



2024 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 2024. 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 Emergency Room	FSA Flexible Spending Account	HMO Health Maintenance Organization	HRA Health Reimbursement Account	HSA Health Savings Account	PCP Primary Care Physician	PPO Preferred Provider Organization
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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 2024 wellness rewards you and your enrolled spouse/partner earn. No employee contributions allowed Optional employee contributions to Health Care FSA: Up to \$3,050 in 2024			
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
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

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	IN NETWORK	OUT OF NETWORK		
Emergency/ Urgent Care Services	ER: Plan pays 80% Urgent Care: \$12 copay per visit	ER: Plan pays 80% 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)	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	Inpatient: Plan pays 90% Outpatient: Plan pays 80%	Inpatient: Plan pays 70% Outpatient: Plan pays 70% (after calendar year deductible)	Inpatient: Plan pays 90% Outpatient: \$10 copay	Plan pays 90%
Chiropractic Care	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		In-network care provided by a licensed chiropractor is covered under regular plan benefits. Precertification is required after the eighth visit per calendar year	\$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.			
	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	Inpatient: Plan pays 90% Outpatient: Plan pays 80%	Inpatient: Plan pays 70% Outpatient: Plan pays 70% (after calendar year deductible)	Inpatient: Plan pays 90% Outpatient: \$20 copay Certain services must be precertified	\$15 copay
	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, and batteries not included. Repairs or replacements are covered subject to certain limitations and exclusions. Repairs or replacements must be precertified	Evaluation for use of hearing aids: Plan pays 70% 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	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, and batteries not included. Repairs or replacements are covered subject to certain limitations and exclusions. Repairs or replacements must be precertified	Plan pays 60% 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. \$20 copay per hearing exam. 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 ten in-network visits (per concern), then plan coverage begins.			

* 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	Individual: \$3,600 Family: \$4,200		Individual: \$2,500 Family: \$7,500 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.

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. Referrals are not required for specialty care		DeltaCare USA Managed care option—all dental care must be coordinated through your network dentist. Must use DeltaCare USA contracted dentists.
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, diagnostic or orthodontic services		None
Annual Maximum Benefit	\$750 per person (\$500 for out-of-network care)	\$2,000 per person (\$1,500 for out-of-network care)	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
	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: <ul style="list-style-type: none"> • 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

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 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, 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

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

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

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. If you elect Supplemental LTD after this time, **Evidence of Insurability (EOI)** will be required. 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, 2024. 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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