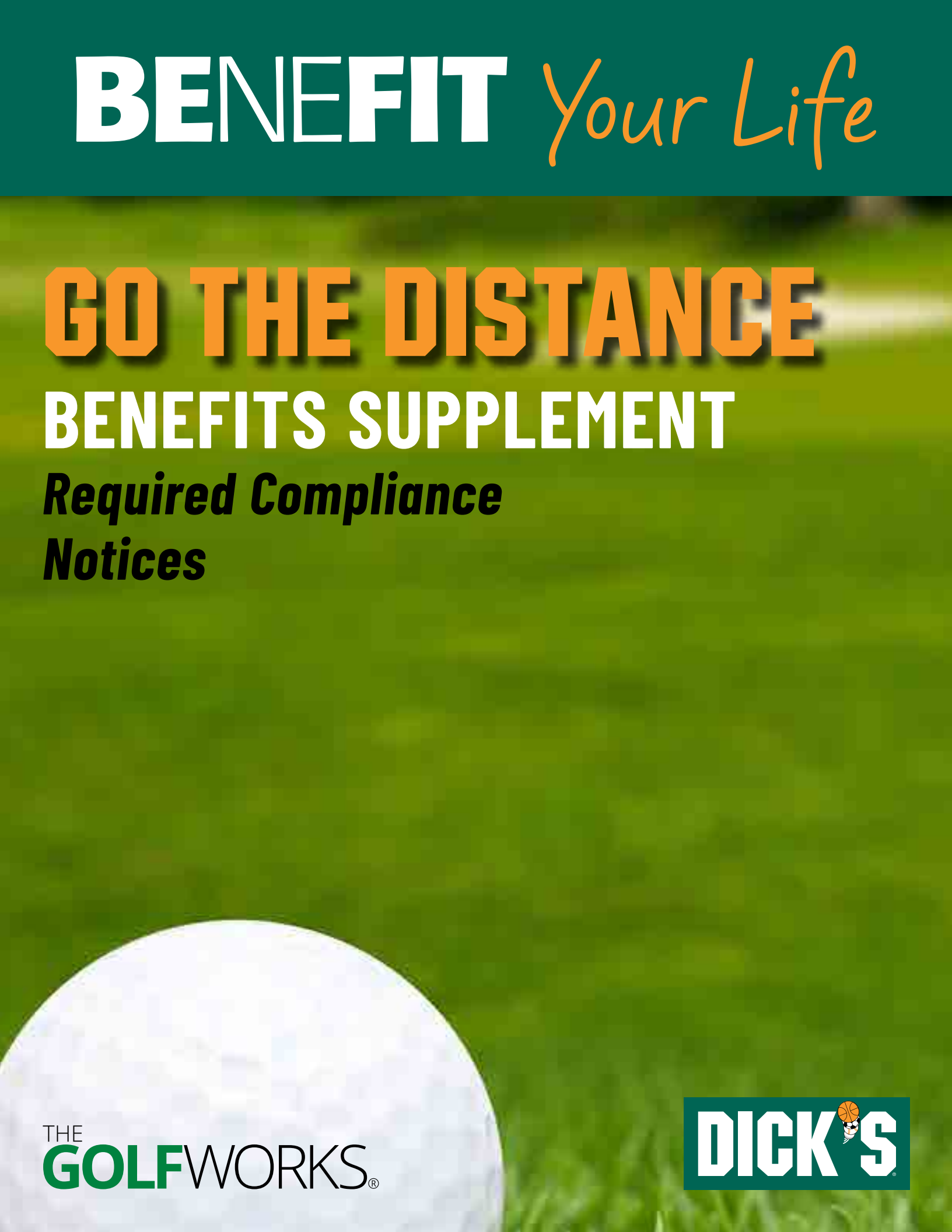
BENEFIT *Your Life*

GO THE DISTANCE

BENEFITS SUPPLEMENT

Required Compliance Notices



THE GOLFWORKS®

DICK'S

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. See the compliance section for more details. Some other key notices include CHIPRA, HIPAA Privacy, and Notice of Coverage Options (Marketplace Notice). If you have any questions, please reach out to the contact listed on the back cover of this guide.

REQUIRED COMPLIANCE NOTICES

Each year, we are required to provide teammates with important legal notices and plan disclosures. While you are not required to do anything with these documents, you should review them and keep them for your records.

The legal notices provide you with important plan disclosures and your rights under different federal government provisions. A Summary Annual Report briefly outlines the information submitted to the Internal Revenue Service for certain benefit plans offered by DICK'S Sporting Goods. Notices like the Summary of Benefits and Coverage (separate document) may help you better understand the benefits available to you as a DICK'S Sporting Goods teammate.

If you have any questions about these notices, please contact the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 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).

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.
- Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

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 this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

MENTAL HEALTH PARITY & ADDICTION ACT

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at Benefits@dcsg.com.

MICHELLE'S LAW

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact the Benefits department at Benefits@dcsg.com.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site:
http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1.866.4-USA-DOL or visit this site: http;//www.dol.gov/vets.
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

WELLNESS PROGRAM DISCLOSURES

Cigna Healthcare Wellness Experience is a voluntary wellness program available to all medically enrolled employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Cholesterol, HDL, LDL, A1C, Glucose and Triglycerides You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $350 for completing a Health Assessment, completing a biometric screening and getting an annual physical or well-woman exam. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive $50 in rewards for each activity. Participants receive $100 for completing the annual physical or well-woman exam.

Additional incentives of up to $150 may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as chronic condition support, health coaching, and clinical management. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and DICK'S Sporting Goods, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, Cigna Healthcare Wellness Experience will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are clinicians, health educators/coaches, and administrative personnel in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the contact the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

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 July 31, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: **http://myalhipp.com** Phone: 1.855.692.5447	Health Insurance Premium Payment (HIPP) Program Website: **http://dhcs.ca.gov/hipp** Phone: 916.445.8322 Email: **hipp@dhcs.ca.gov** Fax: 916.440.5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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**	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: **http://myarhipp.com** Phone: 1.855.MyARHIPP (1.855.692.7447)	Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1.877.357.3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678.564.1162, Press 1

GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: 678.564.1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program/All other Medicaid

Website: https://www.in.gov/medicaid/

http://www.in.gov/fssa/dfr/

Family & Social Services Administration Phone: 1.800.403.0864

Member Services Phone: 1.800.457.4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/medicaid

Phone: 1.800.338.8366

Hawki Website: https://hhs.iowa.gov/medicaid/plans-programs/hawki

Hawki Phone: 1.800.257.8563

HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program

HIPP Phone: 1.888.346.9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1.800.792.4884 HIPP Phone: 1.800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1.855.459.6328 Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kynect.ky.gov

Phone: 1.877.524.4718

Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1.888.342.6207 (Medicaid hotline) or 1.855.618.5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1.800.442.6003 TTY: Maine relay 711

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1.800.977.6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 1.800.862.4840 TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/

Phone: 1.800.657.3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573.751.2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1.800.694.3084 Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1.855.632.7633

Lincoln: 402.473.7000

Omaha: 402.595.1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – Medicaid

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	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid Phone: 1.800.356.1561 CHIP Premium Assistance Phone: 1.609.631.2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1.800.701.0710 (TTY: 711)	Website: http://dss.sd.gov Phone: 1.888.828.0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1.800.541.2831	Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1.800.440.0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov Phone: 919.855.4100	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/
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1.844.854.4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1.800.250.8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1.888.365.3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select and https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1.800.432.5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1.800.699.9075	Website: https://www.hca.wa.gov Phone: 1.800.562.3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1.800.692.7462 CHIP Phone: 1.800.986.KIDS (5437) CHIP Website: https://www.pa.gov/agencies/dhs/resources/chip	Website: http://mywvhipp.com/ https://dhhr.wv.gov/bms Medicaid Phone: 304.558.1700 CHIP Toll-free phone: 1.855.MyWVHIPP (1.855.699.8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1.855.697.4347, or 401.462.0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov badgercareplus/p-10095.htm Phone: 1.800.362.3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1.888.549.0820	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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137 (expires 1/31/2026).

IMPORTANT NOTICE FROM DICK'S SPORTING GOODS 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 the DICK'S Sporting Goods, Inc. Health and Welfare Plan 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. DICK'S Sporting Goods has determined that the prescription drug coverage offered by the Company's health plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in the DICK'S Sporting Goods, Inc. Health and Welfare Plan coverage as an active employee, please note that your the DICK'S Sporting Goods, Inc. coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in the DICK'S Sporting Goods, Inc. coverage as a former employee.

You may also choose to drop your the DICK'S Sporting Goods, Inc. coverage. If you do decide to join a Medicare drug plan and drop your current the DICK'S Sporting Goods, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **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 DICK'S Sporting Goods changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit http://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).

Date: September 14, 2025
Name of Entity/Sender: DICK'S Sporting Goods, Inc.
Contact-Position/Office: Benefits Department
Address: 345 Court Street, Coraopolis, PA 15108
Phone Number: 1.800.690.7655 ext. 3012, option 5

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice applies to the medical (including the health reimbursement account and certain wellness benefits), dental and vision benefit options under the DICK'S Sporting Goods, Inc. Health and Welfare Plan (the "Plan"), as well as to the health care flexible spending account and health savings account.

THIS NOTICE IS REQUIRED BY FEDERAL LAW — PLEASE REVIEW IT CAREFULLY! THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
Your Plan is permitted by federal privacy laws to use and disclose your personal health information for purposes of treatment, payment and health care operations under certain circumstances. The Plan may also use or disclosure protected health information for other reasons permitted under federal law. Protected health information is the information the Plan creates and obtains in providing benefits to you. Such information may include information regarding your health status, including diagnosis, treatment and claims payment. The Plan may make these uses and disclosures without your written authorization or consent. This notice became effective on April 14, 2003. The notice is updated to reflect changes in the law that are effective on September 23, 2013.

Example of use of your health information for treatment purposes: During the course of your treatment, the physician determines he/she will need to confirm information about your health benefits. The Plan or its business associate will share the information with your physician.

Example of use of your health information for payment purposes: Your physician submits requests for payment to the Plan or its business associate. The Plan or business associate requests and uses information from the physician regarding your medical care given in order to make payment. The Plan will provide information to them about you or your Plan benefits.

Example of use of your information for health care operations: The Plan may obtain services from business associates such as its third party administrator or for legal services for Plan administration and/or benefit claim adjudication. The Plan will share information about you with such business associates as necessary to obtain these services.

To business associates: The Plan may disclose protected health information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree to ensure the continuing confidentiality and security of protected health information.

To the Plan sponsor: The Plan may disclose protected health information to the Plan sponsor for Plan administration functions that the Plan sponsor provides to the Plan. The Plan sponsor will not use or disclose protected health information it receives from the Plan for employment-related activities.

Following Is a List of Other Uses and Disclosures Allowed by the Privacy Rule

- As required by law, the Plan may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- The Plan may disclose protected health information to public authorities as allowed by law to report child abuse or neglect or domestic violence.
- The Plan may disclose to the proper government authorities your protected health information relating to adverse events with respect to food, supplements, products and product defects or post-marketing surveillance information to enable product recalls, repairs or replacements.
- Under certain conditions, the Plan can disclose protected health information to governmental authorities to the extent the disclosure is required by law.
- Federal law allows the Plan to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations, inspections, licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.
- The Plan may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process, and certain other conditions are met.
- The Plan may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.
- The Plan may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
- Consistent with applicable law, the Plan may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of donation and transport.
- To avert a serious threat to health or safety, the Plan may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- The Plan may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes or to public assistance program personnel.
- If you are an inmate of a correctional institution, the Plan may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.
- The Plan may disclose your protected health information to the extent necessary to comply with laws relating to worker's compensation.
- Under certain conditions, the Plan may disclose protected health information for research purposes.
- Under certain conditions, the Plan may disclose protected health information to one of your family members, to a close personal friend, or any other person by you, if the protected health information is directly relevant to the person's involvement with your care or payment related to your care.

Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken. For example, your authorization is required for the use or disclosure of most psychotherapy notes (to the extent the plan records such notes), for uses and disclosures for marketing purposes, including subsidized treatment communications, for the sale of your protected health information, or for other reasons that may not be described in this Notice.

Your Health Information Rights — The records the Plan maintains are the physical property of the Plan. You have the following rights with respect to your protected health information:

1. Right to request a restriction on certain uses and disclosures of your health information by delivering the request in writing to the Plan. The Plan is not required to grant the request. However, you have the right to request that your provider restrict disclosure of your health information to the Plan if you pay your provider out of pocket in full for the relevant services.
2. Right to obtain a paper copy of this notice by making a request to the Plan.
3. Right to inspect and copy your health record and billing record or any other document containing your personal health information in a "designated record set." You may exercise this right by delivering the request in writing to the Plan using the form provided to you upon request. The request may be denied by the Plan for certain reasons. You may request access to electronic health records in electronic format, or direct transmission of electronic health records to an entity or person you designate.
4. Right to appeal a denial of access to your protected health information except in certain circumstances.
5. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to the Plan using the form provided to you upon request. Your request may be denied

by the Plan. You may file a statement of disagreement if your amendment is denied and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.

6. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to the Plan using the form provided to you upon request. An accounting will not include uses or disclosures of information for treatment, payment or health care operations, or disclosures made to you, your representative or individuals involved in your care, or made at your request or with your authorization, or made for national security or intelligence purposes or to law enforcement.

The Plan's Responsibilities – The Plan is required to:

1. Maintain the privacy of your health information as required by law.
2. Provide you with this notice as to the Plan's duties and privacy practices regarding the information the Plan collects and maintains about you.
3. Abide by the terms of this notice.
4. Notify you if the Plan cannot accommodate a requested restriction or request.
5. Notify you in the event of a breach of the security of unsecured personal health information.
6. To the extent prohibited by the Genetic Information Nondiscrimination Act of 2008, the Plan will not use or disclose genetic information, including family medical history or results of genetic tests, for Plan underwriting purposes.

To Request Information or File a Complaint: If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the person listed at the end of this notice. Additionally, if you believe your privacy rights have been violated, you may file a written complaint with the Plan by delivering the written complaint to the person listed at the end of this notice. You may also file a complaint by mailing it or e-mailing it to the Secretary of the U.S. Department of Health and Human Services (also referred to as "HHS"). The Plan cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment. The Plan cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Changes to This Notice: The Plan reserves the right to change its privacy practices and to adopt new practices regarding the protected health information the Plan maintains. If the Plan's privacy practices change, the Plan will amend this notice and will issue a revised notice. You are entitled to receive a revised copy of the notice by calling the person listed at the end of this notice.

Conclusion: The Health Insurance Portability and Accountability Act of 2006 (HIPAA) regulates use and disclosure of protected health information by the Plan. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164 (the "privacy rule"). This notice attempts to summarize the salient portions of the privacy rule that are applicable to the Plan. The privacy rule will supersede any discrepancy between the information in this notice and in the privacy rule.

The Plan also will comply with any state laws that are applicable to you that may provide greater protections than HIPAA. The Plan maintains an appendix to this notice which summarizes certain state laws identified by the Plan as protecting the privacy of health information. You should contactcontact the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

HEALTH INSURANCE MARKETPLACE COVERAGE 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 ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

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

Does Employment-Based 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% [1] 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 through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage-is generally 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. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; 2025 = 9.02%; 2026 = 9.96%; see https://www.irs.gov/pub/irs-drop/rp-25-25.pdf for 2026.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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 or call the Marketplace Call Center at 1.800.318.2596. TTY users can call 1.855.889.4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health 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 an employment-based health plan. Confirm the deadline with your employer or your employment-based 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 the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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 Your Employer

This section contains information about any health coverage offered by your employer. 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.

3. Employer name GolfWorks	4. Employer Identification Number (EIN) 42-1696512
5. Employer address PO Box 3008	6. Employer phone number 740.328.4212
7. City Newark	8. State NJ
	9. ZIP code 43058
10. Who can we contact about employee health coverage at this job? Leann Bednarczyk	
11. Phone number (if different from above) 740.328.4212	12. Email address lbednarczyk@golfworks.com

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

- As your employer, employees that we offer a health plan to are: Regular salaried and full-time hourly teammates
- With respect to dependents, health plan-eligible dependents are: Spouses, domestic partners and children up to age 26 (including children, stepchildren, adopted children, children of domestic partners and children for whom the eligible employee is appointed legal guardian or foster parent).

14. Does the employer offer a health plan that meets the minimum value standard? ☑ Yes (Go to question 15) ☐ No (Stop)
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

15a. How much would the employee have to pay in premiums for this plan? $26.00

15b. How often? ☐ Weekly ☑ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

NOTICES

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* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

** Even if your employer intends this 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.

NOTICE OF EMPLOYEE RIGHTS UNDER THE CONNECTICUT FAMILY AND MEDICAL LEAVE ACT (CTFMLA) & CONNECTICUT PAID LEAVE ACT (CTPL)

CONNECTICUT DEPARTMENT OF LABOR AND CONNECTICUT PAID LEAVE AUTHORITY

Leave Entitlement and Eligibility

The CTFMLA provides eligible employees, after 3 consecutive months on the job, up to 12 weeks of unpaid, job-protected leave during a 12-month period for qualifying family or medical leave reasons. Employees are entitled to return to their same job at the end of leave. The CTPL provides income replacement benefits to eligible employees who are unable to work for the same leave reasons. These leave options may run at the same time.

Qualifying reasons for leave include:

- The birth of a child and care within the first year after birth;
- The placement of a child with employee for adoption or foster care and care for child within the first year after placement;
- To care for a family member with a serious health condition. Family includes spouse (the person to whom one is legally married), sibling, son or daughter, grandparent, grandchild or parent, or an individual related to the employee by blood or affinity;
- Because of the employee's own serious health condition;
- To serve as an organ or bone marrow donor;
- To address qualifying exigencies arising from a spouse, son, daughter or parent's active duty in the armed forces; or
- To care or a spouse, son, daughter, parent or next of kin with a serious injury or illness incurred on active duty in the armed forces.

It also allows eligible employees to receive two extra weeks of leave (up to a total of 14 weeks) in connection with an incapacity that occurs during pregnancy. CTFMLA further allows eligible employees to take up to 26 weeks of leave in a single 12-month period to care for a covered service member with a serious injury or illness.

Employees may also take up to 12 days of leave to deal with the effects of family violence separate from leave time available under state or federal law. While this is not protected under CTFMLA, it is protected under the Connecticut Family Violence Leave Act and an employee can apply for CTPL in connection with these absences.

Leave does not have to be taken all at once. Employees may take leave intermittently (in separate blocks of time) or to reduce their work schedule.

CTFMLA leave is unpaid. However, an employer may require, or an employee may request to use their accrued, paid time off. An employee may choose to preserve up to 2 weeks of their accrued, paid time off. This accrued, paid time off is in addition to the income-replacement benefits available to employees under CTPL.

Applying for Income-Replacement Benefits Under CTPL

Wage replacement benefits under the CTPL may also be available for CTFMLA absences. More information about Connecticut's Paid Leave program and instructions for to apply are available at https://ctpaidleave.org/.

Some employers have received approval from the CT Paid Leave Authority to provide CTPL benefits to their employees through an approved private plan instead of through the state's CTPL program. Employers that have approved private plans are required to notify their employees how to file claims for benefits through their private plan and who the employees can contact for answers to questions about their plan. CTPL benefits are available for up to 12 weeks in a 12-month period, with an additional two weeks available to an employee for incapacity or medical treatment during pregnancy Benefits are limited to 12 days for leave to deal with the effects of family violence.

Employer Notification for CTFMLA Leave

Employees should provide at least 30-days advance notice to their employer of the need to take CTFMLA leave if they can. If they are unable to because they do not know they need leave, the employee must provide notice as soon as they can. An employer may require a medical certification to support a request for leave.

What Is Prohibited?

The CTFMLA prohibits employers from:

- Interfering with or denying any rights provided by the CTFMLA or CTPL. Examples include, but are not limited to, improperly refusing to grant CTFMLA leave or discouraging employees from using CTFMLA leave or applying for CTPL benefits.
- Disciplining, terminating, discriminating against, or retaliating against any individual for taking CTFMLA leave or applying for CTPL benefits, for opposing or complaining about any unlawful practice, or being involved in any proceeding related to the CTFMLA.

If you believe that your CTFMLA rights have been violated, you can either file a complaint directly in Superior Court or with the Connecticut Department of Labor.

To file a CTFMLA complaint with the Connecticut Department of Labor, complete and submit the appropriate CTFMLA complaint form found on the Department's website found at https://portal.ct.gov/DOLUI/newfmlaguidance.

More information about the CTFMLA is available at **The Connecticut Family & Medical Leave Act and CT Paid Leave Appeals** and CTPL at https://portal.ct.gov/DOLUI/newfmlaguidance.

SUMMARY OF MATERIAL MODIFICATIONS
Effective January 1, 2026

Health and Welfare Plan

This"summary of material modification" or "SMM" describes recent changes to the DICK'S Sporting Goods, Inc. Health and Welfare Plan (the "Plan"). Please keep this SMM with your copy of the "summary plan description" or "SPD" for the Plan.

Beginning January 1, 2026, the Plan will include a new resource called "Lantern." To access Lantern, you must be enrolled in the medical benefits portion of the Plan, in which case you will be automatically enrolled in Lantern at no extra cost.

Lantern is a specialty care platform that connects employees to board-certified surgeons and personalized support for little to no out-of-pocket cost. Lantern focuses on surgeries, cancer and infusions. Lantern also provides assistance with travel costs for certain out-of-town surgeries. Lantern is optional, except that you are required to utilize Lantern for bariatric surgery.

For details about Lantern, you should refer to information posted at BenefitYourLifeResources.com. You may also contact the Benefits Department at 1.800.690.7655, extension 3012, option 5 or by email at Benefits@dcsg.com.

SUMMARY ANNUAL REPORT

Health and Welfare Plan

This is a summary of the annual report of the DICK'S Sporting Goods Health and Welfare Plan, EIN 16-1241537 Plan No. 501, for the period January 01, 2024 through December 31, 2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Compsych Corporation, HM Life Insurance Company, Lincoln National Life Insurance Company and Vision Service Plan to pay Accidental Death and Dismemberment, Employee Assistance Plan, Life, Long Term Disability, Short Term Disability, Stop Loss and Vision claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2024 were $14,748,903.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2024, the premiums paid under such "experience-rated" contracts were $1,529,468 and the total of all benefit claims paid under these contracts during the plan year was $1,497,783.

Additional Plan Information

DICK'S Clothing and Sporting Goods, Inc. has also committed itself to pay certain self-funded employee Dental, Prescription Drug, and Medical claims incurred under the terms of the plan.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the Human Resources Department of DICK'S Clothing and Sporting Goods, Inc. at 345 Court Street, Coraopolis, PA 15108-3817, or by telephone at 1.724.273.3500. These portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (DICK'S Clothing and Sporting Goods, Inc., 345 Court Street, Coraopolis, PA 15108-3817) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SUMMARY OF BENEFITS AND COVERAGE

See a separate document for the Summary of Benefits and Coverage for plan specifics. If you have any questions or would like to or obtain more information, contact the Benefits Department at 1.800.690.7655, x3012 (option 5) or at Benefits@dcsg.com.

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REVISED 10/25