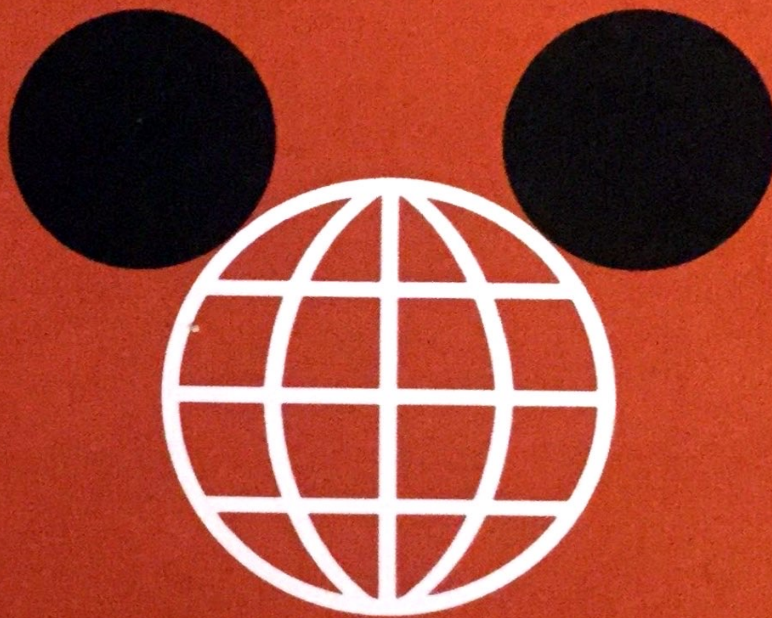
WALT DISNEY PRODUCTIONS
& ASSOCIATED COMPANIES

Employee Benefit Program



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DISNEYLAND

1313 Harbor Blvd. Anaheim, California 92803

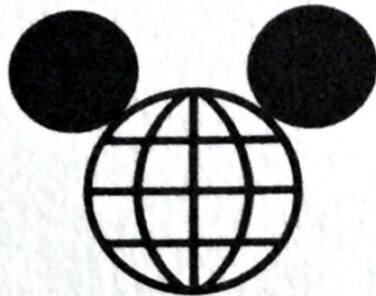
Telephone: (714) 533-4456

GROUP INSURANCE IDENTIFICATION CARD

The undersigned employee (and dependents if enrolled) has been insured for Hospital, Surgical and Medical Benefits under Group Policy No. G-91530 issued by The Prudential Insurance Company. The benefits referred to in this card are subject to the Group Policy provisions, exclusions, definitions and reductions.

For verification of current insurance status and details of this coverage, please contact the Group Insurance office at the address listed above.

D/FP (8/75) ______________________ Employee's Signature



The attached Identification cards will help to identify you and your family members as being enrolled in the Employee Benefit Program administered by Walt Disney Productions.

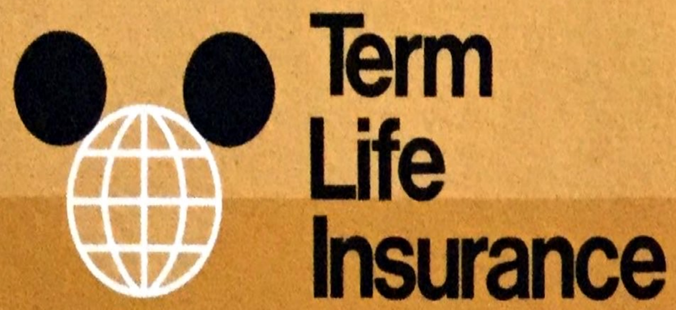
Take this card with you whenever it is necessary to seek medical or related services. Discuss charges that are to be made with those who are to furnish treatment. Generally your doctor or hospital will be pleased to discuss this with you.

Satisfy yourself that the charges will not be more than you would pay if you were not insured, nor more than is generally charged in your area for similar services. If you are in doubt as to the level of the charge, consult with your Group Insurance Department. Remember the amount of charges which are in excess of the customary charges are excluded from the Plan. Also, make sure only necessary services are ordered. In this way you will be doing your part in keeping the Plan available for everyone and at the same time will be holding your own out-of-pocket expense to a minimum.

Major Medical Plan

"For employees who qualify for Full Prudential coverage"

Long Term Disability



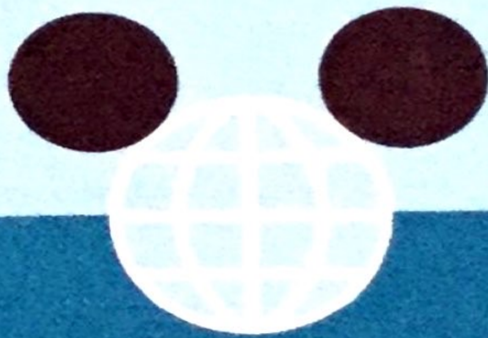
Term Life Insurance

"For employees who qualify for Full Prudential coverage"

EMPLOYEE GROUP INSURANCE PROGRAM

WALT DISNEY PRODUCTIONS
& ASSOCIATED COMPANIES

DISNEYLAND



Major Medical Plan

"For employees who qualify for Full Prudential coverage"

WDP/D-FP (MEDICAL) 8/75

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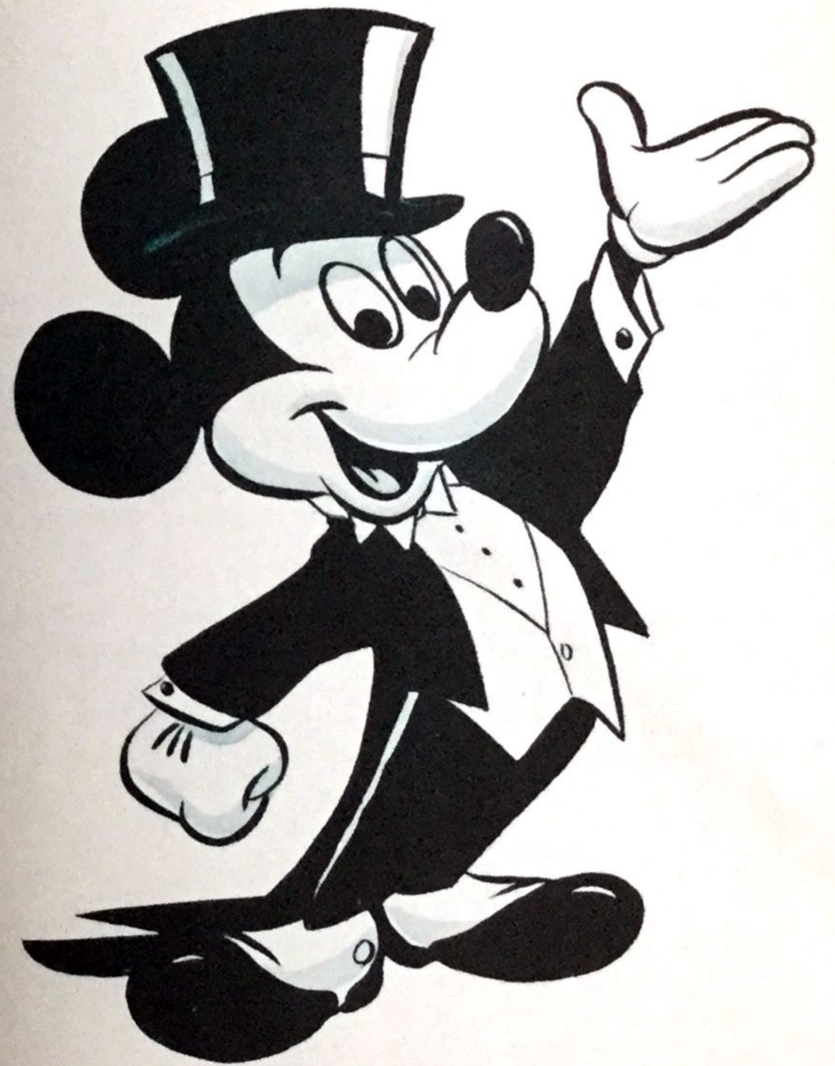

INTRODUCTION

The purpose of the Group Insurance Plan is to provide employees and their dependents with insurance protection against the expenses caused by non-occupational illnesses or injuries. The insurance provides benefits for a wide range of services and supplies for medical care.

The Company pays a substantial portion of the cost of the Plan and the entire cost of its administration, thus bringing this valuable protection within the reach of everyone.

The insurance has been carefully developed to provide worthwhile protection for you and your family and we encourage your participation.

WDP/D:FP-8/75

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MEDICARE SUPPLEMENT PLAN 24

ELIGIBILITY

If you are a regular-permanent employee scheduled to work 20 or more hours per week, you may enroll yourself and your eligible dependents in the Group Major Medical Insurance Plan.

If you do not enroll within 31 days after you could first be insured, you will be required to furnish evidence of good health for yourself and for each eligible dependent.

EFFECTIVE DATE OF INSURANCE

If you have enrolled, the insurance will become effective on the first day of the calendar quarter (January 1, April 1, July 1, or October 1) following your completion of one month of continuous employment.

If you are not actively at work on the day the insurance would ordinarily have become effective, it will not become effective for you or your dependents until you return to active employment under conditions which are within the eligibility requirements of this Group Insurance Plan.

A dependent (except a new-born child) who is confined for medical care or treatment in any institution or at home when the insurance would ordinarily have become effective will not be covered until given a final release by the doctor from all such confinement.

For a sickness or injury that has caused medical expenses during the 90 days before you or a dependent becomes insured, a "pre-existing condition" exclusion applies under the Major Medical Expense Insurance, as explained on page 15.

CONTRIBUTIONS

When you enroll you will be notified of your weekly contribution rate by the Group Insurance Office. For your convenience, your contribution is deducted from your pay.

WDP/D:FP 8/75

ELIGIBLE DEPENDENTS ARE:

Your spouse (unless legally separated)

Your unmarried children less than 19 years of age.

Unmarried children who are age 19 but less than 23 are also eligible if they depend upon you for support and maintenance and are full-time students in an educational institution.

"Children" include stepchildren, foster children and legally adopted children, provided they depend upon you for support and maintenance.

No evidence of good health is required to add newly acquired dependents if they are enrolled within 31 days following the date they first became eligible dependents.

A new born child is eligible from birth except for hospital room and board charges during the first seven days unless such charges are for a diagnosed sickness or injury.

No one will be eligible as a dependent who is eligible as an employee, or who is in military service.

If both parents are insured as employees, children may be included as dependents of one parent only.

A child who is physically or mentally incapable of self-support upon attaining age 19 may be continued under the health care insurance while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. This privilege also will apply to a child who has remained in the Group Insurance Plan beyond his nineteenth birthday if he later ceases to be a qualified dependent and is then physically or mentally incapable of self-support and is not married. To continue a child under this provision, proof of incapacity must be received by Prudential within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

NOTE: Anyone who is eligible for Medicare, employee or dependent, see page 24 for description of Medicare Supplement Plan.

SUMMARY OF BENEFITS

MAJOR MEDICAL EXPENSE INSURANCE

BENEFITS NOT SUBJECT TO A DEDUCTIBLE

Hospital Expenses

The insurance pays 90% of eligible charges for room and board and other hospital services. Room and board charges are limited to charges for semi-private room accommodations.

Provision also is made for covered expenses for convalescent nursing home care following certain hospitalization. Details appear on page 10.

Ambulance Expenses

The insurance pays 90% of ambulance service for local travel.

Surgical Expenses

The insurance pays 90% of the Reasonable and Customary charges for the Primary Surgeon and Assistant Surgeon.

Anesthesia Expenses

The insurance pays 90% of eligible charges for the Anesthetist.

Diagnostic X-ray and Laboratory Expenses

The insurance pays 90% of the eligible charges for X-ray and laboratory examinations.

Accident Expenses

All eligible expenses incurred within 90 days of an accident are paid at the rate of 90%.

Maternity Expenses

The insurance pays up to a maximum of $350 for any one pregnancy. Additional benefits are available under other parts of the Major Medical Expense Insurance for specified complications of pregnancy.

SUMMARY OF BENEFITS

MAJOR MEDICAL DEDUCTIBLE AND COINSURANCE:

Other eligible expenses are subject to deductible and coinsurance as outlined below:

DEDUCTIBLE $100 Calendar Year Deductible per individual (with a $250 Family Maximum).

COINSURANCE 90% of eligible expenses paid by the Group Insurance Plan.

10% of eligible expenses paid by the employee.

OTHER FEATURES OF THE PLAN:

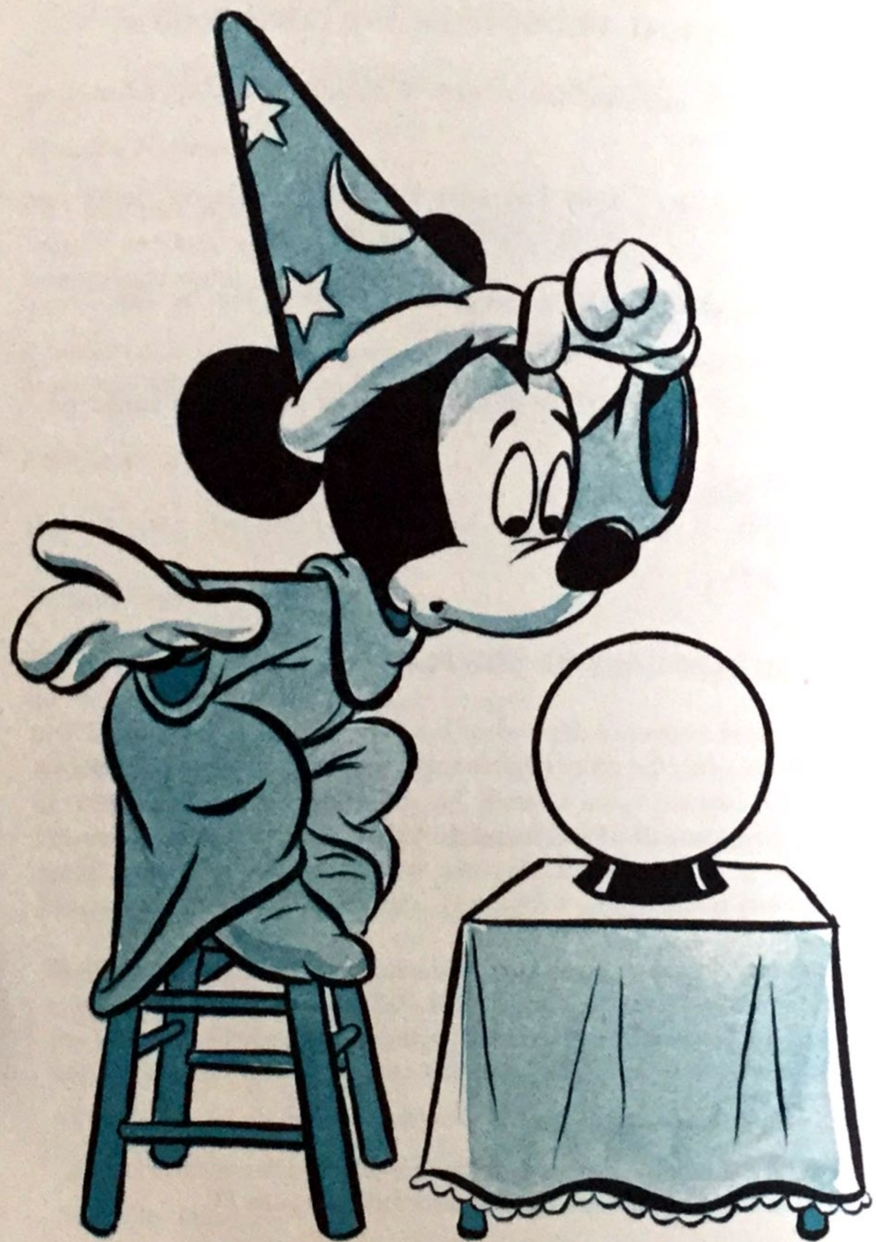
After you or a covered dependent has satisfied the deductible of $100 in a calendar year, the other eligible expenses (listed on page 13) are paid at 90%.* However, once a family has collectively accumulated $250 in eligible expenses (but not more than $100 for any one member), benefits will be paid the rest of the year for all covered members without additional deductibles.

However, if at any point during the year eligible expenses of a **family paid for by you** reach a total of $1,000 (including expenses used to satisfy the deductible), the rate of payment on the eligible expenses will be increased to a full 100%* and that rate will continue to apply for the rest of the year.

*50% of the eligible expenses in the case of certain treatment of mental, psychoneurotic and personality disorders (See page 15).

MAXIMUM MAJOR MEDICAL EXPENSE BENEFIT

The maximum lifetime benefit is $500,000 per individual ($20,000 maximum for mental, psychoneurotic and personality disorders).



MAJOR MEDICAL EXPENSE INSURANCE

For You and Your Covered Dependents

The Major Medical Expense Insurance applies to covered expenses for the treatment of injuries and sicknesses.

BENEFITS NOT SUBJECT TO DEDUCTIBLE

HOSPITAL EXPENSES

For each confinement, the insurance will pay 90% of the following eligible hospital expenses:

1. **Room and Board** — Charges for semi-private room and board.

2. **Other Hospital Services** — Expense incurred during a hospital stay resulting in a room and board charge for services and supplies furnished by the hospital for medical care such as operating room, X-rays, laboratory tests, medicines, etc., but not professional services. Pre-admission X-ray and laboratory tests in the hospital are also included provided the resulting confinement starts within 10 days.

Even if there is no room and board charge, the expenses for the services and supplies in item 2 above will be paid under this part of the insurance if the visit is for emergency care within 48 hours after an accident or is for a surgical procedure. Otherwise these expenses will be combined with the "Other Eligible Expenses" listed on page 13.

AMBULANCE EXPENSES

The insurance will pay 90% of the charges for ambulance service for local travel.

SURGICAL EXPENSES

This part of the insurance will pay 90% of the reasonable and customary fees of your primary surgeon and assistant surgeon for the following doctors' services:

1. The immediate pre-operative examination by the doctor performing the procedure.
2. Performance of the procedure.

3. Assistance with the procedure where required by the nature of the procedure or by the patient's condition, provided not performed in a hospital having available staff physicians qualified to provide such assistance.

4. Post-operative care required by and directly related to the procedure.

The procedure may be performed in the doctor's office, in a hospital or anywhere.

Any of the following will be considered a surgical procedure: cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electocauterizing, tapping (paracentesis), applying plaster casts, administration of pneumothorax, endoscopy or injecting sclerosing solution.

ANESTHESIA EXPENSES

The insurance will pay 90% of the charges for the anesthetist.

DIAGNOSTIC X-RAY AND LABORATORY EXPENSES

The insurance will pay 90% of the eligible charges for X-ray and laboratory examinations.

ACCIDENT EXPENSES

The insurance will pay 90% of all eligible expenses incurred within 90 days of an accident.

For covered dental treatment due to an accident, see MAJOR MEDICAL EXPENSE INSURANCE — LIMITATIONS AND EXCLUSIONS on page 15.

MATERNITY EXPENSES

For Female Employees and Employees' Wives

The following expenses for a covered maternity case will be paid **without a deductible,** up to the maximum of $350 for any one pregnancy:

1. Doctor's fee for an obstetrical procedure.

2. Hospital's bill for room, board, and other services furnished by the hospital for medical care, such as delivery room, operating room, medicines, X-rays, laboratory tests, etc., but not professional services.

3. Fee for administration of anesthetics by a doctor in the hospital.

4. Charges for ambulance service for local travel to and from the hospital.

EXCLUSIONS

A pregnancy commencing before a female employee or an employee's wife becomes insured is not covered.

For specified complications of pregnancy refer to page 13.

CONVALESCENT NURSING HOME EXPENSES:

This benefit will help pay for a convalescent nursing home confinement after a hospital stay of at least five consecutive days that was covered by the insurance. The confinement must start within seven days after release from the hospital and be recommended by your doctor for the condition causing the hospitalization.

The eligible expenses are the nursing home charges, up to a daily limit equal to 50% of the standard semi-private room rate in the hospital from which the patient was transferred, for room, board and other services and supplies furnished by the home for necessary care, excluding personal items and professional services.

Benefits will be available only while the patient is under his doctor's continuous care and requires 24-hour nursing care. A 60-day limit applies to all nursing home care due to the same or related causes.

EXPENSES FOR REMOVAL OF IMPACTED TEETH

	Maximum Payment*
Impacted tooth, one, excision of—(soft tissue impactions excepted)	
Partially unerupted from jaw bone—	
Maxilla	$18.00
Mandible	30.00
Completely unerupted from jaw bone	60.00

*When two or more impacted teeth are excised during the same operative session, the Maximum Payment for all such excisions shall be limited to the sum of (i) the largest Maximum Payment otherwise applicable to one of the excisions and (ii) 50% of the Maximum Payment otherwise applicable to each of the other excisions.

MAJOR MEDICAL DEDUCTIBLE AND COINSURANCE:

The deductible is the first $100 of eligible expenses, other than the expenses that are not subject to a deductible, as previously described, incurred by the individual during the calendar year.

Each insured need satisfy the deductible only once per year even if more than one illness is involved. Once a family has collectively accumulated $250 in eligible charges (but not more than $100 for any one member), benefits will be paid the rest of the year for all covered members without additional deductibles.

Although a new deductible will apply each calendar year, expenses incurred during the last three months in a year which are applied against that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate that year's deductible.

After you or a covered dependent has satisfied the deductible in a calendar year, the other eligible expenses (listed on page 13) are paid at 90%* for all eligible expenses incurred by the individual during the rest of the year. However, if at any point during the year eligible expenses of a family **paid for by you** reach a total of $1,000 (including expenses used to satisfy the deductible), the rate of payment will be increased to a full 100%* and that rate will continue to apply for the rest of the year.

*50% of the eligible expenses in the case of certain treatment of mental, psychoneurotic and personality disorders (see page 15).

OTHER ELIGIBLE EXPENSES

Expenses In or Out of the Hospital

Doctors' services — Home, office and hospital visits, and other medical care and treatment.

Nursing care — Private duty nursing by a registered graduate nurse.

Speech therapy — By a qualified speech therapist to restore speech loss, or correct an impairment, due to (a) a congenital defect for which corrective surgery has been performed, or (b) an injury or sickness except a mental, psychoneurotic or personality disorder.

Physiotherapy — Treatment by a physiotherapist.

Radium treatments and treatments with other radioactive substances.

Medical supplies — Drugs and medicines dispensed by a licensed pharmacist; blood and blood plasma; artificial limbs, eyes and larynx; electronic heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches; rental of wheel chair, hospital bed, or iron lung; oxygen and rental of equipment for its administration.

BENEFIT FOR CERTAIN COMPLICATIONS OF PREGNANCY

The Major Medical Expense Insurance makes certain provisions for the following expenses incurred for a covered maternity case, but not paid by the Basic Maternity Benefit: (a) covered expenses, while hospitalized, for pernicious vomiting or toxemia with convilsions, and (b) covered expenses for the following surgery and related hospital services and other services received after the surgery: Caesarean after six months, intra-abdominal surgery after pregnancy terminates, operation for extra-uterine pregnancy.

OVERALL MAXIMUM FOR EACH INDIVIDUAL

There is an overall maximum Major Medical Expense benefit for you and for each covered dependent of $500,000. Whenever benefits are paid they are charged against the individual's overall maximum. The benefits for expenses due to mental, psychoneurotic and personality disorders will not exceed the limit of $20,000.
However, to prevent anyone from being without medical expense protection due to one or more illnesses or injuries, the insurance contains the following provisions for restroring benefits:

Automatic Reinstatement — On the first of each year, each covered person less than age 65 who then has benefits charged to his overall maximum will automatically have an amount reinstated for future use. The amount to be reinstated each year will be $1000, or the amount needed to bring the maximum back to the full amount, whichever is less.

Request for Reinstatement — At any time after the benefits charged to an individual's overall maximum reach a total of at least $1000, you may arrange to have the full maximum reinstated by furnishing satisfactory proof the individual is in good health.

COORDINATION WITH OTHER PLANS

Our medical insurance program contains a provision coordinating the benefits it pays with those of any other group plans under which you may have coverage. When you make a claim, the benefits under our Group Insurance Plan may be adjusted so that the total benefits you receive will not exceed 100 percent of your allowable expenses. (An "allowable expense" is any reasonable, necessary and customary expense covered by any of the plans under which you may be insured.)

The "other plans" subject to this coordination of benefits arragement are any plans or programs provided or required by law; or any other plans of group insurance or other group coverage, including all pre-payment plans.

LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITION

If any expenses are incurred for an injury or sickness, including a mental, psychoneurotic or personality disorder, during the 90 days before the date you or your dependent become insured, the Major Medical Expense Insurance will not apply to that particular condition until it has caused no expenses for 90 days, or the individual has been covered for one year, whichever is earlier.

MENTAL, PSYCHONEUROTIC AND PERSONALITY DISORDERS

In the case of mental, psychoneurotic and personality disorders, the benefits for a doctor's services will be payable at the rate of 50%, after satisfaction of the yearly deductible, instead of the usual rate. Also, not more than 50 visits in a calendar year nor more than $25 a visit, will be counted as eligible expenses (the maximum payment being $12.50 a visit or 50% of $25).

The above limits do not apply to doctor's services during a hospital confinement resulting in a room and board charge, nor for administering convulsive therapy.

MOUTH CONDITIONS

The insurance does not cover treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure. However, this exclusion does not apply to charges for the removal of impacted teeth as described on page 12 and to charges for the following dental services received within 12 months after an accident: Treatment by a physician, dentist, or dental surgeon of injuries to natural teeth including replacement of such teeth, and related X-rays.

PREGNANCY

The benefits for expenses due to pregnancy are as described in "Maternity Expenses on page 9, and apply only to a covered pregnancy of a female employee or an employee's wife.

THE MAJOR MEDICAL EXPENSE INSURANCE DOES NOT COVER:

1. Services or supplies received as a result of an accident related to employment, or sickness covered under workers' compensation or similar law.

2. Services or supplies (a) furnished by or for the U.S. Government, or (b) furnished by or for any other government unless payment is legally required, or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.

3. Anything not ordered by a doctor, or not necessary for medical care; the portion of a charge for a service or supply in excess of the reasonable and customary charge (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience, or for a substantially equivalent supply).

4. Nursing, speech therapy, or physiotherapy rendered by yourself, spouse, or a child, brother, sister, or parent of yourself or spouse.

5. Services or supplies received as a result of an act of war occurring while covered.

6. Expenses in connection with cosmetic surgery unless due to an accident occurring while covered; examinations in connection with glasses or a hearing aid.

7. Treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations, (b) corns, calluses or toenails, except removing nail roots and care prescribed by an M.D. or D.O. treating metabolic or peripheral-vascular disease.

Other exclusions appear on prior pages describing the Major Medical Expense Insurance.

TERMINATION OF INSURANCE

The insurance for yourself and your dependents will terminate if you discontinue your contributions, if you cease to be an eligible employee, or if the Group Insurance Plan is discontinued. A dependent's insurance will terminate when he is no longer an eligible dependent.

CHANGE TO AN INDIVIDUAL HOSPITAL AND SURGICAL EXPENSE INSURANCE POLICY

The Prudential makes available an individual Hospital and Surgical Expense policy, subject to established rules, to an employee whose Major Medical Expense Insurance is terminated through termination of employment.

This privilege also is available for a covered dependent who ceases to be an eligible dependent for Major Medical Expense Insurance.

Application for the individual policy must be made within 31 days from the termination of the Group coverage and is subject to the employee having been insured under the Group Insurance Plan for at least 3 months.

Additional information may be obtained from the employer by anyone who is eligible for an individual policy. Information also is available from a Prudential home office.

EXTENSION OF BENEFITS

If you or a covered dependent are totally disabled and under the care of a physician for reasons other than pregnancy when your employment terminates, the Major Medical Expense benefits will be extended during the total disability to the end of the next following calendar year. These extended benefits will apply only to expenses due to the sickness or injury which caused the total disability of you or your covered dependent.

The benefits payable during the period the coverage is extended will not exceed the balance of the overall maximum remaining to the individual's credit at the start of the extended period.

For a pregnancy which exists when employment terminates and which would have been eligible for maternity benefits had employment continued, coverage will be extended as follows:

(a) Maternity Benefit — For a period of nine months after termination of employment.

(b) Benefit for Certain Complications of Pregnancy — For the duration of the pregnancy. If the individual is in a hospital at the termination of the pregnancy, the coverage will be further extended while she remains confined in the hospital due to the pregnancy.

DEFINITIONS FOR THE PURPOSE OF THE INSURANCE

Doctor — A licensed practitioner of the healing arts acting within the scope of his practice. Such term also includes the personal advice of a Christian Science Practitioner authorized by The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts.

Hospital — A legally operated institution providing in-patient care and treatment through medical, diagnostic and major surgical facilities on its premises, under supervision of a staff of doctors, and with 24-hour-a-day nursing service; or one accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or a Christian Science Sanatorium, or other institution, approved by the Committee on Christian Science Nursing Homes of The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts. The term does not include a nursing home nor an institution, or part of one, used mainly as a facility for convalescence, nursing, rest, or the aged.

Convalescent Nursing Home — A legally operated institution that (a) for a fee provides convalescents with room, board and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care, (b) is under full-time supervision of a doctor or registered graduate nurse (RN), (c) keeps adequate medical records, (d) if not operated by a doctor, has the services of one available under an established agreement, and, (e) is not an institution, or part of one, used mainly as a rest facility or a facility for the aged.

Registered Graduate Nurse — The term will also include a Christian Science Nurse authorized by The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts.

SPECIAL FEATURES PERTAINING TO CONTINUATION OF MEDICAL COVERAGE

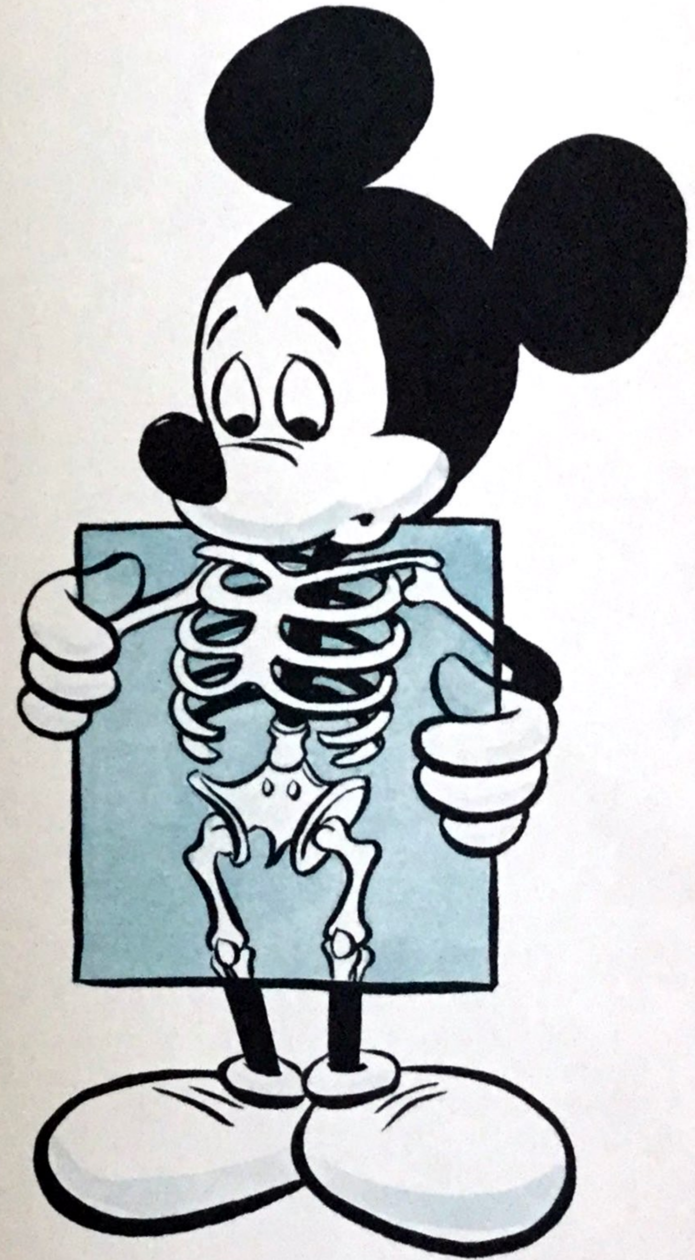
INSURANCE DURING TOTAL DISABILITY — If you become totally disabled, the Company will continue the Major Medical Expense Insurance for you and your insured dependents for 12 months during disability leave of absence at no cost to you. If you remain totally disabled at the end of the disability leave of absence, **your** insurance will be continued under the "Extension of Benefits" for the condition for which you became disabled (see page 17 for details). In addition, regular medical coverage (for all eligible conditions) may be purchased at your own expense, for you and your insured dependents, so long as you remain totally disabled.

INSURANCE AT DEATH OF EMPLOYEE — At your death, the Company will continue the Major Medical Expense Insurance for your insured dependents for 12 months. After the 12 months, the insurance may be continued for your eligible dependents at their expense as long as the required premium payments are made. In all cases, however, coverage will terminate at the death or remarriage of the insured spouse.

INSURANCE AT RETIREMENT — If you have at least one year of employment with the Company and retire at age 65 under the Company Retirement Program, the employee and dependent Major Medical Expense Insurance may be continued at your own expense.

If you have ten years of employment with the Company and retire between the ages of 62 and 65, your employee and dependent Major Medical Expense Insurance may be continued at your own expense.

Additional information regarding these features may be obtained by contacting your Personnel Department or your Group Insurance Department.



HOW TO FILE A CLAIM

Should it become necessary for you to present a claim for yourself or one of your eligible dependents, the necessary claim forms should be obtained from the Group Insurance Department.

All claims for each illness or each accident must be supported by a claim form completed by your attending Physician.

NOTE: Be certain to complete the employee portion of the claim form.

Bills for subsequent medical services for the same condition may be submitted without an additional claim form.

HOSPITAL EXPENSES

Have the hospital complete the hospital claim form or in lieu thereof obtain an itemized statement of charges.

PHYSICIAN'S CHARGES

Obtain itemized bills for all eligible services showing name of patient, date and amount of each charge.

PHARMACY CHARGES

Obtain from the pharmacy an itemized receipt for all eligible charges showing name of patient, prescription number, date and amount of each charge.

NOTE: CASH REGISTER SLIPS ARE NOT ACCEPTABLE.

Registered Nurse or Physiotherapy Charges

Obtain an itemized receipt showing name of patient, number of hours, dates and charges.
Also signature, degree and registry number.

X-ray, Laboratory, Medical Supplies and Equipment

Such services must be prescribed by your doctor.
Obtain itemized bills showing name of patient, type of service or supplies, date and amount of charge.

SURGERY

Surgeon's Fee	$ 700.00
Assistant Surgeon	220.00
Anesthesia	175.00
Total	$1,095.00

HOSPITAL BILL

Room and Board—7 days @ $85.00 (Hospital's Semi-private rate)	$ 595.00
Other Charges (operating room, etc.)	965.00
Total	$1,560.00

NURSING SERVICE

Private Nurses 2 days—24 hours per day	$ 288.00
TOTAL CHARGES	$2,943.00

Here is how the Plan would pay these charges:

Item	Charge	Paid at 90%	Applied To Deductible Provisions
Hospital room and board	$ 595.00	$ 535.50	—0—
Other hospital	965.00	868.50	—0—
Anesthesia	175.00	157.50	—0—
Surgeon's fees	700.00	630.00	—0—
Assistant Surgeon	220.00	198.00	—0—
Private Nurses	288.00	—0—	288.00
Totals	$2,943.00	$2,389.00	$288.00
		less deductible	$100.00
		(not previously satisfied)	
		Balance	$188.00

Plan pays 90% of $188.00 = $169.20

SUMMARY: Total Charges $2,943.00
Plan Pays .... 2,558.20 ($2,389.00 + $169.20)
You Pay ....$ 384.80

ACCIDENT AND SICKNESS INSURANCE

FOR EMPLOYEES (except Employees located in California, New York or New Jersey).

If you are unable to work because of a non-occupational accident or sickness and under the regular care of a doctor, you will receive one half of your weekly wage, with a maximum benefit of $50 per week.

Benefits are payable from the eighth day of disability. Payments will continue as long as you are disabled, up to a maximum of 26 weeks during any one period of disability.

Periods of disability due to the same cause will be considered the same period of disability unless they are separated by return to full-time work for at least two weeks. Periods of disability due to different causes will be considered different periods of disability if they are separated by return to full-time work.

EXCLUSIONS

Benefits will not begin until the day shown in the schedule.

The insurance does not cover:

1. Disability due to an accident related to any employment, or sickness covered under worker's compensation or similar law.

2. Disability due to pregnancy.

See the definition of "doctor" on page 18.

If you have enrolled for coverage under the Company's Long Term Disability Insurance Plan you will receive additional benefits beginning on the 29th day of disability, supplementing the Accident and Sickness Insurance Benefits, in the amount needed to bring the benefit up to your Long Term Disability Benefit amount.

MEDICARE SUPPLEMENT PLAN

(Available only to employees or their dependents who are eligible for Medicare.)

MEDICARE SUPPLEMENT PLAN provides for limited Major Medical expense insurance benefits for all covered individuals who are or could be covered under MEDICARE.

The term "MEDICARE" means Health Insurance for the Aged as provided through the United States Social Security Act, Title XVIII.

When employees or their dependents become eligible for MEDICARE, their Walt Disney Productions and Associated Companies medical coverage is provided through the MEDICARE SUPPLEMENT PLAN.

This coverage is a supplement to Part A and Part B of Medicare, plus coverage in some areas not covered by Medicare.

BENEFITS ARE AS FOLLOWS:

AFTER SATISFACTION OF A $50.00 CALENDAR YEAR DEDUCTIBLE:

A. Plan pays 80% of unreimbursed expenses covered by Part A and Part B of Medicare, such as:

Hospital Deductible	Doctor Visits
Hospital Coinsurance	X-Ray
Surgery	Laboratory Tests
Anesthesia	Out of hospital appliances

B. Plan pays 80% of certain medical expenses not covered by Medicare, such as:

Drugs and Medicines dispensed by a licensed pharmacist.
Private Duty Professional Nursing Services.

C. Lifetime Maximum Major Medical Benefit payable is $500,000.

(For information regarding hospitalization outside the United States, please contact the Group Insurance Dept.)

ELIGIBILITY

You or your dependent will become eligible for the Medicare Supplement Plan on the first day of the month in which you become eligible for Medicare. It will be assumed that you have Medicare coverage whether you sign up for the voluntary plan (Part B of Medicare) or not.

DEDUCTIBLE

The $50 calendar year deductible is a common deductible and may be met in whole or in part by either Medicare or the Medicare Supplement Plan.

LIMITATIONS & EXCLUSIONS

Eligible charges shall not include any charges which are ineligible charges according to the terms and conditions of the Master Group Policy issued by The Prudential.

CLAIMS PROCEDURE:

A separate claim form *is not* necessary.

Itemized billings or the "Explanation of Benefits" Sheet as it comes from Medicare will be accepted by the Group Insurance Dept.

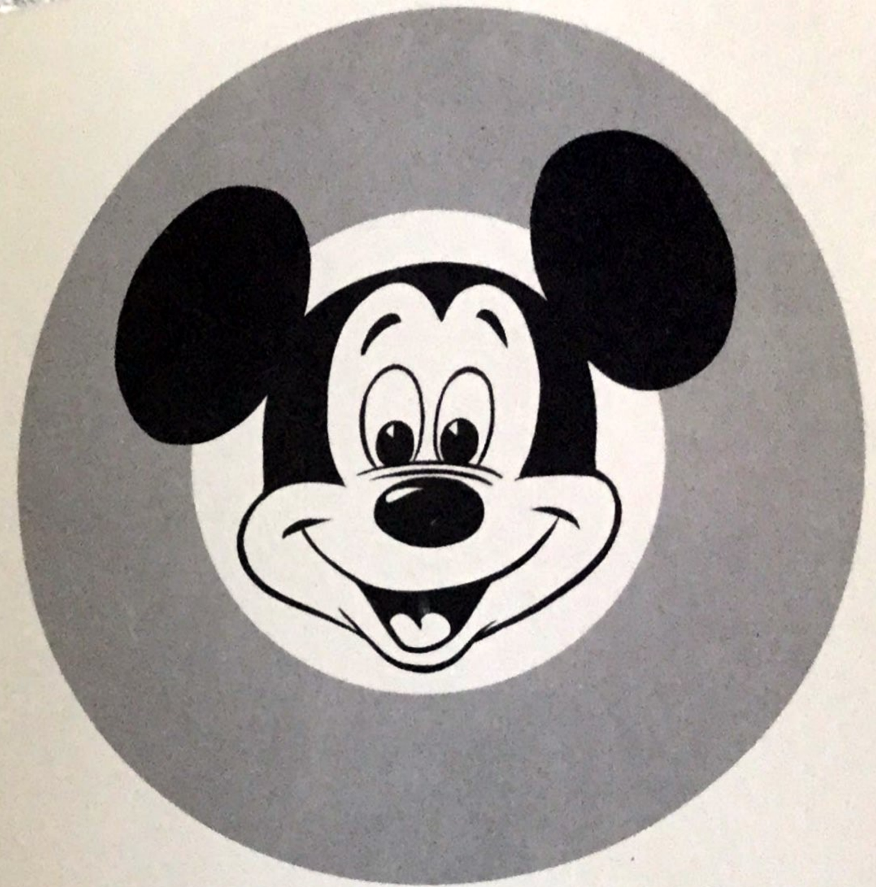
Claims should not be filed with Medicare or the Medicare Supplement Plan until at least $50 of reasonable charges have been incurred during the calendar year.

When medical expenses exceed $50 in a calendar year, submit itemized billings with a Medicare claim form to your local Medicare office.

When claim has been processed by Medicare, they will send you an "EXPLANATION OF BENEFITS" Sheet. This sheet together with receipts for items not covered through Medicare (drugs, medicines, appliances, etc.) should then be submitted to your group insurance office.

IMPORTANT—PLEASE NOTE:

Only members of the family who are eligible for Medicare are covered by the Medicare Supplement Plan. Members of the family who are not eligible for Medicare are provided with the coverage described elsewhere in this booklet.



POLICY AND CERTIFICATES

For simplicity, the Group Insurance Plan has been described in a rather general manner in this booklet. The benefits are described more fully in the individual certificates given to insured employees. The extent of the insurance for each individual is governed at all times by the complete terms of the master Group Insurance Policy issued by The Prudential.

CHANGE OR DISCONTINUANCE OF THE PLAN

The Company expects to continue the Group Insurance Plan indefinitely, but as it is customary in group insurance plans, the right of change or discontinuance at any time must be reserved.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
Western Home Office
Los Angeles, California