DICK'S Sporting Goods, Inc.
Health and Welfare Plan

Summary Plan Description

(For salaried and full-time hourly teammates)

January 2025

TABLE OF CONTENTS

INTRODUCTION 1

ELIGIBILITY TO PARTICIPATE IN PLAN 2

COMMENCING PARTICIPATION IN PLAN 3

TERMINATION OF PARTICIPATION 6

CLAIMS PROCEDURES 7

ADMINISTRATIVE INFORMATION 7

MISCELLANEOUS INFORMATION 10

ADDITIONAL ERISA-REQUIRED INFORMATION 13

OVERVIEW OF HEALTH SPENDING ACCOUNTS 15

ADDITIONAL HEALTH REIMBURSEMENT ACCOUNT INFORMATION 16

ADDITIONAL HEALTH FLEXIBLE SPENDING ACCOUNT INFORMATION 18

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT 20

INTRODUCTION

This document describes the DICK'S Sporting Goods, Inc. Health and Welfare Plan (the "Plan"). The Plan is sponsored by DICK'S Sporting Goods, Inc. ("DICK'S") for the benefit of its eligible employees (teammates), as well as for the benefit of eligible employees of Golf Galaxy, LLC and DICK'S Merchandising & Supply Chain, Inc. DICK'S and those participating affiliated companies are referred to in this document as the "Company." This document does not describe benefits offered under the Plan to employees of GolfWorks.

The Plan is a welfare benefit plan that provides the following benefits to eligible employees and their dependents:

- Medical
- Prescription drug
- Dental
- Vision
- Basic life and accidental death and dismemberment ("AD&D")
- Short-term disability
- Basic long-term disability
- Employee assistance benefits
- Supplemental life and AD&D
- Supplemental long-term disability
- Cigna supplemental insurance coverages (accident insurance, cancer/critical illness insurance and hospital insurance)

The Plan includes a health care flexible spending account (the "HFSA") and a dependent care flexible spending account (the "DFSA"). In addition, the Company offers a health reimbursement account ("HRA") and a health savings account ("HSA") in connection with certain medical plan options.

Additional information about these benefits is provided to you separately. Those booklets, including your Benefits Resource Guide and Benefits Annual Enrollment Playbook, along with the information at www.benefityourliferesources.com, are incorporated into this document and, together with this document, they form the "summary plan description" or "SPD" for the Plan.

In the event that the SPD for the Plan conflicts with the actual Plan documents, including insurance contracts, the Plan documents and insurance contracts will control.

If you have any questions about the Plan, or to request copies of the benefit booklets, please contact the Corporate Benefits Department at 1-800-690-7655, extension 3012, option 5 or by e-mail at Benefits@dcsg.com.

ELIGIBILITY TO PARTICIPATE IN PLAN

In general, you are eligible to participate in the Plan if you are employed by the Company and classified as a regular salaried or full-time hourly teammate. All regular salaried and full-time hourly teammates are eligible to participate in the Plan after you have been employed by the Company in such classification for 30 consecutive days.

Notwithstanding the above, the following individuals are not eligible to participate in the Plan:

- Employees covered by a collective bargaining agreement that does not provide for participation in the Plan
- Leased employees
- Independent contractors
- Seasonal employees

Reclassification

If you are classified by the Company in one of the categories not eligible to participate in the Plan, but the Company is later required by the Internal Revenue Service, the U.S. Department of Labor or any other governmental agency, or by any court or other tribunal, to reclassify you as eligible, you will not be eligible to participate in this Plan until the time you are designated by the Plan administrator as an eligible employee. Such designation shall only provide for eligibility prospectively from the time it is made.

For Dependent Coverage

If you are eligible to participate in the Plan, you may elect to cover your eligible dependents under the medical/prescription drug, dental and vision benefit options of the Plan only if you also elect coverage for yourself. Your eligible dependents include:

- Your spouse (for federal income tax purposes)
- Your children until the end of the month in which they turn age 26, which include (i) your biological children, (ii) your stepchildren, (iii) your adopted children and children placed with you for adoption and (iv) children for whom you are appointed legal guardian or foster parent
- Your adult children who are physically or mentally disabled and dependent on you for support and incurred such disability prior to attaining age 26
- Your same or opposite sex domestic partner as long as the teammate and the domestic partner meet all of the requirements below and sign a Domestic Partner Affidavit:
  - Are at least 19 years of age
  - Are not married to anyone else or related by blood
  - Are in a mutually exclusive and enduring relationship similar to marriage
  - Have shared a common residence for at least 12 months and intend to do so indefinitely
  - Consider themselves life partners
  - Share joint responsibility for each other's common welfare and are financially

interdependent
  - Are both capable of consenting to the domestic partnership
  - Are registered as domestic partners with the state domestic partner registry (if any) of the state in which they reside
- Children of domestic partners until the end of the month in which they turn age 26, only if the domestic partner is enrolled for coverage

Before you may add an individual as a dependent under the medical/prescription drug, dental and/or vision benefits, you must present written documentation (consistent with Plan procedures) demonstrating that the individual is your dependent. If you do not present appropriate written documentation relating to an individual, such individual will not be considered an eligible dependent.

In addition, it is your responsibility to verify your dependent's status upon request. If you do not verify your dependent's status, coverage for that dependent will terminate.

In certain circumstances, the eligibility requirements for certain underlying benefits may be different, and in such cases, the insurance carrier's eligibility requirements will govern.

COMMENCING PARTICIPATION IN PLAN

As shown in the table below, you are automatically enrolled in certain benefits and the Company pays the full cost of those coverages, but for other benefit options, you must affirmatively elect them if you would like them, and either you and the Company share the cost of the coverages, or you pay the full cost of the coverages.

For the benefits options that you must affirmatively elect, you must elect to participate within 31 days from the date you are eligible. If you do not elect coverage within this time frame, you generally will have to wait until the next annual enrollment period.

Salaried Teammates	Full-time Hourly Teammates
You are automatically enrolled in these benefits when eligible, and the Company pays the full cost of the coverages: – Basic life and AD&D – Short-term disability – Basic long-term disability – Employee assistance benefits	You are automatically enrolled in these benefits when eligible, and the Company pays the full cost of the coverages: – Basic life and AD&D – Short-term disability – Employee assistance benefits
You must affirmatively elect these benefits if you would like them, and you and the Company share the cost of the coverages: – Medical/prescription drug* – Dental – Vision – HFSA – DFSA	You must affirmatively elect these benefits if you would like them, and you and the Company share the cost of the coverages: – Medical/prescription drug* – Dental – Vision – HFSA – DFSA

Salaried Teammates	Full-time Hourly Teammates
Note: You may not make contributions to the HFSA if you enroll in the Base HSA Plan or Buy-Up HSA Plan, or you are enrolled in another high deductible health plan.	Note: You may not make contributions to the HFSA if you enroll in the Base HSA Plan or Buy-Up HSA Plan, or you are enrolled in another high deductible health plan.
You must affirmatively elect these benefits if you would like them, and you pay the full cost of the coverages: – Supplemental life and AD&D – Supplemental long-term disability – Cigna supplemental insurance coverages (accident insurance, cancer/critical illness insurance and hospital insurance) Note: Supplemental long-term disability is not offered to all salaried teammates. The Company will notify you if you are eligible for supplemental long-term disability.	You must affirmatively elect these benefits if you would like them, and you pay the full cost of the coverages: – Basic long-term disability – Supplemental life and AD&D – Cigna supplemental insurance coverages (accident insurance, cancer/critical illness insurance and hospital insurance)
*Depending on the medical plan option you select, you are automatically enrolled in the HRA or HSA.	*Depending on the medical plan option you select, you are automatically enrolled in the HRA or HSA.

Paying for Your Benefits

For medical/prescription drug, dental and vision, you pay your contribution toward the cost of coverage through pre-tax payroll deductions. You also make contributions to any HFSA, DFSA or HSA on a pre-tax basis.

For supplemental life and AD&D, supplemental long-term disability, and the Cigna supplemental insurance coverages, you pay for the cost of coverage on an after-tax basis. In addition, full-time hourly teammates who elect to purchase basic long-term disability pay for the cost of coverage on an after-tax basis.

The cost of your coverage is based on a number of factors, including which benefits you select and whether you elect to cover eligible dependents. The cost of coverage generally is set annually. Please refer to Workday for your contribution rates.

Note on Cost of Domestic Partner Coverage:

Unless the domestic partner and the domestic partner's children qualify as tax dependents of the teammate under the Internal Revenue Code, a teammate may not use pre-tax dollars to pay for the coverage of the domestic partner and the domestic partner's children. In addition, the portion of the cost paid by the Company for coverage of the domestic partner and the domestic partner's children is subject to federal income tax and will be included in the teammate's Form W-2. State and local taxes will vary depending on the tax code in your area.

Change in Status

You may make changes during the year only if you have a "change in status." The coverage change you wish to make must be consistent with your change in status. Change in status events include:

- A change in your marital status by reason of marriage, divorce, annulment or legal separation
- A change in the number of dependents due to birth, adoption or placement for adoption, foster care, legal custody, death or the dependent reaching the age limitation for coverage
- You and/or your dependent gain or lose coverage due to relocation, employment change or an increase or decrease in hours
- Significant changes in health coverage rates that are attributable to your spouse's employment
- Entitlement to COBRA, Medicare or Medicaid
- Dissolution of a domestic partnership

You must report a change in status event within 31 days of the event in order to make coverage changes for the current year. Otherwise, you must wait until the next annual enrollment period to make any changes in coverage.

The Plan also permits changes in coverage as required for special enrollment events under the Health Insurance Portability and Accountability Act and the Children's Health Insurance Program Reauthorization Act.

Note on Special Change in Status Rules for Domestic Partner Coverage:

You may enroll your domestic partner or your domestic partner's children mid-year only for change in status events limited to the loss of other health care coverage, the birth of a child, or the adoption of a child. You may drop coverage for a domestic partner or the domestic partner's children mid-year on account of changes in status events limited to the gain of other health care coverage, the dissolution of a domestic partnership and the death of the domestic partner or the domestic partner's children.

Note on Special Rule Relating to Retroactive Medical Coverage:

If you commence participation in the medical benefit option under the Plan within 31 days of experiencing a loss of other medical coverage due to a qualifying change in status event, you will be retroactively enrolled in the medical benefit as of the date immediately following the other loss of coverage. The Company will pay the full cost of the medical benefit premium applicable to the retroactive period between (1) the date immediately following the loss of other medical coverage and (2) the date on which you commence participation in the medical benefit under the Plan.

For more information on change in status events, contact the Corporate Benefits Department at 1-800-690-7655, extension 3012, option 5 or by e-mail at Benefits@dcsg.com.

TERMINATION OF PARTICIPATION

Your medical/prescription drug, dental and vision coverage, as well as employee assistance benefits, will cease on the last day of the month in which you terminate employment or otherwise cease to be eligible.

Your basic life and AD&D, short-term disability, basic long-term disability, supplemental life and AD&D, supplemental long-term disability, and the Cigna supplemental insurance coverages, will cease on your last day of employment.

Your participation in the HFSA and DFSA will cease on your last day of employment, except you may continue to request reimbursement from the HFSA and DFSA for qualifying expenses incurred on or before the date your employment ends, as long as you submit your claims within 90 days of the date you terminate employment or by March 31 following the end of the calendar year, whichever is earlier.

Your participation in the HRA ends when the related medical coverage ends.

As described in more detail later in this booklet, your HSA will go with you when you terminate employment, though any Company contributions to the HSA cease with your last regular paycheck.

If you cease making your contribution toward the cost of coverage or if the Plan terminates, your coverage ends immediately.

Dependent Participation

Coverage for your dependent ends when your coverage ends or on the date your dependent no longer meets the Plan's definition of an eligible dependent. You are required to notify the Plan administrator when an enrolled dependent no longer meets the eligibility criteria.

Leave of Absence

Please contact the Corporate Benefits Department for information about how your benefits will be affected by a leave of absence.

Reemployment

In general, if you terminate employment and are rehired within 91 days, your prior elections automatically will be reinstated. If you terminate employment and are rehired more than 91 days from your termination date you may enroll in benefits, provided any election must be made within 31 days of becoming eligible again.

CLAIMS PROCEDURES

Claims for Benefits

You should refer to the benefit booklets that are distributed separately for a description of the claims procedures applicable to claims for benefits for a particular benefit option. Claims procedures applicable to claims for benefits under the HFSA and DFSA are described in later sections of this booklet.

Claims Relating to Eligibility or Enrollment

You may appeal a claim relating to eligibility to participate or enrollment in the Plan within 180 days following receipt of notice that you are not eligible for or enrolled in the Plan. Such appeal must be made in writing and sent by U.S. mail to the following address:

Corporate Benefits Department
DICK'S Sporting Goods, Inc.
345 Court Street
Coraopolis, PA 15108

The Plan will provide you with notice of its benefit determination on review not later than 60 days after receipt of your appeal. This time period may be extended for an additional 60 days in certain cases.

Exhaustion/Statute of Limitations

For all claims under the Plan (i.e., for claims for benefits and for claims relating to eligibility or enrollment), you must follow the claims procedures before taking action in any court regarding the claim. You must initiate any suit or legal action for benefits under the Plan no later than one year following a final decision on the claim. This one-year limitation period on suits shall apply in any court where a suit is initiated.

Failure to Follow Claims Procedures

In the case of the failure of the Plan to follow the claims procedures, you shall be deemed to have exhausted the administrative remedies under the Plan and shall be entitled to pursue any available remedies under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

ADMINISTRATIVE INFORMATION

This section contains additional information about the Plan, including information that DICK'S is required to provide to you under the Employee Retirement Income Security Act of 1974 ("ERISA"). This section does not apply to the dependent care flexible spending account ("DFSA") or health savings account ("HSA"), as those accounts are not subject to ERISA.

The Role of DICK'S

DICK'S is the Plan sponsor and Plan administrator of the Plan. DICK'S has the responsibility to administer and interpret the Plan and make the final decision on such issues as eligibility and payment of benefits. DICK'S has delegated certain of its responsibilities with respect to the Plan to the Health and Welfare Plan Committee, to the Corporate Benefits Department and to certain third-party vendors.

DICK'S (or its delegate) has the exclusive discretionary right to interpret the terms and provisions of the Plan and to determine any and all questions arising under the Plan, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies or omissions, by general rule or particular decision and to make findings of fact and conclusions of law.

Your Rights Under ERISA

As a participant in any of the ERISA-covered benefits under the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.

- The rules relating to COBRA continuation coverage are different in the case of domestic partners. If a teammate in a domestic partnership experiences a COBRA qualifying

event that is the termination of employment or a reduction in hours, the teammate may elect COBRA coverage, including coverage for the domestic partner. In addition, in the event that the domestic partnership dissolves or the teammate dies, the domestic partner may elect COBRA coverage. Otherwise, COBRA coverage is not offered in the domestic partner context because a domestic partner is not a spouse under federal law.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Future of Plan

DICK'S intends to continue the Plan, but at all times reserves the right to amend, modify, suspend or terminate the employee benefits it offers employees and former employees, including this Plan, without notice. For example, DICK'S may decide to terminate the Plan in the event of a restructuring of its employee benefit programs. This right of DICK'S to amend, modify, suspend or terminate employee benefits cannot be change by any representation to the contrary, even if such representation is made by a Company representative.

The participating affiliated companies likewise have the right at any time and without notice to cease participating in the Plan.

MISCELLANEOUS INFORMATION

Coordination of Benefits

This Plan may or may not coordinate benefits with other plans. If you or your dependent are covered under more than one plan, refer to the component plans' certificate of coverage/plan description to determine how benefits payable under those plans will be coordinated. You should file all such claims with the appropriate plan administrator. Coverage under this Plan plus another plan will not guarantee 100% total reimbursement.

To the extent that any of this Plan's booklets' or SPDs' coordination of benefits provisions do not make this Plan secondary to automobile no-fault, personal injury protection, or medical coverage or do not provide or the definition of "plan" within which this Plan will coordinate, the definition will include any automobile insurance policy. Additionally, the order of benefit determination rules will include the following language: "The Plan is always secondary to automobile no-fault, personal injury protection, or medical payments coverage plans and will coordinate benefits for claims which are payable under those automobile policies."

If the covered person resides in a state where automobile no-fault, personal injury protection, or medical payments coverage is mandatory and the covered person does not have the state mandated automobile coverage, the Plan will deny benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether or not the covered person submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

Subrogation/Reimbursement

If you or your covered dependent receives benefits as the result of an illness or injury caused by another party, the medical plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This process is called subrogation.

The Plan has the right to subrogate claims. This means that the Plan can recover:

- Any payments made as a result of an injury or illness caused by the action or fault of another person;
- A lawsuit settlement from payments made from any source, including automobile or homeowners insurance, whether yours or another's; or
- Any payment made when any other third party is responsible for the condition giving rise to the medical expenses.

The provisions of this section apply to all benefits under the Plan, even if the underlying benefit booklets contain no language or different language on subrogation and reimbursement.

Definitions

The description of the subrogation and reimbursement process uses three terms that you need to understand.

- "Third party" means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "third party injuries."
- "Responsible party" includes any party responsible for payment of expenses associated with the care or treatment of third party injuries.
- "You" or "your" includes anyone on whose behalf this Plan pays or provides any benefits.

Right of Recovery

When the Plan pays benefits to you for expenses incurred due to third party injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on your behalf that are associated with the third party injuries. The Plan's rights of recovery apply to any recoveries made by or on your behalf from the following sources, including, but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy; premises or homeowners' medical payments coverage; or premises or homeowners' insurance coverage; and

- Any other payments from a responsible party or another source intended to compensate you for injuries resulting from an accident or alleged negligence.

When You Accept Plan Benefits

By accepting benefits under this Plan, you specifically acknowledge the Plan's right of subrogation. When this Plan pays health care benefits for expenses incurred due to third party injuries, the Plan shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this Plan. The Plan may proceed against any party with or without your consent.

By accepting benefits under this Plan, you also specifically acknowledge this Plan's right of reimbursement. This right of reimbursement attaches to any payment received by you or your representative from any party responsible for paying for expenses associated with the care or treatment of third party injuries. By providing any benefit under this Plan, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

By accepting benefits under this Plan, you or your representatives further agree to:

- Notify the Plan in writing, within 30 days of the time when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third party injuries sustained by you;
- Cooperate with the Plan and its designees and do whatever is necessary to secure the plan's rights of subrogation and reimbursement under this booklet;
- Give the Plan a first-priority lien on any recovery, settlement, judgment or other source of compensation that may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment or other source of compensation, any and all amounts due to the plan as reimbursement for the full cost of all benefits associated with third party injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by the Plan in writing;
- Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery that specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan; and
- Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of third party injuries.

The Plan's recovery rights under this provision are first priority rights and the Plan is entitled to reimbursement even if such reimbursement results in a recovery to you that is insufficient to compensate you in whole or in part for your damages from a third party injury. The Plan may recover the full cost of all benefits paid by this Plan without regard to any

claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery, and the Plan is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any third party without the prior express written consent of the Plan.

If You Do Not Follow the Process

In the event you or your representative fail to cooperate with the Plan, you shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

Qualified Medical Child Support Orders

If a qualified medical child support order (also called a "QMCSO") is issued by a court for your child, that child will be enrolled in medical, dental and vision benefits, as provided by the order, without regard to the annual enrollment and change in status rules. You may obtain, without charge, a copy of the Plan's procedures for review and implementation of qualified medical child support orders by contacting the Corporate Benefits Department at 1- 800-690-7655, extension 3012, option 5, or by e-mail at Benefits@dcsg.com.

No Guarantee of Employment

The Plan shall not be deemed to constitute a contract of employment between the Company and you. The Plan shall not be deemed to give you the right to be retained in the service of the Company or to interfere with the right of the Company to terminate your employment at any time with or without cause.

ADDITIONAL ERISA-REQUIRED INFORMATION

Under ERISA, DICK'S must provide you with the following additional information:

Name, Address and Telephone Number of Plan Sponsor/Plan Administrator

DICK'S Sporting Goods, Inc.
Attn: Corporate Benefits Department
345 Court Street
Coraopolis, PA 15108
724-273-3400

Employer Identification Number

The Internal Revenue Service has assigned DICK'S the following tax identification number: 16-1241537.

Plan Number/Plan Year

DICK'S files a tax return each year for the Plan called a Form 5500 filing. The number assigned to the Plan for this purpose is 501. The year applicable to the Plan is January 1 to December 31.

Agent for Service of Legal Process

DICK'S Sporting Goods, Inc.
Attn: EVP and Chief People, Purpose and Transformation Officer
345 Court Street
Coraopolis, PA 15108
724-273-3400

Service of legal process may also be made upon the Plan Administrator.

Type of Plan

The Plan is a welfare benefit plan comprised of a group health plan (medical/prescription drug, dental and vision), life and AD&D, disability, health reimbursement account ("HRA"), and health care flexible spending account ("HFSA"), as well as an employee assistance plan.

Type of Administration/Source of Contributions and Funding

The chart below describes how the different benefits offered under the Plan are administered and funded.

Medical	Benefits are paid out of the Company's general assets and administered by Cigna.
Prescription Drug	Benefits are paid out of the Company's general assets and administered by Express Scripts.
Dental	Benefits are paid out of the Company's general assets and administered by United Concordia.
Vision	Benefits are fully-insured and administered by Vision Service Plan ("VSP").
Short-term Disability	Benefits are paid out of the Company's general assets and administered by Lincoln Financial.
Basic Life and AD&D Basic Long-term Disability Supplemental Life and AD&D Supplemental Long-term Disability	Benefits are fully-insured and administered by Lincoln Financial.

HFSA	The HFSA is administered by Inspira. Participants contribute to their HFSA by salary reduction. As part of the transition of the HFSA from MarketLink to Inspira, MarketLink administered the HFSA with respect to certain claims until April 1, 2025.
HRA	The HRA is administered by Inspira. Contributions are made to the HRA by the Company from its general assets.
Employee Assistance	Benefits are administered by Evernorth CONFIDE Behavioral Health Navigator.
Cigna Supplemental Insurance Coverages (accident insurance, cancer/critical illness insurance and hospital insurance)	Benefits are fully-insured and administered by Cigna.

OVERVIEW OF HEALTH SPENDING ACCOUNTS

The Plan includes three types of health spending accounts, as described in the chart below.

	Health Savings Account ("HSA")	Health Reimbursement Account ("HRA")	Health Care Flexible Spending Account ("HFSA")
You must be enrolled in these medical plan options to be eligible for the account	Base HSA Plan Buy-Up HSA Plan	HRA Plan	You are not required to be enrolled in a DICK's medical plan option, but if you enroll in the Base HSA Plan or Buy-Up HSA Plan, or if you are enrolled in another high deductible health plan, you may not make contributions to the HFSA.
Funding	– Both you and the Company may make contributions. – Any Company contribution is described in your annual enrollment materials. – Your contributions are made on a pre-tax basis and subject to an IRS limit.	– Only the Company may make contributions. – The Company's contribution is described in your annual enrollment materials.	– Only you may make contributions. – Your contributions are made on a pre-tax basis and subject to an IRS limit. – The IRS limit is described in your annual enrollment materials.

	Health Savings Account ("HSA")	Health Reimbursement Account ("HRA")	Health Care Flexible Spending Account ("HFSA")
	– The IRS limit is described in your annualenrollment materials.		
Rollover to next year	– Amounts remaining at the end of the year roll over to the next year. – No IRS limit applies to the rollover to the next year.	– Amounts remaining at the end of the year up to a dollar amount limit will roll over to the next year provided you elect the HRA Plan again. – The dollar amount limit is described in your annual enrollment materials.	– Amounts remaining at the end of the year up to the IRS carryover limit will roll over to the next year. – The IRS carryover limit is described in your annual enrollment materials.
When you terminate employment	You HSA account goes with you.	You forfeit the HRA account balance.	You forfeit the HFSA account balance.

ADDITIONAL HEALTH REIMBURSEMENT ACCOUNT INFORMATION

Eligible Expenses

You may use the money in your health reimbursement account ("HRA") to pay for eligible expenses incurred by you, your spouse or eligible dependents. You may not use your HRA for expenses for your domestic partner and your domestic partner's children.

Eligible expenses are described on a list maintained by the administrator for the HRA, Inspira. Please refer to https://inspirafinancial.com for a description of eligible expenses.

If you also participate in the HFSA, the HFSA will reimburse before the HRA.

How You Will Be Reimbursed

You will be issued a debit card for the amount of your annual contribution. You can use your debit card with any provider who accepts it. Be sure to save all your receipts when using your debit card. Inspira may ask you for a copy of your receipts to validate your purchase. If your provider does not accept the debit card, you should pay for the services and then file a claim for reimbursement.

How to Make a Claim for Benefits

Eligible claims incurred under the HRA Plan are automatically sent to your HRA for reimbursement.

If you used your HRA debit card to pay for your expense, you will not need to file a claim for reimbursement. However, if you were not able to use your HRA debit card, you should file a claim for reimbursement with Inspira. You may file a claim through Inspira's website. You also may file a claim by obtaining a claim form from Inspira's website or by calling Inspira at 1-844-212-0494 and mailing or faxing such claim as set forth below:

Inspira Financial
P.O. Box 8396
Omaha, NE 68108-0396
Fax: 855-703-5305

The initial decision to approve or not approve a reimbursement request will be made by Inspira.

Inspira will provide you with notice of an adverse benefit determination not later than 30 days after receipt of your claim. In certain cases, the plan may extend this period for up to 15 days as long as Inspira notifies you prior to the expiration of the 30-day period of the circumstances requiring an extension of time and the date by which Inspira expects to render the benefit determination.

Appeal of Adverse Benefit Determination

You have 180 days following receipt of a notice of an adverse benefit determination in which to submit an appeal. Appeals will be decided by Inspira. The appeal should be mailed to:

Inspira Financial
P.O. Box 8396
Omaha, NE 68108-0396

You may submit written comments, documents, records and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Inspira will provide you with a written or electronic notice of its benefit determination on review not later than 60 days after receipt of your request for review. In certain cases, Inspira may extend this period for up to 60 days as long as Inspira notifies you prior to the initial 60 day period of the circumstances requiring an extension of time and the date by which Inspira expects to render the determination on review.

If You Terminate Employment

If you terminate employment and still have money in your HRA, you may continue to submit claims for expenses incurred prior to the date of termination. Reimbursement requests must be submitted within 90 days of the date you terminate employment.

Reemployment

In general, if you terminate employment and are rehired within 91 days, your prior election automatically will be reinstated, but you cannot be reimbursed for claims incurred during the period that you were not working, unless you elect COBRA.

ADDITIONAL HEALTH FLEXIBLE SPENDING ACCOUNT INFORMATION

Eligible Expenses

You may use the money in your health flexible spending account ("HFSA") to pay for eligible expenses not covered by a Plan, but incurred by you, your spouse or your eligible dependents. You may not use your HFSA for medical expenses for your domestic partner and your domestic partner's children.

Eligible medical expenses are described on a list maintained by the administrator for the HFSA, Inspira. Please refer to https://inspirafinancial.com for a description of eligible expenses.

If you elect to participate in the HSA Plan or HSA Buy-Up Plan, the HFSA will reimburse only dental and vision expenses and is referred to as a "limited purpose health FSA."

If you also participate in the HRA, the HFSA will reimburse before the HRA.

How You Will Be Reimbursed

You will be issued a debit card for the amount of your annual contribution. You can use your debit card with any provider who accepts it. Be sure to save all your receipts when using your debit card. Inspira may ask you for a copy of your receipts to validate your purchase. If your provider does not accept the debit card, you should pay for the services and then file a claim for reimbursement.

How to Make a Claim for Benefits

Reimbursement requests for expenses incurred during the calendar year must be submitted by March 31 of following the calendar year.

You can receive reimbursement for eligible expenses up to your elected annual contribution amount under the HFSA. This means that you do not have to wait until the funds have accumulated in your HFSA in order to receive reimbursement.

If you used your HFSA debit card to pay for your expense, you will not need to file a claim for reimbursement. However, if you were not able to use your HFSA debit card, you should file a claim for reimbursement with Inspira. You may file a claim through the Inspira's website. You also may file a claim by obtaining a claim form from Inspira's website or by calling Inspira at 1-844-212-0494 and mailing or faxing such claim as set forth below:

Inspira Financial
P.O. Box 2495
Omaha, NE 68108
Fax: 888-238-3539

The initial decision to approve or not approve a reimbursement request will be made by Inspira.

Inspira will provide you with notice of an adverse benefit determination not later than 30 days after receipt of your claim. In certain cases, the Plan may extend this period for up to 15 days as long as Inspira notifies you prior to the expiration of the 30-day period of the circumstances requiring an extension of time and the date by which Inspira expects to render the benefit determination.

Appeal of Adverse Benefit Determination

You have 180 days following receipt of a notice of an adverse benefit determination in which to submit an appeal. Appeals will be decided by Inspira. The appeal should be mailed to:

Inspira Financial
P.O. Box 2495
Omaha, NE 68108

You may submit written comments, documents, records and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Inspira will provide you with a written or electronic notice of its benefit determination on review not later than 60 days after receipt of your request for review. In certain cases, Inspira may extend this period for up to 60 days as long as Inspira notifies you prior to the initial 60-day period of the circumstances requiring an extension of time and the date by which Inspira expects to render the determination on review. Reimbursement requests for expenses incurred during the calendar year must be submitted by March 31 following the calendar year.

If You Terminate Employment

If you terminate employment and still have money in your HFSA, you may continue to submit claims for expenses incurred prior to the date of termination. Reimbursement requests must be submitted within 90 days of the date you terminate employment.

Reemployment

In general, if you terminate employment and are rehired within 91 days, your prior election automatically will be reinstated, but you cannot be reimbursed for claims incurred during the period that you were not working, unless you elect COBRA.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The dependent care flexible spending account ("DFSA") allows you to put aside a portion of your pay on a pre-tax basis to pay for certain eligible dependent care (day care) expenses.

Amount of Contributions

Each year during annual enrollment or when first eligible, you elect the amount of your pay that you wish to contribute, if any, to your DFSA. Contributions are deducted from your pay on a pre-tax basis. The amount you can elect to contribute is described in your annual enrollment materials.

You may use the money in your DFSA to pay for child or adult dependent care (day care) expenses for your eligible dependents that are necessary to allow you and your spouse to work, seek employment or attend school on a full-time basis. Your eligible dependent is:

- Your dependent child under age 13 for whom a personal exemption deduction is allowed for federal income tax purposes
- Your spouse (for federal income tax purposes) who is physically or mentally incapable of self-care
- Another dependent who is mentally or physically incapable of self-care, as long as you provide more than one-half of his or her support, you can claim him or her as a dependent on your federal income tax return and he or she spends at least eight hours per day in your home

If you are a divorced parent, you may be eligible to use the DFSA if you must have day care services in order to work, even if you do not claim your child(ren) as dependent(s) on your tax return.

You may not use your DFSA to be reimbursed for day care expenses for your domestic partner and your domestic partner's children.

To be reimbursed, expenses must be incurred during the calendar year and within 2½ months following the end of the calendar year (the "grace period").

Forfeitures

When figuring out the amount you wish to contribute to your account, remember that any amounts remaining in your account in excess of reimbursed expenses will be forfeited. This means that you cannot carry over funds from one year to the next. Expenses are treated as having been incurred when the covered individual is provided with the care that gives rise to the expense – not when the individual is formally billed for the care.

Eligible Expenses

Eligible expenses recognized by the Internal Revenue Service include but are not limited to:

- After-school programs
- Before-school programs
- Care provided at a provider's home
- Care provided in your home (but not by a spouse or dependent child)
- Day care centers
- Day camps
- Tuition for pre-Kindergarten or nursery school

Please refer to https://inspirafinancial.com for a description of eligible expenses.

How to Make a Claim for Benefits

Reimbursement requests for expenses incurred during the calendar year and within 2½ months following the end of the calendar year (the "grace period") must be submitted by March 31 of the following the calendar year.

You can receive reimbursement for eligible expenses only up to the amount of actual contributions you have made to and are still remaining in your DFSA. This means that you have to wait until the funds have accumulated in your DFSA in order to receive reimbursement.

You should file a claim for reimbursement with Inspira. You may file a claim through the Inspira's website. You also may file a claim by obtaining a claim form from Inspira's website or by calling Inspira at 1-844-212-0494 and mailing or faxing such claim as set forth below:

Inspira Financial
P.O. Box 2495
Omaha, NE 68108
Fax: 888-238-3539

The decision to approve or not approve a reimbursement request will be made by Inspira.

If You Terminate Employment

If you terminate employment and still have money in your DFSA, you may continue to submit claims for expenses incurred prior to the date of termination. Reimbursement requests must be submitted within 90 days of the date you terminate employment.

Reemployment

In general, if you terminate employment and are rehired within 91 days, your prior election automatically will be reinstated, but you cannot be reimbursed for claims incurred during the period that you were not working.