

 **Life** | My Benefits

2021 Benefits Summary

**A comprehensive comparison
of all plans offered in Hawaii**

KNOW YOUR OPTIONS BEFORE YOU CHOOSE

Review this summary chart to better understand the Disney benefits offered to you. Items in **red** indicate changes for 2021. When you're ready to enroll, go to **D Life | My Benefits (Benefits.Disney.com)**.

GLOSSARY – Here's a key to the abbreviations you'll see throughout these summary charts.

ER	FSA	HMO	HRA	PCP	PPO
Emergency Room	Flexible Spending Account	Health Maintenance Organization	Health Reimbursement Account	Primary Care Physician	Preferred Provider Organization

DENTAL COVERAGE

You have a choice of dental plan options through Delta Dental, and each covers 100% of eligible network preventive care. For more information, go to Delta Dental's website at wekeepyoumiling.com/disney or call 1-866-902-4835.



PLAN FEATURES	VALUE (No employee contributions are required for coverage)	ADVANTAGE	DELTACARE USA (Managed care option)
PROVIDER NETWORK	DELTA DENTAL PPO To receive the highest level of benefits, use Delta Dental PPO dentists		DELTACARE USA Managed care option—all dental care must be coordinated through your network dentist
NETWORK SERVICE AREA	NATIONWIDE		Available nationwide. You are eligible if you live in the program's service area (i.e., there is a network provider within 20 miles of your home ZIP code)
ANNUAL DEDUCTIBLE	\$25 (\$75 for out-of-network care) per person Does not apply to preventive or orthodontic services		NONE

PLAN FEATURES (CONT.)

VALUE

(No employee contributions are required for coverage)

ADVANTAGE

DELTACARE USA

(Managed care option)

ANNUAL MAXIMUM BENEFIT

\$750 per person
(**\$500** for out-of-network care)

\$2,000 per person
(**\$1,500** for out-of-network care)

NONE

In-network eligible expenses are based on Delta Dental's negotiated rate. Out-of-network eligible expenses are based on the maximum plan allowance. This applies to Preventive Coverage, Basic Coverage and Major Coverage

All covered procedures have a predetermined copay for services by DeltaCare USA dentists including no or low copays for simple restorative services. A complete copay schedule is available at wekeepyousmiling.com/disney

PREVENTIVE COVERAGE

100% coverage for exams, cleanings and X-rays. The amount the plan pays for cleanings does not apply to the annual maximum benefit

100% coverage for exams, cleanings and X-rays. Certain preventive services may be subject to a copay. No copay for in-network fluoride treatment for children up to age 19

BASIC COVERAGE

80% coverage for fillings, root canals and extractions

Copay applies

MAJOR COVERAGE

40% coverage for crowns, bridges, dentures and implants

50% coverage for crowns, bridges, dentures and implants

Copay applies

ORTHODONTIA

Not covered

50% coverage up to **\$2,000** per child to age 26 (lifetime) for in-network care (**\$1,500** for out-of-network care)

You pay a fixed copay for a standard 24-month course of treatment:

- Children under 19: **\$1,700**
- Children 19 to 26 and adults: **\$1,900**
- Retention (removal of appliances and placement of retainers): **\$275**

EMERGENCY TREATMENT, PALLIATIVE (TO RELIEVE PAIN)

Plan pays **100%** of eligible expenses, up to the annual maximum benefit

Copay applies

DENTAL ACCIDENT

Separate accident coverage pays all covered procedures related to the accident at **100%**, up to a separate **\$1,000** calendar year maximum (per person), then regular in- and out-of-network benefits apply

Dental accidents are covered at the same copays as listed in the copay schedule (subject to standard limitations and exclusions); no maximum applies. A complete copay schedule is available at wekeepyousmiling.com/disney

PREDETERMINATION OF BENEFITS

If charges for a course of treatment will exceed **\$500**, have your dentist submit a treatment plan to Delta Dental in advance. Delta Dental will provide you and your dentist with an estimate of coverage

You can contact the plan for a predetermination of benefits. Your dentist must inform you of any additional cost for recommended alternative treatment not covered by the plan

MEDICAL COVERAGE

Disney offers a choice of medical plan options to help you take care of yourself and your family. No employee contributions are required for coverage.



PLAN FEATURES	HMSA PREFERRED PROVIDER PLAN hmsa.com 1-808-948-6111		HMSA HEALTH PLAN HAWAII hmsa.com 1-808-948-6372	KAISER HMO (HI) my.kp.org/disney 1-800-966-5955
	IN NETWORK	OUT OF NETWORK		
PROVIDER NETWORK	HMSA PARTICIPATING PROVIDER NETWORK	USE ANY PROVIDER	HMSA HEALTH PLAN HAWAII PLUS PROVIDER NETWORK	KAISER PERMANENTE
NETWORK SERVICE AREA	Call HMSA Customer Service at 1-808-948-6111 for a referral to a participating provider or treatment center		Call HMSA Customer Service at 1-808-948-6372 for a referral to a participating provider or treatment center	Available in Hawaii only
CARE PROVIDERS	To receive the highest level of medical benefits, use HMSA's Participating Provider Network		Coordinate all services through your PCP	Coordinate all services through your Kaiser physician
HEALTH REIMBURSEMENT ACCOUNT (HRA)	<p>HRA established automatically (if eligible) to help pay for current or future expenses (including deductible) with any 2021 wellness rewards you and your enrolled spouse/partner earn. No employee contributions allowed</p> <p>Optional employee contributions to Health Care FSA: Up to (\$2,750) in 2021)</p>			
CALENDAR YEAR DEDUCTIBLE	NONE	INDIVIDUAL: \$100 FAMILY: \$300	NONE	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES	INDIVIDUAL: \$2,500 FAMILY: \$7,500		INDIVIDUAL: \$2,500 FAMILY: \$7,500 Medical and pharmacy combined	
MEDICAL PLAN ANNUAL MAXIMUM	UNLIMITED			
MEDICAL PLAN LIFETIME BENEFIT	UNLIMITED			
BENEFITS FOR MOST COVERED SERVICES	\$12 copay	Plan pays 70% (after calendar year deductible)	\$20 copay	\$15 copay No benefits are payable outside the network, except in the case of emergency
PREVENTIVE CARE BENEFITS	Plan pays 100%. Contact HMSA for details on covered services	Plan pays 70%	Plan pays 100%	Plan pays 100% for covered services

PLAN FEATURES (CONT.)

HMSA PREFERRED PROVIDER PLAN

hmsa.com 1-808-948-6111

HMSA HEALTH PLAN HAWAII

hmsa.com 1-808-948-6372

KAISER HMO (HI)

my.kp.org/disney 1-800-966-5955

EMERGENCY/ URGENT CARE SERVICES

IN NETWORK	OUT OF NETWORK
ER: Plan pays 80%	ER: Plan pays 80%
URGENT CARE: \$12 copay per visit	URGENT CARE: Plan pays 70%

ER:
\$100 copay per visit (waived if admitted)

URGENT CARE:
\$20 copay

ER:
\$75 copay per visit (waived if admitted)

URGENT CARE:
\$15 copay at a Kaiser Permanente facility within the Hawaii service area

FACILITY SERVICES (ADDITIONAL PHYSICIAN/ SURGEON FEES MAY APPLY)

IN NETWORK	OUT OF NETWORK
Plan pays 90%	Plan pays 70% (after calendar year deductible)

INPATIENT AND OUTPATIENT:
Plan pays **90%**

INPATIENT: **\$75** copay per day
OUTPATIENT: **\$15** copay

X-RAY/ LABORATORY/ IMAGING SERVICES

IN NETWORK	OUT OF NETWORK
INPATIENT: Plan pays 90%	INPATIENT: Plan pays 70%
OUTPATIENT: Plan pays 80%	OUTPATIENT: Plan pays 70% (after calendar year deductible)

INPATIENT: Plan pays **90%**
OUTPATIENT: **\$10** copay

Plan pays **90%**

CHIROPRACTIC CARE

Care provided by a licensed chiropractor is covered under regular plan benefits

\$15 copay; combined 20-visit maximum with acupuncture

FERTILITY TREATMENT

Family building benefit administered by WINFertility provides a lifetime maximum of **\$75,000** for fertility, surrogacy and adoption services, including coverage for egg and sperm freezing.* Limited fertility services, **in-network** only.

Contact **HMSA** for specific details

Contact **Kaiser** for specific coverage

TRANSGENDER BENEFITS

Coverage is provided for transgender benefits. Contact **HMSA** for specific details

Coverage is provided for transgender benefits. Contact **Kaiser** for details

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

IN NETWORK	OUT OF NETWORK
INPATIENT: Plan pays 90%	INPATIENT: Plan pays 70%
OUTPATIENT: Plan pays 80%	OUTPATIENT: Plan pays 70% (after calendar year deductible)

INPATIENT: Plan pays **90%**
OUTPATIENT: **\$20** copay

\$15 copay

Certain services must be precertified

Certain services must be precertified

HEARING AIDS

Evaluation for use of hearing aids: Plan pays **80%** for Hearing Appliances; covered when evaluated by a physician or audiologist. Limited to one hearing aid per ear every 60 months. Fitting, adjustments, repair and batteries not included

Evaluation for use of hearing aids: **\$20** office visit copay. Plan pays **80%** of eligible charges for Hearing Appliances. Limited to one hearing aid per ear every 60 months. Fitting, adjustments, repair and batteries not included

\$15 copay for office or specialist visit. When prescribed by **Kaiser** physician or audiologist, up to one hearing aid per ear covered once every 36 months, limited to lowest priced model. You pay any additional charges

ACUPUNCTURE

Not covered—discount rates available for certain services through **HMSA365**. Contact **HMSA** for specific details.

\$15 copay; combined 20-visit maximum with chiropractic

PREAUTHORIZATION REQUIREMENTS

To receive the highest level of medical benefits, use **HMSA's** Participating Provider Network

Coordinate all services through your **PCP**

All authorizations must be coordinated through your **Kaiser** physician

BEHAVIORAL HEALTH

The Employee Assistance Program (EAP) through Cigna Behavioral Health pays **100%** of the first five **in-network** visits (per concern), then plan coverage begins. Subject to coverage levels and network provider requirements

* You may be required to pay the initial cost of some services and file a claim for reimbursement. Some benefits may be taxable.

PRESCRIPTION DRUG COVERAGE

The information in this section applies to in-network coverage or HMSA-participating retail pharmacies only. Keep in mind:

- Out-of-network benefits do not apply. If you use out-of-network providers, you will be responsible for the entire cost.
- Prescription drug coverage is more cost-effective when you use generic instead of brand-name drugs. If you choose a brand-name drug over a chemically equivalent generic, you will be responsible for the entire cost difference.



For more information or to locate a participating retail pharmacy, go to hmsa.com or my.kp.org/disney.

PLAN FEATURES	HMSA PREFERRED PROVIDER PLAN	HMSA HEALTH PLAN HAWAII	KAISER HMO (HI)
PROVIDER NETWORK	HMSA-PARTICIPATING RETAIL PHARMACIES		KAISER PERMANENTE
RETAIL BENEFITS 30-DAY SUPPLY OR LESS	<p>GENERIC: Up to a \$7 copay</p> <p>PREFERRED FORMULARY BRAND: \$30 copay</p> <p>NON-PREFERRED FORMULARY BRAND: \$30 plus \$45 Non-Preferred Formulary cost share</p> <p>PREFERRED SPECIALTY: \$100 copay</p> <p>BRAND SPECIALTY: \$200 copay</p> <p>90-day supply available for non-specialty oral chemotherapy medications; 30-day limit for specialty oral chemotherapy medications</p> <p>Out of network: For Brand medications, add 20% to above amounts. Specialty drugs not covered</p>		<p>GENERIC and BRAND: Up to a \$15 copay</p> <p>Must use Kaiser pharmacy</p>
MAIL-ORDER BENEFITS 90-DAY SUPPLY MAXIMUM	<p>GENERIC: Up to an \$11 copay</p> <p>PREFERRED FORMULARY BRAND: \$65 copay</p> <p>NON-PREFERRED FORMULARY BRAND: \$65 plus \$135 Non-Preferred Formulary cost share</p> <p>Specialty drugs not covered</p>		<p>GENERIC and BRAND: Up to a \$30 copay</p> <p>Must use Kaiser pharmacy</p>
PHARMACY OUT-OF-POCKET MAXIMUM	<p>INDIVIDUAL: \$3,600</p> <p>FAMILY: \$4,200</p>		<p>INDIVIDUAL: \$2,500 copay</p> <p>FAMILY: \$7,500 copay</p> <p>Medical and pharmacy combined</p>
PRE-AUTHORIZATION STEP THERAPY	Check with HMSA for details		Please consult with your Kaiser pharmacist

VISION COVERAGE

Your two vision plan options offer coverage for an annual eye exam and, like the medical and dental plan options, offer a higher level of benefits when you see a network provider. Also, when you see a network provider, the claims are filed for you. Choose an out-of-network provider and you will need to file a claim yourself. For more information, go to VSP's website at vsp.com or call 1-800-877-7195.

PLAN FEATURES	BASIC VISION No employee contributions are required for coverage		HIGH VISION	
	VSP NETWORK (includes VSP-participating retail locations)	OUT OF NETWORK	VSP NETWORK (includes VSP-participating retail locations)	OUT OF NETWORK
ROUTINE EYE EXAM	Plan pays 100%	Plan pays up to \$19	Plan pays 100%	Plan pays up to \$19
LENSES BENEFIT	\$40 copay (includes single vision, lined bifocal, trifocal and scratch-resistant; polycarbonate lenses are included for dependent children); available every other calendar year	Limited scheduled amount on single vision, lined bifocal and trifocal lenses	\$10 copay (includes single vision, lined bifocal, trifocal, lenticular, progressive, scratch-resistant, UV coating and anti-reflective; polycarbonate lenses are included for dependent children); available once per calendar year	Limited scheduled amount on single vision, lined bifocal and trifocal lenses
FRAMES BENEFIT	Plan pays up to \$130 (up to \$150 for featured frame brands) with 20% discount if price exceeds maximum; available every other calendar year Plan pays up to \$70 at Costco	Plan pays up to \$22	Plan pays up to \$155 (up to \$175 for featured frame brands) with 20% discount if price exceeds maximum; available once per calendar year Plan pays up to \$85 at Costco	Plan pays up to \$22
CONTACT LENSES (IN LIEU OF LENSES AND FRAMES)	\$40 copay for contact lenses exam (fitting and evaluation); plan pays up to \$130 for contact lenses (materials); available every other calendar year	Plan pays up to \$130	\$10 copay for contact lenses exam (fitting and evaluation); plan pays up to \$155 for contact lenses (materials); available once per calendar year	Plan pays up to \$130
COMPUTER VISION CARE	NONE	NONE	\$10 copay for lenses every calendar year. Plan pays up to \$90 for frames, with 20% discount if price exceeds the maximum; available every other calendar year	NONE
ADDITIONAL DISCOUNTS	<ul style="list-style-type: none"> • 30% discount on additional pairs of glasses purchased from the same provider on the day of your exam • 20% discount on additional pairs of glasses purchased within 12 months of your last covered exam • Average 15% off the regular price of laser vision correction or 5% off the promotional price; discounts only available from VSP-contracted facilities 			

Note: You can only get frames/lenses or contact lenses during a calendar year, not both.

INSURANCE COVERAGE

EMPLOYEE LIFE INSURANCE

Disney provides a basic life insurance benefit at no cost to you, and you may also have the option to purchase additional coverage. The levels of life insurance coverage available to you are shown on your **Personal Fact Sheet** or online **Printable Benefit Choices** during enrollment. Coverage is issued by **Securian Financial**.

BASIC COVERAGE

- Disney provides a basic life insurance benefit equal to **one times annual base pay** for hourly employees and **two times annual base pay** for salaried employees
- You can also choose coverage of **\$50,000** (if less than the Company-provided amount)
- Maximum coverage is **\$1,000,000**
- If the value of your basic policy exceeds **\$50,000**, the amount Disney pays in premiums for coverage above **\$50,000** will be considered taxable income and will appear on your annual W-2 Form

SUPPLEMENTAL COVERAGE

- You may have access to supplemental life insurance coverage of up to eight times your annual base pay, subject to the plan coverage maximum of **\$2,000,000**
- You will pay for supplemental coverage through after-tax contributions from your paycheck
- Cost of this coverage is based on your age

DEPENDENT LIFE INSURANCE

Disney provides a basic life insurance benefit for your dependents at no cost to you, and you may elect additional coverage for your spouse/partner and your eligible children, subject to certain limits and **Evidence of Insurability (EOI)** requirements. You may choose from several levels of coverage, **and the cost for spouse/partner coverage is based on your age**. If you and your spouse/partner both work for Disney, only one of you can cover each child, and neither of you may cover the other in spouse/partner life insurance.

SPOUSE/PARTNER LIFE INSURANCE

Ten levels of coverage:

- **\$1,000***
- **\$5,000**
- **\$10,000**
- **\$25,000**
- **\$50,000**
- **\$75,000**
- **\$100,000**
- **\$150,000**
- **\$200,000**
- **\$250,000**

CHILD LIFE INSURANCE

Four levels of coverage:

- **\$1,000***
- **\$5,000**
- **\$10,000**
- **\$20,000**

* The \$1,000 option is paid for by Disney and will be the default option if you do not make an election.

INSURANCE COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Disney provides you with basic AD&D insurance coverage at no cost to you, and you may also have the option to purchase additional coverage. Coverage is issued by Securian Financial.

BASIC COVERAGE

- Disney provides a basic AD&D insurance benefit equal to **one times annual base pay** for hourly employees and **two times annual base pay** for salaried employees

SUPPLEMENTAL COVERAGE

- You may have access to supplemental AD&D insurance coverage of up to four times your annual base pay, subject to the **\$2,000,000** plan maximum
- You will pay for supplemental coverage through after-tax contributions from your paycheck

LONG-TERM DISABILITY (LTD) INSURANCE

You may elect LTD coverage, which pays you a benefit if you cannot work due to an illness or injury. You will pay for LTD coverage with after-tax contributions from your paycheck. EOI is not needed if you are enrolling when first eligible or when changing your LTD coverage option, but may be required if enrolling for the first time in the future. Coverage is issued by **The Hartford**.

LTD/90

Pays **60%** of base pay up to a **\$30,000** maximum monthly benefit. Benefits begin after 90 consecutive days of disability

LTD/180

Pays **60%** of base pay up to a **\$30,000** maximum monthly benefit. Benefits begin after 180 consecutive days of disability

A minimum monthly benefit (the greater of **10%** of your monthly calculated benefit or **\$100**) applies regardless of whether you are receiving other disability benefits

SHORT-TERM DISABILITY (STD) INSURANCE

Because you live in Hawaii, you are required to participate in **Hawaii TDI**, the state disability program. The Company pays the entire cost of this coverage. Coverage is issued by **The Hartford**.

This summary chart has been designed to give you some key information about your benefit options and the program changes under the **Disney Signature Benefits Plan** effective January 1, 2021. However, it does not attempt to spell out all the details, provisions, limitations, restrictions and exclusions of the Plan. The Company reserves the right to amend, suspend or terminate the entire plan(s) or any part of the plan(s) at any time. See your Summary Plan Description, or go to **D Life | My Benefits (Benefits.Disney.com)** for additional information about your Disney benefits.