2025 Benefits Summary

A comprehensive comparison of plans offered in Hawaii

Know your options before you choose

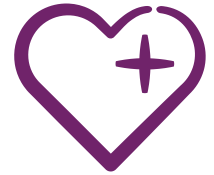
Review these summary charts to better understand the Disney benefits offered to you. Items in **red** indicate changes for 2025. When you're ready to enroll, go to the Disney Benefits Portal.

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

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 Kaiser Permanente	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)	**HRA** established automatically (if eligible) to help pay for current or future expenses (including deductible) with any 2025 wellness rewards you and your enrolled spouse/partner earn. No employee contributions allowed Optional employee contributions to Health Care FSA: Up to **$3,200** in 2025			
Calendar Year Deductible	None	**$100** per person **$300** per family	None	
Calendar Year Out-of-Pocket Maximum For Covered Expenses	**$2,500** per person | **$7,500** per family			**$2,500** per person | **$7,500** per family Medical and pharmacy combined
Medical Plan Annual Maximum	Unlimited			
Medical Plan Lifetime Benefit	Unlimited			
Benefits For Most Covered Services	**$12** copay	You pay **30%** (after calendar year deductible)	**$20** copay	**$15** copay No benefits are payable outside the network, except in the case of emergency
Preventive Care Benefits	You pay **$0**. Contact **HMSA** for details on covered services	You pay **30%**	You pay **$0**	You pay **$0**
Virtual Care	With **HMSA**'s Online Care®, you can talk with a doctor 24/7, 365 days a year without leaving home. Online Care providers are Hawaii licensed and **HMSA** credentialed. Copays may apply			E-visits provide online care from a **Kaiser** provider at no cost 24/7. Video visits available via computer or mobile app

<table>
<tr><th rowspan="2">Plan Features</th><th colspan="2">HMSA Preferred Provider Plan
hmsa.com | 1-808-948-6111</th><th rowspan="2">HMSA Health Plan Hawaii
hmsa.com
1-808-948-6372</th><th rowspan="2">Kaiser HMO (HI)
my.kp.org/disney
1-800-966-5955</th></tr>
<tr><th>IN NETWORK</th><th>OUT OF NETWORK</th></tr>
<tr><td>Emergency/Urgent Care Services</td><td>ER: You pay 20%; $12 copay for ER Doctor visit
Urgent Care: $12 copay per visit</td><td>ER: You pay 20%; $12 copay for ER Doctor visit
Urgent Care: You pay 30%</td><td>ER: $100 copay
Urgent Care: $20 copay</td><td>ER: $75 copay (waived if admitted)
Urgent Care: $15 copay at a Kaiser Permanente facility within the Hawaii service area</td></tr>
<tr><td>Inpatient Facility Services (Additional Physician/Surgeon fees may apply)</td><td>You pay 10%</td><td>You pay 30% (after calendar year deductible)</td><td>You pay 10%</td><td>$75 copay per day</td></tr>
<tr><td>X-Ray/Laboratory/ Imaging Services</td><td>Inpatient: You pay 10%
Outpatient: You pay 20%</td><td>You pay 30% after deductible</td><td>Inpatient: You pay 10%
Outpatient: $10 copay</td><td>You pay 10%</td></tr>
<tr><td>Chiropractic Care</td><td colspan="2">In-network and out-of-network care provided by a licensed chiropractor is covered under regular plan benefits. Precertification is required after the eighth visit per calendar year</td><td>In-network care provided by a licensed chiropractor is covered under regular plan benefits. Precertification is required after the eighth visit per calendar year</td><td>$15 copay; combined 20-visit maximum with acupuncture</td></tr>
<tr><td rowspan="2">Fertility Treatment</td><td colspan="4">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</td></tr>
<tr><td colspan="3">Contact HMSA for specific details</td><td>Contact Kaiser for specific coverage</td></tr>
<tr><td>Transgender Benefits</td><td colspan="3">Coverage is provided for transgender benefits. Contact HMSA for specific details</td><td>Coverage is provided for transgender benefits. Contact Kaiser for details</td></tr>
<tr><td rowspan="2">Physical, Speech and Occupational Therapy</td><td>Inpatient: You pay 10%
Outpatient: You pay 20%</td><td>You pay 30% (after calendar year deductible)</td><td rowspan="2">Inpatient: You pay 10%
Outpatient: $20 copay
Certain services must be precertified</td><td rowspan="2">$15 copay</td></tr>
<tr><td colspan="2">Certain services must be precertified</td></tr>
<tr><td>Hearing Aids</td><td>Evaluation for use of hearing aids: You pay 20% for Hearing Appliances; covered when evaluated by a physician or audiologist. Limited to one hearing aid per ear every 60 months. Fitting, adjustments, and batteries not included. Repairs or replacements are covered subject to certain limitations and exclusions. Repairs or replacements must be precertified</td><td>Evaluation for use of hearing aids: You pay 30% for Hearing Appliances after calendar year deductible; covered when evaluated by a physician or audiologist. Limited to one hearing aid per ear every 60 months. Fitting, adjustments, and batteries not included. Repairs or replacements are covered subject to certain limitations and exclusions. Repairs or replacements must be precertified</td><td>Evaluation for use of hearing aids: $20 office visit copay. You pay 20% of eligible charges for Hearing Appliances. Limited to one hearing aid per ear every 60 months. Fitting, adjustments, and batteries not included. Repairs or replacements are covered subject to certain limitations and exclusions. Repairs or replacements must be precertified</td><td>You pay 40% for Hearing Appliances when prescribed by Kaiser physician or audiologist, up to one hearing aid per ear covered once every 36 months, limited to lowest priced model. $15 copay per hearing exam. You pay any additional charges</td></tr>
<tr><td>Acupuncture</td><td colspan="3">Not covered—discount rates available for certain services through HMSA365.
Contact HMSA for specific details</td><td>$15 copay; combined 20-visit maximum with chiropractic</td></tr>
<tr><td>Preauthorization Requirements</td><td colspan="2">To receive the highest level of medical benefits, use HMSA's Participating Provider Network</td><td>Coordinate all services through your PCP</td><td>All authorizations must be coordinated through your Kaiser physician</td></tr>
<tr><td>Behavioral Health</td><td colspan="4">The Employee Assistance Program (EAP) through Cigna Behavioral Health pays 100% of the first ten in-network visits (per concern), then plan coverage begins</td></tr>
</table>

* 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)	**Generic:** Up to an **$7** copay **Preferred Formulary Brand: $30** copay **Non-Preferred Formulary Brand: $30** plus **$45** Non-Preferred Formulary cost share **Preferred Specialty: $100** copay **Brand Specialty: $200** copay 90-day supply available for non-specialty oral chemotherapy medications; 30-day limit for specialty oral chemotherapy medications **Out of network:** For Brand medications, add **20%** to above amounts. Specialty drugs not covered		**Generic** and **Brand:** Up to an **$15** copay Must use **Kaiser** pharmacy
Mail-Order Benefits 90-Day Supply Maximum	**Generic:** Up to an **$11** copay **Preferred Formulary Brand: $65** copay **Non-Preferred Formulary Brand: $65** plus **$135** Non-Preferred Formulary cost share Specialty drugs not covered		**Generic** and **Brand**: Up to an **$30** copay Must use **Kaiser** pharmacy
Pharmacy Out-of-Pocket Maximum	**$3,600** per person | **$4,200** per family		**$2,500** per person **$7,500** per family Medical and pharmacy combined
Preauthorization Step Therapy	Check with **HMSA** for details		Please consult with your **Kaiser** pharmacist

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.**

<table>
<tr><th>Plan Features</th><th>Value</th><th>Advantage</th><th>DeltaCare USA
(Managed care option)</th></tr>
<tr><td>Provider Network</td><td colspan="2">Delta Dental PPO
To receive the highest level of benefits, use Delta Dental PPO dentists.
Referrals are not required for specialty care</td><td>DeltaCare USA
Managed care option—all dental care must be coordinated through your network dentist. Must use DeltaCare USA contracted dentists</td></tr>
<tr><td>Network Service Area</td><td colspan="2">Nationwide</td><td>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)</td></tr>
<tr><td>Annual Deductible</td><td colspan="2">$25 ($75 for out-of-network care) per person
Does not apply to preventive, diagnostic or orthodontic services</td><td>None</td></tr>
<tr><td rowspan="2">Annual Maximum Benefit</td><td>$750 per person
($500 for out-of-network care)</td><td>$2,000 per person
($1,500 for out-of-network care)</td><td rowspan="2">None
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</td></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>Preventive Coverage</td><td colspan="2">You pay $0 for exams, cleanings and X-rays. The amount the plan pays for cleanings does not apply to the annual maximum benefit</td><td>You pay $0 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</td></tr>
<tr><td>Basic Coverage</td><td colspan="2">You pay 20% for fillings, root canals and extractions</td><td>Contact Delta Dental for copay schedule. Out-of-network services are not covered</td></tr>
<tr><td>Major Coverage</td><td>You pay 60% for crowns, bridges, dentures and implants</td><td>You pay 50% for crowns, bridges, dentures and implants</td><td>Contact Delta Dental for copay schedule. Out-of-network services are not covered</td></tr>
<tr><td>Orthodontia</td><td>Not Covered</td><td>You pay 50%; deductible does not apply. $2,000 lifetime maximum benefit per child to age 26 for in-network care
($1,500 for out-of-network care)</td><td>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</td></tr>
<tr><td>Emergency Treatment, Palliative (To Relieve Pain)</td><td colspan="2">You pay $0</td><td>Contact Delta Dental for copay schedule. Out-of-network services are not covered</td></tr>
<tr><td>Dental Accident</td><td colspan="2">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</td><td>Contact Delta Dental for copay schedule. Out-of-network services are not covered. Standard copays, limitations, and exclusions apply to care for accidental injury</td></tr>
<tr><td>Predetermination of Benefits</td><td colspan="2">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</td><td>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</td></tr>
</table>

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	You pay **$0**	Plan pays up to **$19**	You pay **$0**	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	**$130** allowance; **20%** discount if price exceeds maximum; available every other calendar year	Plan pays up to **$22**	**$155** allowance; **20%** discount if price exceeds maximum; available once per calendar year	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 every 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, 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 • **20%** discount on additional pairs of glasses purchased within 12 months of your last covered exam • **40%** savings on additional complete pairs of prescription glasses applies within 12 months of the initial purchase (lens and frame benefit usage) at the same provider who performed the exam			

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** and may require **Evidence of Insurability (EOI)**
- 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.

Accidental Death & 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

Disney provides you with **Basic LTD** coverage at no cost to you, which pays you a benefit if you cannot work due to an illness or injury. You may also purchase additional coverage, paid with after tax contributions from your paycheck. If you're newly eligible, you will be automatically enrolled in Supplemental LTD unless you actively decline coverage during enrollment. Coverage is issued by **The Hartford**.

BASIC COVERAGE

Disney provides a **Basic LTD** benefit which pays **50%** of base pay up to a maximum of **$2,500** per month

SUPPLEMENTAL COVERAGE

Pays a benefit of **60%** of base pay up to a maximum of **$30,000** per month

Benefits begin after 90 consecutive days of disability, except for California residents whose 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 work 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, 2025. 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 the Disney Benefits Portal for additional information about your Disney benefits.

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