



2026 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 2026. 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 1-808-432-5955
	IN NETWORK	OUT OF NETWORK		
Provider Network	HMSA Preferred Provider Plan Network	Use any Provider	HMSA Health Plan Hawaii Plus	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 Preferred Provider Plan 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 2026 wellness rewards you and your enrolled spouse/partner earn. No employee contributions allowed. Optional employee contributions to Health Care FSA: Up to \$3,300 in 2026			
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	You pay: Office visits: \$12 copay Most other services: 10% to 20%	You pay 30% (after calendar year deductible)	You pay \$20 copay	You pay \$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% (after calendar year deductible)	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

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	IN NETWORK	OUT OF NETWORK		
Emergency/Urgent Care Services	You pay: ER: 20% Urgent Care: \$12 copay per visit	You pay: ER: 20% Urgent Care: 30%	You pay: ER: \$100 copay Urgent Care: \$20 copay	You pay: ER: \$75 copay (waived if admitted) Urgent Care: \$15 copay at a Kaiser Permanente facility within the Hawaii service area
Inpatient Facility Services (Additional Physician/Surgeon fees may apply)	You pay 10%	You pay 30% (after calendar year deductible)	You pay 10%	You pay \$75 copay per day
X-Ray/Laboratory/Imaging Services	You pay: Inpatient: 10% Outpatient: 20%	You pay 30% (after calendar year deductible)	You pay: Inpatient: 10% Outpatient: \$10 copay	You pay 10%
Chiropractic Care	In-network and out-of-network care provided by a licensed chiropractor is covered under regular plan benefits. Preauthorization is required after the 8 th visit per calendar year		In-network care provided by a licensed chiropractor is covered under regular plan benefits. Precertification is required after the 8 th visit per calendar year	You pay \$15 copay; combined 20-visit maximum per year with acupuncture
Fertility Treatment	Family building benefit administered by WIN provides a lifetime maximum of \$75,000 for fertility, surrogacy, and adoption services, including coverage for egg and sperm freezing. ¹ 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	You pay: Inpatient: 10% Outpatient: 20%	You pay 30% (after calendar year deductible)	You pay: Inpatient: 10% Outpatient: \$20 copay Certain services must be preauthorized	You pay \$15 copay
	Certain services must be preauthorized			
Hearing Aids	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 but subject to limits and exclusions; must be preauthorized	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 but subject to limits and exclusions; must be preauthorized	Evaluation for use of hearing aids: you pay \$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 but subject to limits and exclusions; must be preauthorized	You pay 40% for Hearing Appliances when prescribed by a Kaiser physician or audiologist, up to one hearing aid per ear every 36 months. You pay \$15 copay per hearing exam and any additional charges
Acupuncture	Not covered—discount rates available for certain services through HMSA365 . Contact HMSA for specific details			You pay \$15 copay; combined 20-visit maximum per year with chiropractic care
Preauthorization Requirements	To receive the highest level of medical benefits, use HMSA's Preferred Provider Plan Network		Coordinate all services through your PCP	All authorizations must be coordinated through your Kaiser physician
Behavioral Health² (Outpatient)	You pay: Physician: \$12 copay Facility: 10%	You pay: 30% (after calendar year deductible)	You pay: Physician: \$20 copay Facility: \$0 copay	You pay \$15 copay

¹You may be required to pay the initial cost of some services and file a claim for reimbursement. Some benefits may be taxable.

²The **Employee Assistance Program (EAP)** through **Cigna Behavioral Health** pays **100%** of the first 10 **in-network** visits (per topic), then plan coverage begins. For Inpatient Behavioral Health coverage, see **Inpatient Facility Services** above.

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 for Kaiser HMO (HI). 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: You pay up to an \$7 copay</p> <p>Preferred Formulary Brand: You pay \$30 copay</p> <p>Non-Preferred Formulary Brand: You pay \$30 plus \$45 Non-Preferred Formulary cost share</p> <p>Preferred Specialty: You pay 20%</p> <p>Non-Formulary Specialty: You pay 25%</p> <p>Out of network: For Generic, Preferred, and Brand medications, add 20% to above amounts. Specialty drugs not covered</p>		<p>Generic and Brand: You pay up to a \$15 copay</p> <p>Must use Kaiser pharmacy</p> <p>Out of network: Not covered</p>
Mail-Order Benefits (90-Day Supply Maximum)	<p>Generic: You pay up to an \$11 copay</p> <p>Preferred Formulary Brand: You pay \$65 copay</p> <p>Non-Preferred Formulary Brand: You pay \$65 plus \$135 Non-Preferred Formulary cost share</p> <p>Specialty drugs not covered</p> <p>Out of network: Not covered</p>		<p>Generic and Brand: You pay up to a \$30 copay</p> <p>Must use Kaiser pharmacy</p> <p>Out of network: Not covered</p>
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.

Plan Features	Value	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
	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	You pay \$0 for exams, cleanings, and X-rays. The amount the plan pays for cleanings does not apply to the annual maximum benefit		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
Basic Coverage	You pay 20% for fillings, root canals, and extractions		Contact Delta Dental for copay schedule. Out-of-network services are not covered
Major Coverage	You pay 60% for crowns, bridges, dentures, and implants	You pay 50% for crowns, bridges, dentures, and implants	Contact Delta Dental for copay schedule. Out-of-network services are not covered
Orthodontia	Not covered	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)	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
Emergency Treatment, Palliative (To Relieve Pain)	You pay \$0		Contact Delta Dental for copay schedule. Out-of-network services are not covered
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		Contact Delta Dental for copay schedule. Out-of-network services are not covered. Standard copays, limitations, and exclusions apply to care for accidental injury
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		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	You pay \$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	You pay \$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 every 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 every calendar year	Plan pays up to \$22
Contact Lenses (In lieu of lenses and frames)	You pay \$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	You pay \$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		You pay \$10 copay for lenses every calendar year. Plan pays up to \$90 for frames, available every other calendar year	None
Additional Discounts (In-network coverage only)	<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 • 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

* 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. Coverage is issued by **Securian Financial**.

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. Disney 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, 2026. 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.