

STRONG COVERAGE, HEALTHY YOU



2027 BENEFIT GUIDE



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 plan designs and contribution amounts 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 2027?

- Big 5 will continue to offer a medical plan option through Kaiser. There will be slight plan changes to the Kaiser option. Big 5 will now offer an employer-funded account (Health Reimbursement Arrangement, or HRA) attached to the Kaiser plan to assist in offsetting in-network deductible expenses. See pages 7- 9 for more details.
- The dental plans will now be offered through United Healthcare. There will be no changes to the plan designs. There will be one PPO plan and one DHMO plan offering to choose from.
- The vision plan will continue to be offered through VSP. There will be on changes to the plan designs.

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. You will need to select a beneficiary separately for the 401(k) plan.

HEALTH & WELLNESS RESOURCES

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
▪ You ▪ Your household family members	▪ Unlimited phone consultations ▪ In-person or virtual counseling sessions (limits may apply)
TOPICS	CONTACT
▪ 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



READY TO GET STARTED?

Scan the QR code to visit the website and explore your options.

Still have questions? Call at **888.628.4824**



WHERE TO GO FOR CARE

VIRTUAL VISIT (KAISER)	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.

MEDICAL COVERAGE

Plan Features	Kaiser HRA*
	In-Network Only
Annual Deductible Individual/Family	\$2,000 / \$4,000
Annual OOPM Individual/Family	\$4,650 / \$9,300
Big 5 Annual HSA Contribution Individual/Family	N/A
	You pay:
Preventive Care Visit	Covered in full
Telemedicine/Virtual Visit	Covered in full***
Primary Care Visit	\$20***
Specialist Visit	\$30***
Lab & X-ray	20%***
Urgent Care	\$30***
Emergency Room (copay waived if admitted)	\$150***
Outpatient Hospital Services	CO : 20%*** All other states : No charge (deductible does not apply)
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	CA : \$30 copay*** All other states : \$60***
Specialty	20% up to \$250 max***
Prescription Drugs: Mail Order (up to a 90-day supply)	
Generic	\$20 copay***
Formulary Brand	\$60 copay***
Non-Formulary Brand	CA : \$60 copay*** All other states: \$120***

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

**Receiving services out-of-network may result in balance billing.

***After deductible.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Health Reimbursement Arrangements (HRAs) are paired with qualified plans and receive favorable tax treatment in order to help employees pay for out-of-pocket medical expenses.

- The HRA will be administered by HealthEquity
- If this is your first time enrolling in the HRA plan, you will receive an HRA debit card from HealthEquity
- HRA funds can be used to pay all eligible medical and prescription expenses that are subject to a deductible
- Unused HRA funds DO NOT roll over into the next year
- Big 5 funds \$1,250 for individual and \$2,500 for family coverage directly into your HRA

WHY IS AN HRA PLAN OPTION THE RIGHT CHOICE FOR YOU?

1. It saves you money. High Deductible Health Plans (HDHPs) come with much lower premiums than traditional health plans, meaning less money is deducted from your paychecks.
2. An HRA is a fund that is solely paid for by Big 5. Big 5 will contribute \$1,250 for individuals and \$2,500 for family.
3. You can use the HRA to pay for qualified medical expenses.
4. Preventive care, such as routine physicals and child immunizations, are covered one hundred percent by your health plan, so these types of charges will not be charged against your HRA fund.

FREQUENTLY ASKED QUESTIONS

What happens if I've used all my HRA funds?

Once all your HRA funds have been used, you will be responsible for any medical expenses until your total deductible is satisfied. After reaching the deductible, you will be responsible for any applicable coinsurance amount or copayments up to the annual out-of-pocket maximum.

What happens if I've paid some expenses out-of-pocket?

The quickest and most efficient way to receive reimbursements would be to set up for direct deposits through HealthEquity's member portal - [here](#).



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 <https://www.uhc.com/find-a-doctor>

Plan Features	DHMO Plan	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 <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 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.

Medical				
	Employee	Employee + Spouse	Employee + Child(ren)	Family
Kaiser HRA	\$142.50	\$142.50	\$142.50	\$142.50
Dental				
Dental PPO	Dental coverage is included with Big 5's medical plan.			
DHMO	Dental coverage is included with Big 5's medical plan.			
Vision				
VSP	Vision coverage is included with Big 5's medical plan.			

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**.

TRAVELCONNECT

If you are enrolled in Lincoln Financial Life insurance, you have access to TravelConnect. Whether you're traveling for business or heading out for vacation, Lincoln's TravelConnect services are your all-star defense when you're more than 100 miles from home. If a medical emergency, lost passport, or sudden evacuation calls an audible on your trip, you've got a seasoned support team ready to jump in 24/7. From arranging safe travel and emergency evacuations to legal consultations and even pet boarding, TravelConnect helps you stay ahead of the curve. So go ahead and travel with confidence.

Visit **myoncallportal.com** and enter Group ID: LFGTravel123 to access plan documents ,international calling instructions, and destination information.

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.

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	\$5,000	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	\$30,000	
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 18](#) for more information on EOI.

HOW MUCH VOLUNTARY LIFE INSURANCE SHOULD I BUY?

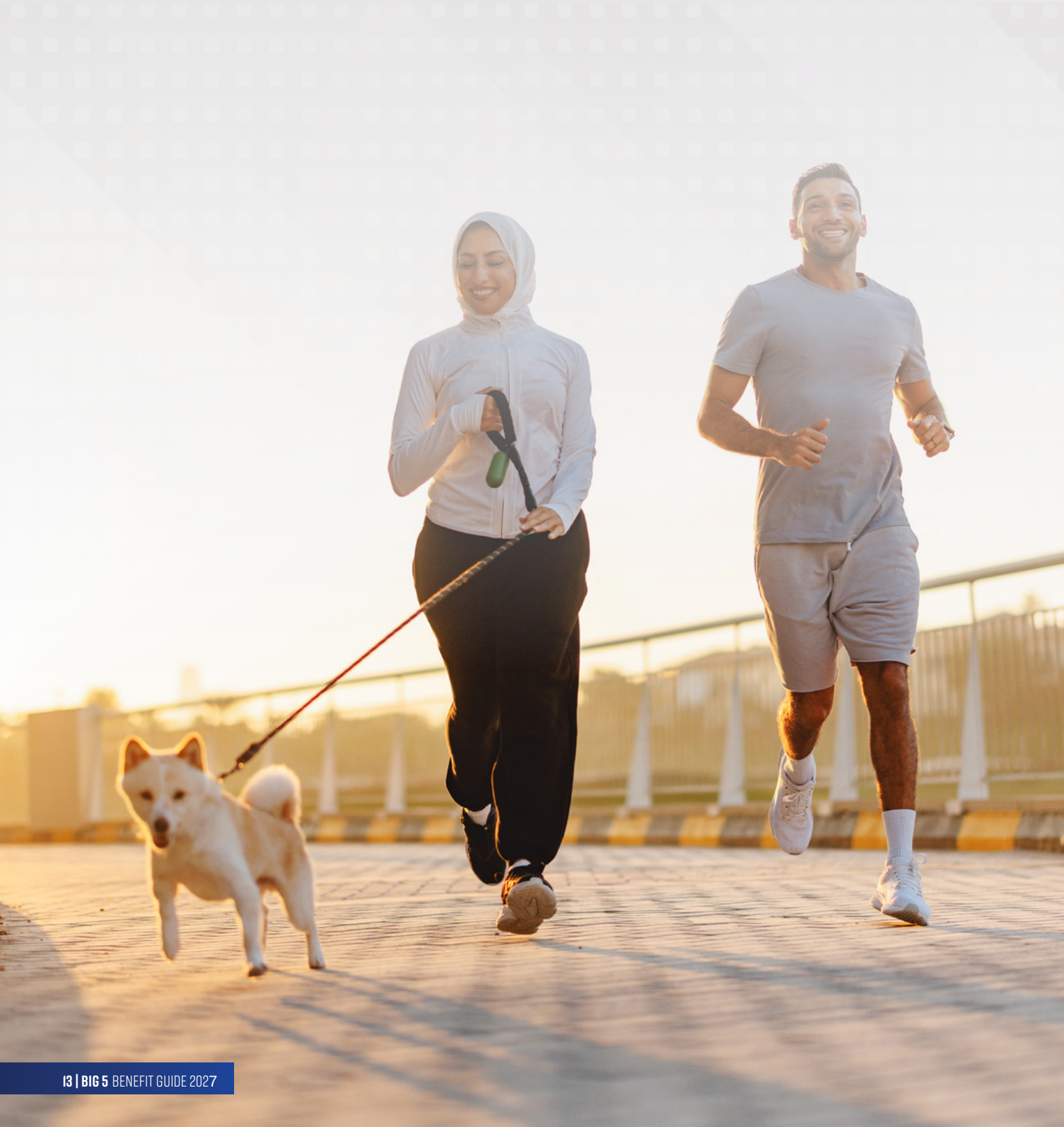
When deciding how much Voluntary Life coverage to buy, consider the following:

- 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?



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

CDHP	EAP	EOI	EPO
Consumer-Driven Health Plan	Employee Assistance Program	Evidence of Insurability	Exclusive Provider Organization
HMO	HSA	LTD	OOPM
Health Maintenance Organization	Health Savings Account	Long-Term Disability	Out-of-Pocket Maximum
POS	STD	RBP	HRA
Point of Service	Short-Term Disability	Reference Based Pricing	Health Reimbursement Arrangement

YOUR BENEFIT CONTACTS

Coverage	Contact Name	Phone	Website/Email
HR Department	Big 5	Call: 310.536.0611 Fax: 310.297.7628	benefits@big5corp.com
Medical	Kaiser Permanente (CA Only)	CO: 1.800.632.9700 OR/WA: 1.800.813.2000 CA: 1.800.464.4000	kp.org
Health Reimbursement Arrangement (HRA)	Health Equity	866.346.5800	healthequity.com
Dental	UnitedHealth Care	800.822.5353	uhc.com/dental
Vision	VSP	800.877.7195	vsp.com
Employee Assistance Program	Guidance Resources	888.628.4824	lincoln4benefits.com or guidanceresources.com User: LFGsupport; Password: LFGsupport1
Life and Disability	Lincoln Financial	800.423.2765	lincolnfinancial.com
Voluntary Pet Insurance	Wishbone	800.891.2565	wishboneinsurance.com/big5sportinggoods customerare@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.

Last updated: 9/24/26



YOUR PLAN RIGHTS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 15 for details.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by **Big 5 LLC**.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that is not considered affordable and doesn't meet certain minimum value standards. The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a new kind of tax credit that lowers your costs.

Does Big 5 LLC's Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1, 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by **Big 5 LLC**, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

Open enrollment for health insurance coverage through the Marketplace generally begins November 1 for coverage starting as early as January the following year. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period when you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. You may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a temporary Marketplace Special Enrollment Period for certain individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. If you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

YOUR PLAN RIGHTS

What About Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in **BIG 5 LLC’S** group plan, you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in the employer’s health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan’s summary plan description or contact your HR representative. Additionally, the Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Big 5 LLC

This section contains information about any health coverage offered by **Big 5 LLC** . If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

If you are not eligible for health insurance coverage through you and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Employer Name: Big 5 LLC	Employer Identification Number:
Employer Address: 2525 El Segundo Blvd., El Segundo, CA 90245	Employer Phone Number: 310-536-0611
Who Can We Contact About Employee Health Coverage At This Job? Karen Whittaker 310-536-0611	

- 1. Indexed annually; see [this link](#) for 2024.
- 2. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

YOUR PLAN RIGHTS

Here is some basic information about health coverage offered by this employer:

1. As your employer, we offer a health plan to:

- ☐ All employees. Eligible employees are:
- ☐ Some employees. Eligible employees are:

Active, full-time employees working 40 or more hours per week and is not classified by Big 5 as a temporary or seasonal employee.

2. With respect to dependents:

- ☐ We do offer coverage. Eligible dependents are:

- *Legal Spouse / Domestic Partner*
- *Biological, adopted, or stepchildren up to age 26*
- *Unmarried children of any age that is incapable of self-support due to a mental or physical disability*

- ☐ We do not offer coverage.

- ☒ **X** If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

****Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.**

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

WOMEN'S RIGHTS AND CANCER ACT NOTICE

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Contact **Big 5 LLC** for more information.

NEWBORNS AND MOTHER'S HEALTH PROTECTION ACT

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2009

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at <http://www.dol.gov/vets>.

NOTICE OF PATIENT PROTECTIONS:

Big 5 LLC 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. For information on how to select primary care provider, and for a list of participating primary care providers, contact **BIG 5 LLC at 310-536-0611**.

For children, you may designate a pediatrician as the primary care provider for the **BIG 5 LLC Health Plan**. You do not need prior authorization from **Big 5 LLC** or from any other person(including a primary care provider) in order to obtain access to obstetrical or gynecological care from health care professional in our network who specializes in obstetrics and gynecology. The health care professional, however, may be required to comply with certain procedure, including obtaining prior authorization for certain services, following a pre-approved treatment plan , or procedures for making referrals. For a listing of participating healthcare professionals who specialize in obstetrics or gynecology, contact **BIG 5 LLC at 310-536-0611**.

NOTICE REGARDING SPECIAL ENROLLMENT

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage 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 and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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).
Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact:

Employer Name: Big 5 LLC	
Employer Identification Number:	
Employer Address: 2525 El Segundo Blvd., El Segundo, CA 90245	Employer Phone Number: 310-536-0611
Who Can We Contact About Employee Health Coverage At This Job?	
Karen Whittaker 310-536-0611	

HIPAA NOTICE OF PRIVACY PRACTICES

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

Big 5 LLC sponsors certain group health plan(s) (collectively, the “Plan” or “We”) to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “Notice”) describes the legal obligations of Big 5 LLC, the Plan, and your legal rights regarding your protected health information, including certain substance use disorder (SUD) records covered by 42 CFR part 2 (Part 2), held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

your past, present or future physical or mental health or condition;

the provision of health care to you; or

the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully insured group health plans offered by our organization, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Big 5 LLC Benefits Department or HIPAA Privacy Officer. Attention: HIPAA Privacy Officer

Phone: __310.536.0611__

Email: __benefits@big5corp.com__

Address: __2525 E El Segundo Blvd.,__
__El Segundo, CA 90245__

Effective Date

This Notice, as revised, is effective February 16, 2026.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information including Substance Use Disorder (SUD) Part 2 records, to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use. For Substance Use Disorder (SUD) treatment, the Plan may share Part 2 records with primary care doctors, behavioral health specialists, or SUD treatment programs to support coordinated and effective treatment planning.

For Payment

We may use or disclose your protected health information, including Substance Use Disorder (SUD) Part 2 records, to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. The Plan may to facilitate payment by ensuring accurate processing and reimbursement of claims.

For Health Care Operations

We may use and disclose your protected health information, including Substance Use Disorder (SUD) Part 2 records, for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information, including SUD treatment records, to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

SUD treatment records received from programs subject to 42 CFR part 2, or testimony relating the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

- 1) the individual identifiers have been removed; or
- 2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- 1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- 2) treating such person as your personal representative could endanger you; or
- 3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of SUD Part 2 treatment records, psychotherapy notes, and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period BIG 5 LLC has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information. For more information, please see [Your Rights Under HIPAA](http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html) (www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html).

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

You are receiving 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 generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

Read this notice carefully to help understand your COBRA rights. Keep in mind that 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as 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 may be required to pay for COBRA continuation coverage.

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

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

SPOUSE If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

DEPENDENT CHILDREN Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

RETIREE COVERAGE

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA 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;
- COMMENCEMENT OF A PROCEEDING IN BANKRUPTCY WITH RESPECT TO THE COMPANY;] OR
- 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 LLC**. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage. COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of **36 months**.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

DISABILITY EXTENSION

If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 total 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 continuation coverage. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

SECOND QUALIFYING EVENT EXTENSION

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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?

Yes. 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 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.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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 LLC** has determined that the prescription drug coverage offered by **Big 5 LLC** 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 15 to December 7. 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 LLC** coverage will not be affected. Upon enrollment in a Medicare drug plan, you may continue the **Big 5 LLC** coverage, and the coverage will coordinate with Part D coverage according to the Medicare Secondary Payer Law. Please contact us for more information about what happens to your coverage if you decide to enroll in a Medicare Part D program.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored coverage, you and your dependents will be able to get this coverage back at a future date, though you may need to wait until **Big 5 LLC**'s next open enrollment period to resume coverage under the group plan.

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 LLC** 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.

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 LLC** changes. You also may request a copy of this notice at any time. For more information about this notice or your current prescription drug coverage, please contact the Big 5 LLC Benefits Department.

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).

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myvalhipp.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)	Health Insurance Premium Payment (HIPP) Program Website: 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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

GEORGIA – Medicaid	INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dftr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – 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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	MASSACHUSETTS – Medicaid and CHIP
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/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicare-health-insurance-premium-payment-program-hipp.html 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 RI te 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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs 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 July 31, 2025, 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

BIG 5
SPORTING GOODS

