Benefits Updates

My Benefits

Annual Notices and Summary of Material Modifications - 2021

This document contains information on changes to Disney benefits plans effective January 1, 2021 (or as otherwise noted). Depending on your job location and work status, not all plans may apply to you. Please keep this document for reference.

IMPORTANT NOTICES REGARDING YOUR DISNEY BENEFITS

The following notices are required to be provided to you each year concerning certain rights and coverages that apply to your Company-provided health and welfare and retirement benefits.

Annual Notice: All Disney medical options provide benefits for mastectomy-related services, including reconstruction and symmetrical appearance surgery, prostheses and physical complications resulting from a mastectomy (including lymphedema). For more information, call your medical carrier's member services number.

Medicaid and Children's Health Insurance Plan (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families: If you are eligible for employer health coverage but cannot afford the premiums, most states have premium assistance programs through Medicaid or CHIP programs which can help pay for coverage. Contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or go to **www.insurekidsnow.gov** for more information, to apply for Medicaid or CHIP, or to find out if your state has a premium assistance program and how to apply. To view the full notice, go to D Life | My Benefits at Benefits.Disney.com and select "Legal and Regulatory Notices" in the bottom menu bar.

Right to request pension estimate: If you are a participant in a Disney pension plan, you have the ability to request an estimate of your plan benefit. You can request an estimate of your current accrued benefit, or you can request an estimate of your benefit projected to a future date. To request a pension estimate electronically:

- Review your accrued pension benefit estimate online any time at **Fidelity NetBenefits**. Click on the Quick Links under your pension plan to be directed to the Pension Summary page.
- Obtain important information from your Pension Summary page, such as your accrued benefit, vesting percentage or the earliest date on which your pension benefit will vest.
- Change the way statements are delivered to you by visiting "Communication" under "Profile" in the top menu bar.

If you are unable to view your accrued pension benefit online, you may call the Disney Benefits Center at 1-800-354-3970 to obtain a free copy of your statement. **No action is required on your part.** This notice is being sent to you as a requirement of the Pension Protection Act of 2006, which requires an annual notice to let you know your accrued pension benefit is available for your review.

Right to elect 401(k) and Retirement Savings Plan investments. If you have not made an active election regarding the investment of your employee and Company-matching contributions in the 401(k) plan*, or Company contributions to the Retirement Savings Plan, and those contributions have been defaulted into a BlackRock LifePath Index Fund, you have the ability to transfer your current and future contributions out of the BlackRock LifePath Index Fund to any of the other available investment options at any time. Access your account online at D Life | My Benefits at **Benefits.Disney.com**, or call the Disney Benefits Center at 1-800-354-3970.

Notice of Your Rights Concerning Employer Securities: Because you may now or in the future have investments in Company stock under the Disney 401(k) Plan**, you should take time to read the notice below on the importance of diversification:

To help achieve long-term retirement security, you should give special consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform well, often cause another asset category, or another particular security, to perform poorly. If your retirement savings is heavily invested in any one company or industry (generally considered to be 20% or more), your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk.

In deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of the Disney 401(k) Plan. No single approach is right for everyone because, among other factors, individuals have different financial goals, time horizons for meeting their goals and different tolerances for risk. You should carefully consider your rights described in this notice and how these rights may affect the amount of money that you invest through the Disney 401(k) Plan in Company stock. It is also important to periodically review your investment portfolio, your investment objectives and the investment options under the Disney 401(k) Plan to help ensure your retirement savings will meet your retirement goals.

**** References to the "401(k) plan" above include the following plans: Disney Savings and Investment Plan, Disney Hourly Savings and Investment Plan, Bamtech Retirement Saving and Investment Plan, 21CF America Consolidated Savings Plan, and Hulu, LLC Retirement Trust.***

*****References to "the Disney 401(k) plan" above include the Disney Savings and Investment Plan and the Disney Hourly Savings and Investment Plan.***

NEW POPULATIONS ELIGIBLE TO PARTICIPATE IN THE *SIGNATURE* BENEFITS PLAN

- Twenty First Century Fox (TFCF) active full-time salaried and hourly employees and their eligible dependents, pre- and post-65 retirees and their eligible dependents, and former employees and their eligible dependents continuing in COBRA coverage are eligible to participate in The *Signature* Benefits Plan. The eligibility requirements for TFCF pre- and post-65 retirees and their eligible dependents are described in The *Signature* Benefits Plan Retiree Programs Summary Plan Description. These employees, former employees, and their dependents ended their participation in the 21st Century Fox America Group Insurance Plan, Fox Entertainment Group Insurance Plan and Fox Retiree Health Plan at midnight on December 31, 2020.
- TFCF active full-time salaried and hourly employees eligible for Long-Term Disability (LTD) coverage under The *Signature* Benefits Plan are defaulted into the LTD-180 option and received a one-time Company stipend of $89 to cover a portion of their 2021 LTD premium. The stipend was paid via payroll during the month of January 2021.
- Hulu LLC active full-time salaried and hourly employees and their eligible dependents, and terminated employees and their eligible dependents continuing COBRA coverage, are eligible to participate in The *Signature* Benefits Plan. Hulu employees eligible to enroll in The *Signature* Benefits Plan medical plan options received a one-time stipend to cover the increase in their medical plan contributions. The stipend was deposited into the employees' Health Savings Account (HSA) or Health Reimbursement Account (HRA). These employees, former employees, and their dependents ended participation in the Hulu LLC Employee Benefit Plan effective at midnight on December 31, 2020.
- BAMTECH LLC active full-time salaried and hourly employees and their eligible dependents, and terminated employees and their eligible dependents continuing COBRA coverage, are eligible to participate in The *Signature* Benefits Plan.

MEDICAL AND PRESCRIPTION DRUG PROGRAMS

- Three TFCF retiree medical options are added and offered exclusively to TFCF pre- and post-65 retirees who are eligible for retiree medical coverage (as described in The *Signature* Benefits Plan Retiree Programs Summary Plan Description). The new retiree medical options are Cigna TFCF Pre-65 PPO, Cigna TFCF Pre-65 EPO and UHC TFCF Post-65 PPO. The medical and pharmacy coverage levels offered under these retiree medical options are the same as the coverage levels that these TFCF retirees were offered in 2020 under the Fox Retiree Health Plan. The pharmacy benefits are administered by Express Scripts (ESI). These retiree medical options and the prescription drug program are described in The *Signature* Benefits Plan Retiree Programs Summary Plan Description and the applicable benefits booklets listed therein.
- The Claims Administrator for the Cigna Global MED/80 medical plan option's prescription drug program is changing from Cigna Pharmacy to Express Scripts, Inc.
- The following services are added to the list of covered preventive care services:
  - For adults: Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for persons who are at high risk of HIV acquisition.
  - For women: Perinatal depression counseling interventions or referrals for pregnant and postpartum women who are at increased risk of perinatal depression.

AFFORDABLE CARE ACT (ACA) MEDICAL COVERAGE ELIGIBILITY CHANGES DUE TO COVID-19

- Pursuant to the Affordable Care Act (ACA), the Company offers basic medical coverage to eligible "non-full-time" (regular part-time and temporary/recurring) employees and Cast Members. An employee who is not a full-time employee is generally eligible for benefits under The *Signature* Benefits Plan if the employee averages at least 30 hours per week during a "measurement period" of 365 days (with at least 1,560 cumulative hours over this time). These rules are described in further detail in the Summary Plan Description. The following changes apply due to the COVID-19 pandemic:
  - For the 2020 plan year, non-full-time employees and Cast Members will have their furlough hours during the look-back period included in the tabulation of the required hours under the "initial measurement period" and the "ongoing measurement period."
  - Non-full-time employees and Cast Members who do not meet the hours requirement for medical coverage for the 2021 plan year, but did meet the hours requirement for medical coverage for the 2020 plan year, will be eligible for the Plan's ACA medical option for the 2021 plan year.
  - Non-full-time employees and Cast Members with greater than 1,050 hours between October 6, 2019 and March 15, 2020 will have their hours from October 6, 2019 to March 15, 2020 projected (*i.e.* annualized) to October 5, 2020 to determine eligibility for the Plan's ACA medical plan option for the 2021 plan year.

DENTAL PROGRAM

- Advantage and Value dental options' age restriction on sealant coverage is removed.
- Advantage and Value dental options' coverage of major restorative services (*i.e.* crowns, inlays, onlays, cast restorations, and prosthodontic appliances) is changing from five years to seven years.

WELLNESS REWARDS PROGRAM

- The Wellness Rewards Program, which is offered to all active full-time, U.S.-based (and U.S. expatriate) employees, Cast Members, and their spouses or domestic partners who are enrolled in a medical option under The *Signature* Benefits Plan, has been redesigned to change the way eligible participants earn their rewards.
- Employees and their spouses or domestic partners will be able to earn a $300 reward by completing one activity that consists of the completion of a medical preventive exam or screening (as described in the "Preventive Exam/Screening Reward" section of the Summary Plan Description). The $300 reward for the employee and spouse or domestic partner will be deposited into the employee's Health Savings Account (HSA), Health Reimbursement Account (HRA) or paid via payroll if the employee does not have a HSA or HRA.
- The Wellness Rewards Program will continue to be administered by Cigna, on Cigna's MotivateMe platform accessed through mycigna.com.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT AND HEALTH SAVINGS ACCOUNTS

- Health Care Flexible Spending Account (FSA) –The maximum annual contribution to a Health Care FSA will increase from $2,700 to $2,750.
- Health Savings Accounts (HSA) – For active employees and COBRA participants enrolled in the Consumer Choice medical plan option, the maximum annual contribution (Company and participating employee) to an HSA will increase from $3,550 to $3,600 for those electing individual coverage and from $7,100 to $7,200 for family coverage. Employee contribution maximums are decreased by the potential amount of Company-paid wellness rewards and the annual Company contribution to the Health Savings Account for eligible active employees enrolled in the Consumer Choice medical plan option.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

- The Supplemental Spouse/Domestic Partner Life Insurance benefit rates are redesigned to age-banded rates in five-year increments that range from age <25 to 70+.
- The Supplemental Spouse/Domestic Partner Life Insurance benefit will be available at three additional coverage levels of $150,000, $200,000 and $250,000.
- Payroll credits will be discontinued for employees opting into a level of Basic Employee Life Insurance and Basic AD&D Insurance coverage that is lower than what the Company provides.
- The Basic Employee Life Insurance and Basic AD&D Insurance $5,000 coverage option is eliminated. The Basic Employee Life Insurance and Basic AD&D Insurance coverage options available are: Salaried employees – two-times annual base pay or $50,000. Hourly employees – one-time annual base pay or $50,000, if annual base pay is lower than $50,000.
- The Supplemental Child Life Insurance benefit will be available at an additional $20,000 coverage level.

DISABILITY INSURANCE

- Long-Term Disability (LTD) rates are being reduced 5% for the LTD-90 option and 38% for the LTD-180 option.
- The maximum weekly benefit provided under the Temporary Disability Insurance for eligible employees in Hawaii will be the 2021 maximum weekly benefit amount set by the Hawaii Department of Labor and Industrial Relations.
- Cigna Long Term and Short Term Disability options are being added to The *Signature* Benefits Plan, exclusively for Hulu employees, as set forth in Exhibits A and B.

STREAMING SERVICES (FORMERLY BAMTECH)

- Streaming Services employees eligible to receive the Company subsidy for medical, dental, vision and LTD coverage will move from 100% subsidy to a 50% subsidy.

EMPLOYEES ON FURLOUGH LEAVE OF ABSENCE

- Effective April 19, 2020, the Company waived employee contributions for medical, dental, vision, short-term disability, long-term disability and supplemental life and AD&D insurance for all employees on a furlough leave of absence. For plan year 2020, the Company grossed-up any taxes that resulted from any imputed income generated from Company contributions for medical and life insurance.
- For certain coverages (such as employee life insurance, flexible spending accounts, long-term disability, and short-term disability) employees may be required to be "actively at work" on the day coverage is scheduled to begin. Effective April 19, 2020, all "actively at work" requirements under The *Signature* Benefits Plan are waived for all employees on a furlough leave of absence.

COVID-19 CHANGES

The following are changes to coverage under The Signature *Benefits Plan that were implemented during the 2020 plan year due to the COVID-19 pandemic.*

- Effective March 1, 2020, telehealth visits covered under The *Signature* Benefits Plan medical options are provided at zero copay to the participant and covered dependents through December 31, 2021.
- Effective March 1, 2020, in-network virtual office visits covered under The *Signature* Benefits Plan medical options related to COVID-19 testing or treatment are provided at no cost to the participant and covered dependents. Virtual office visits are office visits that are conducted by the participant's doctor via telephone or online.
- Effective March 1, 2020, COVID-19 related testing (including home testing) and treatment are covered under The *Signature* Benefits Plan medical options. Copays, deductibles and coinsurance are waived for in-network and out-of-network COVID-19 related testing (including home testing), and copays, deductibles and coinsurance are waived for in-network COVID-19 treatment. This provision will remain effective during the COVID-19 National Emergency, as defined by the U.S. Department of Labor.
- Effective March 1, 2020, Express Scripts medication authorizations have been extended 90 days from their expiration date.
- Effective March 1, 2020, Express Scripts waiting periods for ongoing maintenance prescriptions have been waived and participants can refill their prescriptions 15 days prior to next standard refill.
- Health Savings Account (HSA) 2019 contribution deadline has been extended to July 15, 2020, per IRS regulations.
- Effective January 1, 2020, the following health care expenses have been added to the list of medical expenses that can be reimbursed from the Health Care FSA, Health Reimbursement Account, and Health Savings Account, per the CARES Act:
  - Over-the-counter medicine and drugs used to alleviate pain or treat sickness or injuries, without a prescription
  - Menstrual care products
- Effective March 1, 2020 the Employee Assistance Program (EAP) number of visits has been expanded from five to 10 visits per issue per year through December 31, 2021.
- For the period of March 1, 2020 to December 31, 2020, participants in the Dependent Care Flexible Spending Account (DCFSA) in 2020 are allowed to stop participation, or increase or decrease their contribution at any time, regardless of whether they experience a qualified life event. Any change made will be limited to amounts no less than amounts already reimbursed.
- For the period of March 1, 2020 to December 31, 2020, participants in the Health Care Flexible Spending Account (HCFSA) in 2020 are allowed to stop participation, increase or decrease their contribution at any time, regardless of whether they experience a qualified life event. Participants that stop their contributions can only spend up to the amount they have contributed. Any change made will be limited to amounts no less than amounts already reimbursed.

- A grace period to incur expenses under the Dependent Care FSA has been added for plan year 2020. The grace period allows participants with DCFSA balances at the end of the 2020 plan year to continue to incur claims through March 15, 2021.
- The *Signature* Benefits Plan will provide the following deadline extensions. For purposes of this section, the "Outbreak Period" means the period from March 1, 2020 to 60-days after the announced end of the national emergency concerning the COVID-19 outbreak.
  - In determining the election period due to a HIPAA special enrollment event, the Plan will disregard the Outbreak Period or such other date announced by the United States Departments of Labor, Internal Revenue Service, and Department of the Treasury (the "Departments"). Any deadline regarding a HIPAA special enrollment election period that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments.
  - In determining the deadline to elect COBRA coverage, the Plan will disregard the Outbreak Period or such other date announced by the Departments. Any deadline regarding electing COBRA coverage that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments.
  - In determining the date for payment of COBRA premiums, the Plan will disregard the Outbreak Period or such other date announced by the Departments. Any deadline regarding the date for payment of COBRA premiums that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments. The deadline for COBRA premiums under The *Signature* Benefits Plan will be as follows: COBRA participants are allowed an extra 90 days to make their premium payments. If premium payments are not made within the extra 90 days, COBRA coverage will be terminated retroactively to the last day of the month for which COBRA premiums were made. If premium payments are not made within the extra 90 days but are made within the extended deadline, COBRA coverage will be retroactively reinstated.
  - In determining the deadline for employees and their covered dependents to notify the Plan of a COBRA qualifying event (*e.g.* divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the Plan), and the deadline to notify the Plan of a disability determination from the Social Security Administration, the Plan will disregard the Outbreak Period or such other date announced by the Departments. Any deadline for these qualifying events or disability determination that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments.
  - In determining the deadline to file a claim for benefits under the Plan, except for the Dependent Care Flexible Spending Account, the Plan will disregard the Outbreak Period or such other date announced by the Departments. Any deadline to file a claim for benefits that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments.
  - In determining the deadline to file an appeal under the Plan, except for the Dependent Care Flexible Spending Account, the Plan will disregard the Outbreak Period or such other date announced by the Departments. Any deadline to file an appeal that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments.
  - In determining the filing date for a request for external review under the Plan, the Plan will disregard the Outbreak Period or such other date announced by the Departments. Any deadline to file a request for external review, including the additional period for perfecting such a request, that would otherwise occur or accrue during the Outbreak Period will be tolled until the end of the Outbreak Period or such other date announced by the Departments.

DISNEY ASSOCIATED COMPANIES' RETIREMENT PLAN

- Amended plan to credit 1,000 hours of service for the 2020 plan year to any DACRP eligible employee active as of the effective date of the COVID-19 furlough (April 19, 2020) and subject to a furlough between April 19, 2020, and December 31, 2020. However, any additional service credit resulting from this change will not preclude a participant from starting payment after termination of employment before age 55 (if otherwise eligible) or from taking a lump sum that was otherwise available.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.

DISNEY SALARIED PENSION PLAN-D

- Effective as of January 1, 2020, amended plan to include TFCF America, Inc. (for employee transfers on and after December 31, 2020) as a designated Disney affiliated company; recognizing prior service with TFCF America, Inc.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.

DISNEY SALARIED PENSION PLAN-A

- Effective as of January 1, 2020, amended plan to include TFCF America, Inc. (for employee transfers on and after December 31, 2020) as a designated Disney affiliated company; recognizing prior service with TFCF America, Inc.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.

21ST CENTURY FOX AMERICA RETIREMENT PLAN

All Participants

- Benefits accrued on and after January 1, 2021, will be determined under the Disney plan formula (the "Disney Formula Benefit"), which is described in the Notice of Plan Change dated October 1, 2020.
- If a participant elects to receive the participant's Disney Formula Benefit prior to the participant's normal retirement date, then that portion of the benefit will be reduced by 5/12 of 1% for each month by which the date the participant's early retirement benefit begins precedes the normal retirement date.
- Lump sum payments of a participant's Disney Formula Benefit with a present value greater than $100,000 are not permitted. Participants may elect a lump sum for the benefit portion accrued before January 1, 2021, regardless of the present value of such portion.
- A participant who transfers from a participating employer to another affiliate on and after January 1, 2021, will have the participant's service with such entity taken into account, in accordance with Plan rules for crediting service, to the same extent as if such entity were a participating employer. Note that in no event shall there be any duplication of benefits.
- If a participant dies and there is no designated beneficiary, or the designated beneficiary predeceased the participant, then the participant's beneficiary shall be the participant's surviving spouse. If there is no surviving spouse, then any benefit due will be paid in the following order: (i) the participant's domestic partner, or if none; (ii) the participant's natural and legally-adopted children (equally), or if none; (iii) the participant's parents (equally), or if none; (iv) the participant's brothers and sisters, (equally), or if none; (v) the participant's estate.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72 (or, if later, January 1, 2021).

- The actuarial assumptions used to calculate the amount of a benefit when it is paid in a different time, period or manner from the normal form that begins at the participant's normal retirement age have been changed so that the Plan will use the interest rate and mortality table specified by the Internal Revenue Service for purposes of determining the present value of a qualified joint and survivor annuity. However, if the actuarial equivalent value of your benefit would be greater by applying the definition of "Actuarial Equivalent" in effect on December 31, 2020, to the portion of your benefit accrued as of December 31, 2020, then the participant will receive that greater amount.
- For annuity starting dates on or after January 1, 2021 participants may elect a 20-year Certain and Life form of benefit payment.
- If a married participant elects to receive the participant's vested accrued benefit with the participant's spouse as the designated beneficiary for a 100% or 75% survivor benefit, and the participant dies before the participant's annuity starting date, then the spouse will receive the survivor benefit elected by the participant as if the participant had died on the participant's annuity starting date.
- Years of service for vesting purposes will be determined under the Disney Pension Plan D rules, which are as follows:
  - A participant's years of vesting service are equal to the greater of:
    - The number of plan years beginning on or after January 1, 2012 in which the participant received 1,000 hours of service as an employee of the company or an affiliated employer; or
    - The complete years and months a participant is employed by the company or an affiliated employer after December 31, 2011. For this purpose, employment generally includes (1) any absence from employment up to one year and (2) any approved leave of absence up to two years if a participant returns to work or dies before the leave ends.
  - Participants covered by another retirement plan while an employee of the company might have service under that plan count towards years of service for vesting purposes under the Plan.
  - Participants employed by an employer that was acquired by the company might have service with the acquired employer count towards years of service for vesting purposes under the Plan.
  - Years of vesting service also include each plan year before January 1, 2012, in which the participant received 1,000 hours of service as an employee of the company or an affiliated employer.
  - Alternatively, if the participant has at least three years of vesting service under the terms of the plan in effect on December 31, 2020, and would, under such terms have more years of vesting service, vesting service shall be determined under those terms.
- If an unmarried active participant dies on or after January 1, 2021, a death benefit will be payable in the same amount and form as if the participant's beneficiary were the participant's spouse.
- Participants who complete at least one hour of service on or after January 1, 2021, will be 100 percent vested in the participant's accrued benefit after three years of vesting service. Participants who do not complete at least one hour of service on or after January 1, 2021, continue to need five years of vesting service to be 100 percent vested in the participant's accrued benefit.
- The definition of "Compensation" for post-2020 earnings in the pre-2021 pension formula includes base pay (excluding overtime, bonuses, commissions, relocation reimbursement, stock options, or other extraordinary payments as determined by the Pension Committee). The definition of "Compensation" for post-2020 earnings in the post-2020 pension formula includes base pay, overtime, regular bonuses (when paid), commissions, before-tax contributions you make to any Disney 401(k) plan, if you're eligible, and before-tax contributions you make for any Company-provided health and welfare coverage (including qualified transportation benefits).
- If a participant becomes totally and permanently disabled on or after January 1, 2021, generally the participant will not accrue additional credited service beginning on the earliest of the participant's (a) normal retirement date or, if later, if the participant is eligible to receive long-term disability ("LTD") benefits under an LTD plan maintained by a participating employer, the first day of the first calendar month in which the participant is no longer entitled to receive such LTD benefits, (b) early retirement date if the participant elects to commence receiving the participant's benefit on such date, or (c) recovery from the participant's total and permanent disability.

Appendix A Participants **(Legacy 21st Century Fox America Employees' Pension Plan Formula)**

- For disabilities incurred on or after January 1, 2021, the definition of "Disability" means a total and permanent disability that entitles the participant to a disability benefit under the provisions of the Social Security Act.
- For disabilities incurred on or after January 1, 2021, the definition of "Disability Retirement Date" means the date on which a participant suffers a Disability and terminates service with all affiliates.
- For participants retiring on or after January 1, 2021, the definition of "Early Retirement Age" means the time a participant attains age 55 and completes 3 years of vesting service.
- For annuity starting dates on or after January 1, 2021 participants may elect a 20-year Certain and Life form of benefit payment.

Appendix B Participants **(Legacy Fox Pension Plan Formula)**

- Participants who complete at least one hour of service on or after January 1, 2021, and reach age 55, are eligible to receive an early retirement benefit upon completing 3 years of vesting service, so long as they terminate employment for any reason other than death.
- If a participant is receiving benefits and is rehired on or after January 1, 2021, monthly benefit payments will not be suspended.
- With respect to participants who have a frozen benefit from the NW Pension Plan, the 15-year certain and life form of benefit is available only if the participant's benefit commences prior to July 1, 2021.
- Effective January 1, 2021, participants eligible to receive a benefit under Exhibit B-III of the Plan (certain participants with service with the CBS/Fox Company) who are entitled to receive a minimum benefit may no longer elect, for benefits beginning on and after January 1, 2021, the contingent annuitant option under which 66-2/3% of the reduced annuity shall be continued for the lifetime of the contingent annuitant designated by the participant.

DISNEY HOURLY SAVINGS AND INVESTMENT PLAN

- Effective January 1, 2020, adoption of COVID-19 related CARES Act (Coronavirus Aid, Relief, and Economic Security) provisions:
  - $100,000 coronavirus-related distribution for certain individuals impacted by the COVID-19 health emergency, which generally refers to a participant (a) who was diagnosed with the virus, (b) whose spouse or dependent was diagnosed with the virus, or (c) who experienced adverse financial consequences resulting from the pandemic on account of quarantine or a reduction in work (a "Coronavirus Qualified Individual"), and the distribution may be repaid to the plan during the next three years
  - One-year delay for any loan to a Coronavirus Qualified Individual with a repayment scheduled to occur between April 22, 2020, and December 31, 2020 (the loan will continue to accrue interest)
  - Deferral of Required Minimum Distributions that would have started in 2020 unless specifically requested by participant
- Effective as of December 31, 2020, inclusion of Hulu, TFCF and National Geographic entities as designated Disney affiliated companies; recognizing prior service with these entities.
- Effective as of December 31, 2020, transfer of TFCF Consolidated Savings Plan hourly participant account balances (other than participants employed by National Geographic entities) into the Disney Hourly SIP.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.

DISNEY SAVINGS AND INVESTMENT PLAN

- Effective January 1, 2020, adoption of COVID-19 related CARES Act (Coronavirus Aid, Relief, and Economic Security) provisions:
  - $100,000 coronavirus-related distribution for Coronavirus Qualified Individuals (as defined above), and the distribution may be repaid to the plan during the next three years

  - One-year delay for any loan to a Coronavirus Qualified Individual with a repayment scheduled to occur between April 22, 2020, and December 31, 2020 (the loan will continue to accrue interest)
  - Deferral of Required Minimum Distributions that would have started in 2020 unless specifically requested by participant
- Effective as of December 31, 2020, inclusion of Hulu, TFCF and National Geographic entities as Designated Disney Affiliated Companies; recognizing prior service with these entities.
- Effective as of December 31, 2020, transfer of TFCF Consolidated Savings Plan non-hourly participant account balances (other than participants employed by National Geographic entities) into the Disney SIP.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.

DISNEY RETIREMENT SAVINGS PLAN

- Defined eligibility for Bamtech and TFCF employees transferring into Disney legal entities to be no later than the later of 365 days after the employee's hire date or January 1, 2020
- Inclusion of Hulu, TFCF and National Geographic entities as Designated Disney Affiliated Companies; recognizing prior service with these entities.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.

DISNEY KEY EMPLOYEES RETIREMENT SAVINGS PLAN

- Effective as of January 1, 2020, the Bamtech Key Employee plan is merged into the Disney Key Employees Retirement Savings Plan.
- Effective as of January 1, 2020, Hulu and National Geographic entities are included as Participating Employers, provided that Hulu employees' benefits shall be determined by reference to the Hulu, LLC Retirement Trust, and National Geographic employees' benefits shall be determined by reference to the 21st Century Fox America Consolidated Savings Plan.
- For purposes of determining the gross contribution amount a participant will receive under the Disney Key Employees Retirement Savings Plan, the aggregate amount of employer contributions will be based on the lesser of (i) the applicable contribution percentage under the participant's qualified plan and (ii) 9%.

21CF AMERICA CONSOLIDATED SAVINGS PLAN

- Effective as of January 1, 2020, adoption of COVID-19 related CARES Act (Coronavirus Aid, Relief, and Economic Security) provisions:
  - $100,000 coronavirus-related distribution for Coronavirus Qualified Individual (as defined above) the distribution may be repaid to the plan during the next three years
  - One-year delay for any loan to a Coronavirus Qualified Individual with a repayment scheduled to occur between April 22, 2020, and December 31, 2020 (the loan will continue to accrue interest)
  - Deferral of Required Minimum Distributions that would have started in 2020 unless specifically requested by participant
- A participant who transfers from a participating employer to another affiliate on and after January 1, 2021, will have the participant's service with such entity taken into account, in accordance with Plan rules for crediting service, to the same extent as if such entity were a participating employer. Note that in no event shall there be any duplication of benefits.
- Any participant who is an employee of Personnel Area 3661, known as Aftershock LA Studios, within Business Area 432, known as FoxNext, shall have a fully vested interest in his or her accounts under the Plan as of February 7, 2020.

- Any participant who is an Employee of Personnel Area 3660, known as trueX Inc, within Business Area 396, known as Non ESPN Addressable Ad Sales, shall have a fully vested interest in his or her accounts under the Plan as of September 17, 2020.
- Effective as of December 31, 2020, all account balances in the Plan, other than those that are attributable to participants employed on the date of transfer by National Geographic Partners, LLC or NGC Networks US, LLC, were transferred to the Disney Savings and Investment Plan, or, if the participant is classified in the records of the employer as an hourly employee on the date of transfer (or, if earlier, the date such the participant most recently was employed by TFCF Corporation (or a predecessor or affiliate)), then the participant's account balance was transferred to the Disney Hourly Savings and Investment Plan.
- A participant may make Roth contributions, Roth catch-up contributions, and in-Plan Roth rollover contributions to the Plan in a manner similar to an election to make an elective deferral or rollover and subject to similar withdrawal and distribution rules.
- After-tax contributions are no longer permitted. Plan provisions pertaining to after-tax contributions or after-tax contribution accounts shall be applicable only with respect to contributions made prior to January 1, 2021.
- Effective as of January 1, 2020, if a participant attains age 70½ after December 31, 2019, required minimum distributions must generally begin no later than April 1 of the calendar year following the calendar year in which the participant attains age 72.
- Each Employee who starts employment on or after January 1, 2021, will be eligible to participate in the Plan as of the later of (i) the 90th day following the start of employment or (ii) the attainment of age 18.
- "Compensation" means, with respect to salaried Employees, their base salary (excluding overtime, bonuses, relocation reimbursement, stock options, incentive compensation, profit participation, compensation for extended work week, or other extraordinary payments, as determined by the Committee), and, with respect to hourly Employees, their base straight-time pay, which is the number of hours worked multiplied by the hourly rate (excluding overtime, bonuses, relocation reimbursement, stock options, or other extraordinary payments, as determined by the Committee).
- Participants may defer up to 50% (100% if catch-up eligible) of his or her Compensation in any plan year. However, the following limitations apply to specific categories of deferrals:
  - no more than 50% of Compensation may be deferred, respectively and in the aggregate, as elective deferrals or Roth contributions;
  - no more than 75% of Compensation may be deferred, respectively and in the aggregate, as pre-tax catch-up contributions or Roth catch-up contributions.
- With respect to a participant that was automatically enrolled in the Plan and hired or rehired on or after January 1, 2021, the automatic enrollment provisions are modified so that (a) the initial automatic contribution rate is 4%, which will increase by 1% annually up to a maximum of 10% (except that, if the date on which the participant is first automatically enrolled in the Plan occurs less than six months prior to the date on which the annual increase would otherwise occur, the annual increase for that year will not be applied to that participant), and (b) the participant will be provided with a notice explaining the automatic enrollment within 35 days prior to the participant's initial automatic enrollment.
- The rate of employer matching contributions shall be as follows: (a) with respect to salaried participants, 50% of a participant's contributions of up to the first 4% of Compensation deferred, and (b) with respect to hourly participants, 75% of a participant's contributions up to the first 4% of Compensation deferred, *plus* 50% of a participant's contributions above 4% and up to 8% of Compensation deferred. A participant's elective deferrals and Roth contributions will be taken into account for the calculation of the matching contribution. Eligible employees hired or rehired on or after January 1, 2021, will be eligible to receive matching contributions beginning 365 days following his or her date of hire.

- Effective January 1, 2021 nonelective employer contributions will be made to eligible salaried employees on a quarterly basis and calculated using age and service as detailed below:

Combined Age and Service	Applicable Contribution Percentage
Less than 45	3%
At least 45 but less than 75	6%
75 or more	9%

- For purposes of this calculation, an eligible employee is credited with age and years of service as if it is the last day of the applicable plan year and compensation will consist of the eligible employee's base salary, regular bonuses, overtime, and commissions.
- Vesting schedules in effect on December 31, 2020 shall continue to apply to employer matching contributions and employer non-elective contributions made prior to January 1, 2021. A participant shall always be immediately vested for their own contributions and employer matching contributions post-2020; non-elective contributions made on or after January 1, 2021 have a 3-year cliff vesting schedule.
- The restriction on making an in-service withdrawal from a participant's after-tax contribution account more than once per calendar quarter is eliminated.
- On or after January 1, 2021, the maximum term of a loan made to a participant for the purpose of acquiring a principal residence is 30 years.
- If a participant dies and there is no designated beneficiary, or the designated beneficiary predeceased the participant, then the participant's beneficiary shall be the participant's surviving spouse. If there is no surviving spouse, then any benefit due will be paid in the following order: (i) the participant's domestic partner, or if none; (ii) the participant's natural and legally-adopted children (equally), or if none; (iii) the participant's parents (equally), or if none; (iv) the participant's brothers and sisters, (equally), or if none; (v) the participant's estate.

This Summary of Material Modifications (SMM) applies to the following benefit plans sponsored by The Walt Disney Company, E.I.N. 95-4545390:

- The *Signature* Benefits Plan, Plan 660
- Disney Salaried Pension Plan D, Plan 010
- Disney Salaried Pension Plan A, Plan 022
- Disney Associated Companies' Retirement Plan, Plan 014
- Disney Savings and Investment Plan, Plan 011
- Disney Hourly Savings and Investment Plan, Plan 026
- Disney Retirement Savings Plan, Plan 015
- Bamtech Media Benefit Plan, Plan 501
- Bamtech Retirement Saving and Investment Plan, Plan 001
- 21st Century Fox America Consolidated Savings Plan, Plan 006
- 21st Century Fox America Retirement Plan, Plan 001

If you have any questions regarding the information in this SMM, please contact:
The Investment and Administrative Committee (IAC) at 500 South Buena Vista Street, Burbank CA 91521

This Summary of Material Modifications is designed to highlight certain information about Disney benefits plan changes effective January 1, 2021 (unless otherwise indicated). However, it does not attempt to spell out all the details, provisions, limitations, restrictions and exclusions of the Plans. The Company reserves the right to amend, suspend, or terminate an entire Plan or any part of the Plan(s) at any time. See your Summary Plan Descriptions for the Plans for additional information about these Plans. The Walt Disney Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please go to ***Benefits.Disney.com*** *for the full text of the nondiscrimination notice as well as information on language assistance for those who do not speak English.*

EXHIBIT A

LONG-TERM DISABILITY SUMMARY (HULU EMPLOYEES)

Effective January 1, 2021, a Long-Term Disability option is added to the *Signature* Benefits Plan, exclusively for Hulu employees. This option is fully insured by Cigna.

Additional details on this coverage are contained in your certificate of insurance for Group Policy No. LK-964071. This certificate of insurance is incorporated and is a part of this Summary of Material Modification. As with all insured benefits, the terms of the certificate of insurance controls when describing specific benefits that are covered or insurance related terms. You may obtain a copy of the certificate of insurance by contacting the Plan.

Eligibility
All active, full-time employees of Hulu who are regularly working a minimum of 30 hours per week are eligibility for this plan.

Monthly Benefit
This plan pays a benefit of up to 60% of your monthly covered earnings — to a maximum of $20,000 per month. Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

Definition of Disability
Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 80% or more of your indexed earnings. Cigna will require proof of earnings and continued disability.

Covered Earnings
Covered earnings means your wages or salary, not including bonuses, commissions, overtime pay or other extra compensation. Any increase in an Employee's covered earnings will not be effective during a period of continuous Disability.

Elimination Period
You must be continuously disabled for 90 days before benefits may be payable.

Benefit Duration
Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period shown below, or until you no longer qualify for benefits, whichever occurs first.

Your benefit period begins on the first day after you complete your elimination period. And, should you remain disabled, your benefits continue according to the following schedule, depending on your age at the time you become disabled.

Age at Disability	**Age 62 or younger**	**63**	**64**	**65**	**66**	**67**	**68**	**69+**
Duration of Payments (months)	To age 65 or the date the 42nd monthly benefit is payable, if later	36	30	24	21	18	15	12

Termination of Disability Benefits
Your benefits will terminate on the earliest of any of the following dates: the date Cigna determines you are no longer disabled; the date you earn from any occupation more than the percentage of indexed earnings as defined in your definition of disability; the date the maximum benefit period ends; the date you cease to get appropriate care; the date you die; the date you refuse to participate without good cause in all required phases of the rehabilitation plan; the date you fail to cooperate with Cigna in the administration of the claim. Benefits may be resumed if you begin to cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

Cost
The cost of this insurance program is paid by the Company.

Effects of Other Income Benefits
The disability benefit provided by this plan is a total benefit; that is, it will be reduced by any disability benefits payable on behalf of you or your dependents, or a qualified third party on behalf of you or your dependents, whether or not you are actually receiving them.

Other income sources that may reduce your benefits under this plan include:

- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits.
- Benefits payable by a Canadian and/or Quebec provincial pension plan.
- Amounts payable under the Railroad Retirement Act.
- Amounts payable under local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer.
- Employer-paid portion of company retirement plan benefits.
- Amounts payable by company sponsored salary continuation plan.
- Amounts payable by any franchise or group insurance or similar plan.
- Benefits payable under work-loss provisions of any mandatory “no fault” auto insurance.
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
- Amounts payable under any workers’ compensation (including temporary or permanent disability benefits), occupational disease, and unemployment compensation. This includes damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted.

Income sources that WILL NOT reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies.
- Individual deferred compensation agreements.
- Employee savings plans, including thrift plans, stock options or stock bonuses.
- Individual retirement funds, such as IRA or 401(k) plans.
- Profit-sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan.

Earnings While Disabled
During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre- disability covered earnings. After that, benefits will be reduced by 50% of earnings from employment.

Pre-existing Conditions
Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures) or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

Limited Benefit Period
Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders (including psychosomatic illnesses).

Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime limit is exhausted. Once the 24-month benefits are exhausted, the plan pays no further benefits.

Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months: Alcoholism, drug addiction or abuse.

Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime limit is exhausted. Once the 24-month benefits are exhausted, the plan pays no further benefits.

Exclusions
This plan does not pay benefits for a disability which results, directly or indirectly, from any of the following: Suicide, attempted suicide, or whenever you injure yourself on purpose; war or any act of war, whether or not declared; active participation in a riot; commission of a felony; the revocation, restriction or non-renewal of your license, permit or certification necessary for you to perform the duties of your occupation, unless solely due to injury or sickness otherwise covered by the policy.

In addition, Cigna will not pay disability benefits for any period of disability during which you are incarcerated in a penal or corrections institution for any reason.

Plan Termination
Coverage terminates on the earliest of the following dates: if the group policy is terminated, if you cease to be in active service, if you are no longer a member of an eligible class of employees, the day after the last date for which premium has been paid by you or the employer, or the date you become eligible for a plan of benefits intended to replace this coverage.

If you are disabled and receiving benefits under this plan, your benefits and coverage will continue until the expiration of your benefit period, or until you no longer qualify for benefits under the plan, whichever comes first.

When Coverage Takes Effect
Your coverage takes effect on the later of the program's effective date, the date you become eligible, the date Cigna receives your completed enrollment form, or the date you authorize any necessary payroll deductions.

If you have to submit evidence of good health, your coverage takes effect on the date Cigna agrees, in writing, to cover you.

If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

Family Survivor Benefit
If you die while receiving disability benefits, Cigna will pay a survivor benefit based on 100% of the total of your last month's benefit plus the amount of any disability earnings by which this benefit had been reduced for that month. This plan pays a single lump sum equal to 3 months of benefits. Cigna pays this benefit directly to your lawful spouse or domestic partner/civil union partner, or to your children in equal shares, if there is no lawful spouse or domestic partner/civil union partner. If you have no lawful spouse, domestic partner/civil union partner, or children, Cigna pays this benefit to your estate.

Claims and Appeals Provisions

Notice of Claim
Written notice of claim, or notice by any other electronic/telephonic means authorized by Cigna, must be given to Cigna within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by Cigna, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at Cigna's home office in Philadelphia, Pennsylvania or to Cigna's agent. Notice should include Hulu's name, the policy number and your name and address.

Claim Forms
When Cigna receives notice of claim, Cigna will send claim forms for filing proof of loss. If Cigna does not send claim forms within 15 days after notice is received by Cigna, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by Cigna, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with Cigna in Cigna's administration of your claim, Cigna may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
You must provide written proof of loss to Cigna, or proof by any other electronic/telephonic means authorized by Cigna, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by Cigna, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by Cigna, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by Cigna, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by Cigna, must be furnished to Cigna at intervals Cigna requires. Within 30 days of a request, written proof of continued disability and appropriate care by a physician must be given to Cigna.

Review of Your Claim
The Plan Administrator has appointed Cigna as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. Cigna shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by Cigna shall be final and binding on participants and beneficiaries to the full extent permitted by law.

Cigna has 45 days from the date it receives your claim for disability benefits to determine whether or not benefits are payable to you in accordance with the terms and provisions of the policy. Cigna may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, Cigna must notify you in writing that its review period has been extended for up to two additional periods of 30 days. If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, Cigna may require a medical examination of you at its own expense; or additional information regarding the claim. If a medical examination is required, Cigna will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, Cigna must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from Cigna. If your claim is denied, in whole or in part, you must receive a written notice from Cigna within the review period. Cigna's written notice must include the following information:

- The specific reason(s) the claim was denied.
- Specific reference to the policy provision(s) on which the denial was based.
- Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
- A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the plan made by the Social Security Administration.
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol does not exist.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the

terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to Cigna within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by Cigna, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by Cigna will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

Cigna has 45 days from the date it receives your request to review your claim and notify you of its decision. Under special circumstances, Cigna may require more time to review your claim. If this should happen, Cigna must notify you, in writing, that its review period has been extended for an additional 45 days. Once its review is complete, Cigna must notify you, in writing, of the results of the review. If your appeal is denied, Cigna's written notice must include the following information:

- The specific reason(s) the appeal was denied.
- Specific reference to the policy provision(s) on which the denial was based.
- A statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the plan made by the Social Security Administration.
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol does not exist.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

EXHIBIT B

SHORT-TERM DISABILITY SUMMARY (HULU EMPLOYEES)

Effective January 1, 2021, a Short-Term Disability option is added to the *Signature* Benefits Plan, exclusively for Hulu employees. This option is self-funded. Claims are funded by the Company.

Additional details on this coverage are contained in your certificate of insurance for Group Policy No. SHD-962420 This certificate of insurance is incorporated and is a part of this Summary of Material Modification. As with all insured benefits, the terms of the certificate of insurance controls when describing specific benefits that are covered or insurance related terms. You may obtain a copy of the certificate of insurance by contacting the Plan.

Eligibility
Active, full-time employees of Hulu who are regularly working a minimum of 30 hours per week are eligible for this plan.

Weekly Benefit
This plan pays a benefit of up to 70% of your weekly covered earnings — to a maximum of $3,500 per week, and a minimum benefit of $25.00 per week.

Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

Definition of Disability
Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your covered earnings from working in your regular occupation. Cigna will require proof of earnings and continued disability.

Covered Earnings
Covered earnings means your wages or salary, not including bonuses, commissions, overtime pay and other extra compensation.

Elimination Period
You must be disabled for 0 days for accident and 7 calendar days for sickness.

Maximum Benefit Period
13 weeks for Accident and Sickness

Termination of Disability Benefits
Your benefits will terminate on the earliest of the following dates: the date Cigna determines you are no longer disabled; the date you earn more than the percentage of covered earnings as defined in your definition of disability; the date the maximum benefit period ends; the date you are no longer receiving appropriate care; the date you refuse to fully cooperate without good cause in all required phases of the rehabilitation plan and assessment; the date you fail to cooperate with Cigna in the administration of the claim; the date you die. Benefits may be resumed if you begin to cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

Cost
The cost of this insurance program is paid by the Company.

Effects of Other Income Benefits
The disability benefit provided by this plan is a total benefit; that is, it will be reduced by any disability benefits payable on behalf of you or your dependents, or a qualified third party on behalf of you or your dependents, whether or not you are actually receiving them.

Other income sources that may reduce your benefits under this plan include:

- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits.
- Benefits payable by a Canadian and/or Quebec provincial pension plan.

- Amounts payable under the Railroad Retirement Act.
- Amounts payable under any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer.
- Employer-paid portion of company retirement plan benefits.
- Amounts payable by company sponsored salary continuation plan.
- Amounts payable by any franchise or group insurance or similar plan.

Earnings While Disabled
Benefits will be reduced if benefits plus income from employment exceeds 100% of pre- disability covered earnings.

Exclusions
This plan will not pay any disability benefits for a disability that results, directly or indirectly, from any of the following: suicide, attempted suicide, or whenever you injure yourself on purpose; war or any act of war, whether or not declare; active participation in a riot; commission of a felony; the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or sickness otherwise covered by the policy; any cosmetic surgery or surgical procedure that is not medically necessary; an injury or sickness for which you are entitled to benefits from worker's compensation or occupational disease law; an injury or sickness that is work-related.

In addition, Cigna will not pay disability benefits for any period of disability during which you are incarcerated in a penal or corrections institution.

Plan Termination
Coverage terminates on the earliest of the following dates: if the group policy is terminated, if you cease to be in active service, if you are no longer a member of an eligible class of employees, the day after the last date for which premium has been paid by you or the employer, the date you become eligible for a plan of benefits intended to replace this coverage, or the date benefits end for failure to comply with the terms and conditions of the policy.

When Coverage Takes Effect
Your coverage takes effect on the date you become eligible. If you are not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

Claims and Appeals Provisions

Claimant Cooperation Provision
If you fail to cooperate with Cigna in Cigna's administration of your claim, Cigna may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
You must provide written proof of loss to Cigna within 90 days after the date of the loss for which a claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible. In any case, written proof must be given not more than a year after that 90 day period. If written proof of loss is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Within 30 days of a request, written proof of continued disability and appropriate care by a physician must be given to Cigna.

What You Should Do and Expect If You Have a Claim
When you are eligible to receive benefits under the plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from Cigna. All claims you submit must be on the claim form or in the electronic or telephonic format provided by Cigna. You must complete your claim according to directions provided by Cigna. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it Cigna.

The Plan Administrator has appointed Cigna as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. Cigna shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related

findings of fact. All decisions made by Cigna shall be final and binding on participants and beneficiaries to the full extent permitted by law.

Cigna has 45 days from the date it receives your claim for disability benefits to determine whether or not benefits are payable to you in accordance with the terms and provisions of the policy. Cigna may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, Cigna must notify you in writing that its review period has been extended for up to two additional periods of 30 days. If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, Cigna may require a medical examination of you at its own expense; or additional information regarding the claim. If a medical examination is required, Cigna will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, Cigna must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from Cigna. If your claim is denied, in whole or in part, you must receive a written notice from Cigna within the review period. Cigna's written notice must include the following information:

- The specific reason(s) the claim was denied.
- Specific reference to the policy provision(s) on which the denial was based.
- Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
- A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the plan made by the Social Security Administration.
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol does not exist.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to Cigna within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by Cigna, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by Cigna will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

Cigna has 45 days from the date it receives your request to review your claim and notify you of its decision. Under special circumstances, Cigna may require more time to review your claim. If this should happen, Cigna must notify you, in writing, that its review period has been extended for an additional 45 days. Once its review is complete, Cigna must notify you, in writing, of the results of the review. If your appeal is denied, Cigna's written notice must include the following information:

- The specific reason(s) the appeal was denied.
- Specific reference to the policy provision(s) on which the denial was based.
- A statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the plan made by the Social Security Administration.
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol does not exist.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.