

 **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 wekeepyoumiling.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		DELTACARE USA Managed care option—all dental care must be coordinated through your network dentist
NETWORK SERVICE AREA	NATIONWIDE		Available nationwide. You are eligible if you live in the program's service area (i.e., there is a network provider within 20 miles of your home ZIP code)
ANNUAL DEDUCTIBLE	\$25 (\$75 for out-of-network care) per person Does not apply to preventive or orthodontic services		NONE

PLAN FEATURES (CONT.)

VALUE

ADVANTAGE

DELTACARE USA

(Managed care option)

ANNUAL MAXIMUM BENEFIT

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

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

NONE

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

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

PREVENTIVE COVERAGE

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

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

BASIC COVERAGE

80% coverage for fillings, root canals and extractions

Copay applies

MAJOR COVERAGE

40% coverage for crowns, bridges, dentures and implants

50% coverage for crowns, bridges, dentures and implants

Copay applies

ORTHODONTIA

Not covered

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

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

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

EMERGENCY TREATMENT, PALLIATIVE (TO RELIEVE PAIN)

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

Copay applies

DENTAL ACCIDENT

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

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

PREDETERMINATION OF BENEFITS

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

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

MEDICAL COVERAGE – 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

PROVIDER NETWORK

IN NETWORK

MEDICAL: Cigna Open Access Plus
BEHAVIORAL HEALTH/SUBSTANCE ABUSE:
 Cigna Behavioral Health

OUT OF NETWORK

USE ANY PROVIDER
 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). 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
 Medical and pharmacy combined

All family members contribute toward the family deductible

INDIVIDUAL: \$3,100 FAMILY: \$6,200
 Medical and pharmacy combined

All family members contribute toward the family deductible

CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES

INDIVIDUAL: \$4,000 FAMILY: \$8,000
 Medical and pharmacy combined

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
 Medical and pharmacy combined

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

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

IN NETWORK

MEDICAL: Cigna Open Access Plus
BEHAVIORAL HEALTH/SUBSTANCE ABUSE:
 Cigna Behavioral Health

Note: If you are referred to an **out-of-network** provider by an **in-network** provider, **out-of-network** benefits still apply

OUT OF NETWORK

USE ANY PROVIDER
 To receive the highest level of medical benefits,
 use **Cigna Open Access Plus** providers

PROVIDER NETWORK

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

Optional employee contributions to Health Care FSA: Up to **\$2,750** in 2021

CALENDAR YEAR DEDUCTIBLE

INDIVIDUAL: \$1,200 FAMILY: \$2,400

INDIVIDUAL: \$2,300 FAMILY: \$4,600

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES

INDIVIDUAL: \$6,000 FAMILY: \$12,000
 Medical and pharmacy combined

INDIVIDUAL: \$12,000 FAMILY: \$24,000

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

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:

- **\$150** copay per ER visit (waived if admitted)
- **\$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.** 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

mycigna.com 1-800-577-7498

PROVIDER NETWORK

MEDICAL: Cigna Network
BEHAVIORAL HEALTH/SUBSTANCE ABUSE: Cigna Behavioral Health
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

Optional employee contributions to **Health Care FSA:** Up to **\$2,750** in 2021

CALENDAR YEAR DEDUCTIBLE

INDIVIDUAL: \$300 FAMILY: \$600

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES

INDIVIDUAL: \$3,500 FAMILY: \$7,000

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

\$20 copay for network office visits (**\$10** at Center for Living Well)
\$40 copay for network specialist visits
Plan pays **90%** of negotiated rate after calendar year deductible for most other covered services

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

mycigna.com 1-800-577-7498

EMERGENCY/ URGENT CARE SERVICES

\$200 copay per ER visit (waived if admitted)
\$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.
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

mycigna.com 1-800-577-7498

(Eligible Southern California residents only)

ADVENTHEALTH CASTCARE

askallegiance.com/disneyah 1-855-999-1522

ORLANDO HEALTH CAST ADVANTAGE

askallegiance.com/disneyoh 1-855-999-1522

(Eligible Central Florida residents only)

KAISER HMO (CA)

my.kp.org/disney 1-800-464-4000

KAISER HMO (WA)

kp.org/wa 1-888-901-4636

(Eligible Washington State residents only)

PROVIDER NETWORK

MEDICAL: Cigna Value Network
**BEHAVIORAL HEALTH/
SUBSTANCE ABUSE:**
Cigna Behavioral Health

All medical care must be coordinated through your PCP

MEDICAL: AdventHealth or Orlando Health
**BEHAVIORAL HEALTH/
SUBSTANCE ABUSE:**
Cigna Behavioral Health

All medical care must be coordinated through your PCP

MEDICAL: Kaiser Permanente
**BEHAVIORAL HEALTH/
SUBSTANCE ABUSE:**
Cigna Behavioral Health (EAP), then Kaiser providers

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

Optional employee contributions to Health Care FSA: Up to **\$2,750** in 2021

CALENDAR YEAR DEDUCTIBLE

INDIVIDUAL: \$300 FAMILY: \$600

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

NONE

CALENDAR YEAR OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES

INDIVIDUAL: \$3,500 FAMILY: \$7,000

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

**INDIVIDUAL: \$1,500
FAMILY: \$3,000**

Medical and pharmacy combined

MEDICAL PLAN ANNUAL MAXIMUM

UNLIMITED

MEDICAL PLAN LIFETIME BENEFIT

UNLIMITED

BENEFITS FOR MOST COVERED SERVICES

\$10 copay for network office visits
\$40 copay for network specialist visits
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)
\$40 copay for network specialist visits
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

mycigna.com 1-800-577-7498

(Eligible Southern California residents only)

ADVENTHEALTH CASTCARE

askallegiance.com/disneyah 1-855-999-1522

ORLANDO HEALTH CAST ADVANTAGE

askallegiance.com/disneyoh 1-855-999-1522

(Eligible Central Florida residents only)

KAISER HMO (CA)

my.kp.org/disney 1-800-464-4000

KAISER HMO (WA)

kp.org/wa 1-888-901-4636

(Eligible Washington State residents only)

EMERGENCY/ URGENT CARE SERVICES

\$200 copay per ER visit (waived if admitted)

\$30 copay per urgent care facility visit (waived if admitted)

\$200 copay per ER visit (waived if admitted)

\$50 copay per urgent care facility visit (waived if admitted)

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

\$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.*

Plan pays **90%** of negotiated rate for covered fertility services **in-network** after calendar year deductible.

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. Must be referred by **PCP**

\$20 copay per visit. Must be referred by **PCP**

\$20 copay per visit. Limited benefits for speech therapy. 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. 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. Contact **Kaiser** for details

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. See Prescription Drug lists at Benefits.Disney.com or contact Express Scripts for details	GENERIC: Up to a \$4 copay BRAND: You pay 35% of the cost, up to \$80 per prescription	Only National Preferred Formulary drugs are covered. Some drugs require preauthorization
HOME DELIVERY BENEFITS (90-DAY SUPPLY MAXIMUM) 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. See Prescription Drug lists at Benefits.Disney.com or contact Express Scripts for details	GENERIC: Up to an \$8 copay BRAND: You pay 30% of the cost, up to \$160 per prescription	Only National Preferred Formulary drugs are covered. Some drugs require preauthorization
ANNUAL PRESCRIPTION DEDUCTIBLE	INDIVIDUAL: \$1,600 FAMILY: \$3,200 Medical and pharmacy combined	NONE	
PHARMACY OUT-OF-POCKET MAXIMUM	INDIVIDUAL: \$4,000 FAMILY: \$8,000 Medical and pharmacy combined	INDIVIDUAL: \$6,000 FAMILY: \$12,000 Medical and pharmacy combined	INDIVIDUAL: \$3,500 FAMILY: \$7,000 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 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

PROVIDER NETWORK

RETAIL BENEFITS (30-DAY SUPPLY OR LESS)

HOME DELIVERY BENEFITS (90-DAY SUPPLY MAXIMUM)

SAME PRICING AVAILABLE OVER-THE-COUNTER AT WALGREENS, CENTER FOR LIVING WELL AND PHARMACY FOR LIVING WELL

ANNUAL PRESCRIPTION DEDUCTIBLE

PHARMACY OUT-OF-POCKET MAXIMUM

PRE-AUTHORIZATION/STEP THERAPY/SPECIALTY MEDICATIONS

VALUE SELECT HMO

ADVENTHEALTH CASTCARE

ORLANDO HEALTH CAST ADVANTAGE

KAISER HMO (CA)

KAISER HMO (WA)

EXPRESS SCRIPTS

KAISER PERMANENTE

GENERIC: Up to a **\$4** copay
BRAND: You pay **35%** of the cost, up to **\$100** per prescription

GENERIC: Up to a **\$4** copay
BRAND: You pay **35%** of the cost, up to **\$80** per prescription

GENERIC: **\$10** copay
BRAND: **\$25** copay

Only National Preferred Formulary drugs are covered. Some drugs require preauthorization

Only formulary-listed drugs are covered

GENERIC: Up to an **\$8** copay
BRAND: You pay **30%** of the cost, up to **\$200** per prescription

GENERIC: Up to an **\$8** copay
BRAND: You pay **30%** of the cost, up to **\$160** per prescription

GENERIC: **\$20** copay (CA: 100-day supply)
BRAND: **\$50** copay (CA: 100-day supply)

Only National Preferred Formulary drugs are covered. Some drugs require preauthorization

Only formulary-listed drugs are covered

NONE

INDIVIDUAL: \$3,500
FAMILY: \$7,000

Medical and pharmacy combined

INDIVIDUAL: \$1,500
FAMILY: \$3,000

Medical and pharmacy combined

Some drugs require preauthorization/Step Therapy. Step Therapy applies for most specialty medications. Specialty drugs are required to be dispensed through Express Scripts' Accredited specialty pharmacy unit. Contact Express Scripts for details

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 Plan pays up to \$70 at Costco	Plan pays up to \$22	Plan pays up to \$155 (up to \$175 for featured frame brands) with 20% discount if price exceeds maximum; available once per calendar year Plan pays up to \$85 at Costco	Plan pays up to \$22
CONTACT LENSES (IN LIEU OF LENSES AND FRAMES)	\$40 copay for contact lenses exam (fitting and evaluation); plan pays up to \$130 for contact lenses (materials); available every other calendar year	Plan pays up to \$130	\$10 copay for contact lenses exam (fitting and evaluation); plan pays up to \$155 for contact lenses (materials); available once per calendar year	Plan pays up to \$130
COMPUTER VISION CARE	NONE		\$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**
- You will pay for supplemental coverage through after-tax contributions from your paycheck
- Cost of this coverage is based on your age

DEPENDENT LIFE INSURANCE

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

SPOUSE/PARTNER LIFE INSURANCE

Ten levels of coverage:

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

CHILD LIFE INSURANCE

Four levels of coverage:

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

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

INSURANCE COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

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

BASIC COVERAGE

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

SUPPLEMENTAL COVERAGE

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

LONG-TERM DISABILITY (LTD) INSURANCE

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

LTD/90

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

LTD/180

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

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

SHORT-TERM DISABILITY (STD) INSURANCE

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.