacted their own version of the Newborns' Act for insured coverage. In these states, State law can govern in lieu of the Federal requirements.

What group health plans must comply with the Newborns' Act?

If a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act applies if the coverage is "self-insured" by an employment-based plan.

If the coverage is provided by an insurance company or HMO (an "insured" plan), and your State has a law regulating coverage for newborns and mothers that meets specific criteria, then State law, rather than the Newborns' Act, applies. If this is the case, the State law may differ slightly from the Newborns' Act requirements, so it is important to know which law applies to the coverage offered by your plan.

For those plans with coverage that is insured by an insurance company or HMO, contact your State insurance department for the most current information on the State laws that pertain to hospital length of stay in connection with childbirth.

For those plans covered by the Federal law, the following questions apply:

When does the 48-hour (or 96-hour) period start?

If a woman delivers her baby in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. As an example: if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. For example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

Who is the attending provider?

An attending provider is an individual licensed under State law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. A nurse midwife or a physician assistant may be an attending provider if licensed in the State to provide maternity or pediatric care in connection with childbirth. A health plan, hospital, insurance company, or HMO, however, would not be an attending provider.

The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

May a group health plan require an individual to get permission (sometimes called prior authorization or precertification based upon medical necessity) for a 48-hour or 96-hour hospital stay?

A plan cannot deny a mother or her newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that the mother or her attending provider has failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans generally can require an individual to notify the plan of the pregnancy in advance of an admission in order to use certain providers or facilities or to reduce the individual's out-of-pocket costs.

Under the Newborns' Act, may group health plans impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth?

Yes, but only if the deductible, coinsurance, or other cost-sharing for the latter part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80 percent of the cost of the hospital stay. However, a plan covering 80 percent of the cost of the first 24 hours could not reduce coverage to 50 percent for the second 24 hours.

Does the Newborns' Act require a plan to offer maternity benefits?

No. The Newborns' Act does not require plans to provide coverage for hospital stays in connection with childbirth. However, other legal requirements, including Title VII of the Civil Rights Act of 1964, may require this type of coverage. Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission. See the agency's Website at eeoc.gov.

Are group health plans required to tell participants and beneficiaries about the Newborns' Act and any applicable State law protections?

A group health plan that provides maternity or newborn infant coverage must include in its SPD a statement describing the Federal or State law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child. If the Federal Newborns' Act law applies in some

areas in which the plan operates and State laws apply in others, the SPD must describe the Federal and State law requirements that apply in each area covered by the plan.

The Women's Health and Cancer Rights Act Notice

Does WHCRA apply to individuals who have not been diagnosed with cancer but who must undergo a mastectomy due to other medical reasons?

Despite the title, nothing in the law limits entitlement to WHCRA benefits to cancer patients. If an individual is receiving benefits in connection with a mastectomy and the group health plan covers mastectomies, then the individual is entitled to WHCRA benefits.

Also, despite the title, nothing in the law limits WHCRA entitlements to women.

Does WHCRA mandate minimum hospital lengths of stay in connection with mastectomy or breast reconstruction?

No, but many State laws applicable to insured coverage provide more protections than WHCRA. Thus, if a plan provides coverage through an insurance company, covered individuals may be entitled to minimum hospital stays under State law. If your plan is insured, check with your State insurance department for more information.

May group health plans impose deductibles or coinsurance requirements on the coverage specified in WHCRA?

Yes, but only if the deductibles and coinsurance are consistent with those established for other medical/surgical benefits under the plan or coverage.

Can my plan refuse to cover reconstructive surgery benefits because the mastectomy was performed when the participant was covered under a different insurance company?

If the plan provides coverage for mastectomies and the participant is receiving benefits under the plan that is related to a mastectomy, then the plan generally is required to cover reconstructive surgery upon request. In addition, the plan generally is required to cover the other benefits specified in WHCRA. It does not matter that the participant was not enrolled in the current plan and/or was not covered by the same insurance company at the time of the mastectomy.

There are additional related protections under the Affordable Care Act. For plan years beginning on or after January 1, 2014, a group health plan generally cannot limit or deny benefits relating to a health condition that was present before enrollment in the plan (a preexisting condition). For more information see the Affordable Care Act section of this publication at page 9 or visit the Affordable Care Act Web page of the Department of Labor's Employee Benefits Security Administration (EBSA) at dol.gov/ebsa/healthreform/ or the Department of Health and Human Services' Website at HealthCare.gov.

Is my plan required to provide preventive services related to the detection of breast cancer?

Under the Affordable Care Act, plans must provide certain preventive services, such as breast cancer mammography screenings for women 40 years of age and older, with no copayment, coinsurance or deductible (or other cost-sharing). For more information, visit HealthCare.gov/what-are-my-preventive-care-benefits/.

WHCRA does not require coverage for preventive services related to the detection of breast cancer.

What information should be included in the notice provided when participants enroll in the plan?

The enrollment notice must state that, for an individual who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The enrollment notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction and other benefits specified in WHCRA may be subject only to deductibles and coinsurance limits consistent with those established for other medical/surgical benefits under the plan or coverage.

What information should be included in the annual notice to participants in the plan?

The annual notice should describe the four categories of coverage required and should contain information on how to obtain a detailed description of the mastectomy-related benefits available under the plan. To satisfy this annual notice requirement, the plan may provide the same notice it provided to individuals upon enrollment in the plan if it contains the appropriate information as described above.

How must the plan provide these notices to participants?

These notices must be delivered in accordance with the Department of Labor's disclosure rules applicable to furnishing Summary Plan Descriptions. For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. A separate notice must be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant. To avoid duplication of notices, a group health plan can satisfy the WHCRA notice requirements by contracting with another party that provides the required notice. For example, in the case of an insured group health plan, the plan will satisfy the notice requirements with respect to a particular participant if the issuer timely provides the notice including the information required by WHCRA.

Where can I find more information about the requirements under WHCRA?

WHCRA is administered by the U.S. Departments of Labor and Health and Human Services.

For more information regarding an employer-sponsored group health plan's responsibilities under WHCRA, visit the Website of the Department of Labor's Employee Benefits Security Administration at [dol.gov/ebsa/ healthlawschecksheets.html](https://dol.gov/ebsa/healthlawschecksheets.html)

For more information on WHCRA, visit the Website of the Department of Health and Human Services' Centers for Medicare & Medicaid Services at cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html.

If you would like more information on WHCRA benefits, call your plan administrator 310-536-0611.

Patient Protection Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

Kaiser Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser at www.kp.org.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

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

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	CALIFORNIA Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	INDIANA Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	LOUISIANA Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofr/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	MISSOURI Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov	NEBRASKA Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	NEW YORK Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	NORTH DAKOTA Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	OREGON Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	RHODE ISLAND Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItte Share Line)
SOUTH CAROLINA Medicaid	SOUTH DAKOTA Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	UTAH Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	VIRGINIA Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	WEST VIRGINIA Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	WYOMING Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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