2026 Benefits

Your Benefits. Your Choice.

DDC
DINÉ DEVELOPMENT CORPORATION

Contents

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Getting Started

2026 Benefits

January 1, 2026 through December 31, 2026

Medicare Part D Notice

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

No matter where you are in your career, Diné Development Corporation (DDC) supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and more benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

Who's eligible for benefits?

When you can enroll

Most benefits are effective as of the date of hire; however, a few voluntary plans will begin on the first day of the month following date of hire. All enrollments must be completed within 30 days of becoming eligible. If you waive benefits initially, your next opportunity to enroll will be during the annual open enrollment period.

Existing employees may only enroll during the annual open enrollment or if they experience a qualifying life event (QLE). See page 6 for more details.

Employees

Full-time employees working 30 or more hours per week are eligible for all benefits.

Eligible dependents

- Legally married spouse or domestic partner
- Biological children, stepchildren, foster children, legally adopted children (including children placed with you for adoption), children for whom you are the legal guardian, or domestic partner's children up to age 26
- Children and children of domestic partners over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

Please review the chart on page 5 for more details.

Benefits eligibility chart

The below chart outlines which employees are eligible for each benefit type, along with dependent eligibility and the benefit start date for each benefit.

Benefit	Employee Eligibility	Dependent Eligibility	Benefit Start Date
Medical	Full-Time Employees	Spouse, Domestic Partner, Children, DP Children	Date of Hire
Dental	Full-Time Employees	Spouse, Domestic Partner, Children, DP Children	Date of Hire
Vision	Full-Time Employees	Spouse, Domestic Partner, Children, DP Children	Date of Hire
Health Savings Account (HSA)	Full-Time Employees	Spouse, Children	Date of Hire
Flexible Spending Accounts (all types)	Full-Time & Part-Time Employees	Spouse, Children	Date of Hire
Basic Life and AD&D	Full-Time Employees	N/A	Date of Hire
Voluntary Life and AD&D	Full-Time Employees	Spouse, Domestic Partner, Children, DP Children	Date of Hire
Short-Term Disability	Full-Time Employees	N/A	Date of Hire
Long-Term Disability	Full-Time Employees	N/A	Date of Hire
Voluntary Whole Life	Full-Time Employees	Spouse, Domestic Partner, Children, DP Children	First of Month Following Date of Hire *
Supplemental Health: Accident, Critical Illness, & Hospital Indemnity	Full-Time & Part-Time Employees	Spouse, Domestic Partner, Children, DP Children	First of Month Following Date of Hire
Pet Insurance Pet Discount	Full-Time & Part-Time Employees	N/A	First of Month Following Date of Hire *
TRICARE Supplemental Coverage	Full-Time Employees	Spouse, Children	First of Month Following Date of Hire *
401(k)	Full-Time & Part-Time Employees	N/A	Date of Hire
Employee Assistance Program	Full-Time Employees	Spouse, Domestic Partner, Children, DP Children	Date of Hire
LifeBalance	Full-Time & Part-Time Employees	Spouse, Domestic Partner, Children, DP Children	Date of Hire

*Enrollment in the plan will begin on the first day of the month after enrollment requirements are satisfied with the individual carrier

Changing your benefits through a Qualifying Life Event

Click to play video

Life happens

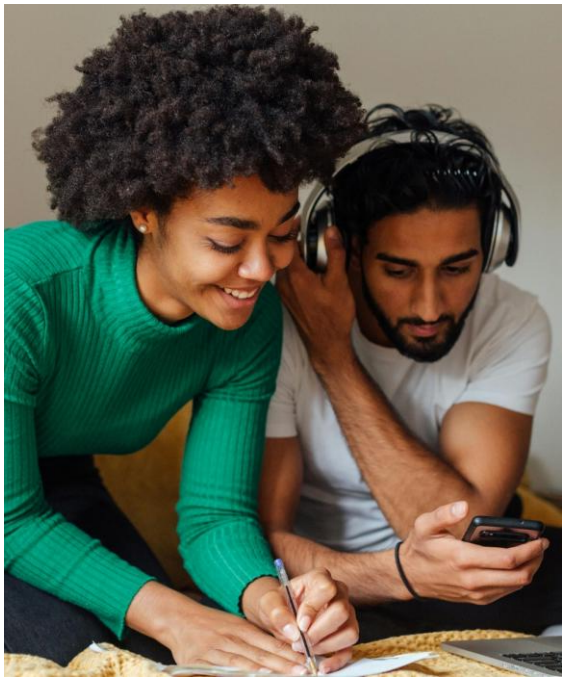
A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you experience a life changing event, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, domestic partner, dependent child(ren), or domestic partner's dependent children
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP)

You must submit any changes within 30 days after the event.

Enrolling for benefits



Workday Benefits Portal

Workday is an online system that enables you to make all your benefit decisions in one place.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover
- Review your enrollment materials to understand your benefit options and costs for the coming year

Getting started

- Log in to Workday.com
- The KnowBe4 Defender screen will verify your access and may flash briefly
- Once verified, click “DDC Authenticator Selector PROD”
- Click your profile icon in the top right corner and select “View Profile” to review your personal information
- Next to your profile icon, click the inbox icon to access “My Tasks”, then click “Let’s Get Started” within the Open Enrollment workflow
- Make your benefit elections, and add dependents and beneficiaries
- Review your selection summary and check the “I Accept” box after reviewing the acknowledgement statement
- Click “Submit to complete your enrollment
- Print your summary for your records

The easy way to get benefits info

ddc.mybenefits.life

MyBenefits.Life® gives you all your benefits information in one place

You can do just about anything online these days. Why should accessing your benefits information be any different? MyBenefits.Life® is a website that gives you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life®

Benefits	See benefit details for all DDC plans.
Enroll	Time to enroll? Find detail instructions here.
Documents	Read important benefit plan notices ("the fine print").
Contacts	Find benefits and carrier contact information.
Get help	Need help? Reach helpful resources.

Have questions about your benefits?

Click to play video

Contact your Alliant Benefit Advocate

Email: benefitsupport@alliant.com

Phone: (800) 489-1390

Hours: 5 a.m.–5 p.m. (Pacific Time) Monday–Friday

Get help from a Benefit Advocate

Are you getting married and you're not sure how or when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefit experts who can help you understand and use your healthcare benefits and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Problems with health care claims or billing, when warranted
- Coverage changes due to life events (such as marriage, a new child, or divorce)

Claims assistance

If you need claims assistance, you may need to complete a HIPAA authorization form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited-duration basis, and only to the individuals listed on the form. You can end the permissions granted by the form at any time. Your Benefit Advocate will provide the form to you when needed.

Medical

Words To Know

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

Copay: A set fee (rather than coinsurance) for certain healthcare services—for example, a doctor's office visit. You pay the copay at the time you receive care.

Deductible: The total healthcare costs you pay with your own money before your plan will start to pay a portion.

Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your share of the cost (your coinsurance) is 20%. You are billed for your coinsurance after your visit.

Out-of-pocket maximum: Once you've spent this amount on covered medical services, your insurance pays 100% of most eligible expenses for the rest of the plan year.

In-network/out-of-network: In-network services will always be the lowest-cost option. Out-of-network (OOP) services will cost more or may not even be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

Cigna OAP 500

You always pay the deductible and copayment. The coinsurance shows what you pay after the deductible.

	In Network	Out of Network
Deductible (embedded)	**Individual:** $500 **Family:** $1,000	**Individual:** $6,000 **Family:** $12,000
Accumulation period	Plan Year	
Out-of-pocket maximum (embedded)	**Individual:** $6,000 **Family:** $12,000	**Individual:** $13,700 **Family:** $27,400
Office visit	$40 copay (primary care) $80 copay (specialist)	20% coinsurance after deductible
MD Live Virtual Visit	$40 copay (primary/urgent care) $80 copay (specialist)	Not Covered
Online Physician Visit	$40 copay (primary care) $80 copay (specialist)	20% coinsurance after deductible
Lab	0% coinsurance (deductible waived)	20% coinsurance after deductible
X-ray	0% coinsurance after deductible	20% coinsurance after deductible
Urgent care	$75 copay	20% coinsurance after deductible
Emergency room	$500 copay	Covered as in network
Hospitalization	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery	0% coinsurance after deductible	20% coinsurance after deductible
Prescription drugs		
Deductible	None	None
Annual out-of-pocket maximum	Combined with Medical	Combined with Medical
30-day Retail		
Generic	$15 copay	50% coinsurance (deductible waived)
Preferred Brand name	$35 copay	50% coinsurance (deductible waived)
Non-preferred Brand name	$60 copay	50% coinsurance (deductible waived)
90-day Retail or Mail order		**Retail only**
Generic	$38 copay	50% coinsurance (deductible waived)
Brand name	$88 copay	50% coinsurance (deductible waived)
Specialty	$150 copay	50% coinsurance (deductible waived)

Cigna OAP 1000

You always pay the deductible and copayment. The coinsurance shows what you pay after the deductible.

	In Network	Out of Network
Deductible (embedded)	**Individual:** $1,000 **Family:** $3,000	**Individual:** $6,000 **Family:** $12,000
Accumulation period	Plan Year	
Out-of-pocket maximum (embedded)	**Individual:** $6,000 **Family:** $12,000	**Individual:** $13,700 **Family:** $27,400
Office visit	$30 copay (primary care) $60 copay (specialist)	40% coinsurance after deductible
MD Live Virtual Visit	$30 copay (primary/urgent care) $60 copay (specialist)	Not Covered
Online Physician Visit	$30 copay (primary care) $60 copay (specialist)	40% coinsurance after deductible
Lab	0% coinsurance (deductible waived)	40% coinsurance after deductible
X-ray	20% coinsurance after deductible	40% coinsurance after deductible
Urgent care	$75 copay	40% coinsurance after deductible
Emergency room	$500 copay	Covered as in network
Hospitalization	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible
Prescription drugs		
Deductible	None	None
Annual out-of-pocket maximum	Combined with Medical	Combined with Medical
30-day Retail		
Generic	$15 copay	50% coinsurance (deductible waived)
Preferred Brand name	$35 copay	50% coinsurance (deductible waived)
Non-preferred Brand name	$60 copay	50% coinsurance (deductible waived)
90-day Retail or Mail order		**Retail only**
Generic	$38 copay	50% coinsurance (deductible waived)
Brand name	$88 copay	50% coinsurance (deductible waived)
Specialty	$150 copay	50% coinsurance (deductible waived)

Cigna HDHP 3000

You always pay the deductible and copayment. The coinsurance shows what you pay after the deductible.

	In Network	Out of Network
Deductible (embedded)	**Individual:** $3,000 **Individual within a Family:** $3,400 **Family:** $6,000	**Individual:** $6,000 **Individual within a Family:** $6,000 **Family:** $12,000
Accumulation period	Plan Year	
Out-of-pocket maximum (embedded)	**Individual:** $6,550 **Family:** $13,100	**Individual:** $13,100 **Family:** $26,200
Office visit	20% coinsurance after deductible	40% coinsurance after deductible
MD Live Virtual Visit	20% coinsurance (deductible waived)	Not Covered
Online Physician Visit	20% coinsurance (deductible waived)	40% coinsurance after deductible
Lab	20% coinsurance after deductible	40% coinsurance after deductible
X-ray	20% coinsurance after deductible	40% coinsurance after deductible
Urgent care	20% coinsurance after deductible	40% coinsurance after deductible
Emergency room	20% coinsurance after deductible	Covered as in network
Hospitalization	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible
Prescription drugs		
Deductible	Combined with Medical	Combined with Medical
Annual out-of-pocket maximum	Combined with Medical	Combined with Medical
30-day Retail		
Generic	20% coinsurance after deductible	20% coinsurance after deductible
Preferred Brand name	20% coinsurance after deductible	20% coinsurance after deductible
Non-preferred Brand name	20% coinsurance after deductible	20% coinsurance after deductible
90-day Retail or Mail order		**Retail only**
Generic	20% coinsurance after deductible	20% coinsurance after deductible
Brand name	20% coinsurance after deductible	20% coinsurance after deductible
Specialty	20% coinsurance after deductible	20% coinsurance after deductible

Engage

Click to play videos

In vs. Out-of-Network

Virtual Healthcare

Maximize Your Health Benefits

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

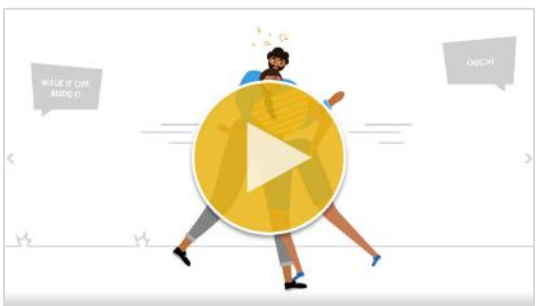
- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

Know where to go

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for …
Nurse line ($) Often available 24/7 at no cost	• Quick answers from a trained nurse: – to determine if immediate care is needed – for home treatment options & advice
Online visit ($) Often available 24/7	• Non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit ($$) Typically open during regular business hours	• Routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care ($$$) Typically open with extended evening and weekend hours	• Urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room ($$$) Open 24/7	• Life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

Alternative facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Procedure	Alternative	Features	Savings*
Surgery	Ambulatory surgical center	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% vs. a hospital stay
Physical therapy	Outpatient facility	• Most cases are suited for outpatient physical therapy • Same types of treatments and similarly skilled therapists as inpatient facilities	40 to 60% vs. a hospital setting
Sleep study	Home testing	• Diagnoses obstructive sleep apnea • Cost is often covered by insurance if considered medically necessary	Up to $4,500 vs. a lab
Infusion therapy	Home or outpatient infusion	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% vs. a hospital stay

**Savings estimates are based on in-network facilities and providers*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital.

You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings.

Some alternative facilities include a fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Preventive care

Typical screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Prescriptions breaking your budget?

Click to play video

The formulary drug tiers determine your cost

$	Generic drugs
$$	Brand-name drugs
$$$	Specialty drugs

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

Register for myCigna

Steps to register online

Access myCigna.com and click “register”. Select “Start Registration”.

Activate account by following prompted steps.

Also available for download from Apple store or Google play store.

Register on myCigna.com to access a range of tools

- Find in-network doctors and medical services
- View ID card information
- Review your coverage
- Manage and track claims
- Order refills or speak with a Home Delivery pharmacist
- Use the Price a Medication Tool to compare real-time drug pricing
- Compare cost and quality information for doctors and hospitals
- Access a variety of health and welfare tools and resources
- Sign up to receive alerts when new plan documents are available
- Track your account balances and deductibles

*Please be aware that Cigna is no longer printing and mailing ID cards. You can download and print ID cards from myCigna.com.

Dental

Our Plans

Ameritas Dental Base Plan

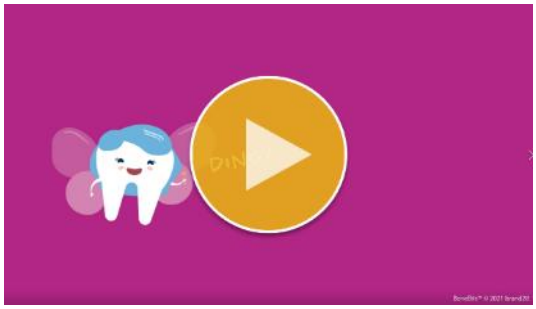
Ameritas Dental Buy-up Plan

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



Ameritas Dental Base Plan

You always pay the deductible and copayment. The coinsurance shows what you pay after the deductible.

	In Network	Out of Network
Annual deductible	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150
Annual plan maximum	$2,000	$2,000
Diagnostic & preventive *Three cleanings per year are included	0% (deductible waived)	0% (deductible waived)
Basic services	20% coinsurance after deductible	20% coinsurance after deductible
Major services	50% coinsurance after deductible	50% coinsurance after deductible
Orthodontia	Not Covered	Not Covered
Carryover Benefit	During each benefit year, if a member has at least one dental claim and their total dental claims are $750 or less, $400 will automatically carry over to the next year's annual maximum. If a member only sees in-network dentists during the plan year, they will earn an additional $200 in carryover benefit. Each covered family member receives their own carryover benefit. The maximum amount of carryover benefit you can accumulate is $1,200.	
Fusion Benefit	If you don't use the full $2,000 dental annual plan maximum in any given plan year, you can apply up to $100 to help pay for vision expenses such as eye exams, glasses, or contacts.	

Ameritas Dental Buy-up Plan

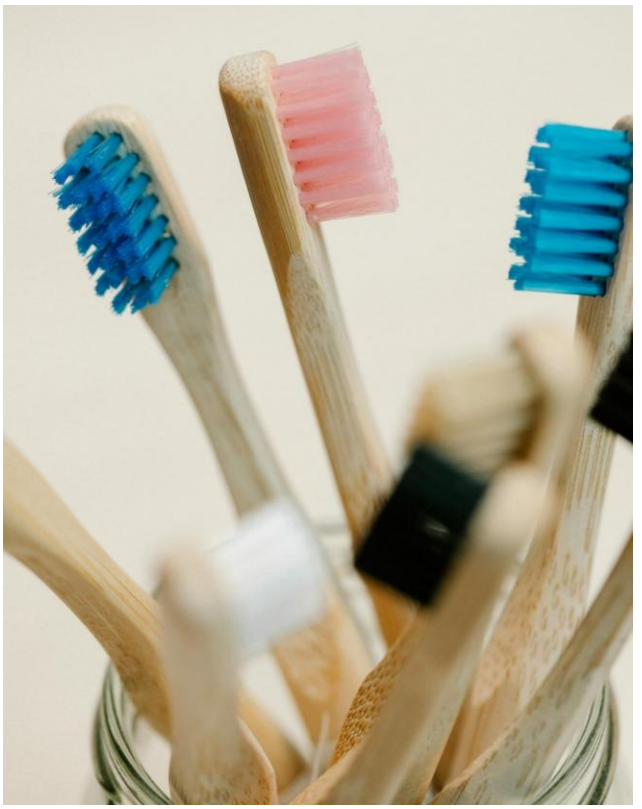
You always pay the deductible and copayment. The coinsurance shows what you pay after the deductible.

	In Network	Out of Network
Annual deductible	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150
Annual plan maximum	$2,500	$2,500
Diagnostic & preventive *Three cleanings per year are included	0% (deductible waived)	0% (deductible waived)
Basic services	20% coinsurance after deductible	20% coinsurance after deductible
Major services	50% coinsurance after deductible	50% coinsurance after deductible
Orthodontia	50% coinsurance Child and Adult	50% Child and Adult
Orthodontia lifetime maximum	$1,500	$1,500
Carryover Benefit	During each benefit year, if a member has at least one dental claim and their total dental claims are $750 or less, $400 will automatically carry over to the next year's annual maximum. If a member only sees in-network dentists during the plan year, they will earn an additional $200 in carryover benefit. Each covered family member receives their own carryover benefit. The maximum amount of carryover benefit you can accumulate is $1,200.	
Fusion Benefit	If you don't use the full $2,500 dental annual plan maximum in any given plan year, you can apply up to $100 to help pay for vision expenses such as eye exams, glasses, or contacts.	

Register for Ameritas

Register for Ameritas benefits portal to access a range of tools

- Find in-network dentists
- View and print ID cards
- Review your coverage
- Manage and track claims
- Track your account balances and deductibles



Steps to register online

- Access ameritas.com and click “Sign In”
- Select “Member Sign In” under “Dental, Vision & Hearing”
- Select “Register”, then choose “Member” or “Dependent”
- Activate account by following prompted steps
- The Ameritas Benefits app is available for download from Apple store or Google play store

Vision

Our Plans

Ameritas VSP Vision Plan

Ameritas EyeMed Vision Plan

Click to play video

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like LASIK and PRK.

DDC's vision benefits are offered through Ameritas and allow you to choose between the two largest networks – VSP or EyeMed. The network you choose will be the network for both you and any covered dependents for the plan year. Network changes may only occur during Open Enrollment.

Ameritas Vision Plan
(VSP Choice Network)

		In Network	Out of Network
Exam	Coverage	$20	Reimbursed up to $45
	Frequency	1 per 12 months	1 per 12 months
Materials	Coverage	$20	N/A
Frames	Coverage	Covered in full up to $130 after $20 materials copay + 20% off remaining balance	Reimbursed up to $70
	Frequency	1 per 12 months	1 per 12 months
Lenses – Single Vision	Coverage	100% after $20 materials copay	Reimbursed up to $30
	Frequency	1 per 12 months	1 per 12 months
Lenses – Bifocal	Coverage	100% after $20 materials copay	Reimbursed up to $50
	Frequency	1 per 12 months	1 per 12 months
Lenses – Trifocal	Coverage	100% after $20 materials copay	Reimbursed up to $65
	Frequency	1 per 12 months	1 per 12 months
Contacts	Coverage	Covered in full up to $130 (instead of eyeglasses)	Reimbursed up to $105
Fit & Folow-up Exam	Coverage	Up to $60	N/A
	Frequency	1 per 12 months	1 per 12 months

Ameritas Vision Plan
(EyeMed Insight Network)

		In Network	Out of Network
Exam	Coverage	$20	Reimbursed up to $35
	Frequency	1 per 12 months	1 per 12 months
Materials	Coverage	$20	N/A
Frames	Coverage	Covered in full up to $130 after $20 materials copay + 20% off remaining balance	Reimbursed up to $65
	Frequency	1 per 12 months	1 per 12 months
Lenses – Single Vision	Coverage	100% after $20 materials copay	Reimbursed up to $25
	Frequency	1 per 12 months	1 per 12 months
Lenses – Bifocal	Coverage	100% after $20 materials copay	Reimbursed up to $40
	Frequency	1 per 12 months	1 per 12 months
Lenses – Trifocal	Coverage	100% after $20 materials copay	Reimbursed up to $55
	Frequency	1 per 12 months	1 per 12 months
Contacts	Coverage	Covered in full up to $130 + 15% off remaining balance (instead of eyeglasses)	Reimbursed up to $104
Fit & Folow-up Exam	Coverage	Up to $40	N/A
	Frequency	1 per 12 months	1 per 12 months

Register with VSP or EyeMed

Register with VSP or EyeMed to access a range of tools

- Find in-network providers
- View and print ID cards
- Manage and track claims
- Track your account balances and deductibles

See page 23 for information on how to register for Ameritas Benefits to review your vision plan coverage.

Steps to register online - VSP

- Access vsp.com and click “Create an Account”
- Activate account by following prompted steps
- The VSP Vision Care app is available for download from Apple store or Google play store

Steps to register online - EyeMed

- Access eyemed.com, scroll over “Login” and click “Member”
- Select “Need to register?”
- Activate account by following prompted steps
- The EyeMed Members app is available for downloading from Apple store or Google play store

Tax-Advantaged Accounts

Our Plans

Health Savings Account

Healthcare Flexible Spending Account

Limited-Purpose Flexible Spending Account

Dependent Care Flexible Spending Account

Transportation & Parking FSA

What is the benefit of these accounts?

Using tax-favored accounts helps you save on out-of-pocket expenses. You can save for both short-term and long-term costs.

Contributions and withdrawals are not federally taxed and can be used to cover eligible healthcare expenses for you and your family.

Health Savings Account (HSA)

Click to play videos

Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the Cigna HDHP 3000 plan
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare
- Not tax dependent on someone else's tax return
- Not enrolled in your own or a spouse's Healthcare Flexible Spending Account (FSA), unless it's a "Limited Purpose" FSA for dental and vision expenses

*These amounts are estimated due to rounding and the contributions are made each pay period. To receive the company contribution, the individual must be enrolled in a qualifying plan and employed by DDC. Additional criteria may apply. Employees who enroll domestic partners will receive the employee only company contribution amounts.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the Fidelity HSA works

- Your HSA account is set up after you enroll in DDC's HDHP medical plan. You must open your account to contribute HSA funds and receive DDC's employer contribution.
- To help you get started, DDC will contribute to your HSA the following amounts:

  Individual: $1,200* per year
  Family: $1,400* per year
- You may contribute up to the limit set by the IRS (includes DDC's employer contribution).

  Individual: $4,400 per year
  Family: $8,750 per year
  Age 55+: $1,000 extra per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company. While the IRS has limits for how much you may contribute within a single tax year, there is no cap for the balance within your HSA account.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

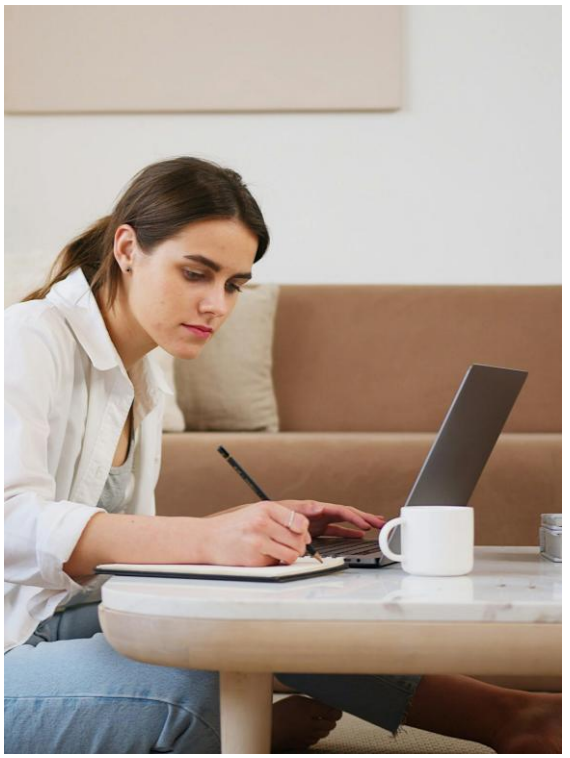
Find out more

- Eligible Expenses
- Ineligible Expenses
- IRS Publication 502

Register for Fidelity

Register for Fidelity to access a range of tools

- View your account balance
- Manage investments
- Access savings tools
- Order a checkbook
- Reimburse yourself if you paid your provider out-of-pocket



Steps to register online

- Access netbenefits.com and click “Register as a new user”
- Select “Yes” and then press “Continue”
- Activate account by following prompted steps
- The Fidelity NetBenefits app is also available for download from Apple store or Google play store

Healthcare Flexible Spending Account (FSA)

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high-deductible health plan like our Cigna HDHP 3000 plan, you can only participate in the Limited Purpose FSA for dental and vision expenses.

Find out more

- Eligible Expenses
- Ineligible Expenses
- IRS Publication 502

Set aside healthcare dollars for the year

A Healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the UMB FSA works

- You estimate what your and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- For those enrolled in an HSA, you have the option to participate in the Limited Purpose FSA, which you can use to cover eligible dental and vision expenses only.
- You can contribute up to $3,400, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $680 to use the following year. Any additional remaining balance will be forfeited.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables, but here's an example using single-filer status and marginal federal income tax rates:

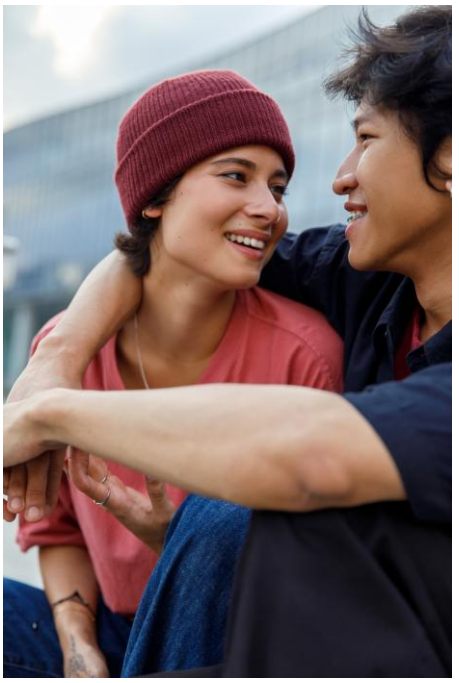
$60,000 annual pay, contributing $1,700 to FSA

$374	$130	$504
22% income tax savings	7.65% FICA tax savings	Total FSA tax savings

$120,000 annual pay, contributing $3,300 to FSA

$792	$252	$1,044
24% income tax savings	7.65% FICA tax savings	Total FSA tax savings

HSA vs. Healthcare FSAs



Each of these plans offer valuable tax savings, but in different ways. For starters, you must enroll in the Cigna HDHP 3000 plan to participate in the health savings account (HSA). If you are enrolled in the HDHP, you can still elect an FSA, but it must be limited-purpose (for dental and vision expenses only).

Click to play video

Benefits	HSA	Healthcare FSA	Limited-Purpose FSA
Compatible plan types	HDHP	PPO, OAP, HMO, or unenrolled	HDHP, or unenrolled
Funds can be used for myself and my family	✓	✓	✓
Contributions & withdrawals are not federally taxed	✓	✓	✓
Spending requirement	None—money stays in your account until you need it	Roll over up to $680 per year (any additional amount is forfeited)	Roll over up to $680 per year (any additional amount is forfeited)
I keep the funds if I leave the company	✓	✗ (Funds available while enrolled in COBRA)	✗ (Funds available while enrolled in COBRA)
Funds can earn investment income	✓	✗	✗
Maximum allowed contribution in 2026	$4,400 Individual $8,750 Family (extra $1,000 age 55+)	$3,400 (not including rollover)	$3,400 (not including rollover)
When are funds available?	You can spend funds only after they have accumulated in the account	You can withdraw funds immediately, up to the annual amount you elected	You can withdraw funds immediately, up to the annual amount you elected

Paying for daycare? Make it tax-free!

Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $7,500 per year tax-free

A Dependent Care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by UMB.

Here's how the DCFSA UMB Plan works

You set aside money from your paycheck, before taxes, to pay for work-related daycare expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for daycare for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

You can’t change your FSA election amount mid-year unless you experience a qualifying life event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Save on commuting expenses

Can I change my election if my work schedule or location changes?

Yes, you can change your commuter allocations any month. Update it online by the 15th of the month for it to be effective by the first of the following month.

If you are working from home, there are no commuting expenses to reimburse.

Transportation savings accounts—up to $340 per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by UMB.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

Set aside up to $340 per month for work-related parking expenses and up to $340 per month for work-related commute expenses.

Register for UMB FSA

Register at UMB for access to a range of tools

- View account balances
- Find claim forms
- Submit and track claims
- Access monthly account summary reports
- Use the “Expense” tab to organize, manage and track expenses

Steps to register online

- Access umb.com and click “Login”
- Select “HSA/Flex Accounts”
- Click “Sign up for Online Access” and select “Benefit Spending Account” under “Account Type”
- Activate account by following prompted steps
- The UMB Benefit Spending Account app is also available for download from Apple store or Google play store

Life & Disability

Name Your Beneficiaries

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D, and Disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the voluntary plans section for details.

Company provided Life and AD&D Insurance

*A note about taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic life insurance pays your beneficiary a lump sum if you pass away. AD&D (accidental death & dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by DDC.

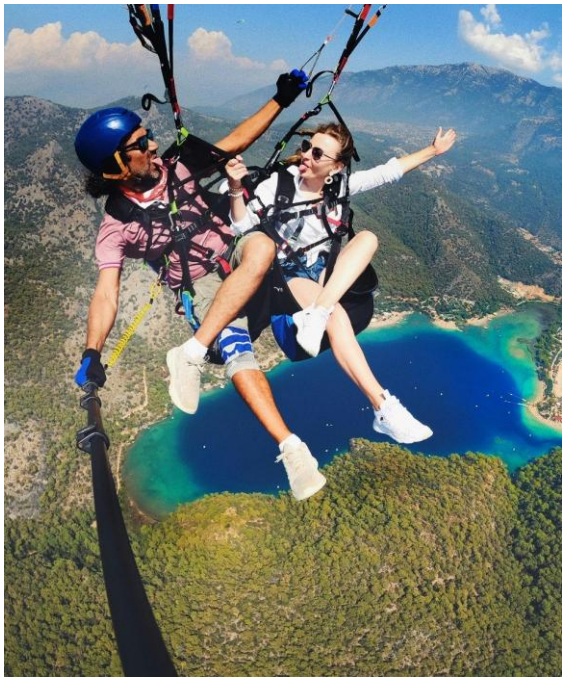
The Hartford Basic Life and AD&D Plan

$150,000* flat benefit amount.

Your benefit amount will be reduced based on the schedule below.

Your Age	Reduction %
65	35%
70	60%
75	75%

Voluntary Life and AD&D Insurance



Guaranteed issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life and AD&D insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or children if you purchase coverage for yourself. Elections for voluntary Life and Voluntary AD&D are made separately and do not need to match.

The Hartford Voluntary Life and AD&D

Employee	$10,000 increments up to the lesser of 5x earnings or $500,000. Guaranteed issue of $150,000, if elected during your new hire period.
Spouse	$5,000 increments up to the lesser of 50% of employees benefit or $100,000. Guaranteed issue of $50,000, if elected during your new hire period. Employees must purchase coverage for themselves to purchase coverage for their spouse.
Children	$10,000 ($250 benefit for ages 15 days to 6 months). Employees must purchase coverage for themselves to purchase coverage for their children.

The Hartford Voluntary Life and AD&D costs

If you elect Voluntary Life and/or AD&D coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to calculate the premium amount that will be deducted from your paycheck.

Voluntary Life Insurance (semi-monthly rate per $1,000 of coverage)

Age	Employee	Spouse / Domestic Partner
<30	$0.039	$0.050
30–34	$0.052	$0.060
35–39	$0.065	$0.075
40–44	$0.091	$0.100
45–49	$0.166	$0.175
50–54	$0.273	$0.280
55–59	$0.520	$0.530
60–64	$0.767	$0.775
65–69	$0.816	$0.825
70+	$0.929	$0.940

Voluntary AD&D (semi- monthly rate per $1,000 of coverage)

Employee	Spouse / Domestic Partner
$0.018	$0.0125

Calculate your Life and/or AD&D semi-monthly cost

1. Desired coverage amount

You: $	Spouse/DP: $

2. Divide step 1 by [1,000] =

You:	Spouse/DP:

3. Multiply step 2 by rate from the tables at left =

You: $	Spouse/DP: $

4. Add you + spouse from step 4 =

Total semi-monthly cost: $

Child Life and AD&D Insurance

Coverage type	Semi-monthly for $10,000 of benefit
Life insurance	$0.275
AD&D insurance	$0.100
Total	$0.375

Premium includes all eligible children. *Eligible children include dependent children and domestic partner children under age 26 as long as you apply for and are approved for coverage for yourself.*

Short-Term Disability Insurance

File a claim

Step 1: Know when it's time to file a claim.

If your absence is scheduled, call The Hartford 30 days prior to your last day of work. If unscheduled, please call The Hartford as soon as possible.

Step 2: Have this information handy!

Name, address and other key identification information.

Name of your department and last full day of active work.

The nature of your claim or leave request.

Your treating physician's name, address, phone and fax numbers.

Step 3: Call or file online.

Call The Hartford at (888) 301-5615 or file online at thehartford.com/mybenefits

Expect the unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

STD Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. DDC pays the cost of this coverage.

The Hartford STD Plan

Weekly benefit amount	60% of earnings, up to a maximum of $3,000
Benefits begin	After seven (7) consecutive days of a disability due to accident or sickness
Maximum payment period	13 weeks (including the seven (7)-day waiting period)

Long-Term Disability Insurance

Things to know about LTD insurance

- It can protect you from having to tap into your retirement savings
- You can use LTD benefits however, you need, for housing, food, medical bills, etc
- Benefits can last a long time—from weeks to even years—if you remain eligible.
- Benefits are taxed

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for long-term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. DDC pays the cost of this coverage.

The Hartford LTD Plan

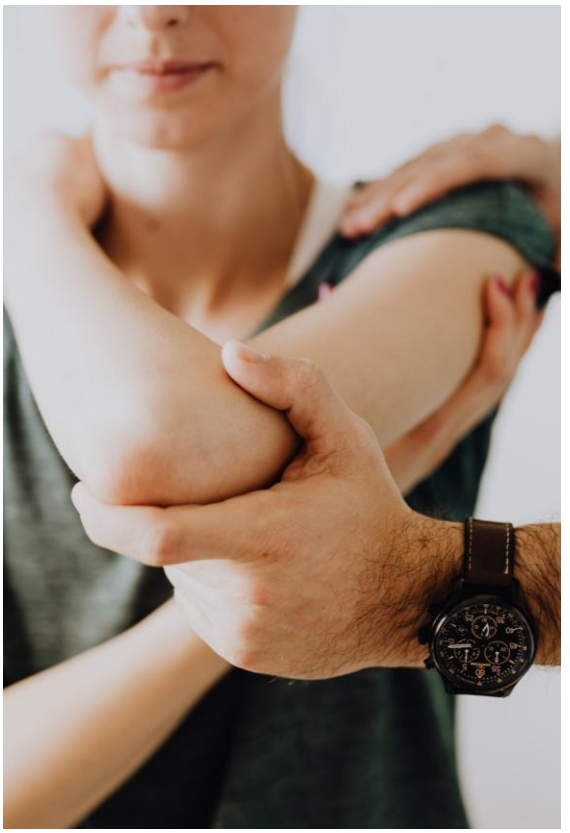
Monthly benefit amount	60% of earnings, up to a maximum of $10,000
Benefits begin	After 90 days of disability
Maximum payment period	Social Security normal retirement age if disabled prior to age 63. The maximum duration for those 63 and older follows this schedule.

Age When Disabled	Benefits Payable
Age 63	To normal retirement age or 42 months, if greater
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

Register for The Hartford My Benefits

Register for My Benefits through The Hartford to access a range of tools

- Review your coverage
- Find claim forms
- Submit claims



Steps to register online

- Access thehartford.com/mybenefits and click “Don’t have an account? Register Now”
- Activate account by following prompted steps

Voluntary Plans

Our Plans

Whole Life Insurance

Voluntary Accident Insurance

Voluntary Critical Illness Insurance

Voluntary Hospital Indemnity Insurance

Pet Insurance

TRICARE Supplemental Coverage

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

MassMutual Whole Life Insurance

Guaranteed issue

No medical questionnaire for amounts under $100K.

Simplified underwriting (one medical question) for amounts between $100K and $250K.

Steps to register online

- Access massmutual.com and click “Sign Up”
- Click “Register”
- Also available for download from Apple store or Google play store

Protecting those you leave behind

Whole Life insurance is a permanent policy, which gives you guaranteed protection for your loved ones that lasts a lifetime. It can help you prepare for the unexpected by providing a generally income-tax-free death benefit, along with coverage that builds cash value.

Features and benefits

Built in guarantees	Guaranteed death benefit Guaranteed cash value Guaranteed level premium
Dividends	Permanent insurance that allows you to be eligible to receive dividends each year, beginning on the certificate’s second anniversary.
Chronic care benefit	Offers the ability to receive an advance, acceleration, or a portion of the death benefit, paid in a lump sum.
Portable coverage	You own the certificate along with the accumulated cash value and you can take it with you, even if you leave the company.

The Hartford Voluntary Accident Insurance

Things to consider

Accident insurance from The Hartford helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, as well as physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The benefit amount depends on the type and severity of your injury and can be used any way you choose.

Refer to The Hartford policy for complete benefit details, definitions, limitations and exclusions.

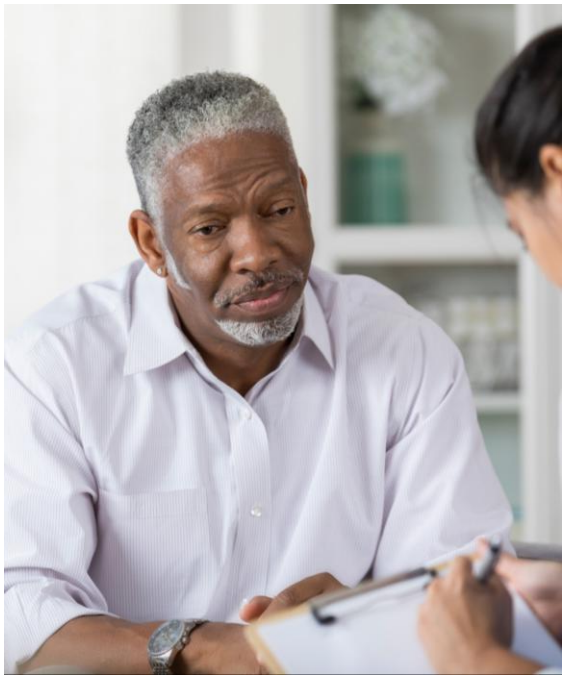
Benefits	Base Plan	Buy-up Plan
Initial accident	$150	$200
Initial care visit	$100 - $300	$200 - $500
Ambulance	$300 - $2,000	$400 - $2,500
Follow-up care	$25 - $1,000	$50 - $1,500
Hospital admission	$3,500 - $7,000	$4,500 - $9,000
Hospital confinement	$200 - $1,000 per day	$250 - $1,500 per day
Brain injury	$200 - $1,000	$250 - $1,500
Burns & lacerations	$50 - $15,000	$50 - $25,000
Dislocations & fractures	$100 - $1,500	$150 - $5,000
Surgery	$150 - $2,500	$200 - $5,000
Death & dismemberment	$400 - $150,000	$500 - $240,000
Loss of hearing, sight or speech	$5,000 - $30,000	$7,500 - $50,000
Paralysis	$10,000 - $30,000	$15,000 - $50,000
Coma	$15,000	$20,000
Prosthetic device	$1,000 - $2,000	$2,000 - $4,000
Organized amateur sports injury	Additional 25% (up to $2,000 per accident) of benefit	

Health screening or prevention benefit

Covered members will receive $100 per calendar year if you undergo a covered health screening or accident prevention screening or visit. Examples include immunizations, blood tests, cancer screenings, chest X-rays, annual or sports physicals and stress tests. This benefit helps offset the cost of premium for the coverage.

Semi-Monthly Premium	Base Plan	Buy-up Plan
Employee Only	$4.39	$6.90
Employee + Spouse	$7.02	$11.04
Employee + Child(ren)	$7.62	$12.03
Employee + Family	$11.44	$18.05

The Hartford Voluntary Critical Illness Insurance



Things to consider

Critical Illness insurance from The Hartford can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. This benefit can be used to offset medical costs.

Benefits	
Coverage amount	Employee: Options of $10,000, $20,000 or $30,000 Spouse/child: Benefit is 50% of employee's coverage
Benign brain tumor	Early diagnosis: 10% Advanced diagnosis: 50%
Bone marrow failure	25%
Burn	100%
Cancer	Invasive: 100% Non-invasive: 25% Skin: $250 one time
Coma	100%
Covered childhood illnesses	100%
Heart conditions	100%
Infectious diseases	25%
Loss of hearing, sight or speech	100%
Major organ failure or transplant	100%
Neurological conditions	100%
Permanent paralysis	100%

Refer to The Hartford policy for complete benefit details, definitions, limitations and exclusions.

Health screening benefit

Covered members will receive $50 per calendar year if you undergo a covered health screening. Examples include blood tests, cancer screenings, chest X-rays, and stress tests. This benefit helps offset the cost of premium for the coverage.

The Hartford Voluntary Critical Illness costs

If you elect Critical Illness coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to calculate the premium amount that will be deducted from your paycheck.

Voluntary Critical Illness Insurance (semi-monthly rate per $1,000 of coverage)

Age	Employee	Spouse / Domestic Partner
<25	$0.090	$0.085
25–29	$0.120	$0.115
30–34	$0.160	$0.160
35–39	$0.215	$0.215
40–44	$0.305	$0.310
45–49	$0.465	$0.470
50–54	$0.665	$0.635
55–59	$0.895	$0.830
60–64	$1.255	$1.130
65–69	$1.730	$1.535
70–74	$2.260	$2.060
75–79	$2.885	$2.650
80+	$3.585	$3.325
Child(ren)		$0.180

Premium includes all eligible children. *Eligible children include dependent children and domestic partner dependent children under age 26 as long as you apply for and are approved for coverage for yourself.*

Calculate your Critical Illness semi-monthly cost

1. Desired coverage amount

You:	Spouse/DP*:	Child*:

2. Divide step 1 by [1,000] =

You:	Spouse/DP:	Child:

3. Multiply step 2 by rate from the tables at left =

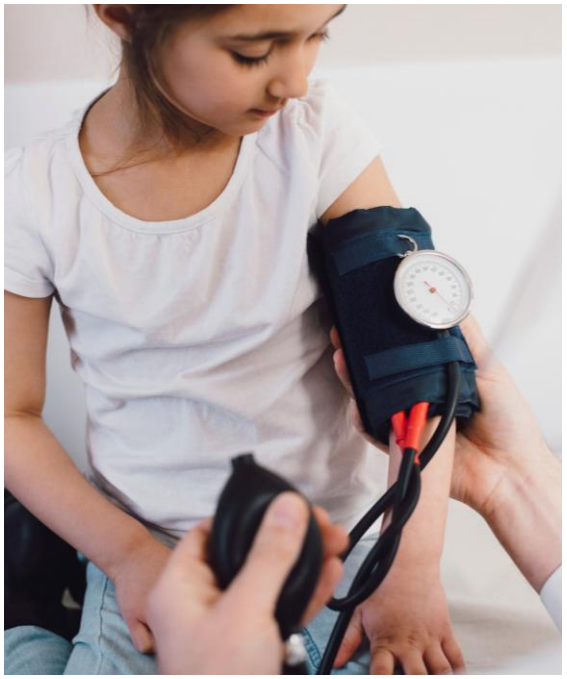
You: $	Spouse/DP: $	Child: $

4. Add you + spouse + child(ren) from step 4 =

Total semi-monthly cost: $	

*Spouse and child coverage amount is 50% of employee's coverage amount

The Hartford Voluntary Hospital Indemnity Insurance



Benefits	Base Plan	Buy-up Plan
Hospital admission	$1,000 (once per year)	$2,000 (once per year)
Daily hospital confinement	$150 per day up to 360 days per year	$150 per day up to 360 days per year
Daily ICU confinement	$300 per day up to 30 days per year	$300 per day up to 30 days per year
Mental illness confinement	$150 per day up to 30 days per year	$150 per day up to 30 days per year
Substance abuse confinement	$150 per day up to 30 days per year	$150 per day up to 30 days per year
Newborn routine hospital care	$150 per live birth	$150 per live birth

Refer to The Hartford policy for complete benefit details, definitions, limitations and exclusions.

Health screening benefit

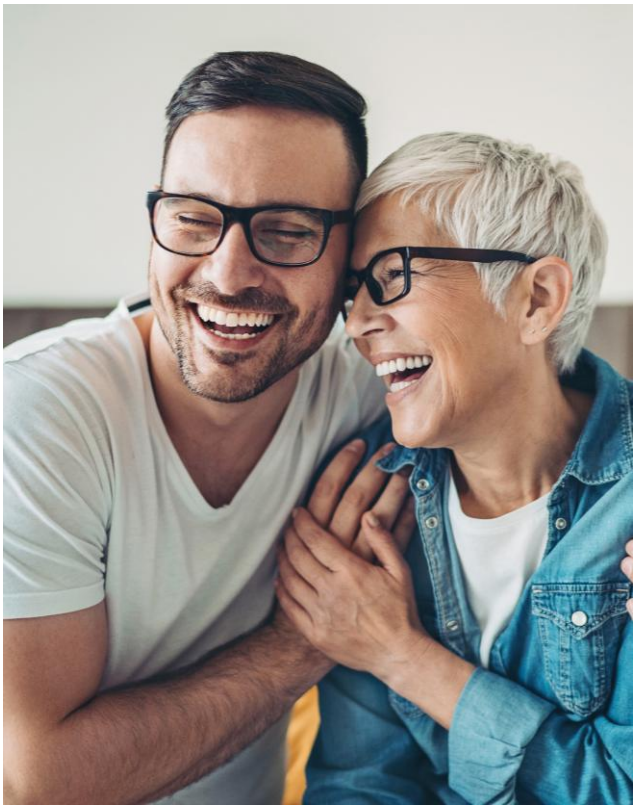
Covered members will receive $50 per calendar year if you undergo a covered health screening. Examples include blood tests, cancer screenings, chest X-rays, and stress tests. This benefit helps offset the cost of premium for the coverage.

Things to consider

Hospital Indemnity insurance from The Hartford can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit — paying for medical bills, childcare, or for regular living expenses like groceries—it is your decision.

Semi-Monthly Premium	Base Plan	Buy-up Plan
Employee Only	$7.75	$11.89
Employee + Spouse	$16.41	$25.53
Employee + Child(ren)	$14.45	$21.75
Employee + Family	$24.27	$37.10

Register online and file a claim with The Hartford



Steps to register online

- Access thehartford.com/benefits/myclaim and click “Create an Account Here”
- Activate account by following prompted steps

File a claim

Step 1: Have this information handy!

Name, address and other key identification information for yourself (and your dependent if they are the claimant).

Supporting medical documentation including discharge papers, test results, physician notes, itemized bills, medical records or explanation of benefits.

Step 2: File your claim.

Call The Hartford at(866) 547-4205 or file online at thehartford.com/benefits/myclaim.

You can also download the claim form and fax it to (469) 417-1952 or mail it to:
The Hartford Supplemental Insurance Benefit Department
PO Box 99906
Grapevine, TX 76099

Enter your basic information, select the type of claim you’re filing, and check off each box that applies for your claim in the “Benefit Information” section.

Step 3: Claims review.

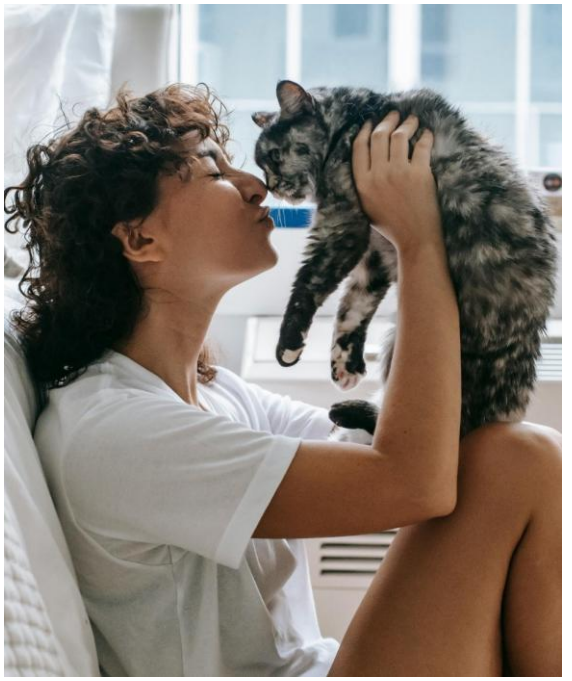
Your claim will be reviewed, and someone will reach out if additional information is needed.

Your voluntary benefits coverage with The Hartford will be reviewed to determine if you are eligible for additional benefits. For example, if you are filing a critical illness claim and forgot to mention a qualifying hospital stay, The Hartford will process a hospital indemnity claim as well.

Step 4: Receive your payment

Upon approval your claim will be paid between 3-10 business days via mail or electronic funds transfer (standard mail times apply).

Pet Benefit Solutions Pet Insurance



Contact information

See the Plan Contacts section of this guide for contact information.

Steps to register online

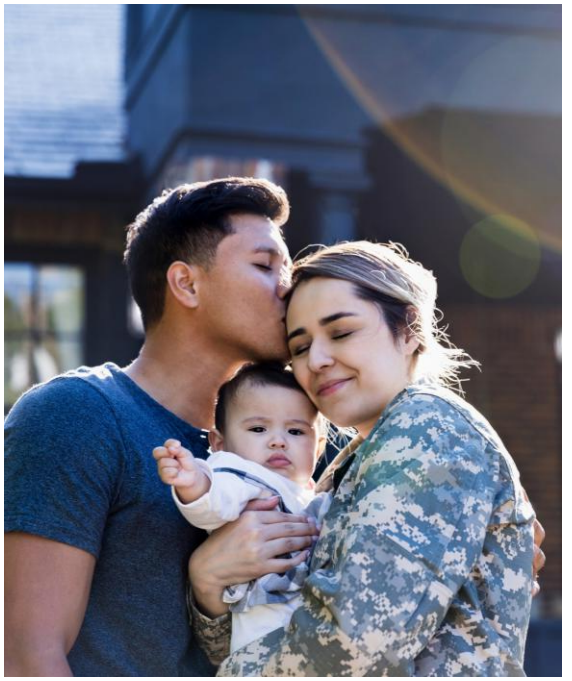
- Access petbenefits.com/land/ddc-dine and click “Login here”
- Click “Register”
- Enter the email address you used to enroll in benefits and your password

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Pet Benefit Solutions provides coverage options through Total Pet Plan and Wishbone Pet Insurance. You can enroll in this program anytime.

Additional pet benefits and pet insurance plans are available through the LifeBalance Program. Please refer to page 59 for more details.

TRICARE Supplemental Coverage



Steps to register online

- Access selmanco.com/eService and click “Register Now”
- Enter your ID number, zip code, and date of birth
- You will then receive a confirmation email, please follow the prompts in the email

If TRICARE is your primary health insurance, the TRICARE Supplement Insurance Plan through Selman and Co. can help cover your out-of-pocket costs through your employer.

- Supplements all three (3) retiree TRICARE plans (PRIME, Select, Retired Reserve)
- If a claim was covered under primary TRICARE but left a cost, this may cover the difference
- Covers the same physicians and pharmacies your primary TRICARE uses
- Greater access to civilian providers
- Coverage cost share/copayments and applicable excess charges
- Continuation of coverage once separated from your employer (restrictions apply)
- Guaranteed issue (no medical forms to complete and no pre-existing condition limitation)

Semi-Monthly Premium	
Employee Only	$33.75
Employee + Spouse	$66.25
Employee + Child(ren)	$66.25
Employee + Family	$89.25

Financial Wellness

Plans To Help You Save

401(k) Retirement Savings Plan

Alliant Medicare Solutions

Is it time for a financial wellness checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money. You can reduce your tax burden and work toward your retirement goals.

Save now, enjoy later

Click to play video

What are your plans?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k) retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

With the company match and compound interest, that "small amount" can grow over time. You'll be a retirement saver before you know it.

See page 30 with information on how to register for Fidelity NetBenefits.

*The IRS contribution limit is projected to increase to $24,500 and the catch-up contribution limits are projected to increase to $8,000 for those ages 50 to 59 or 64+ and to $11,500 for those ages 60 to 63 for 2026.

401(k) Retirement Savings plan—up to $23,500* per year (or more)

Our 401(k) retirement savings plan helps you save for retirement. The plan offers tax savings now through pre-tax contributions and/or tax savings *after* you retire through a Roth after-tax option. Employees 18 and older are eligible to join the plan as of your date of hire.

Visit the Fidelity website at netbenefits.com to manage your account, investments and contributions.

Fidelity offers a variety of quality investment options. You'll also have access to special services such as automatic account rebalancing and personal investment assistance from a licensed investment counselor.

Maximum annual contribution	Up to $23,500* per year. If you're 50 to 59 or 64 or older, save an additional $7,500* per year. If you are 60 to 63, you can save an additional $11,250* per year.
DDC contributions	100% of the first 3% that you set aside, and 50% of the next 2%. Please see the Summary Plan Description for details on when you are vested in (own) contributions from DDC.

Important differences of a Roth 401(k)

- You pay taxes when you contribute, at your current tax rate
- Account interest and dividends are not taxed if you meet certain criteria
- Like a traditional 401(k), you can withdraw money without penalties when you reach age 59½, but you must have held the account for at least 5 years
- You are not forced to take distributions at age 70½. You can keep the money in your Roth account as long as you want

Nearing 65? Get to know Medicare

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

alliantmedicaresolutions.com

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Important deadlines ahead

Most people become eligible for Medicare at age 65. At that time, you'll need to make some important decisions about your health insurance.

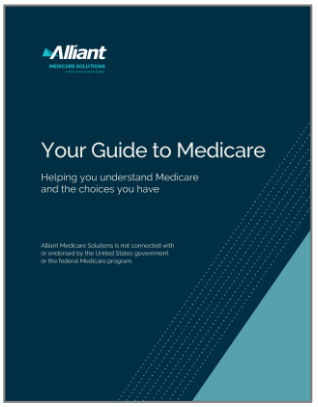
But the choice isn't always easy. Maybe you'll keep working after 65. Maybe you have dependents covered by your DDC sponsored insurance. Maybe you're just not sure which options could work best for your situation.

Alliant Medicare Solutions

Through DDC you have access to Alliant Medicare Solutions, a free service you, your family, and your friends can use to figure out the best Medicare options for you.

How it works

- Gather your current health insurance information
- Call Alliant Medicare Solutions at **(877) 888-0165** to talk to a licensed insurance agent about your current coverage, your Medicare options, and what might work best for your situation
- Alliant Medicare Solutions can help you enroll in Medicare or email policy information for you to review



Your Guide to Medicare

Social Security Planning

Medicare 101

Wellbeing & Balance

"The key to keeping your balance is knowing when you've lost it. "

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, substance use disorder, mental health and family issues.
- Maximize your physical well-being.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

Employee Assistance Program (EAP)

Contact the EAP

Phone:

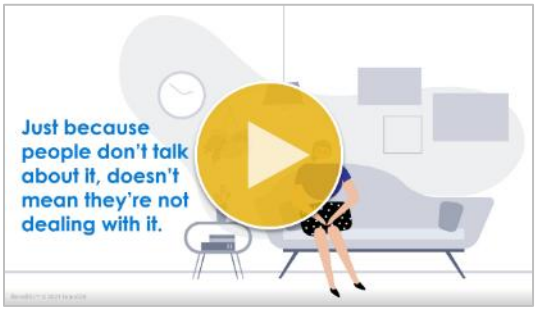
(800) 964-3577

Website: guidanceresources.com

Company code: HLF902
Company name: ABILI

Select “Ability Assist Program” to create your own confidential username and password.

Click to play video



Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through The Hartford can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3 visits
- Unlimited web access to helpful articles, resources, and self-assessment tools

Counseling

- Relationship challenges
- Emotional distress
- Job stress
- Communication issues
- Interpersonal conflict
- Alcohol or drug use
- Loss and grief

Elder care

- Help finding care resources for elderly or disabled relatives

Legal

- Local attorney referrals
- Family law (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Parenting & childcare

- Quality referrals
- Family day care centers
- Infant centers and preschools
- Before- and after-school care
- 24-hour care

Financial

- Money/debt management
- Identity theft resolution
- Tax issues

Online resources

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics

Mental health resources

Too often, stigma around mental health prevents people from getting the support they need. But challenges with mental health are very common—every year, 1 in 5 U.S. adults experiences a mental health issue. Regardless of age, ethnicity, background, or income, people from all walks of life can struggle with their mental health.

If you or any of your dependents are experiencing feelings of isolation, depression, or despair, please make use of the mental health services available to you through our medical plans. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

In-network mental health services*

Plan	Outpatient	Inpatient
Cigna OAP 500	**Office Visit:** $80 **Other Outpatient Services:** 0% (deductible waived)	0% after deductible
Cigna OAP 1000	**Office Visit:** $60 **Other Outpatient Services:** 20% (deductible waived)	20% after deductible
Cigna HDHP 3000	20% after deductible	20% after deductible

**Deductible waived for online visits for the Cigna HDHP 3000 plan. If your preferred mental health provider is out-of-network, services may cost more or may not be covered under certain plans. Refer to the complete medical plan tables earlier in this guide for more information on out-of-network coverage.*

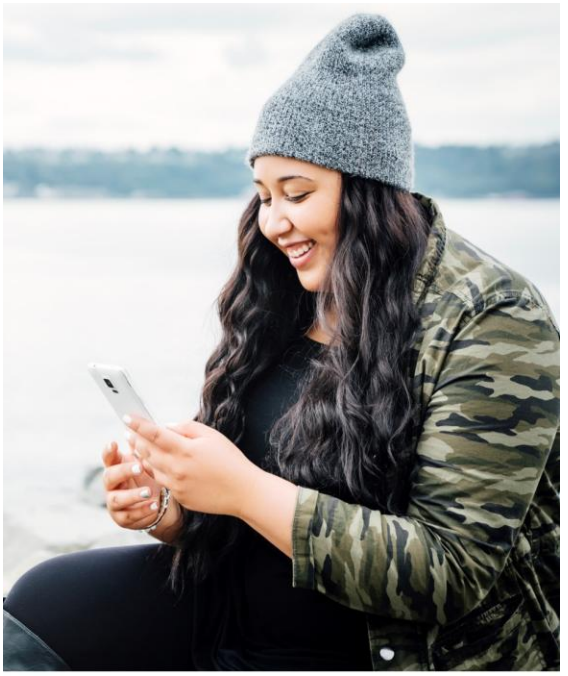
Mental health services through MD Live

Sometimes the hardest part about addressing a mental health issue is taking the first step. Telemedicine services from MD Live provided by Cigna can make that step a bit easier. You can schedule an immediate video or phone consultation with a provider anywhere, any time. To learn more and set up your account, go to myCigna.com.

Other Important Crisis Support Resources

- National Suicide Prevention Line: call or text 988
- National Domestic Violence Hotline: call (800) 799-7233 or text START to 88788
- Crisis Text Line: text HOME to 741741
- Cigna Healthcare Veterans Support Line: call (855) 244-6211

Digital mental health resources



Billing information

Headspace Coaching: you pay the same cost-share as you would for an office visit. This applies to one session per 30 days. Rate includes unlimited access to a coach and Headspace classes and content.

Therapy and Psychiatry: your cost-share is the same as an office visit based on your company's plan design.

MDLIVE and Meru: copay/coinsurance and deductible apply.

Talkspace: calculates the amount of time spent texting. Once the minutes add up to a billable amount (usually a 60-minute session), the provider issues a claim.

These services provide real-time support via live video or texting for Cigna members.

Headspace Care

Virtually connects members with a certified coach via texting and app-based programs to help them manage anxiety, depression, and daily stressors. A coach can add a licensed therapist or psychiatrist to the care team.

MDLIVE

Therapists and board-certified psychiatrists offer convenient virtual care options for behavioral care as well as primary care, urgent care, and dermatology.

Meru Health

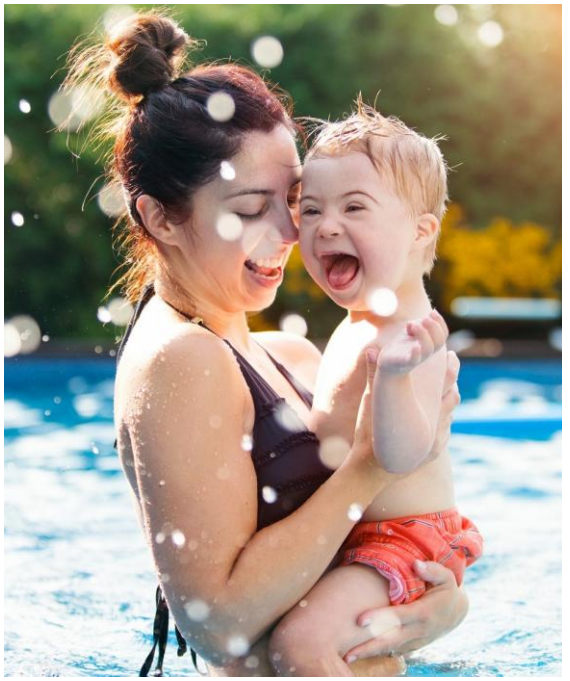
Combines the best of science, technology and human support to help you overcome mental health challenges. You can schedule a free screening session right now.

Talkspace

Provides personalized care for all by making mental health access safe, quick and easy. You can expect immediate, responsive care to support your needs.

Make time to enjoy life

LifeBalance



Questions?

Member Services:

(888) 754-5433

info@LifeBalanceProgram.com

Get discounts at thousands of businesses focused on your wellbeing

The LifeBalance Program works like an online coupon book, offering discounts at thousands of participating businesses nationwide. Discounts are available at health clubs, fitness studios, online retailers, sporting goods stores, amusement parks, movie theaters, hotels, ski resorts, pet benefits, and more.

Create an account to access discounts

- Navigate to DDC.LifeBalanceProgram.com
- Enter your preferred email address, then click "Let's Get Started“
- Enter all required info, create a password for your account, answer the prompts, and then click "Sign In“

Once you've set up your account, you can browse the discounts by clicking the "Find Savings By Interest" tile on the home page. You can also use the search box to look for businesses by name or location.

For the rest of your household too!

This benefit is also available to family members in your household, so encourage them to create their free accounts at DDC.LifeBalanceProgram.com.

Travel Assist

Get started with Travel Assistance

US and Canada: (800) 243-6108
Outside US: (202) 828-5885

Email: assist@lmglobal.com

Travel Assistance with Identity Theft Support

Travel Assistance is available when traveling more than 100 miles from home and for 90 days or less. Services include, but are not limited to:

- Medical assistance, including worldwide medical referrals, medical monitoring, prescription transfer, replacement of medical devices and corrective lenses
- Emergency transports, medical repatriations and evacuations and repatriations of mortal remains
- Pre-trip information, loss luggage/document assistance and legal referrals

Identity theft support services provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if theft occurs.

Caseworkers help review credit information, and if a theft has occurred, will notify major credit bureaus, assist with completing an identity theft affidavit, help with replacing credit/debit cards and more.

Compassionate services beyond your benefits

Continue caring for your loved ones even after you're gone.

It feels good, knowing that you're supporting those who depend on you. But sometimes that support needs to go beyond paying the bills. Your Life insurance comes with a suite of services that go beyond the financial benefits – helping you and your loved ones through the moments that matter.

The Hartford FamilySource

Access personal convenience services for needs like childcare, eldercare, education, etc.

The Hartford LegalConnect

Meet with an attorney for legal issues, such as civil suits, personal/family matters and issues with the Internal Revenue Service.

The Hartford FinancialConnect

Unlimited telephone access to on-staff financial advisors for budgeting, debt, credit, tax issues, retirement planning, etc.

HealthChampion Health Care Navigation

Offers you and your dependents Health Care Navigation support if disabled or diagnosed with a critical illness. Specialists that will assist with a variety of both administrative and clinically related concerns.

Register online at guidanceresources.com.

Company code: HLF902 / Company name: ABILI

Select "Ability Assist Program" to create your own confidential username and password.

Funeral Planning

A suite of online tools that assist with pre-planning and entails a step-by-step checklist, an expert care team, will preparation and burial arrangements.

Register online at join.empathy.com/hartfordcare.

Once you register, access services by calling (229) 544-2332.

Will Preparation

The Hartford helps your protect your family's future by creating a will online, back by online support from licensed attorneys.

Register online at join.empathy.com/hartfordcare.

Once you register, access services by calling (229) 544-2332.

Bereavement services

To access bereavement services:

Visit: empathy.com/partner/Hartford

To register: join.empathy.com/Hartford

Access code via app: EMP-HART

Contact: Hartford@empathy.com

For questions, call: (270) 681-1364

Getting through a loss is hard. Getting support shouldn't be.

Bereavement services provide a personalized bereavement solution built to help families deal with the many challenges that loss can bring. Empathy provides high-quality, complimentary, on-demand support for every group life beneficiary anticipating or dealing with loss, so that they and their families have everything they need during this difficult time.

This includes grief support services, estate and probate services, helpful planning tools, digital app, document storage, after-loss support, and access to online content designed to assist with the grieving process.

Beneficiary Assist

Additional insured and Beneficiary Assist services provide compassionate expertise to help employees or their loved ones cope with emotional, financial, and legal issues that arise before or after a loss. Includes unlimited phone contact with professionals, as well as five face-to-face sessions. Additionally, health care support services are available for employees that are terminally ill.

Access these services by calling (800) 411-7239.

Identity Theft Coverage

If you are enrolled in one of the Cigna medical plans, you qualify for this coverage at no cost to you and any children under the age of 18.

To access IdentityForce:

- Visit: cigna.identityforce.com/starthere
- Enter your name, zip code and date of birth and click “Get Started”

No one should have to deal with a lifetime of damage that could result from identity theft. Security incidents, scams, and fraud continue to grow as our world becomes increasingly digitalized and virtual, and protecting personal information is essential.

The IdentityForce coverage offered through Cigna proactively monitor the Dark Web, credit reports, and real-time fraud issues, and will help fix any compromises to personal information. They will make sure your identity is restored without the burden of phone calls and paperwork.

Plan Feature (not a full listing)	Coverage
Password Manager	•
Bank & Credit Card Activity Alerts	•
ID Vault and Secure Storage	•
Advanced Fraud Monitoring	•
Change of Address Monitoring	•
Court Records Monitoring	•
Dark Web Monitoring	•
Compromised Credentials Alerts	•
Social Media Activity Alerts	•
Data Breach Notification	•
SSN Monitoring	•
Medical ID Fraud Protection	•
Lost Wallet Assistance	•
Child Monitoring (Dark Web and SSN)	•
Investment Account Activity Alerts	•
Credit Freeze and Lock (Adult and Child)	•
Credit Report Monitoring (Daily)	1 Bureau
Credit Report and Score (Quarterly)	1 Bureau
White Glove Restoration	•
Deceased Family Member Fraud Remediation	•
Identity Theft Insurance	$1,000,000

Important Plan Information

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit costs for 2026
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Your semi-monthly benefit costs

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

Medical	Cigna OAP 500	Cigna OAP 1000	Cigna HDHP 3000
Employee Only	$163.43	$134.39	$75.49
Employee + Spouse	$367.72	$302.38	$169.85
Employee + Child(ren)	$343.20	$282.22	$158.53
Employee + Family	$473.95	$389.73	$218.92

Dental	Ameritas Dental Base Plan	Ameritas Dental Buy-up Plan
Employee Only	$4.70	$7.26
Employee + Spouse	$11.81	$18.99
Employee + Child(ren)	$11.81	$18.99
Employee + Family	$11.81	$18.99

Vision	Ameritas Vision Plan
Employee Only	$0.98
Employee + Spouse	$1.96
Employee + Child(ren)	$1.66
Employee + Family	$2.74

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Diné Development Corporation if your domestic partner is your tax dependent.

Plan contacts and resources

Helpful Resources

MyBenefits.Life
ddc.mybenefits.life

Benefit Advocate
benefitsupport@alliant.com
(800) 489-1390

LifeBalance
info@LifeBalanceProgram.com
(888) 754-5433

Medical, Dental, and Vision Plans

Cigna Medical
Policy No. 00637778
myCigna.com
Members: (866) 494-2111
Pre-enrollment line for non-members: (888) 806-5094

Ameritas Dental
Policy No. 010-067112
ameritas.com
(800) 487-5553

Ameritas VSP Vision
Policy No. 010-067112
ameritas.com
(800) 487-5553
vsp.com
(800) 877-7195

Ameritas EyeMed Vision
Policy No. 010-067112
ameritas.com
(800) 487-5553
eyemed.com
(866) 289-0614

Health Savings Account (HSA)

Fidelity
netbenefits.com
(800) 544-3716

Life and AD&D

The Hartford
Policy No. 898868
thehartford.com/mybenefits
(860) 547-5000

Employee Assistance Program (EAP)

The Hartford
guidanceresources.com
(800) 964-3577

Flexible Spending Account (FSA)

UMB
umb.com
(877) 743-9482

Disability

The Hartford
Policy No. 898868
thehartford.com/mybenefits
(888) 301-5615

401(k) Retirement

Fidelity
netbenefits.com
(800) 835-5097

Supplemental Health

The Hartford
Policy No. 898868
thehartford.com/benefits/myclaim
(866) 547-4205

TRICARE Supplemental Medical

Selman & Co.
selmanco.com/eservice
(800) 638-2610

Whole Life

MassMutual
massmutual.com
(844) 975-7522

Pet Insurance

Pet Benefit Solutions
petbenefits.com/land/ddc-dine
(800) 891-2565

Glossary

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Glossary

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as “ineligible,” “not covered,” or “not allowed.”

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network
Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan’s allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn’t require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a “formulary,” is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician’s assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as “immunizations,” vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

Plan documents

Important documents for our health plan are available at the back of this guide. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Diné Development Corporation Health and Welfare Benefit Plan

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available at ddc.mybenefits.life.

- Cigna OAP 500 SBC
- Cigna OAP 1000 SBC
- Cigna HDHP 3000 SBC

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Diné Development Corporation Health and Welfare Benefit Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Important plan information

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan provides the option for you to select a Primary Care Physician (PCP)
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Illinois Consumer Disclosure Act:** Provides to Illinois employees a list that compares the essential health insurance benefits offered by the employer's group health plan with the essential health benefits regulated by the State of Illinois
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills.

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Determining eligibility

Look-back measurement method

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Diné Development Corporation uses the look-back measurement method to determine group health plan eligibility.

New employees hired to work full-time: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of your date of hire.

New employees hired to work a part-time, variable hour or seasonal schedule: If you are hired into a part-time position, a position where your hours vary and Diné Development Corporation is unable to determine—as of your date of hire—whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months. Your IMP will begin on the first of the month following your hire date. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12 months period during which Diné Development Corporation counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Diné Development Corporation uses the standard measurement period and associated stability period annual cycle set forth below:

Measurement period: STARTS: November 1st. DURATION: 12 months time to determine if you work 130+ hours per month on average—used to establish if you are "full-time" or "part-time" for medical eligibility.

Stability period: STARTS: January 1st. DURATION: 12 months time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

Medicare Part D Notice

Important Notice from Diné Development Corporation 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 Diné Development Corporation 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. Diné Development Corporation has determined that the prescription drug coverage offered by the Diné Development Corporation Employee Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Diné Development Corporation coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-

enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under Diné Development Corporation Employee Benefits Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Diné Development Corporation prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Diné Development Corporation 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 Diné Development Corporation 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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: 10/15/2025
Name of Entity/Sender: Diné Development Corporation
Contact-Position/Office: Karen Holbrook, Human Resources Business Partner
Phone Number: (937) 812-2568

Women's Health and Cancer Rights Act

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). 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.

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, call your plan administrator (937) 812-2568.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (937) 812-2568.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Diné Development Corporation's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Diné Development Corporation's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Diné Development Corporation's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Diné Development Corporation describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (937) 812-2568.

Notice of Choice of Providers

The Diné Development Corporation Employee Benefits Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

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

You do not need prior authorization from Diné Development Corporation Employee Benefits Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Cigna at 866-494-2111 or go to myCigna.com to search providers.

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
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
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
FLORIDA – Medicaid
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 and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)

HIPP Phone: 1-888-346-9562

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: 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
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-866-614-6005
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – 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 Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Diné Development Corporation
Employer State of Situs:	Arizona
Name of Issuer:	Cigna
Plan Marketing Name:	Cigna OAP 500, Cigna OAP 1000, Cigna HSA 3000
Plan Year:	January 1, 2026 – December 31, 2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes

10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes

32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	Yes
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes
Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.				

The ‘No Surprises’ Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

View a sample notice and consent form (PDF).

This applies to you if you’re a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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 9.96%[1] of your annual household income, or if the coverage through your employment does not

[1] Indexed annually; see https://www.healthcare.gov/glossary/affordable-coverage/ for 2026.

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 9.96% of the employee's household income.[12]

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.

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.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2025, through July 31, 2026.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either submit a new application or update an existing application on HealthCare.gov between March 31, 2025 and July 31, 2026, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2025, and July 31, 2026, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP**

[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.

coverage. In addition, 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, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2025, and July 10, 2025, you can request this special enrollment in the employment-based health plan through September 8, 2025. 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 Karen Holbrook at (937) 812-2568 or karen.holbrook@ddc-dine.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	4. Employer Identification Number (EIN)
Diné Development Corporation	77-0651649
5. Employer address	6. Employer phone number
8840 E. Chaparral Rd, Suite 145	(717) 262-9750

7. City	8. State	9. ZIP code
Scottsdale	AZ	85250

10. Who can we contact about employee health coverage at this job?	
Karen Holbrook	
11. Phone number (if different from above)	12. Email address
(937) 812-2568	karen.holbrook@ddc-dine.com

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    All full-time employees working 30 or more hours per week.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouses or domestic partners, children up to age 26, and disabled adult children.

  - ☐ We do not offer coverage.

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will

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

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

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

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.
a. How much would the employee have to pay in premiums for this plan? $ $75.49
b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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)

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