Life | My Benefits

# 2021 Benefits Summary

## A comprehensive comparison of all plans

(excluding Hawaii and Puerto Rico)

# KNOW YOUR OPTIONS BEFORE YOU CHOOSE

Review these summary charts 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 this summary chart.

| ER | FSA | HMO | HRA | HSA | PCP | PPO |
|---|---|---|---|---|---|---|
| Emergency Room | Flexible Spending Account | Health Maintenance Organization | Health Reimbursement Account | Health Savings 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 wekeepyousmiling.com/disney or call 1-866-902-4835.**

| PLAN FEATURES | VALUE | ADVANTAGE | DELTACARE USA (Managed care option) |
|---|---|---|---|
| PROVIDER NETWORK | DELTA DENTAL PPO<br>To receive the highest level of benefits, use **Delta Dental PPO** dentists | | DELTACARE USA<br>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<br>Does not apply to preventive or orthodontic services | | NONE |

| PLAN FEATURES (CONT.) | VALUE | 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**<br>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** |
| | **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** | | |
| 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:<br>• Children under 19: **$1,700**<br>• Children 19 to 26 and adults: **$1,900**<br>• 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—PPOs

**Disney offers a choice of medical plan options to help you take care of yourself and your family.**

## PLAN FEATURES

## CONSUMER CHOICE

mycigna.com 1-800-577-7498

| PLAN FEATURES | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| PROVIDER NETWORK | **MEDICAL:** Cigna Open Access Plus<br>**BEHAVIORAL HEALTH/SUBSTANCE ABUSE:** Cigna Behavioral Health | **USE ANY PROVIDER**<br>To receive the highest level of medical benefits, use **Cigna Open Access Plus** providers |
| | Note: If you are referred to an **out-of-network** provider by an **in-network** provider, **out-of-network** benefits still apply | |
| NETWORK SERVICE AREA | **NATIONAL** | |
| SAVINGS/ REIMBURSEMENT ACCOUNT | **HSA** established automatically to help pay for current or future expenses (including deductible).<br>Any 2021 wellness rewards you and your enrolled spouse/partner earn will be deposited in your HSA | |
| | **DISNEY CONTRIBUTION** — INDIVIDUAL: **$500** — FAMILY: **$1,000** | |
| | **OPTIONAL EMPLOYEE CONTRIBUTION MAXIMUM** — INDIVIDUAL: **$2,800** — FAMILY: **$5,600** | |
| | **CATCH-UP CONTRIBUTION:** If you are age 55 or older, you may be eligible to contribute an additional **$1,000** | |
| CALENDAR YEAR DEDUCTIBLE | **INDIVIDUAL: $1,600 FAMILY: $3,200**<br>Medical and pharmacy combined<br>All family members contribute toward the family deductible | **INDIVIDUAL: $3,100 FAMILY: $6,200**<br>Medical and pharmacy combined<br>All family members contribute toward the family deductible |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES | **INDIVIDUAL: $4,000 FAMILY: $8,000**<br>Medical and pharmacy combined<br>All family members contribute toward the family out-of-pocket maximum. If expenses for a family member reach $6,850, the plan will pay 100% of that individual's eligible expenses for the remainder of the year | **INDIVIDUAL: $8,000 FAMILY: $16,000**<br>Medical and pharmacy combined<br>All family members contribute toward the family out-of-pocket maximum |
| MEDICAL PLAN ANNUAL MAXIMUM | **UNLIMITED** | |
| MEDICAL PLAN LIFETIME BENEFIT | **UNLIMITED** | |
| BENEFITS FOR MOST COVERED SERVICES | Plan pays **80%** of negotiated rate after calendar year deductible | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |
| PREVENTIVE CARE BENEFITS | Plan pays **100%** for covered services. Contact **Cigna** for details | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |

* For some covered services, an allowable **Medicare** reimbursement rate is not established. In these cases, the maximum reimbursable charge is based on the amount charged for that service by **80%** of health care professionals in the area where it is received. Expenses applied to **in-network** deductibles and out-of-pocket maximums do not apply to **out-of-network** deductibles and out-of-pocket maximums, and vice versa.

# PLAN FEATURES (CONT.)

# CONSUMER CHOICE

mycigna.com 1-800-577-7498

| PLAN FEATURES (CONT.) | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| EMERGENCY/ URGENT CARE SERVICES | Plan pays **80%** of negotiated rate after calendar year deductible | |
| INPATIENT FACILITY SERVICES | Plan pays **80%** of negotiated rate after calendar year deductible | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible.* You or your doctor must contact **Cigna** before admission or procedure, or an additional **$500** deductible may apply, which does not apply to the out-of-pocket maximum. It is your responsibility to make sure **Cigna** is contacted |
| X-RAY/LABORATORY/ IMAGING SERVICES | Plan pays **80%** of negotiated rate after calendar year deductible | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |
| CHIROPRACTIC CARE | Plan pays **80%** of negotiated rate after calendar year deductible, up to 35 visits per calendar year (**in-** and **out-of-network** combined) for all conditions | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible,* up to 35 visits per calendar year (**in-** and **out-of-network** combined) for all conditions |
| 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.** Plan pays **80%** of negotiated rate for covered fertility services **in-network** after calendar year deductible. Contact **Cigna** for details | Not covered |
| TRANSGENDER BENEFITS | Coverage is provided for transgender benefits. Contact **Cigna** for details | |
| CARDIAC REHAB, PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY | Plan pays **80%** of negotiated rate after calendar year deductible, up to 50 visits per calendar year (unlimited physical, speech and occupational therapy visits for autism spectrum disorders; **in-** and **out-of-network** combined) for all conditions. Speech therapy requires preauthorization. Contact **Cigna** for details | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible,* up to 50 visits per calendar year (unlimited physical, speech and occupational therapy visits for autism spectrum disorders; **in-** and **out-of-network** combined) for all conditions. Speech therapy requires preauthorization. Contact **Cigna** for details |
| HEARING AIDS | Plan pays **80%** of negotiated rate after calendar year deductible, up to **$3,000** per ear for each covered individual, every three years. Includes testing, fitting and repairs up to allowance. Services can be accessed through Amplifon or hearing aids can be purchased from an **out-of-network** retailer | |
| ACUPUNCTURE | Plan pays **80%** of negotiated rate after calendar year deductible, up to 10 visits per calendar year (**in-** and **out-of-network** combined) for all conditions | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible,* up to 10 visits per calendar year (**in-** and **out-of-network** combined) for all conditions |
| PREAUTHORIZATION REQUIREMENTS | Your doctor is responsible for obtaining any required authorization from **Cigna** | |
| BEHAVIORAL HEALTH† | Plan pays **80%** of negotiated rate after calendar year deductible. Prior authorization required. For Applied Behavioral Analysis (ABA), contact **Cigna** for details | Plan pays **50%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |

* For some covered services, an allowable **Medicare** reimbursement rate is not established. In these cases, the maximum reimbursable charge is based on the amount charged for that service by **80%** of health care professionals in the area where it is received. Expenses applied to **in-network** deductibles and out-of-pocket maximums do not apply to **out-of-network** deductibles and out-of-pocket maximums, and vice versa.

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

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

# MEDICAL COVERAGE–PPOs (cont.)

**Disney offers a choice of medical plan options to help you take care of yourself and your family.**

## PLAN FEATURES

## BASIC PPO

mycigna.com 1-800-577-7498

| PLAN FEATURES | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| PROVIDER NETWORK | **MEDICAL:** Cigna Open Access Plus<br>**BEHAVIORAL HEALTH/SUBSTANCE ABUSE:** Cigna Behavioral Health | **USE ANY PROVIDER**<br>To receive the highest level of medical benefits, use **Cigna Open Access Plus** providers |
| | Note: If you are referred to an **out-of-network** provider by an **in-network** provider, **out-of-network** benefits still apply | |
| NETWORK SERVICE AREA | **NATIONAL** | |
| SAVINGS/ REIMBURSEMENT ACCOUNT | 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<br>Optional employee contributions to Health Care FSA: Up to **$2,750** in 2021 | |
| CALENDAR YEAR DEDUCTIBLE | **INDIVIDUAL: $1,200 FAMILY: $2,400**<br>All family members contribute toward the family deductible. Claims for a family member are covered at the plan coinsurance when his/her individual deductible is satisfied or when the family deductible is satisfied, whichever happens first | **INDIVIDUAL: $2,300 FAMILY: $4,600** |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES | **INDIVIDUAL: $6,000 FAMILY: $12,000**<br>Medical and pharmacy combined<br>All family members contribute toward the family out-of-pocket maximum. Claims for a family member are covered at **100%** when his/her individual out-of-pocket maximum is satisfied or when the family out-of-pocket maximum is satisfied, whichever happens first | **INDIVIDUAL: $12,000 FAMILY: $24,000** |
| MEDICAL PLAN ANNUAL MAXIMUM | **UNLIMITED** | |
| MEDICAL PLAN LIFETIME BENEFIT | **UNLIMITED** | |
| BENEFITS FOR MOST COVERED SERVICES | Plan pays **70%** of negotiated rate after calendar year deductible | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |
| PREVENTIVE CARE BENEFITS | Plan pays **100%** for covered services. Contact Cigna for details | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |

* For some covered services, an allowable **Medicare** reimbursement rate is not established. In these cases, the maximum reimbursable charge is based on the amount charged for that service by **80%** of health care professionals in the area where it is received. Expenses applied to **in-network** deductibles and out-of-pocket maximums do not apply to **out-of-network** deductibles and out-of-pocket maximums, and vice versa.

# PLAN FEATURES (CONT.)

# BASIC PPO

mycigna.com 1-800-577-7498

| | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| EMERGENCY/ URGENT CARE SERVICES | Plan pays **70%** of negotiated rate after calendar year deductible, plus you pay a separate:<br>• **$150** copay per **ER** visit (waived if admitted)<br>• **$50** copay per urgent care facility visit (waived if admitted) | |
| INPATIENT FACILITY SERVICES | Plan pays **70%** of negotiated rate after calendar year deductible | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible.* You or your doctor must contact **Cigna** before admission or procedure, or an additional **$500** deductible may apply, which does not apply to the out-of-pocket maximum. It is your responsibility to make sure **Cigna** is contacted |
| X-RAY/LABORATORY/ IMAGING SERVICES | Plan pays **70%** of negotiated rate after calendar year deductible | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible* |
| CHIROPRACTIC CARE | Plan pays **70%** of negotiated rate after calendar year deductible, up to 35 visits per calendar year (**in-** and **out-of-network** combined) for all conditions | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible,* up to 35 visits per calendar year (**in-** and **out-of-network** combined) for all conditions |
| 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.**<br>Plan pays **70%** of negotiated rate for covered fertility services **in-network** after calendar year deductible. Contact **Cigna** for details | Not covered |
| TRANSGENDER BENEFITS | Coverage is provided for transgender benefits. Contact **Cigna** for details | |
| CARDIAC REHAB, PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY | Plan pays **70%** of negotiated rate after calendar year deductible, up to 50 visits per calendar year (unlimited physical, speech and occupational therapy visits for autism spectrum disorders; **in-** and **out-of-network** combined) for all conditions. Speech therapy requires preauthorization. Contact **Cigna** for details | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible,* up to 50 visits per calendar year (unlimited physical, speech and occupational therapy visits for autism spectrum disorders; **in-** and **out-of-network** combined) for all conditions. Speech therapy requires preauthorization. Contact **Cigna** for details |
| HEARING AIDS | Plan pays **70%** of negotiated rate after calendar year deductible, up to **$3,000** per ear for each covered individual, every three years. Includes testing, fitting and repairs up to allowance. Services can be accessed through Amplifon or hearing aids can be purchased from an **out-of-network** retailer | |
| ACUPUNCTURE | Plan pays **70%** of negotiated rate after calendar year deductible, up to 10 visits per calendar year (**in-** and **out-of-network** combined) for all conditions | Plan pays **40%** based on two times the allowable Medicare reimbursement rate after calendar year deductible,* up to 10 visits per calendar year (**in-** and **out-of-network** combined) for all conditions |
| PREAUTHORIZATION REQUIREMENTS | **Your doctor** is responsible for obtaining any required authorization from **Cigna** | **You** are responsible for obtaining any required authorization from **Cigna** |
| BEHAVIORAL HEALTH† | Plan pays **70%** of negotiated rate after calendar year deductible. Prior authorization required. For Applied Behavioral Analysis (ABA), contact **Cigna** for details | Plan pays **40%** based on two times the allowable **Medicare** reimbursement rate after calendar year deductible.* Requires preauthorization |

* For some covered services, an allowable **Medicare** reimbursement rate is not established. In these cases, the maximum reimbursable charge is based on the amount charged for that service by **80%** of health care professionals in the area where it is received. Expenses applied to **in-network** deductibles and out-of-pocket maximums do not apply to **out-of-network** deductibles and out-of-pocket maximums, and vice versa.

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

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

# MEDICAL COVERAGE—HMOs

**Disney offers a choice of medical plan options to help you take care of yourself and your family.**

| PLAN FEATURES | CIGNA HMO<br>mycigna.com 1-800-577-7498 |
|---|---|
| PROVIDER NETWORK | **MEDICAL:** Cigna Network<br>**BEHAVIORAL HEALTH/SUBSTANCE ABUSE:** Cigna Behavioral Health<br>All medical care must be coordinated through your **PCP** |
| NETWORK SERVICE AREA | Available in all states except Hawaii, Montana, Nebraska, North Dakota, South Dakota and Wyoming, and certain ZIP codes in Central Florida |
| SAVINGS/ REIMBURSEMENT ACCOUNT | **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<br>Optional employee contributions to **Health Care FSA**: Up to **$2,750** in 2021 |
| CALENDAR YEAR DEDUCTIBLE | **INDIVIDUAL: $300** **FAMILY: $600**<br>All family members contribute toward the family deductible<br>Claims for a family member are covered at the plan coinsurance when his/her individual deductible is satisfied or when the family deductible is satisfied, whichever happens first |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES | **INDIVIDUAL: $3,500** **FAMILY: $7,000**<br>Medical and pharmacy combined<br>All family members contribute toward the family out-of-pocket maximum. Claims for a family member are covered at **100%** when his/her individual out-of-pocket maximum is satisfied or when the family out-of-pocket is satisfied, whichever happens first |
| MEDICAL PLAN ANNUAL MAXIMUM | **UNLIMITED** |
| MEDICAL PLAN LIFETIME BENEFIT | **UNLIMITED** |
| BENEFITS FOR MOST COVERED SERVICES | **$20** copay for network office visits (**$10** at Center for Living Well)<br>**$40** copay for network specialist visits<br>Plan pays **90%** of negotiated rate after calendar year deductible for most other covered services<br>No benefits are payable outside the network, except in the case of emergency |
| PREVENTIVE CARE BENEFITS | Plan pays **100%** for covered services. Contact **Cigna** for details |

| PLAN FEATURES (CONT.) | CIGNA HMO<br>mycigna.com 1-800-577-7498 |
|---|---|
| EMERGENCY/ URGENT CARE SERVICES | **$200** copay per **ER** visit (waived if admitted)<br>**$50** copay per urgent care facility visit (waived if admitted) |
| INPATIENT FACILITY SERVICES | Plan pays **90%** of negotiated rate after calendar year deductible |
| X-RAY/LABORATORY/ IMAGING SERVICES | Plan pays **90%** of negotiated rate at outpatient facility and **100%** at a contracted independent facility |
| CHIROPRACTIC CARE | Self-refer to a contracted provider for up to 35 visits per calendar year; **$20** copay per visit |
| 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.* Plan pays **90%** of negotiated rate for covered fertility services **in-network** after calendar year deductible.<br>Contact **Cigna** for details |
| TRANSGENDER BENEFITS | Coverage is provided for transgender benefits. Contact **Cigna** for details |
| CARDIAC REHAB, PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY | **$20** copay per visit. Must be referred by **PCP** |
| HEARING AIDS | Plan pays **90%** of negotiated rate after calendar year deductible, up to **$3,000** per ear for each covered individual, every three years. Includes testing, fitting and repairs up to allowance. Services can be accessed through Amplifon or hearing aids can be purchased from an **out-of-network** retailer |
| ACUPUNCTURE | **$20** copay, up to 10 visits per calendar year for all conditions |
| PREAUTHORIZATION REQUIREMENTS | All medical care must be coordinated through your **PCP** |
| BEHAVIORAL HEALTH** | Contact **Cigna** for details |

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

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

# MEDICAL COVERAGE—REGIONAL HMOs

**Disney offers a choice of medical plan options to help you take care of yourself and your family.**

| PLAN FEATURES | VALUE SELECT HMO<br>mycigna.com 1-800-577-7498<br>(Eligible Southern California residents only) | ADVENTHEALTH CASTCARE<br>askallegiance.com/disneyah 1-855-999-1522<br><br>ORLANDO HEALTH CAST ADVANTAGE<br>askallegiance.com/disneyoh 1-855-999-1522<br>(Eligible Central Florida residents only) | KAISER HMO (CA)<br>my.kp.org/disney 1-800-464-4000<br><br>KAISER HMO (WA)<br>kp.org/wa 1-888-901-4636<br>(Eligible Washington State residents only) |
|---|---|---|---|
| PROVIDER NETWORK | **MEDICAL: Cigna Value Network**<br>**BEHAVIORAL HEALTH/ SUBSTANCE ABUSE: Cigna Behavioral Health**<br>All medical care must be coordinated through your **PCP** | **MEDICAL: AdventHealth** or **Orlando Health**<br>**BEHAVIORAL HEALTH/ SUBSTANCE ABUSE: Cigna Behavioral Health**<br>All medical care must be coordinated through your **PCP** | **MEDICAL: Kaiser Permanente**<br>**BEHAVIORAL HEALTH/ SUBSTANCE ABUSE: Cigna Behavioral Health (EAP),** then **Kaiser** providers<br>All care must be coordinated through **Kaiser Permanente** doctors and facilities |
| NETWORK SERVICE AREA | Available in Los Angeles, Orange, San Bernardino and Riverside counties in Southern California. Contact **Cigna** for details | Available in certain Central Florida ZIP codes only. Contact **provider network** for details | Available in California and certain Washington State ZIP codes only. Contact **Kaiser** for details |
| SAVINGS/ REIMBURSEMENT ACCOUNT | 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<br>Optional employee contributions to **Health Care FSA**: Up to **$2,750** in 2021 | | |
| CALENDAR YEAR DEDUCTIBLE | **INDIVIDUAL: $300 FAMILY: $600**<br>All family members contribute toward the family deductible<br>Claims for a family member are covered at the plan coinsurance when his/her individual deductible is satisfied or when the family deductible is satisfied, whichever happens first | | **NONE** |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES | **INDIVIDUAL: $3,500 FAMILY: $7,000**<br>Medical and pharmacy combined | | **INDIVIDUAL: $1,500**<br>**FAMILY: $3,000**<br>Medical and pharmacy combined |
| | All family members contribute toward the family out-of-pocket maximum. Claims for a family member are covered at **100%** when his/her individual out-of-pocket maximum is satisfied or when the family out-of-pocket is satisfied, whichever happens first | | |
| MEDICAL PLAN ANNUAL MAXIMUM | **UNLIMITED** | | |
| MEDICAL PLAN LIFETIME BENEFIT | **UNLIMITED** | | |
| BENEFITS FOR MOST COVERED SERVICES | **$10** copay for network office visits<br>**$40** copay for network specialist visits<br>Plan pays **90%** of negotiated rate after calendar year deductible for most other covered services | **$20** copay for network office visits (**$10** at Center for Living Well)<br>**$40** copay for network specialist visits<br>Plan pays **90%** of negotiated rate after calendar year deductible for most other covered services | **$20** copay |
| | No benefits are payable outside the network, except in the case of emergency | | |
| PREVENTIVE CARE BENEFITS | Plan pays **100%** for covered services. Contact **Cigna** for details | Plan pays **100%** for covered services. Contact **provider network** for details | Plan pays **100%** for covered services. Contact **Kaiser** for details |

# PLAN FEATURES (CONT.)

| | VALUE SELECT HMO<br>mycigna.com 1-800-577-7498<br>(Eligible Southern California residents only) | ADVENTHEALTH CASTCARE<br>askallegiance.com/disneyah 1-855-999-1522<br><br>ORLANDO HEALTH CAST ADVANTAGE<br>askallegiance.com/disneyoh 1-855-999-1522<br>(Eligible Central Florida residents only) | KAISER HMO (CA)<br>my.kp.org/disney 1-800-464-4000<br><br>KAISER HMO (WA)<br>kp.org/wa 1-888-901-4636<br>(Eligible Washington State residents only) |
|---|---|---|---|
| EMERGENCY/ URGENT CARE SERVICES | **$200** copay per ER visit (waived if admitted)<br>**$30** copay per urgent care facility visit (waived if admitted) | **$200** copay per ER visit (waived if admitted)<br>**$50** copay per urgent care facility visit (waived if admitted) | **$100** copay per ER visit (waived if admitted)<br>**$20** copay per urgent care facility visit |
| INPATIENT FACILITY SERVICES | Plan pays **90%** of negotiated rate after calendar year deductible | | **$250** copay per admission |
| X-RAY/LABORATORY/ IMAGING SERVICES | Plan pays **90%** of negotiated rate at an outpatient facility and **100%** at a contracted independent facility | | Plan pays **100%** |
| CHIROPRACTIC CARE | Self-refer to a contracted provider for up to 35 visits per calendar year; **$10** copay per visit | Self-refer to a contracted provider for up to 35 visits per calendar year; **$20** copay per visit | **$15** copay per visit, up to 30 visits per calendar year |
| 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.*<br>Plan pays **90%** of negotiated rate for covered fertility services **in-network** after calendar year deductible.<br>Contact **Cigna** for details | Contact **Allegiance** Customer Service for details | Contact **Kaiser** for details |
| TRANSGENDER BENEFITS | Coverage is provided for transgender benefits. Contact **Cigna** for details | Coverage is provided for transgender benefits. Contact **Allegiance** Customer Service for details | Coverage is provided for transgender benefits. Contact **Kaiser** for details |
| CARDIAC REHAB, PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY | **$10** copay per visit.<br>Must be referred by **PCP** | **$20** copay per visit.<br>Must be referred by **PCP** | **$20** copay per visit.<br>Limited benefits for speech therapy.<br>Contact Kaiser for details |
| HEARING AIDS | Plan pays **90%** after calendar year deductible, up to **$3,000** per ear for each covered individual, every three years. Includes testing, fitting and repairs up to allowance.<br>Services can be accessed through Amplifon or hearing aids can be purchased from an **out-of-network** retailer | Plan pays **90%** after calendar year deductible, up to **$3,000** per ear for each covered individual, every three years. Includes testing, fitting and repairs up to allowance. Services must be accessed through Amplifon or another IDS supplier | You pay **$20** copay. Plan pays up to **$3,000** per ear (if required) for each covered individual, every 36 months. Repairs covered up to allowance after warranty expires |
| ACUPUNCTURE | **$10** copay, up to 10 visits per calendar year for all conditions | **$20** copay, up to 10 visits per calendar year for all conditions | CA: Limited benefits.<br>Contact **Kaiser** for details<br>WA: **$20** copay per visit, up to 12 visits per calendar year |
| PREAUTHORIZATION REQUIREMENTS | All medical care must be coordinated through your **PCP** | | All authorizations must be coordinated through your **Kaiser** physician |
| BEHAVIORAL HEALTH** | Contact **Cigna** for details | Contact **provider network** for details | Contact **Kaiser** for details |

* You may be required to pay the initial cost of some services and file a claim for reimbursement. Some benefits may be taxable.
** The **Employee Assistance Program (EAP)** through **Cigna Behavioral Health** pays **100%** of the first five **in-network** visits (per concern), then plan coverage begins.

# PRESCRIPTION DRUG COVERAGE

**The information in this section applies to in-network coverage or participating network 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.**
- **You have the option to fill non-specialty 90-day prescriptions for less than the cost of three monthly refills at Walgreens pharmacies through the Express Scripts Smart90 Program (if enrolled in a Cigna medical option).**

**For more information about Express Scripts, go to express-scripts.com or call 1-800-375-0596.**
**For more information about Kaiser Permanente, go to my.kp.org/disney or call 1-800-464-4000.**

| PLAN FEATURES | CONSUMER CHOICE | BASIC PPO | CIGNA HMO |
|---|---|---|---|
| PROVIDER NETWORK | EXPRESS SCRIPTS | | |
| RETAIL BENEFITS (30-DAY SUPPLY OR LESS) | Plan pays **80%** after calendar year deductible. Certain drugs may be covered at **100%** and/or not subject to deductible.<br><br>See Prescription Drug lists at **Benefits.Disney.com** or contact **Express Scripts** for details | **GENERIC:** Up to a **$4** copay<br>**BRAND:** You pay **35%** of the cost, up to **$80** per prescription<br><br>Only National Preferred Formulary drugs are covered. Some drugs require preauthorization | |
| HOME DELIVERY BENEFITS (90-DAY SUPPLY MAXIMUM)<br>SAME PRICING AVAILABLE OVER-THE-COUNTER AT WALGREENS, CENTER FOR LIVING WELL AND PHARMACY FOR LIVING WELL | Plan pays **80%** after calendar year deductible. Certain drugs may be covered at **100%** and/or not subject to deductible.<br><br>See Prescription Drug lists at **Benefits.Disney.com** or contact **Express Scripts** for details | **GENERIC:** Up to an **$8** copay<br>**BRAND:** You pay **30%** of the cost, up to **$160** per prescription<br><br>Only National Preferred Formulary drugs are covered. Some drugs require preauthorization | |
| ANNUAL PRESCRIPTION DEDUCTIBLE | **INDIVIDUAL: $1,600**<br>**FAMILY: $3,200**<br>Medical and pharmacy combined | **NONE** | |
| PHARMACY OUT-OF-POCKET MAXIMUM | **INDIVIDUAL: $4,000**<br>**FAMILY: $8,000**<br>Medical and pharmacy combined | **INDIVIDUAL: $6,000**<br>**FAMILY: $12,000**<br>Medical and pharmacy combined | **INDIVIDUAL: $3,500**<br>**FAMILY: $7,000**<br>Medical and pharmacy combined |
| PRE-AUTHORIZATION/ STEP THERAPY/ SPECIALTY MEDICATIONS | Some drugs require preauthorization/Step Therapy. Step Therapy applies for most specialty medications. Specialty drugs are required to be dispensed through Express Scripts' Accredo specialty pharmacy unit. Contact **Express Scripts** for details<br><br>**Some medications, including compound prescriptions, will not be covered unless approved by Express Scripts through the prior authorization process** | | |

# PRESCRIPTION DRUG COVERAGE–REGIONAL HMOs

| PLAN FEATURES | VALUE SELECT HMO | ADVENTHEALTH CASTCARE<br>ORLANDO HEALTH CAST ADVANTAGE | KAISER HMO (CA)<br>KAISER HMO (WA) |
|---|---|---|---|
| PROVIDER NETWORK | EXPRESS SCRIPTS | | KAISER PERMANENTE |
| RETAIL BENEFITS (30-DAY SUPPLY OR LESS) | GENERIC: Up to a **$4** copay<br>BRAND: You pay **35%** of the cost, up to **$100** per prescription | GENERIC: Up to a **$4** copay<br>BRAND: You pay **35%** of the cost, up to **$80** per prescription | GENERIC: **$10** copay<br>BRAND: **$25** copay<br>Only formulary-listed drugs are covered |
| | Only National Preferred Formulary drugs are covered. Some drugs require preauthorization | | |
| HOME DELIVERY BENEFITS (90-DAY SUPPLY MAXIMUM)<br>SAME PRICING AVAILABLE OVER-THE-COUNTER AT WALGREENS, CENTER FOR LIVING WELL AND PHARMACY FOR LIVING WELL | GENERIC: Up to an **$8** copay<br>BRAND: You pay **30%** of the cost, up to **$200** per prescription | GENERIC: Up to an **$8** copay<br>BRAND: You pay **30%** of the cost, up to **$160** per prescription | GENERIC: **$20** copay (CA: 100-day supply)<br>BRAND: **$50** copay (CA: 100-day supply)<br>Only formulary-listed drugs are covered |
| | Only National Preferred Formulary drugs are covered. Some drugs require preauthorization | | |
| ANNUAL PRESCRIPTION DEDUCTIBLE | NONE | | |
| PHARMACY OUT-OF-POCKET MAXIMUM | INDIVIDUAL: **$3,500**<br>FAMILY: **$7,000**<br>Medical and pharmacy combined | | INDIVIDUAL: **$1,500**<br>FAMILY: **$3,000**<br>Medical and pharmacy combined |
| PRE-AUTHORIZATION/ STEP THERAPY/ SPECIALTY MEDICATIONS | Some drugs require preauthorization/Step Therapy. Step Therapy applies for most specialty medications. Specialty drugs are required to be dispensed through Express Scripts' Accredo specialty pharmacy unit. Contact **Express Scripts** for details<br>**Some medications, including compound prescriptions, will not be covered unless approved by Express Scripts through the prior authorization process** | | 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 | | 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<br><br>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<br><br>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** | | **$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** | • **30%** discount on additional pairs of glasses purchased from the same provider on the day of your exam<br>• **20%** discount on additional pairs of glasses purchased within 12 months of your last covered exam<br>• 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

* Amount of coverage may vary based on the terms of an applicable collective bargaining agreement.

## 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

If you are an eligible hourly employee living in a state that does not have a required state disability program,* the Company provides a basic **STD** benefit at no cost to you. Coverage is issued by **The Hartford**.

### BASIC COVERAGE

Disney provides a basic **STD** benefit equal to **60%** of base pay up to **$200** per week for eligible hourly employees

### SUPPLEMENTAL COVERAGE

Eligible hourly employees may elect a supplemental **STD** benefit, up to a combined maximum of **$1,154** per week. You pay for supplemental coverage through after-tax contributions from your paycheck

* Required state disability programs apply if you live in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island.

Eligibility may vary based on your job status, location and the terms of any applicable bargaining agreement.

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.

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