
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://benefits.sonypictures.com> or call 1-833-9-SONY-01. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-network Individual: <b>\$150</b> /Family: <b>\$300</b> Out-of-network: <b>Not applicable</b>	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-network: Individual <b>\$3,000</b> /Family: <b>\$6,000</b> ; Out-of-network: <b>Not applicable</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<p>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover.</p> <p>Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards</p>	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

	satisfying your out-of-pocket maximums.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For in-network providers, see <a href="http://www.aetna.com/dsepublic/#/sony">www.aetna.com/dsepublic/#/sony</a> or call 1-888-385-1053	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 copay / visit; deductible does not apply.	Not covered	———— None ————
	<a href="#">Specialist</a> visit	\$35 copay / visit; deductible does not apply	Not covered	———— None ————
	<a href="#">Preventive care/screening/immunization</a>	No charge; deductible does not apply	Not covered	Age and frequency schedules may apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% coinsurance	Not covered	———— None ————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	———— None ————
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.express-scripts.com/sonypics">https://www.express-scripts.com/sonypics</a> .	Generic drugs	\$10 copay/prescription (retail); \$20 copay/prescription (mail order)	Not covered	Maintenance prescriptions: Must be filled at a CVS pharmacy or through mail order; mail order cost share applies, covers 90-day supply.  All other prescriptions: Covers up to 30-day supply (retail prescription); 31-90 day supply (mail order prescription).  Please see "Important Questions" regarding the plan's out-of-pocket limit.
	Preferred brand drugs	30% coinsurance (retail - minimum \$25/prescription; maximum \$75/prescription); (mail order - minimum \$55/prescription; maximum \$125/prescription)	Not covered	
	Non-preferred brand drugs	40% coinsurance (retail - minimum \$40/prescription; maximum	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at <https://benefits.sonypictures.com> or call 1-833-9-SONY-01 to request a copy

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		\$100/prescription); (mail order - minimum \$70/prescription; maximum \$150/prescription)		
	<a href="#">Specialty drugs</a>	Specialty Drugs follow the respective tier's cost sharing	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	_____ None _____
	Physician/surgeon fees	10% coinsurance	Not covered	_____ None _____
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% coinsurance	10% coinsurance	Non-emergency use not covered.
	<a href="#">Emergency medical transportation</a>	10% coinsurance	10% coinsurance	Non-emergency use not covered.
	<a href="#">Urgent care</a>	\$35 copay/visit; deductible does not apply	Not covered	Non-urgent use not covered.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	_____ None _____
	Physician/surgeon fees	10% coinsurance	Not covered	_____ None _____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office: \$20 copay / visit; other outpatient services: 10% coinsurance, deductible does not apply.	Not covered	_____ None _____
	Inpatient services	10% coinsurance	Not covered	_____ None _____
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	_____ None _____
	Childbirth/delivery facility services	10% coinsurance	Not covered	_____ None _____

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% coinsurance	Not covered	Coverage is limited to 120 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$35 copay/visit; deductible does not apply	Not covered	Limited to 60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<a href="#">Habilitation services</a>	10% coinsurance, deductible does not apply.	Not covered	————— None —————
	<a href="#">Skilled nursing care</a>	10% coinsurance	Not covered	Coverage is limited to 120 days per calendar year.
	<a href="#">Durable medical equipment</a>	10% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	<a href="#">Hospice services</a>	10% coinsurance	Not covered	————— None —————
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	You may have other vision coverage not described here.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	You may have other dental coverage not described here.

### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental care (Adult &amp; Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency services outside of the U.S.</li> <li>• Routine eye care (Adult &amp; Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture: 30 visits per calendar year</li> <li>• Bariatric surgery</li> <li>• Chiropractic care: 30 visits per calendar year</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids: 1 hearing aid per ear annually, no dollar maximum</li> <li>• Private duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Fertility treatment: Fertility counseling and assisted reproductive technology treatments up to 4 SMART cycles administered through Progyny. Call 833-404-2011 to register.</li> </ul> |
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\* For more information about limitations and exceptions, see the plan or policy document at <https://benefits.sonypictures.com> or call 1-833-9-SONY-01 to request a copy

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Aetna at 1-888-385-1053, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Additionally, a consumer assistance program can help you file your appeal. Contact information is at <http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html>

### **Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-385-1053.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-385-1053.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-385-1053.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-385-1053.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist</a> copay	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,730</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$70
Coinsurance	\$1,220
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,500</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist</a> copay	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,390</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$530
Coinsurance	\$1,150
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,890</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist</a> copay	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,930</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$110
Coinsurance	\$150
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$410</b>