



2026 Benefits

Your Benefits. Your
Choice.

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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
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 *
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](https://www.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	<ul style="list-style-type: none">• Quick answers from a trained nurse:<ul style="list-style-type: none">- to determine if immediate care is needed- for home treatment options & advice
Online visit (\$) Often available 24/7	<ul style="list-style-type: none">• Non-emergency health issues:<ul style="list-style-type: none">- cold, flu, allergies, headache, migraine- rashes, skin conditions- minor injuries- mental health concerns
Office visit (\$\$) Typically open during regular business hours	<ul style="list-style-type: none">• Routine medical care and management:<ul style="list-style-type: none">- preventive care- illnesses and injuries- existing conditions
Urgent care (\$\$\$) Typically open with extended evening and weekend hours	<ul style="list-style-type: none">• Urgent but not life-threatening conditions:<ul style="list-style-type: none">- sprains or stitches- animal bites- high fever or respiratory infections
Emergency room (\$\$\$) Open 24/7	<ul style="list-style-type: none">• Life-threatening conditions requiring immediate care:<ul style="list-style-type: none">- 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

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.

Typical screenings for adults

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

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

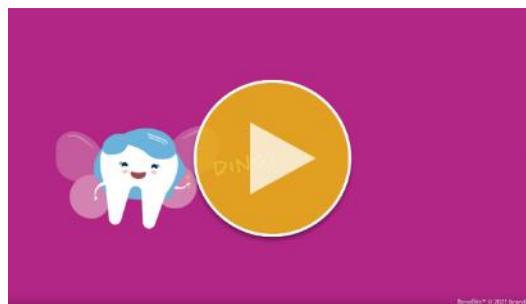
Ameritas Dental Buy-up Plan

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](https://www.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

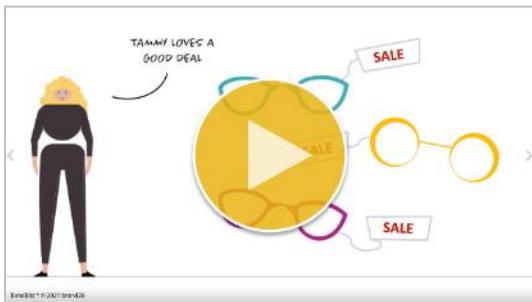


Vision

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 & Follow-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 & Follow-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

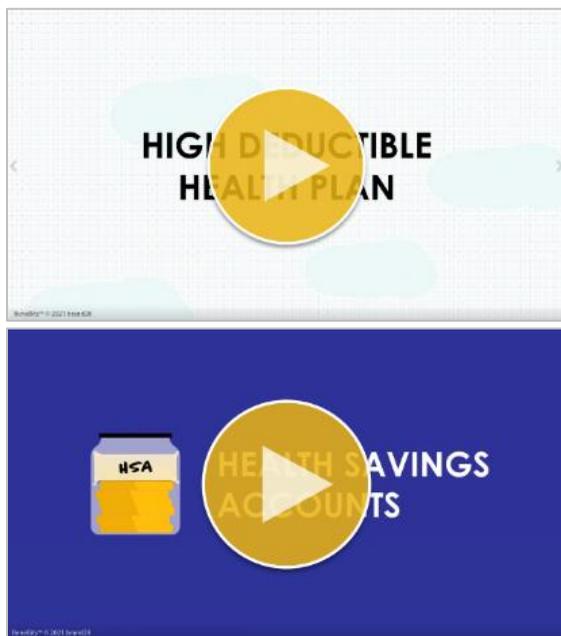
What is the benefit of these accounts?

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



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.

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.

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 22% income tax savings	\$130 7.65% FICA tax savings	\$504 Total FSA tax savings
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\$120,000 annual pay, contributing \$3,300 to FSA

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



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

Total semi-monthly cost: \$	
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*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



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.

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

TRICARE Supplemental Coverage



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)

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

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
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.

Nearing 65? Get to know Medicare



alliantmedicareolutions.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.

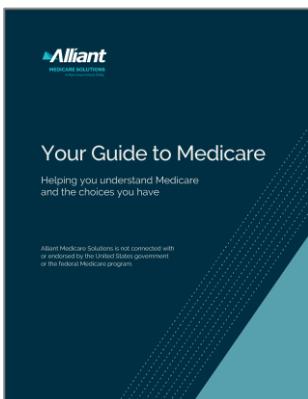
But the choice isn't always easy. Maybe you'll keep working after 65. Maybe you have dependents covered by your DDC sponsored insurance. Maybe you're just not sure which options could work best for your situation.

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.

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.

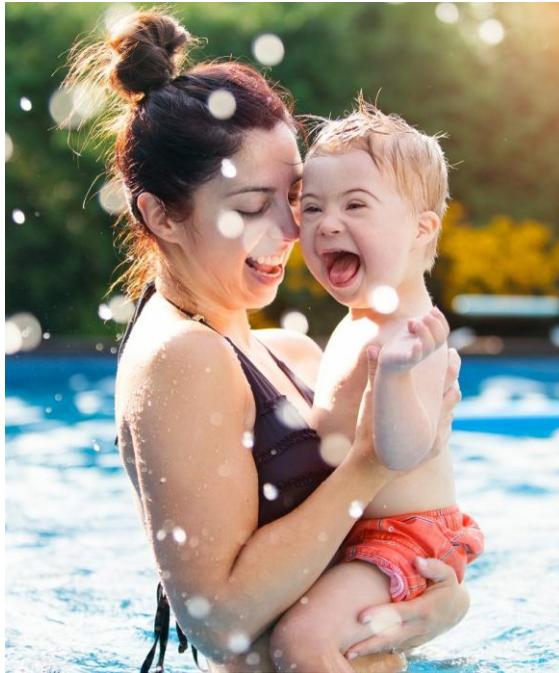
Meru Health

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



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	\$453.98	\$433.52	\$359.47
Employee + Spouse	\$1,021.45	\$975.42	\$808.80
Employee + Child(ren)	\$953.35	\$910.38	\$754.89
Employee + Family	\$1,316.53	\$1,257.20	\$1,042.46

Dental	Ameritas Dental Base Plan	Ameritas Dental Buy-up Plan
Employee Only	\$13.42	\$20.73
Employee + Spouse	\$33.75	\$54.25
Employee + Child(ren)	\$33.75	\$54.25
Employee + Family	\$33.75	\$54.25

Vision	Ameritas Vision Plan
Employee Only	\$2.97
Employee + Spouse	\$5.95
Employee + Child(ren)	\$5.04
Employee + Family	\$8.31

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

Flexible Spending Account (FSA)

UMB

umb.com

(877) 743-9482

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 that 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.

