Sony Pictures Entertainment Inc.
Health and Welfare Benefits Plan
Summary Plan Description
January 2024

This summary plan description (SPD) provides a summary of your benefits updated as of January 1, 2024. It describes benefits provided to you by the Sony Pictures Entertainment Inc. Health and Welfare Benefits Plan (the "plan" or "SPE Benefits Plan") your plans and your rights under the plans. The SPD is based on official plan documents. It is not, nor is it intended to be, the official plan document, a contract between Sony and any employee or contractor, or a guarantee of future employment or benefits. Every effort has been made to ensure the accuracy of this information.

Note: This SPD is supplied solely for the purpose of helping you understand the plans—not to replace, amend, or add to the plans. To the extent that any of the information in this SPD is inconsistent with any official plan document, the provisions set forth in the official plan documents will govern in all cases. SPE reserves the right to amend, modify, or terminate, in whole or in part; any or all of the plan(s) or program(s) at any time and for any reason or for no reason by appropriate corporate action. Any such changes may affect the benefits payable to you and/or family members.

In addition, there may be situations where the plan(s) provides different benefits to different employee groups. This SPD identifies those benefits that are applicable to you based on your employee group. If you have questions about the benefits available to you, contact the SPE Benefits Center at 1-833-976-6901.

The Plan Administrator, or its duly authorized delegate, has the sole and absolute discretionary authority to interpret and apply the terms of the plans.

Also, in the event any provisions of this SPD may be held illegal or invalid for any reason, such illegality or invalidity will not affect remaining sections of this SPD, or the SPD will be construed and enforced as if the illegal or invalid provisions had never been included.

The information in this SPD is provided on https://benefits.sonypictures.com in the Basic/Resources section. (Log on to SPE Benefits Center at **https://benefitscenter.spe.sony.com** on the Internet or via your location's Intranet home page.) You have the ability to view the SPD on the Web site, and print pages of this SPD from the Web site. If there are any discrepancies between the information on the Web site and this printed copy, the Web site version will control.

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SPE Benefits Overview

The SPE Benefits Plan is designed to protect you financially in case of illness, accident, or death. SPE offers a variety of plan options and coverage levels so you can choose the coverage that's right for you.

Enrolling for Coverage

You receive some coverage automatically once you become eligible (Refer to page 22). For other coverage, you need to enroll. If you don't enroll, you'll be assigned certain coverage for you alone; your eligible dependents will not be covered. (For some benefits, you'll be assigned "No Coverage".)

If you're a new employee, you have thirty-one days to enroll for benefits from the date your benefits enrollment information is provided. You'll make elections for the rest of the current plan year (January 1 to December 31). You can then make changes during any annual enrollment period (certain changes could require Evidence of Insurability to be provided)

If you're a current employee covered under the plan, you can change your coverage during the annual enrollment period.

If you have a qualified change in status, you can make mid-year changes to your coverage that are consistent with your status change (See "Changing Your Coverage During the Year" on page 26).

If You Have Other Medical Coverage Available

You may be eligible for coverage under more than one medical plan—for example, your spouse may be able to cover you under their employer's plan. In this case, you can waive medical coverage under the SPE plan, but you must certify that you have coverage elsewhere.

Having coverage under more than one medical plan doesn't necessarily mean you get more benefits. Most plans coordinate benefits, which mean your total benefit is limited to what you would receive under the plan with the highest coverage level. (See "Coordination of Benefits," page 112.)

Be sure to review the medical benefits offered by both plans carefully before making your enrollment choices.

Note: If you waive medical coverage initially for you and your dependents due to having other medical coverage, you can enroll yourself and your dependents at a later date—for example, during annual enrollment or if you lose other medical coverage (see "Changing Your Coverage During the Year," page 26)

Paying for Coverage

SPE pays a significant share of the SPE Benefits Plan costs no matter which options you choose and whether you cover family members.

You pay your share of the cost (if any) for the following coverages with **before-tax** payroll deductions, if eligible:

- Medical;
- Dental;
- Vision;
- Health Care Flexible Spending Account or Health Savings Account (HSA) (depending upon which medical plan you are enrolled in); and
- Dependent Care Flexible Spending Account.

You pay for the following coverages with **after-tax** payroll deductions, if eligible:

- Supplemental Life Insurance
- Dependent Child Life Insurance;
- Supplemental LTD coverage;
- Legal Plan;
- Voluntary Group Accident Insurance; and
- Voluntary Hospital Indemnity Insurance.

You pay for the following coverages directly to the insurance company on an after-tax payroll basis

- Voluntary Long-Term Care & Life Insurance Program

Payroll deductions and direct payments to insurers will begin as soon as administratively possible. Please note that some coverage may result in "imputed income" to you. Additional information about imputed income is discussed in the relevant benefit coverage sections within this SPD.

Eligibility for Coverage

Who Is Eligible for Employee Coverage

You are eligible to participate in one or more Plan benefits set forth in the table below if you are:

- Employed and classified by a Participating Employer as an eligible employee who satisfies the eligibility criteria set forth in the table for that benefit, and
- Not otherwise excluded from that benefit (as indicated), and
- Satisfy the eligibility criteria set forth in the underlying Benefit Description for the benefit.

To be considered an employee, the Participating Employer must treat you as its employee for employment tax withholding purposes. Your employer has the sole and complete discretionary authority to classify employees and other individuals performing services for it, and to determine whether the eligibility requirements set forth herein have been satisfied. Individuals who are not classified as members of an eligible category do not meet the eligibility requirements and are not eligible for benefits under the Plan, even if your employer later determines that their classification is erroneous or should be retroactively revised. If a classification of an individual or group as ineligible is determined to be incorrect or is revised retroactively, the individual nevertheless will remain ineligible. This ineligible status will apply for all periods prior to the date your employer or other authority concludes that the classification was incorrect and should be revised. A list of Participating Employers is set forth on page 17.

Benefit	Eligibility Requirements	Specific Exclusions
PPO (includes medical, prescription drugs) **Dental PPO (Group Dental)**	Employees whose employment is with a Participating Employer listed in Appendix A who are not union employees and who are classified by the Employer as either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the United States; (ii) a Show Hire Employee; (iii) Covered under a Term Deal, provided that the Employer's agreement with the producer with respect to the Term Deal expressly states the Employee is eligible to participate in the Plan; or (iv) a SPA Term Deal Employee.	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal (except as otherwise specifically provided) • An intern • A trainee • A temporary employee • A consultant • A Production Hire • A Project Hire • Represented for collective bargaining with respect to the terms and conditions of the employee's employment with the Employer (except as otherwise specifically provided) • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.

HDHP (includes, medical, prescription drugs) with HSA*	Employees whose employment is with a Participating Employer listed in Appendix A who are not union employees and who are classified by the Employer as either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the United States; (ii) a Show Hire Employee; (iii) Covered under a Term Deal, provided that the Employer's agreement with the producer with respect to the Term Deal expressly states the Employee is eligible to participate in the Plan; or (iv) SPA Term Deal Employee; or (v) a trainee; or (vi) an intern OR A full-time Employee (regularly scheduled to work 20 hours per week over a five-day work week for an indefinite period) working in the US, and classified by the Employer as: (i) a Production Hire on an Imageworks production working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B2 Employer"; (ii) a Project Hire working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer";	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal (except as otherwise specifically provided) • A temporary employee • A consultant • A Production Hire • A Project Hire • Represented for collective bargaining with respect to the terms and conditions of the employee's employment with the Employer (except as otherwise specifically provided) • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.
EPO (includes medical, prescription drugs)	Employees whose employment is with a Participating Employer listed in Appendix A, who are not union employees and who are classified by the Employer as either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the US; (ii) a Show Hire Employee at "B1 Employer"; (iii) covered under a Term Deal (if agreement with the producer expressly provides for eligibility); or	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal (except as otherwise specifically provided) • A temporary employee • A consultant • A Production Hire (except as otherwise specifically provided) • A Project Hire (except as otherwise specifically provided) • Represented for collective bargaining with respect to the terms and conditions of the

	(iv) SPA Term Deal employee; or (v) a trainee; or (vi) an intern OR A full-time Employee (regularly scheduled to work 20 hours per week over a five-day work week for an indefinite period) working in the US, and classified by the Employer as: (i) a Production Hire on an Imageworks production working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage, and employment with a "B2 Employer"; (ii) a Project Hire working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer";	employee's employment with the Employer (except as otherwise specifically provided) • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program; An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.
HMO (includes medical, prescription drugs)	Employees whose employment is with a Participating Employer listed in Appendix A, who are not union employees and who are classified by the Employer as either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the US; (ii) a Show Hire Employee at "B1 Employer"; (iii) covered under a Term Deal (if agreement with the producer expressly provides for eligibility); or (iv) SPA Term Deal employee; or (v) a trainee; or (vi) an intern OR A full-time Employee (regularly scheduled to work 20 hours per week over a five-day work week for an indefinite period) working in the US, and classified by the Employer as: (i) a Production Hire on an Imageworks production working in the State of California	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal (except as otherwise specifically provided) • A temporary employee • A consultant • A Production Hire (except as otherwise specifically provided) • A Project Hire (except as otherwise specifically provided) • Represented for collective bargaining with respect to the terms and conditions of the employee's employment with the Employer (except as otherwise specifically provided) • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program; • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.

	or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage, and employment with a "B2 Employer"; (ii) a Project Hire working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; (iii) an Employee of the Employer represented by Local 174 of the Office & Professional Employees International Union (OPEIU) who has not met the initial eligibility requirements for the Motion Picture Industry Health Plan	
Dental DMO	Employees whose employment is with a Participating Employer listed in Appendix A, who are not union employees and who are classified by the Employer as either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the US; (ii) a Show Hire Employee at "B1 Employer"; (iii) covered under a Term Deal (if agreement with the producer expressly provides for eligibility); or (iv) SPA Term Deal employee; or (v) a trainee OR A full-time Employee (regularly scheduled to work 20 hours per week over a five-day work week for an indefinite period) working in the US, and classified by the Employer as: (i) a Production Hire on an Imageworks production working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage, and employment with a "B2 Employer"; (ii) a Project Hire working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal (except as otherwise specifically provided) • An intern • A temporary employee • A consultant • A Production Hire (except as otherwise specifically provided) • A Project Hire (except as otherwise specifically provided) • Represented for collective bargaining with respect to the terms and conditions of the employee's employment with the Employer (except as otherwise specifically provided) • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program; • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.

	Coverage and employment with a "B3 Employer";	
Vision	Employees whose employment is with a Participating Employer listed in Appendix A, who are not union employees and who are classified by the Employer as either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the US; (ii) a Show Hire Employee at "B1 Employer"; (iii) covered under a Term Deal (if agreement with the producer expressly provides for eligibility); or (iv) or SPA Term Deal employee; or (v) a trainee OR A full-time Employee (regularly scheduled to work 20 hours per week over a five-day work week for an indefinite period) working in the US, and classified by the Employer as: (i) a Production Hire on an Imageworks production working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage, and employment with a "B2 Employer"; (ii) a Project Hire working in the State of California or New York who has received open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; (iii) an Employee of the Employer represented by Local 174 of the Office & Professional Employees International Union (OPEIU) who has not met the initial eligibility requirements for the Motion Picture Industry Health Plan	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal (except as otherwise specifically provided) • An intern • A temporary employee • A consultant • A Production Hire (except as otherwise specifically provided) • A Project Hire (except as otherwise specifically provided) • Represented for collective bargaining with respect to the terms and conditions of the employee's employment with the Employer (except as otherwise specifically provided) • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program; • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.

Flex Benefits (FSAs premium pay, & HSA)	Employees whose employment is with a Participating Employer listed in Appendix A who are not union employees, and are classified by the Employer as either: (i) Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the United States; or (ii) a Show Hire Employee	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal or SPA Term Deal • An intern • A trainee • A temporary employee • A consultant or independent contractor (or their employees) • A Production Hire • A Project Hire • Represented for collective bargaining with respect to the terms and conditions of employment with the Employer • A nonresident alien with no United States source income. • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program. • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.
Life Insurance, AD&D	Employees whose employment is with a Participating Employer listed in Appendix A who are not union employees, and who are classified by the Employer as, either: (i) a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the United States; or (ii) a Show Hire Employee; or (iii) Covered under a Term Deal, provided that the Employer's agreement with the producer with respect to the Term Deal expressly states that you are eligible to participate in this Plan; or (iv) SPA Term Deal employee.	• Eligible to participate in another health and welfare plan sponsored by the Employer • An intern • A trainee • A temporary employee • A consultant or independent contractor (or their employees) • A Production Hire • A Project Hire • Represented for collective bargaining with respect to the terms and conditions of employment with the Employer • A nonresident alien with no United States source income. • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program. • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions
Long Term Disability	Employees whose employment with a Participating Employer listed in Appendix B, who are not union employees, and who are classified by the Employer as a Regular, full-time Employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal or SPA Term Deal • A Show Hire • An intern • A trainee • A temporary employee

	in the United States.	• A consultant or independent contractor (or their employees) • A Production Hire • A Project Hire • Represented for collective bargaining with respect to the terms and conditions of employment with the Employer • A nonresident alien with no United States source income. • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program. • An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions
Employee Assistance Plan	Employees who are eligible for a Participating Employer sponsored medical plan.	All applicable medical plan exclusions.
Voluntary Group Accident Insurance	Employees who are eligible for a Participating Employer sponsored medical plan.	• All applicable medical plan exclusions.
Voluntary Hospital Indemnity Insurance	Employees who are eligible for a Participating Employer sponsored medical plan.	• All applicable medical plan exclusions.
Business Travel Accident	All full-time active employees, their spouse, domestic partner and dependent children (up to age 19 years or up to age 23 if a full-time student), who are traveling on the business of or at the expense of the Policyholder outside their country of residence or permanent assignment.	• A temporary employee • A consultant or independent contractor (or their employees) • Persons for whom coverage is prohibited under applicable law or who are not covered by comprehensive medical insurance which complies with legal and regulatory requirements in their country of permanent assignment will not be considered eligible for this policy.

Benefit	Eligibility Requirements	Specific Exclusions
Severance Pay	Employees whose is with a participating Employer listed in Appendix A who are not union employees, and who are classified by the Employer as a Regular, full-time at –will employee (regularly scheduled to work at least 20 hours per week over a five-day work week for an indefinite period) working in the United States.; OR classified by the Employer as a Show Hire and employed by "B1 Employer"	Employed pursuant to a Term Deal • An intern • A trainee • A temporary employee • A consultant • A Show Hire (except as otherwise specifically provided under the Severance Pay Policy with respect to eligible employees of Sony Pictures Imageworks Inc.) • A Production Hire • A Project Hire • An employee whose conditions of employment are determined by a written contract • Represented for collective bargaining with respect to the terms and conditions of the employee's employment with the Employer • A nonresident alien with no United States source income • An employee hired under a special program such as a summer internship, a program for students or the disadvantaged, or a rehabilitation or training program • An employee regularly based outside of the United States. This exclusion applies to all employees who are entitled to severance pay under the laws of any foreign jurisdiction, and to those employees regularly based abroad who are not eligible under foreign severance pay laws An employee performing services in a profession for which a guild has been established, irrespective of whether the employee is a member of such guild; eligible to become a member of such guild; and/or eligible to participate in the guild's benefit plan(s), if any. This exclusion has some exceptions.

Benefit	Eligibility Requirements	Specific Exclusions
Expat Benefits	Employee in a Class of Eligible Employees (defined below), who is an eligible, full-time Employees, who normally work at least 20 hours a week. **Classes of Eligible Employees** The following Classes of Employees are eligible for this insurance: • *All full-time Expatriates and Third Country Nationals* • *Employees working outside the United States.* • *All full-time Inpatriate Employees.* "Expatriate" means an Employee who is working outside his country of citizenship. "Inpatriate" means an Employee of the Policyholder who is a citizen of another country working in the United States. "Third Country National" generally means an Employee of the Policyholder who works outside his country of citizenship, and outside the Policyholder's country of domicile. Persons for whom coverage is prohibited under applicable law will not be considered eligible under this component plan.	A class of employee that is not a "Class of Eligible Employees".

* *The HSA is not an SPE sponsored benefit. It's an account owned by the employee. It is an employee's responsibility to make sure he/she is eligible to enroll in an HSA. For more information about the HSA, contact Inspira Financial at 1-888-678-8242 or online at www.inspirafinanical.com*

IMPORTANT: ***To be eligible for any Plan benefit, you, your Spouse, Domestic Partner and/or Children must also satisfy the eligibility criteria set forth in the underlying Benefit Description for that benefit. The Benefit Descriptions for each Plan benefit are attached to this Summary Plan Description. In the event of any conflict between this Summary Plan Description and a Benefit Description with respect to the eligibility requirements for a specific benefit, the underlying Benefit Description will govern.***

Participating companies as of January 1, 20224, are:

Component Benefits	Participating Employers
PPO and HDHP with HSA (includes medical, prescription drugs); Vision, Dental PPO (Group Dental)	19 Recordings Inc., 7th Floor Productions LLC., Affirm Entertainment, Inc., Columbia Pictures Industries, Inc, Columbia TriStar Marketing Group., CPE Holdings, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc., CPE US Networks, Inc., CPLBE Inc.,, CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, Global Mastering & Servicing, HO Currency Upload Company, Industrial Media Inc., Industrial Media Production Inc., IPC Television LLC., Quadra Production Inc., Screen Gems, Inc., SET Distribution, LLC., Sharp Entertainment LLC., Sony Pictures Television International Ad Sales, Sony Pictures Animation Inc., Sony Picture Cable Ventures, Sony Pictures Imageworks Inc., Sony Pictures Releasing Corp., Sony Pictures Classics, Sony Pictures Entertainment Inc., Sony Pictures Home Entertainment., Sony Pictures Studios Inc., Sony Pictures Post Production Services Inc., Sony Pictures Television Inc., Sony Pictures Releasing International. Corp., Sony Pictures Virtual Reality Inc., SPE Corporate Services, SPT Network Games, Inc., This Machine Filmworks LLC., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition

HMO and EPO (includes medical, vision, prescription drugs); Vision, DMO	Columbia Pictures Industries, Inc, Columbia TriStar Marketing Group., CPT Holdings, Inc., Screen Gems, Inc., Sony Pictures Animation Inc., Sony Pictures Classics, Sony Pictures Imageworks Inc., Sony Pictures Entertainment Inc., Sony Pictures Home Entertainment., Sony Pictures Studios Inc., Sony Pictures Television Inc., TriStar Pictures, Inc.,

Flex Benefits (FSAs & premium pay; HSA)	19 Recording Inc., 7th Floor Production LLC., Affirm Entertainment, Inc., Columbia Pictures Industries, Inc, Columbia TriStar Marketing Group, CPE Holdings, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc., CPE US Networks, Inc., CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, Global Mastering & Servicing, HO Currency Upload Company, Industrial Media Inc., Industrial Media Production Inc., IPC Television LLC., Quadra Productions, Inc., Screen Gems, Inc., SET Distribution, LLC., Sharp Entertainment LLC., Sony Pictures Television International Ad Sales, Sony Pictures Animation Inc., Sony Pictures Cable Ventures, Sony Pictures Imageworks Inc., Sony Pic. Releasing Corp., Sony Pictures Classics, Sony Pictures Entertainment Inc., Sony Pictures Home Entertainment, Sony Pictures Post Production Services, Inc., Sony Pictures Studios Inc., Sony Pictures Television Inc., Sony Pictures Releasing Int'l. Corp., Sony Pictures Virtual Reality Inc., SPE Corporate Services, SPT Network Games, This Machine Filmworks LLC., Inc., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
Life Insurance, AD&D	19 Recording Inc., 7th Floor Production LLC., Affirm Entertainment, Inc., Columbia Pictures Industries, Inc, Columbia TriStar Marketing Group, CPE Holdings, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc., CPE US Networks, Inc., CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, Global Mastering &Servicing, HO Currency Upload Company, Industrial Media Inc., Industrial Media Production Inc., IPC Television LLC., Quadra Productions, Inc., Screen Gems, Inc., SET Distribution, LLC., Sharp Entertainment LLC., Sony Pic Television International Ad Sales, Sony Pictures Animation Inc., Sony Pictures Cable Ventures, Sony Pictures Imageworks Inc., Sony Pictures Releasing Corp., Sony Pictures Classics, Sony Pictures Entertainment Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services, Inc., Sony Pictures Studios Inc., Sony Pictures TV Inc., Sony Pictures Releasing International Corp., Sony Pictures Virtual Reality Inc., SPE Corporate Services, SPT Network Games, Inc., This Machine Filmworks LLC., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
LTD	19 Recording Inc., 7th Floor Production LLC., Affirm Entertainment, Inc., Columbia Pictures Industries, Inc, Columbia TriStar Marketing Group, CPE Holdings, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc., CPE US Networks, Inc., CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, Global Mastering & Servicing, HO Currency Upload Company, Industrial Media Inc., Industrial Media Production Inc., IPC Television LLC., Quadra Productions, Inc., Screen Gems, Inc., SET Distribution, LLC., Sharp Entertainment LLC., Sony Pic Television International Ad Sales, Sony Pictures Animation Inc., Sony Pictures Cable Ventures, Sony Pictures Imageworks Inc., Sony Pictures Releasing Corp., Sony Pictures Classics, Sony Pictures Entertainment Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services, Inc., Sony Pictures Studios Inc., Sony Pictures Television Inc., Sony Pictures Releasing International Corp., Sony Pictures Virtual Reality Inc., SPE Corporate Services, SPT Network Games, Inc., This Machine Filmworks LLC., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
EAP	Same as medical plans
Voluntary Group Accident Insurance	Same as medical plans
Voluntary Hospital Indemnity Insurance	Same as medical plans
BTA	As determined by Employer in its discretion
Component Benefits	**Participating Employers**
Severance	19 Recording Inc., 7th Floor Production LLC., Affirm Entertainment, Inc., Columbia Pictures Industries, Inc, Columbia TriStar Marketing Group, CPE Holdings, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc., CPE US Networks, Inc., CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, Global Mastering & Servicing, HO Currency Upload Company, Industrial Media Inc., Industrial Media Production Inc., IPC Television LLC., Quadra Productions, Inc., Screen Gems, Inc., SET Distribution, LLC., Sony Pic Television International Ad Sales, Sony Pictures Animation Inc., Sony Pictures Cable Ventures, Sony Pictures Imageworks Inc., Sony Pictures Releasing Corp., Sony Pictures Classics, Sony Pictures Entertainment Inc., Sony Pictures Home Entertainment, Sony Pictures Post Production Services, Inc., Sony Pictures Studios Inc., Sharp Entertainment LLC., Sony Pictures Television Inc., Sony Pictures Releasing International. Corp., Sony Pictures Virtual Reality Inc., SPE Corporate Services, SPT Network Games, Inc., This Machine Filmworks LLC., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE

	Acquisition
Expat Benefits	As determined by Employer in its discretion

If you have questions about your eligibility, call the SPE Benefits Center Service Center at 1-833-976-6901 and speak with a SPE Benefits Center Service Center representative.

Who Isn't Eligible for Employee Coverage

If you're in one of these groups, you're generally **not** eligible for coverage under the plan:

- Part-time employees scheduled to work fewer than twenty (20) hours per week;
- Temporary employees;
- Employees covered by a collective bargaining agreement—unless participation is agreed to through the collective bargaining process;
- Leased employees;
- Independent contractors, consultants, or other individuals identified by Sony as part of SPE's contingent workforce and not employed as regular Sony employees. (**Note:** This exclusion applies regardless of whether the individual is subsequently reclassified or treated as an employee under common law principles by the IRS, or any other governmental agency or authority, or a court—including any reclassification in settlement of any claim or action relating to each individual's employment status.);
- Seasonal employees;
- Employees eligible for similar coverage under another benefits plan by another Sony affiliate;
- Employees of a participating company or any other group determined by SPE not to be eligible to participate; and
- Employees of any non-U.S. affiliated company (including Sony Corporation of Japan) and transferred on a temporary basis for a fixed period of time.

If you have questions about your eligibility, call the **benefits at Sony** Service Center at 1-833-976-6901 and speak with a Service Center representative.

Eligibility Rules for Rehired Employees

When you return to work at the company, the same eligibility rules that apply to new hires are effective.

Your coverage options depend on when you return to work.

In the same plan year—If you return in the same month in which your employment ended, you receive the same coverage you had when your employment ended (provided you remain eligible for each coverage option). If you return to employment in a different month, you will have thirty-one (31) days from your rehire date to make a new Flexible Spending Account and Health Spending Account elections.

In a different calendar year—If you return in a different calendar year, you'll have thirty-one days to enroll in the plans for which you're eligible.

Eligibility for Retiree Health Care Coverage

You may be eligible for retiree health care coverage when you leave SPE. Please refer to the separate "Retiree Medical Plan" document in the Plan Information section of https://benefits.sonypictures.com website if you are eligible to participate in the Retiree Medical Plan.

Note: Receipt of these documents does not waive any eligibility requirements.

Important Information about Your Benefits and Medicare

If you become eligible for Medicare while working, your Sony benefits will not change. If you enroll in Medicare in addition to your Sony medical plan, Medicare will pay secondary. This means Medicare will only pay for expenses that are not covered by your Sony medical plan.

In addition, according to IRS rules, you cannot enroll in Medicare and contribute to a Health Savings Account (HSA). Once you enroll in Medicare, you can continue to use money already in your HSA, but no further contributions can be made.

However, when you leave Sony and elect COBRA, you will need to enroll in Medicare, as Medicare will become your primary insurance coverage. Your COBRA coverage will pay secondary, even if you do not enroll in Medicare.

Eligibility Rules for Survivors

If you die while employed by SPE, your surviving spouse/domestic partner and dependent children who are covered by an SPE medical, dental and/or vision plan at the time you die will automatically continue to have coverage at no cost to them for up to three months under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage while they continue to meet the plan's definition of an eligible dependent.

For more information on COBRA, see "When Coverage Ends" on page 47

Dependents You Can Cover

As an eligible employee, you can enroll your eligible dependents for coverage in these plans:

- Medical
- Dental
- Vision;
- Dependent Life Insurance;
- Accidental Death & Dismemberment Insurance;
- Voluntary Group Accident Insurance;
- Voluntary Hospital Indemnity Insurance
- Voluntary Long-Term Care & Life Insurance Program
- Aura Identity Protection

Your eligible dependents may include:

- Your lawful spouse or domestic partner—see below for definitions (if you wish to enroll a domestic partner, see below for eligibility rules)
- Your children and/or children of your domestic partner up to age 26
- Unmarried children of any age who became physically or mentally disabled by age 26 and depend on you for financial support
- Children recognized as having a right to coverage under a Qualified Medical Child Support Order (QMCSO).

For purposes of this SPD, children who are eligible for coverage under one or more of SPE's plans will be described as "eligible dependents" or "eligible dependent children" even though they may not qualify as your tax dependent.

If one or more of your dependents are also eligible SPE employees, special rules apply (see page 24).

Important Note: Whenever you enroll a dependent (spouse, domestic partner or child) for the first time, you may be required to verify that dependent's eligibility at that time. In addition, SPE performs periodic audits of dependents' continuing eligibility for coverage. If you are asked to provide proof of your dependents' eligibility as part of the audit process and it is determined that you have intentionally covered an ineligible individual by providing false, incomplete, or misleading information, the ineligible dependent's coverage will be terminated immediately (with retroactive effect to the date of ineligibility). You will also be liable for repayment of any claims or premiums paid by SPE on behalf of the ineligible individual. Further, you may be subject to disciplinary action, up to and including termination of employment.

Spouse Eligibility Rules

If you're eligible for coverage, you can enroll your spouse for coverage under the company's plans. (If your spouse is also an eligible SPE employee, special rules apply—see page 24). Your spouse is the person of the opposite or same sex to whom you're legally married.

Note: If you're eligible for retiree coverage (refer to the separate "Retiree Health Care Coverage Eligibility" document on this Web site), you can't add new dependents or change coverage after retirement. For example, if you marry after retirement, you cannot add coverage for your spouse.

If your spouse serves in the military, your spouse is **not** eligible for coverage.

Domestic Partner Eligibility Rules

Definition of Eligible Domestic Partner

Health care (medical, dental, and vision) and domestic partner life insurance coverage are available to your qualifying domestic partner (same or opposite sex) if you participate in the SPE Benefits Plan. If you enroll a domestic partner, you can also enroll the eligible dependent children of your domestic partner who resides with you. You and your domestic partner must meet the requirements of A **or** must meet and attest to the requirements of B (as shown below), to be eligible for coverage:

A.)

- You are registered domestic partners or civil union partners in the state where you reside.

OR

B.)

- You're each other's sole domestic partner. You're emotionally committed to each other for mutual care and support and intend to remain so indefinitely; and
- You have resided together in the same principal residence for a full six (6) months and intend to remain so indefinitely; and
- You're jointly responsible for each other's financial welfare and basic living expenses (you're financially interdependent); and
- You're both at least age 18 and mentally competent to consent to a contract under the laws of the state where you reside; and
- You're not related by blood closer than would bar marriage under applicable law in effect where you reside; and
- You're not legally married to each other and you're not legally married or separated from anyone else.

Domestic partners who serve in the military are **not** eligible for coverage.

If your domestic partner is also an eligible company employee, special rules apply—see page 24.

Paying for a Domestic Partner's Coverage and Tax Considerations

Federal (and most state) tax laws and regulations don't currently recognize domestic partners as qualifying for tax-free benefits. As a result, if you enroll your domestic partner and any of your domestic partner's children, you'll have additional taxable (imputed) income reported to you reflecting the value of the coverage provided. You'll be taxed on the portion of cost paid by SPE, and your share of the cost is paid on an after-tax basis.

The additional taxable income will be added on a pay period basis. Federal and state income taxes, as well as FICA taxes, will be withheld each pay period, and your total taxable income amounts will be reported on your Form W-2 at year-end. You can view the amount of additional taxable income incurred as a result of covering your domestic partner and children of your domestic partner on the SPE Benefits Center site.

Note: Some states permit tax free benefits for domestic partners. If you live in such a state, you may be able to request a refund from the state when you file your taxes. Please consult with your tax advisor.

Child Eligibility Rules

Definition of Eligible Child

Children under age 26 are eligible for Plan benefits if:

- the child is born to you, your Spouse or Domestic Partner;
- the child is placed with you, your Spouse or Domestic Partner for adoption (regardless of whether the adoption is final);
- a child acquired by you, your Spouse or Domestic Partner through legal guardianship (or, if approved by the Plan Administrator in its sole and complete discretion, legal custody);
- the child is your, your Spouse's or Domestic Partner's foster child legally placed by a licensed agency; or
- your stepchild who must either live with you in a regular parent/child relationship for part of the year or be considered a dependent by the IRS.

Children who serve in the military are **not** eligible for coverage.

Children of an eligible domestic partner can be covered under the Sony health care plans if you cover the domestic partner and if the child:

- Is a child of your domestic partner who lives with you in a regular parent/child relationship; and
- Doesn't otherwise qualify as your "legal dependent" under the federal tax code.

Note: For a child of a domestic partner who isn't your tax dependent, the value of the child's coverage will be added to your taxable income.

Age Requirements

You can cover your children regardless of their marital and/or student statuses under SPE's medical, dental, and vision plans and dependent child life insurance until the end of the month of their 26th birthday. However, this coverage does not extend to grandchildren, even if the parent of the child is covered as a dependent.

For coverage under the Dependent Life Insurance Plan, a child's insurance begins at live birth (stillborn or unborn children are not eligible).

Rules for Disabled Children

In general, a disabled child age 26 or older is eligible for coverage if they are determined by the health plan to be:

- Incapable of self-support because of a mental or physical disability; and
- Incapable of earning a living.

The child must be disabled before age 26 and covered in the plan.

Separate, more restrictive rules may apply depending on your medical plan's coverage provisions. It is important to contact your plan's member services directly for details.

To continue coverage, adequate proof of the continuation of your child's disability must be provided to the plan's Claims Administrator. Proof may be requested, but not more frequently than an annual exam at the expense of the Claims Administrator. Contact your health plan's

member services when your child becomes disabled to learn how to certify their disability status.

For your child's coverage to continue you must notify the SPE Benefits Center by calling 1-833-976-6901 and speaking with a representative once the health plan administrator certifies the child's disability status.

Qualified Medical Child Support Order
If SPE is requested to provide health coverage to your child pursuant to a court order, SPE will honor the terms of such order provided that it meets the requirements of a Qualified Medical Child Support Order (QMCSO).

The Plan Administrator determines whether the court order is a QMCSO. If it is, the child gains eligibility for coverage if not already covered by you, whether or not the child is an eligible dependent. The child can also gain eligibility for coverage if the company receives a National Medical Support Notice and determines it to be a QMCSO. In these situations, the company can take deductions from your pay for the child's coverage.

The plan will cover your child from the date the QMCSO is approved until the end date or age stated in the order, but **not** beyond the normal eligibility age. Your child will be added to whatever coverage you're enrolled in. If you're not already enrolled, you'll be given the opportunity to elect coverage for yourself and your child. Otherwise, you'll be assigned coverage under the Consumer Choice Plan. Please note that you must be enrolled in the same coverage as your child.

If a QMCSO requires someone other than you—for example, your ex-spouse—to provide health coverage for your child, you can drop coverage under SPE's plan for that child if they actually becomes covered under the other person's plans. See "If Your Child Loses Eligibility" in the chart on page 28.

Contact the SPE Benefits Center at 1-833-976-6901 as soon as you're aware of any court proceedings that may affect your child's eligibility for coverage under the company's plans. You'll be notified by SPE if a proposed QMCSO is received.

If you want further information about QMCSO procedures, this information is available free of charge on request from the SPE Benefits Center.

Employees Within the Same Family

Health Plan Coverage
If you and your spouse/domestic partner are both eligible SPE employees, you can cover your spouse/domestic partner as a dependent for health care coverage. For example, you can cover your spouse/domestic partner as a dependent for medical coverage and your spouse/domestic partner can elect no medical coverage.

You can also cover your spouse/domestic partner as a dependent for dental and vision coverage.

Alternatively, you may both choose employee only coverage, in which case you can each elect different plans. However, if you also enroll dependents, they must be enrolled in the option selected by the spouse with the earlier birth date in the calendar year. The birthday rule does not apply to children of domestic partners (therefore, either employee may cover any eligible children).

Dependent Life Insurance
These rules apply to coverage under Spouse/Domestic Partner Life Insurance and Dependent Child Life Insurance when both you and your spouse/domesticpartner or child are eligible employees:

- You can't choose this coverage for each other—that is, you can't be enrolled as an employee and a covered spouse/domestic partner.
- Both you or your spouse/domestic partner can purchase Dependent Child Life Insurance for your eligible children.
- If your spouse/domestic partner or child is eligible for insurance as an employee, they cannot be enrolled as a dependent.

Flexible Spending Account Coverage
These rules apply to coverage under the Flexible Spending Accounts (FSAs) when both you and your spouse/domestic partner are eligible employees:

- Both of you can enroll in the Health Care Spending Account, and each can contribute the maximum annual amount allowed to individuals.
- Both of you can enroll in the Dependent Care Spending Account, but your combined contributions can't exceed the maximum annual amount. Please note, unmarried domestic partners are each eligible to contribute up to the maximum annual amount.

Health Savings Account Coverage
If you and your spouse/domestic partner have medical coverage under the Consumer Choice Plan and have enrolled in the Health Savings Account (HSA), the following rules apply:

- If one employee has enrolled in family coverage, only that employee is eligible to participate in the HSA and receive the company contribution. However, that employee will receive the "family" HSA contribution if family coverage has been selected under the Consumer Choice Plan.
- If both employees have enrolled in employee only coverage, each employee is eligible to participate in the HSA on their own, but the combined contribution for both employees cannot exceed the maximum amount allowed for families. Also note, if each employee enrolls separately and one employee covers dependent children, that employee will be eligible for the "family" company contribution. In the case of unmarried domestic partners, each employee can contribute only up to the individual maximum amount.

Enrollment

If you meet the eligibility requirements for employee coverage, you're eligible to choose coverage under the SPE Benefits Plan within 31 days of your hire date or the date you became benefits eligible, subject to the terms of the underlying policies. As long as you enroll by your deadline, the coverage you choose will automatically be retroactive to your hire date or date you became benefits eligible. You can enroll in these plans:

- Medical;
- Dental;
- Vision;
- Supplemental Life and AD&D Insurance;
- Spouse/Domestic Partner Life Insurance;
- Dependent Child Life Insurance; Health Care Flexible Spending Account or Health Savings Account and Limited Purpose Flexible Spending Account (depending upon which medical plan you are enrolled in);
- Dependent Care Flexible Spending Account; and
- Legal Plan
- Voluntary Group Accident Insurance; and
- Voluntary Hospital Indemnity Insurance
- Voluntary Long-Term Care & Life Insurance Program*

*New hires may enroll in the Voluntary Long-Term Care & Life Insurance Program during a separate dedicated enrollment window

In addition, you'll receive some coverage automatically, without making an election. This automatic coverage begins as of the date you first become benefits-eligible (note you must be actively at work for the Life and disability plans to go into effect) and includes:

- Basic Life Insurance (equal to one times your annual base salary and Accidental Death and Dismemberment (AD&D) Insurance (equal to 100% of your Basic Life Insurance amount);
- Long Term Disability (LTD)
- Employee Assistance Plan
- Business Travel Accident Insurance

During the year, you can only change your coverage if you have a qualified change in status (see page 30).

Please note: SPE's Medical Plan options meet or exceed federal requirements for affordable minimum coverage. SPE intends to continue to provide affordable healthcare coverage for our employees and their families. If you have coverage through the Health Insurance Marketplace or any other provider and would like to elect SPE coverage, check with your current plan administrator to confirm mid-year change rules for dropping coverage before you enroll in SPE's plan. For additional information about healthcare reform visit www.healthcare.gov.

Initial Enrollment for a Newly Eligible Employee

You have 31 days from the day your enrollment information is sent to you to enroll for coverage once you become eligible. You can enroll on the SPE Benefits Center **https://benefitscenter.spe.sony.com**, or by calling 1-866-941-4773 and speaking with a SPE Benefits Center representative.

When you enroll, you need to provide information about the dependents you want to cover. For some plans, you will then be assigned a coverage category.

If You Don't Enroll, Coverage Is Assigned
If you do not affirmatively enroll or decline coverage within this election period and subject to any different default rules as may be established by the Plan Administrator and described the initial enrollment materials, you will be assigned the following employee-only coverage:

Benefit Plan*	**Coverage Assigned****
Medical	HDHP
Dental	No Coverage
Vision	Employee Only
Employee Life and AD&D	Basic Life & AD&D
LTD	Basic LTD
Health Care FSA	No contribution
Dependent Care FSA	No contribution
Health Savings Account (HSA)	No contribution

Employee Assistance Plan	Coverage (employee)
Business Travel Accident Plan	Coverage
Severance Pay Plan	Coverage
Legal Plan	No coverage
Voluntary Group Accident Insurance	No coverage
Voluntary Hospital Indemnity Insurance	No coverage

* *Based on general plan eligibility requirements.*

** *In addition, automatic enrollment in certain coverage may preclude enrollment in certain options during the next enrollment period.*

Coverage will be effective as of the date of hire or, if later, eligibility date, after your enrollment materials are timely received in good order or you are automatically enrolled in accordance with the above default rules, all in accordance with such rules and procedures as may be established by the Plan Administrator. In addition, the effective date of your coverage will be subject to such additional requirements as may be specified in the Benefit Description for that benefit (e.g., coverage for life insurance may be conditioned upon evidence of insurability, etc.).

This assigned coverage stays in effect until the next annual enrollment period, unless you have a qualified change in status that allows you to change your coverage.

HSA Eligibility and Enrollment

An HSA is ***not an SPE sponsored plan***. It is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of eligible medical expenses. It is your responsibility to make sure you are eligible to enroll in an HSA. You are eligible to contribute to an HSA if you meet the requirements of § 223 of Internal Revenue Code, participate in the high deductible health plan, and have not elected any disqualifying non-high deductible health plan coverage.

To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) or contact Inspira Financial at 1-888-678-8242 or online at www.inspirafinancial.com.

Annual Enrollment

Each fall, you can enroll for coverage for the next plan year. You'll receive information when it's time to enroll, and you can enroll on SPE Benefits Center or by calling the SPE Benefits Center before the enrollment deadline. You're encouraged to carefully review your coverage needs and options for coverage each year and actively enroll.

You must enroll during the annual enrollment period if:

- You want to change any of your or your dependents' current coverage elections;
- You want to enroll a new dependent for coverage;
- You want to contribute to a Flexible Spending Account (FSA) (Health Care Spending Account or Dependent Care Spending Account) or Health Savings Account for the coming year (note: if

you're enrolled in the Consumer Choice Plan, you are eligible to start, stop or change your contributions to the HSA at any time during the year);
- You're enrolled in a plan option that won't be offered next year and don't want to be assigned coverage.

Your FSA and/or HSA elections, if any, will not be carried over. Your FSA and HSA contributions are discontinued at the end of the current plan year. You must actively elect to participate in these accounts each year.

For Supplemental Life Insurance, you can elect or increase your coverage up to the guaranteed issue by only one option level at a time without evidence of insurability (EOI). If you wish to increase more than one option level or if your increase exceeds either 5X annual Insured Earnings or $1,000,000 in coverage, you will be required to provide EOI. If you have been previously declined, you will also need be required to provide EOI for any increases. You'll learn when you're making your coverage choices if restrictions or EOI requirements apply.

For Basic Life Insurance, if you elected the $50,000 option to avoid imputed income and wish to increase to one- times pay, you will be required to provide EOI.

For Spouse/Domestic Partner Life insurance, you can elect to increase coverage by one (1) option up to a maximum of $50,000, or elect coverage for the first time at the $10,000 level. If you select a coverage amount over $50,000, evidence of insurability will be required.

For Dependent Child Life coverage, you may elect or increase coverage in any amount with no evidence of insurability required.

For Voluntary Long-Term Care & Life Insurance Program coverage, your medical underwriting requirements may change based on when you elect coverage and whether you are increasing coverage. See the Voluntary Long-Term Care & Life Insurance Program section for more information.

Declining Medical Coverage
You can decline medical coverage if you have coverage elsewhere. You'll be required to certify that you have coverage elsewhere as part of your enrollment process.

If you decline medical coverage and your other medical coverage ends at a later date, this event qualifies as a change in status, so you can make certain changes to your coverage during the same plan year.

If You Don't Actively Enroll During Annual Enrollment
If you don't make new coverage choices during annual enrollment, your current choices, if available, are carried over for the next plan year with the exception of FSA and HSA elections (both of which require an annual election each year for participation). If you don't want to be assigned this coverage, you must choose another option during annual enrollment.

If your current coverage option is no longer available for the coming year (for example, your medical plan option is eliminated), you're automatically assigned a new option at the same coverage tier as indicated during the enrollment process.

Mid-Year Coverage Changes

If you become eligible to make new enrollment choices during the year due to a qualified change in status, you can make certain coverage changes through a SPE Benefits Center representative within 31 days of the status change. (See page 30) for details on what qualifies and the types of changes allowed.) Your new coverage for most benefits begins as of the date of your status change (for example, on the date you get married). For life insurance, the effective date is the date of the election, providing you are actively at work and any required Evidence of Insurability is approved, if applicable.

However, to become effective, the change must be on record with the SPE Benefits Center within 31 days of the qualified change in status. You can notify the SPE Benefits Center at https://benefitscenter.spe.sony.com or by calling 1-833-976-6901 and speaking with a representative If you fail to notify the SPE Benefits Center in a timely manner, you will not be able to make any changes to your benefits elections until the following annual enrollment period.

Under certain other circumstances, you may become eligible to make new enrollment choices during the year. If you don't submit a new choice by the indicated enrollment deadline, you're assigned coverage automatically.

Coverage Categories

When you enroll for medical, dental, or vision coverage, you enter information about the dependents you want to cover. They can include your spouse or domestic partner and any eligible dependent children. Then, for the medical, dental, and vision plans, you're assigned one of these coverage categories, which affects the price you pay for the coverage based on the number of dependents you choose to cover for that particular plan:

- Employee Only;
- Employee Plus Spouse/Domestic Partner;
- Employee Plus Child(ren); and
- Employee Plus Family.

If you elect Dependent Life Insurance, all eligible dependent children are covered automatically with no evidence of insurability requirement.

Your eligible dependents receive automatic coverage under Employee Assistance Plan (EAP) whether or not you enroll them in an active medical plan.

If one or more family members are also eligible SPE employees, special rules apply (see page 24).

Changing Your Coverage During the Year

Rules for Changing Employee Coverage

Federal laws set specific rules about the types of coverage changes employees may make during the year.

After annual enrollment ends, your choices generally stay in effect for the entire plan year (January 1 through December 31). If you are a new hire, your coverage elections will remain in effect for the rest of the plan year during which you are hired (or rehired).

In special circumstances, as a result of a qualified change in status, however, you can enroll in coverage or change your choices during the plan year.

Qualified Changes in Status

During the plan year, you can change your benefit coverage if a qualified change in status affects your or your dependents' eligibility under the SPE plans or another employer's plans. Some benefits (particularly those paid for on an after-tax basis) may provide you with more or less flexibility to make mid-year coverage changes. If you are seeking to make a change in coverage during the plan year, please review any such restrictions in the applicable benefit policies.

If you're eligible to make coverage changes, your changes must be consistent with the change in status. (Refer to the chart beginning on page 28.) They must also mirror any changes your spouse, domestic partner, or child makes to their coverage under another employer's plans. For example, you may only drop medical coverage in the SPE plan if you are adding coverage under your spouse's health insurance.

These situations qualify as a change in status:

- Your legal marital status changes:
    - You get married.
    - You get divorced, or legally separated, your marriage is annulled, or your spouse dies.
- The number of your eligible children changes:
    - You gain a dependent as a result of birth, adoption, placement for adoption, or legal guardianship.
    - Your child gains or loses eligibility for coverage under the SPE Benefits Plan.
    - Your child dies.
- You move to a new address or worksite resulting in a change to plan eligibility.
- Your or your dependents' benefits eligibility changes because:
    - You take or return from a leave of absence.
    - You gain or lose eligibility as a result of a change in work schedule or status.

    - They gains or loses eligibility as a result of a change in work schedule or status.
    - They gains a benefit option or loses coverage.
    - Their cost for coverage increases or decreases significantly.
    - They makes new coverage choices during his or her employer's annual enrollment.
- Your or your family member's Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from another employer expires.
- You or your family member becomes entitled to or loses Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)
- You or your family member loses coverage under a government's or educational institution's plan.

You can also make mid-year changes to your health care coverage if:

- Your domestic partner becomes eligible for or loses coverage under their employer's plan.
- Your domestic partnership ends.
- Your domestic partner dies.

Eligibility if You Initially Decline Health Care Coverage
Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), if you waive healthcare plan coverage for yourself or your dependents (including your spouse) because you or your dependents are covered under other health insurance coverage, you may—in the future—be able to enroll yourself or your dependents in a health care plan, provided that you request enrollment within thirty one days after your other coverage ends.

Timing of Coverage Change Requests
If you have a qualified change in status and need to change your coverage during the year, you must do so within thirty-one days of the event that makes the change necessary. Otherwise, you can't make a coverage change before the next annual enrollment period unless you or your eligible family member has another qualified change in status.

Benefit Coverage Changes Allowed

You can use the chart that follows to identify the type of changes allowed in your health care options, life insurance, LTD coverage, and Spending Accounts if you have a qualified change in status. Keep in mind, during the plan year, you can generally change your benefits coverage if a qualifying change in status affects your eligibility, your spouse's or domestic partner's eligibility, or your child's eligibility under the SPE plans or another employer's plans. Some benefits (particularly those paid for on an after-tax basis) may provide you with more or less flexibility to make mid-year coverage changes. If you are seeking to make a change in coverage during the plan year, please review any such restrictions in the applicable benefit policies.

Note:

If you're eligible to make coverage changes, your changes must be consistent with the change in status. They must also correspond to any changes your spouse, domestic partner, or child makes to his or her coverage under another employer's plans. For example, if one of your dependents loses coverage under Sony's medical plan because they are no longer eligible, you would not be permitted to cancel coverage for any of your other dependents based on that qualifying event and you would not be able to change your Dependent Care FSA elections based on this event.

If you change your Flexible Spending Account contributions, you can be reimbursed for charges related to a status change only if incurred on or after the date of the event. Special rules apply if you take a leave of absence—see page 40

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
You Get Married				
Under the Medical Plan, you can change your plan option. In addition, under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your spouse Add coverage for any eligible children Drop coverage for yourself if you become covered under your spouse's plan Drop coverage for any eligible children if they become covered under your spouse's plan	You can enroll in, increase, decrease, or drop coverage in the following plans: Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease LTD Plan coverage	You can start, increase, decrease, or stop your contributions to the: Health Care Spending Account and/or Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for your spouse; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for any eligible children
You Get Divorced				
Under the Medical Plan, you can change your plan option. In addition, under the Medical, Dental, and Vision Plans: If your ex-spouse is covered under the Medical, Dental, or Vision Plans, you must drop their coverage If you or your dependent children lose coverage under your ex-spouse's plan, you can enroll yourself and/or your eligible children in the Medical, Dental, and Vision Plans If your children or stepchildren are no longer considered eligible dependents, you must drop their coverage (COBRA coverage is available, see page 46) If a Qualified Medical Child Support Order (QMCSO) is received by SPE, you may be required to provide medical, dental, and vision coverage for your eligible child. You may receive further information on QMCSOs at no charge by contacting the SPE Benefits Center at 1-833-976-9601	You can enroll in, increase, decrease or drop coverage in the following plans: Employee Life and AD&D Insurance or Dependent Life Insurance coverage	You can increase or decrease LTD Plan coverage	You can start, increase, decrease, or stop your contributions to the: Health Care Spending Account and/or Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your ex-spouse; Drop coverage for any eligible children

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
Your Spouse Dies				
Under the Medical Plan, you can change your plan option. In addition, under the Medical, Dental, and Vision Plans: If you lose coverage under your spouse's plan as result of their death, you can enroll in coverage If your eligible children lose coverage under your spouse's plan, you can add them to your coverage If your spouse was covered under the company's plans, you must drop their coverage; this may result in a change in coverage category	You can enroll in, increase, decrease or drop coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease LTD Plan coverage	You can start, increase, decrease, or stop your contributions to the: Health Care Spending Account and/or Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for your spouse; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse; Drop coverage for any eligible children
You Have or Adopt a Child				
Under the Medical Plan, you can change your plan option. In addition, under the Medical, Dental, and Vision Plans, you can: Add coverage for your spouse or domestic partner Add coverage for any eligible children Enroll yourself if you're not already covered Drop coverage for yourself	You can enroll in, increase, decrease or drop coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease LTD Plan coverage	You can start, increase, decrease, or stop your contributions to the: Health Care Spending Account Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic partner; Drop coverage for any eligible children
Your Child Gains Eligibility Under the SPE Benefits Plan				
Under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your spouse or domestic partner Add coverage for any eligible children ***If the Child Will Be Covered Due to a QMCSO*** If the child will be covered under the Medical, Dental,	You can change your Employee Life and AD&D Insurance or Dependent Life Insurance ***If the Child Will Be Covered Due to a QMCSO*** You can change Child Life Insurance	You can increase or decrease LTD Plan coverage ***If the Child Will Be Covered***	You can start or increase your contributions to the: Health Care Spending Account Dependent Care Spending Account ***If the Child Will Be Covered Due to a QMCSO***	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
and/or Vision Plans as a result of a QMCSO, you can: Enroll yourself if you're not already covered Add coverage for the affected child You can't enroll your spouse, domestic partner, or any other eligible children for coverage		***Due to a QMCSO*** You can increase or decrease LTD Plan coverage	You can start or increase your Health Care Spending Account contributions. However, you can't change your Dependent Care Spending Account contributions.	partner; Drop coverage for any eligible children
Your Child Loses Eligibility Under the SPE Benefits Plan				
When your child loses eligibility under the Medical, Dental, and Vision Plans: You must drop coverage for that child You can't change your own or any other family member's coverage Your coverage category may change as a result Your child may be able to continue health care coverage through COBRA (see page 46) ***If the Child's Coverage Will Be Dropped Due to a QMCSO*** If the child will be covered by another person's medical, dental, or vision plan as a result of a QMCSO, you can drop coverage under the corresponding SPE plans for that child Your coverage category may change as a result You can't change your own or any other family member's medical, dental, or vision coverage	You can change Employee Life and AD&D or Dependent Life coverage ***If the Child's Coverage Will Be Dropped Due to a QMCSO*** You can't change Employee Life or AD&D coverage. You can drop Child Life coverage if the child losing coverage is the only dependent covered.	You can increase or decrease LTD Plan coverage ***If the Child's Coverage Will Be Dropped Due to a QMCSO*** You can increase or decrease LTD Plan coverage	You can stop or decrease your contributions to the: Health Care Spending Account and/or Dependent Care Spending Account ***If the Child's Coverage Will Be Dropped Due to a QMCSO*** You can stop or decrease your Health Care Spending Account contributions. However, you can't change your Dependent Care Spending Account contributions.	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic partner; Drop coverage for any eligible children

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
Your Child Dies				
Under the Medical, Dental, and Vision Plans: You must drop coverage for the child who has died; this may cause a change in coverage category You can't change your own or any other family member's coverage	You can enroll in, increase, decrease or drop coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease your LTD Plan coverage	You can stop or decrease your contributions to the: Health Care Spending Account and/or Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic partner; Drop coverage for any eligible children
You Move to a New Address or Work Site Resulting in a Loss of Plan Eligibility				
You can choose different plan option coverage under the Medical, Dental, and Vision Plans for you and your covered dependents if **both** of these apply: You transfer to a new work site or move to an area with a different zip code that affects access to participating **provider**s under your current coverage and Your current plan option is no longer available at your new location (if your current plan option remains available, you can't make a change until the next open enrollment) You cannot change the dependents you cover under the plans	You can't change your coverage in the following plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change your LTD Plan coverage	You can't change your Health Care Spending Account contributions You can start, increase, decrease, or stop your contributions to the Dependent Care Spending Account	You can't change coverage
You Move to a New Address or Work Site Resulting in a Gain of Plan Eligibility				
You can choose different plan option coverage under the Medical, Dental, and Vision Plans for you and your covered dependents if **both** of these apply: You transfer to a new work site or move to an area with	You can't change your coverage in the following plans: Employee Life and AD&D Insurance or	You can't change your LTD Plan coverage	You can't change your Health Care Spending Account contributions You can start, increase, decrease, or stop	You can't change coverage

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
a different zip code that affects access to participating **provider**s under your current coverage, and Your current plan option is no longer available at your new location (if your current plan option remains available, you can't make a change until the next open enrollment) You cannot change the dependents you cover under the plans	Dependent Life Insurance		your contributions to the Dependent Care Spending Account	
You Gain Benefits Eligibility Due to a Work Situation Change (for example, from part-time to full-time employment)				
Under the Medical, Dental, and Vision Plans, you can: Enroll yourself Add coverage for your spouse or domestic partner Add coverage for your eligible children	You can enroll in, increase, decrease or drop coverage in either of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can enroll in LTD Plan coverage	You can start contributing to the: Health Care Spending Account Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic partner; Drop coverage for any eligible children
You Lose Benefits Eligibility Due to a Work Situation Change (for example, from full-time to part-time employment)				
Coverage will end effective at midnight of the last day of the month in which you lost benefit eligibility You'll be offered COBRA coverage (see page 46) *All other changes listed in this chart are effective on the date of the event. See page 43 When Coverage Ends for more information.	Coverage will end effective at midnight of the day you lost benefit eligibility. You may be able to port Employee Life coverage to a direct bill basis or convert life coverage to an individual policy	Coverage will end effective at midnight of the day you lost benefit eligibility	Coverage will end effective at midnight of the day you lost benefit eligibility For the Health Care Spending Account, you'll be offered COBRA coverage	Coverage will end effective at midnight of the day you lost benefit eligibility You may be able to port or coverage to an individual policy on a direct bill basis

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
Your Family Member Gains Benefits Eligibility Due to a Work Situation Change				
They: Start a job Have a change in work schedule (for example, from part-time to full-time employment) Are transferred to a different work site				
If you and/or your family members become covered under another employer's plans, you can change your medical plan option and/or make these changes under the Medical, Dental, and Vision Plans: Drop your coverage Drop coverage for your spouse or domestic partner Drop coverage for any affected children	You can enroll in, increase, decrease or drop coverage in either of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease your LTD Plan coverage	***Health Care Spending Account*** You can stop or decrease contributions, if your family member starts a new job. You can't change your election if he or she has a change in work status or work site transfer, whether or not they have a change in eligibility. In those situations, you can't change contributions ***Dependent Care Spending Account*** You can start or increase contributions, except when your family member has a change in work status or work site transfer, whether or not they have a change in eligibility. In those situations, you can't change contributions.	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic partner; Drop coverage for any eligible children

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
[You and/or] Your Family Member Loses Benefits Eligibility Due to a Work Situation Change				
They: Leave a job Have a change in work schedule (for example, from full-time to part-time employment) Are transferred to a different work site				
Under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you lost coverage under your family member's plan, are eligible for coverage under the company's plans, and aren't already covered by the plans Add coverage for your spouse or domestic partner, if they lost coverage Add coverage for any affected children	You can enroll in, increase, decrease or drop coverage in either of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance coverage	You can increase or decrease LTD Plan coverage	***Health Care Spending Account*** You can start or increase your contributions, except when your family member has a change in work status or work site. In those situations, you can't change your contributions ***Dependent Care Spending Account*** You can decrease or stop your Account contributions, except when your family member has a change in work status or work site. In those situations, you can't change your contributions.	Enroll yourself if you're not already covered; Add coverage for your spouse/domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your spouse/domestic partner; Drop coverage for any eligible children
Your Family Member Gains a Benefit Option Under Another Employer's Plan				
If you and/or your family members become covered under another employer's plans, you can make these changes under the Medical, Dental, and Vision Plans: Drop your coverage Drop coverage for your spouse or domestic partner Drop coverage for any affected children	You can enroll in, increase, decrease or drop coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease your LTD Plan coverage	You can't change your Health Care Spending Account contributions You can decrease or stop your contributions to the Dependent Care Spending Account	You can't change coverage
Your Family Member Loses Coverage Under Another Employer's Plan				

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
These situations are examples of what's considered a loss of coverage: Your spouse's, domestic partner's, or child's employer discontinues a benefit plan The HMO in which you or your family members are enrolled is no longer available where you live The plan significantly reduces the benefits related to a specific medical condition for which you or a family member is being treated The medical care **provider**s under a plan option are significantly reduced (for example, when a hospital leaves a health plan network				
Under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your spouse or domestic partner Add coverage for any eligible children	You can enroll in, increase, decrease or drop coverage in any of these plans if your spouse loses coverage: Employee Life and AD&D Insurance or Dependent Life Insurance If a child's employer discontinues a benefit plan, you can't change your coverage in the following plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease your LTD Plan coverage	You can't change your Health Care Spending Account contributions You can start, increase, decrease, or stop your contributions to the Dependent Care Spending Account	You can't change coverage
Your Family Member's Cost for Coverage Increases Significantly				
If you drop other coverage, you can make these changes under the Medical, Dental, and Vision Plans: Enroll yourself if you're not already covered Add coverage for your spouse or domestic partner Add coverage for any affected children	You can't change coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change your LTD Plan coverage	You can't change your Health Care Spending Account contributions You can start, increase, decrease, or stop your contributions to the Dependent Care Spending Account	You can't change coverage
Your Family Member's Cost for Coverage Decreases Significantly				
If you and/or your family members become covered under another employer's plans due to a decrease in a	You can't change coverage in any of these plans:	You can't change your LTD	You can't change Health Care Spending Account contributions	You can't change coverage

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
family members' cost for coverage, you can make these changes under the Medical, Dental, and Vision Plans: Drop your coverage Drop coverage for your spouse or domestic partner Drop coverage for any affected children	Employee Life and AD&D Insurance or Dependent Life Insurance	Plan coverage	You can decrease or drop your contributions to the Dependent Care Spending Account	
Your Family Member's Annual Enrollment does not Correspond with Employee's Annual Enrollment				
Under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your spouse or domestic partner Add coverage for affected children Drop coverage for your spouse Drop coverage for yourself if you become covered under your spouse's or domestic partner's plan Drop coverage for any eligible children if they become covered under your spouse's or domestic partner's plan	You can't change coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change your LTD Plan coverage	You can't change your Health Care Spending Account contributions You can start, increase, decrease, or stop your contributions to the Dependent Care Spending Account	You can't change coverage

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
COBRA Coverage From Another Employer Expires COBRA coverage through another employer is considered to have expired when the 18-, 29-, or 36-month coverage continuation period you or your dependent was entitled to expires (loss of COBRA coverage does not include failure to pay a premium)				
If Your COBRA Coverage Under Another Employer Expires You can change your medical plan option and/or under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your affected spouse or domestic partner if they loses coverage Add coverage for any affected eligible children if they lose coverage ***If Your Family Member's COBRA Coverage Expires*** You can change your medical plan option and/or under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your affected spouse or domestic partner Add coverage for any affected eligible children	You can't change your coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change your LTD Plan coverage	You can start or increase your Health Care Spending Account contributions You can't change your Dependent Care Spending Account contributions	You can't change coverage
You or Your Family Member Becomes Entitled to or Loses Medicare or Medicaid (including CHIPs)				
If You or Your Family Member Becomes Entitled to Medicare or Medicaid If you become entitled you can drop medical, dental and vision coverage for you and your dependents If your family member becomes entitled, you can drop coverage only for the person who becomes entitled to Medicare or Medicaid	You can't change your coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change LTD Plan coverage	You can start, increase, decrease, or stop your contributions to the Health Care Spending Account You can't change your Dependent Care Spending Account contributions	You can't change coverage

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
You can't change any other family member's medical, dental, or vision coverage				
If You or Your Family Member Loses Medicare or Medicaid Under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for the eligible dependent who loses Medicare or Medicaid coverage (your spouse, domestic partner, or child) You can't change any other family member's medical, dental, or vision coverage	You can't change your coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change LTD Plan coverage	You can't change your Health Care Spending Account or Dependent Care Spending Account contributions	You can't change coverage

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
You or Your Family Member Loses Coverage Under a Government's or Educational Institution's Plan				
Under the Medical, Dental, and Vision Plans, you can: Enroll yourself if you're not already covered Add coverage for your spouse or domestic partner Add coverage for affected children	You can't change your coverage in any of these plans: Employee Life and AD&D Insurance or Dependent Life Insurance	You can't change LTD Plan coverage	You can't change your contributions to the: Health Care Spending Account) and/or Dependent Care Spending Account	You can't change coverage
Your Domestic Partner Is Eligible for Coverage				
If you're covered, you can change your medical plan option and/or under the Medical, Dental, and Vision Plans, you can: Drop coverage for yourself Add coverage for your domestic partner Add coverage for any eligible children you gain through your domestic partnership	You can enroll in, increase, decrease or drop coverage in either of these plans: Employee Life and AD&D Insurance coverage or Dependent Life Insurance	You can increase or decrease your LTD coverage	You can start, increase, decrease, or stop your contributions to the: Health Care Spending Account Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for your domestic partner; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for any eligible children
You End a Domestic Partnership				
If you're covered, you can change your medical plan option and/or under the Medical, Dental, and Vision Plans, you can: If your ex-domestic partner is covered under the Medical, Dental, or Vision Plans, you must drop their coverage If any children are no longer considered eligible dependents, you must drop their coverage If you or your children lose coverage under your ex-domestic partner's plan, you can enroll in the Medical, Dental, and Vision Plans	You can enroll in, increase, decrease or drop coverage in either of these plans: Employee Life and AD&D Insurance coverage or Dependent Life Insurance	You can increase or decrease your LTD Plan coverage	You can't change your contributions to the Health Care Spending Account. You can start, increase, decrease or stop Dependent Care Spending Account.	Enroll yourself if you're not already covered; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your ex-domestic partner; Drop coverage for any eligible children
Your Domestic Partner Dies				

Health Care Coverage	Life and AD&D Insurance	LTD Optional Coverage	Spending Accounts	Legal Plan, Hospital Indemnity, and Accident Plan
If you're covered, you can change your medical plan option and/or under the Medical, Dental, and Vision Plans, you can: If you or your children lose coverage under your domestic partner's plan, you can enroll in coverage; your coverage category may change If your domestic partner was covered under the company's plans, you must drop his or her coverage If your domestic partner's children either become eligible dependents or cease to qualify as eligible dependents due to your domestic partner's death, you may be able to or required to enroll/disenroll them in coverage.	You can enroll, increase, decrease or drop your Employee Life and AD&D Insurance or Dependent Life Insurance	You can increase or decrease your LTD Plan coverage	You can't change your contributions to the Health Care Spending Account You can start, increase, decrease or stop Dependent Care Spending Account	Enroll yourself if you're not already covered; Add coverage for any eligible children; Drop coverage for yourself; Drop coverage for your domestic partner; Drop coverage for any eligible children

Leave of Absence

Special rules apply if you take a leave of absence. Changes you can make may depend on the type of leave and whether or not your leave is paid or unpaid.

Types of Leaves of Absence

The types of leaves available are:

- Disability;
- Military;
- Personal; and
- Family Leave.

Your leave of absence may also qualify as a Family and Medical Leave Act of 1993 (FMLA) leave due to:

- Your own serious health condition;
- Care for a newborn, adopted child, or foster child; and
- Care of a spouse, parent, or child with a serious health condition.

For information about the type of leave for which you may qualify and taking a leave of absence, refer to the Employee Handbook posted on SPE's intranet, mySPE.

Allowable Changes

If you qualify for an approved leave of absence, you may make certain changes in your SPE Benefits Plan coverages. For Employee Life Insurance, any increases (subject to EOI requirements) in coverage while you are out on a leave, will not be effective until you return to work.

During the plan year, you can change your benefits coverage if your qualified change in status affects your eligibility, your spouse's or domestic partner's eligibility, or your child's eligibility under the SPE plans or another employer's plans.

If you're on an approved paid leave, your SPE plan eligibility doesn't change. Your coverage continues automatically for up to one year, and SPE's plan provisions restrict making changes unless you're making a change during annual enrollment, or you have a qualified change in status. However, you may change your Dependent Care Flexible Spending Account contributions if your needs have changed as a result of your leave.

During a period of an approved paid or unpaid FMLA leave, you may drop coverage in any or all of the following plans*:

- Medical;
- Dental;
- Vision;
- Health Care or Limited Purpose Flexible Spending Account;
- Dependent Care Flexible Spending Account;
- Supplemental Life Insurance (for unpaid leave only);
- Spouse/Domestic Partner Life Insurance;
- Dependent Child Life Insurance;
- Voluntary Group Accident Insurance; and
- Voluntary Hospital Indemnity Insurance

SPE will continue to pay for Basic Life Insurance and LTD while you are on an approved leave of absence up to one year. Subject to the terms of your policy, Voluntary LongTerm Care & Life Insurance generally continues until your coverage lapses or you cancel your policy . See the Voluntary Long Term Care and Life Insurance section for more information.

* During an unpaid FMLA leave and/or other unpaid leave of absence, your coverage under the Legal plan will terminate automatically. You may re-enroll in the Legal Plan when you return from your unpaid leave or transition to a paid leave.

Paying for Benefits

Depending on the type of leave you are on determines whether you need pay for your benefits through payroll deduction or by after-tax dollars with a benefits bill:

- If you are on an approved Short -Term Disability (STD) medical leave and are receiving STD pay by SPE during your leave, you will continue to pay your share for benefits through payroll deductions.

- If you are not on an approved STD medical or paid parental leave (e.g., bonding with child, caring for a parent unpaid personal or FMLA leave or you are being paid through a state plan) and are receiving: Vacation, PTO, Vacation Bank pay or are completely unpaid by SPE, during

your leave:

- For up to the first thirty days, your benefit coverage will continue.
- After thirty days, you'll be responsible for direct payment of your share of coverage on an after-tax basis for any period from the first day of your unpaid approved leave of absence. You'll be billed for your portion of the cost of coverage. Your coverage will end if you fail to pay within the time frame indicated; however, when you return from your leave, you may elect coverage effective with the date of your return. Evidence of insurability may be required for Life Insurance.

If You Return From a Leave of Absence

During the plan year, you can change your benefits coverage if a qualified change in status (such as returning from a leave) affects your eligibility, your spouse's or domestic partner's eligibility, or your child's eligibility under the Sony plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the change in status. They must also correspond to any changes your spouse, domestic partner, or child makes to their coverage under another employer's plans.

You may change your coverage when you return from a leave only if you were dropped from coverage due to nonpayment, or you voluntarily decided not to continue coverage when your leave of absence began.

When Coverage Ends

When Eligibility Ends

In general, your eligibility for coverage ends effective at midnight on the date that any one of the following events occurs:

- You no longer meet the eligibility requirements.
- You retire or leave Sony employment.
- You're no longer eligible for the program due to a change in your employment status.
- You transfer to a position that isn't eligible or doesn't offer these types of plans.
- You stop making required payments.
- You die.
- The plans are discontinued or amended.

Your Spouse's or Domestic Partner's Eligibility

In general, your spouse's or domestic partner's eligibility ends and they lose coverage effective at midnight on the date that any one of the following events occurs:

- Your eligibility ends.
- You and your spouse get divorced or have your marriage annulled.
- Your domestic partnership ends.
- Your spouse or domestic partner enters the military.
- Your spouse or domestic partner dies.

Your Child's Eligibility

In general, your child's eligibility ends and they lose coverage effective at midnight on the date that any one of the following events occurs (unless noted otherwise):

- Your eligibility ends.
- Your child turns age 26 (coverage ends at midnight on the last day of the month in which your child turns 26).
- Your child enters the military.
- Your child loses disabled dependent status.
- Adoption proceedings for that child are discontinued.
- You're no longer the child's legal guardian.
- Your child dies.

If you're enrolled in a Health Maintenance Organization (HMO), your state's laws may allow you to extend your child's coverage. Contact your HMO for details.

Your child may be eligible to enroll in health insurance through the Children's Health Insurance Program (CHIP), depending on the state in which you reside. See page 316 for more information.

Your child's loss of eligibility qualifies as a change in status, so you can change your coverage. It also may allow them to choose continuation of health care coverage under COBRA.

When Coverage Ends

Timing

In general, SPE-provided health coverage in these plans ends at midnight of the last day of the month in which your **last day of active employment** or your last day as an eligible employee occurs:

- Medical;
- Dental;
- Vision;
- Employee Assistance Plan

In general, SPE-provided welfare coverage in these plans ends at midnight of your **last day of active employment** or your last day as an eligible employee occurs:

- Basic and Supplemental Life and Accidental Death and Dismemberment (AD&D) Insurance;
- Dependent Life Insurance;
- Basic and Supplemental Long Term Disability (LTD) Coverage;
- Health Care Flexible Spending Account/Health Savings Account;
- Dependent Care Flexible Spending Account;
- Legal Plan;
- Voluntary Group Accident Insurance;
- Voluntary Hospital Indemnity Insurance.

Coverage in a particular plan may end sooner if:

- You're no longer eligible due to a change in your employment status.
- You transfer to a position that isn't eligible for a plan or you transfer to a Sony company that doesn't offer the plan.
- You stop making any required contributions.
- If available in a particular benefit area, you choose the "No Coverage" option for that benefit area.
- SPE stops providing the plan.

Note: Your and/or your dependents' coverage may be terminated immediately (and, if applicable, with retroactive effect) if you knowingly provide false information on your enrollment form, intentionally cover an ineligible dependent, or fraudulently use services or **provider**s. If coverage is terminated for reasons of fraudulent behavior, you could also lose the right to continue coverage under COBRA (see page 46). In addition, determining whether an individual has engaged in fraud or intentional misrepresentation for the purpose of obtaining coverage or benefits is within the sole and absolute discretionary authority of the Plan Administrator.

Special rules apply if you take FMLA or military leave from the company. See details below under "Coverage You Can Continue."

After you leave, you can continue to submit health plan claims for expenses incurred before your coverage ended. Health Care, Limited Purpose, and Dependent Care Spending Account claims must be submitted by March 31 of the next calendar year for eligible expenses you incur before your coverage ends. If you are enrolled in the Health Savings Account, you will no longer be eligible to contribute to the account, but you can continue to reimburse yourself for eligible, out-of-pocket expenses or roll over your account to another employer's Health Savings Account program.

Your spouse and dependent child's coverage ends when your coverage ends or, if sooner, when your spouse or dependent child no longer qualifies as a dependent under the plan.

Coverage You Can Continue

You and your covered dependents may be able to continue medical, dental, vision, and/or Health Care Spending Account coverage through COBRA. You must elect COBRA coverage within sixty days of your coverage end date. You'll automatically receive COBRA information in the mail after you leave.

Whether you retire, leave SPE employment, or are otherwise no longer eligible for coverage, the following rules apply for other SPE Benefits Plan coverage:

- Basic and Supplemental Life and AD&D insurance ends. Dependent Life insurance ends. However, some coverage may be converted to an individual policy (see below) or continued under the portability provisions.
- If you have LTD coverage, coverage ends on your last day of eligibility under the plan.
- Subject to the terms of the policy, your Voluntary Long-Term Care and Life Insurance benefits should generally continue after you terminate employment until you stop paying premiums. Please refer to your policy for more details regarding termination of coverage.

Continuing Group Life and AD&D Insurance as an Individual Life and AD&D Insurance Policy
If your coverage ends because you leave SPE or you're no longer eligible for coverage, you can continue your Basic and Supplemental Life Insurance (but not the AD&D coverage) policy without having to prove good health. You would pay the cost of this individual policy.

Your individual policy can be for an amount up to the total of the Basic and Supplemental Life Insurance coverage you have in effect when you leave. Your individual policy will not include AD&D benefits that are part of your SPE plan.

You can also continue Dependent Life Insurance as an individual policy.

To continue your coverage, you must submit a written application and pay the first month's premium within thirty-one (31) calendar days after your SPE insurance is terminated or reduced.

The individual policy will take effect at the end of this thirty-one day period. If you should die during this thirty-one-day (31) calendar period, your beneficiary will receive the maximum amount you're eligible to convert.

You can obtain information about portability and continuing coverage from SPE Benefits Center.

Continuing Voluntary Group Accident Insurance as an Individual Insurance Policy
If your coverage ends because you leave Sony or you're no longer eligible for coverage, you can continue your Voluntary Group Accident Insurance. You would pay the cost of this individual policy.

You must complete the Portability Coverage Election Form and return it to us along with payment the first premium for the portability coverage not later than thirty (30) calendar days after your coverage under the policy terminates. Portability coverage will be effective on the day after benefits under the policy terminate.

The initial premium rates will be based on the premium rates in effect at the time you apply for

portability coverage. You must also pay any portion of the premium previously paid by the policyholder for the coverage.

A grace period of thirty-one (31) calendar days after the premium due date will be allowed for the payment of each premium. Aetna will not pay benefits under this policy in the absence of payment of the current premium, subject to this grace period.

You'll receive information about portability and continuing coverage from the benefits at Sony Service Center after your employment ends.

Continuing Voluntary Hospital Indemnity Insurance as an Individual Insurance Policy
If your coverage ends because you leave Sony or you're no longer eligible for coverage, you can continue your Voluntary Hospital Indemnity Insurance. You would pay the cost of this individual policy.

You must complete the Portability Coverage Election Form and return it to us along with payment the first premium for the portability coverage not later than thirty (30) calendar days after your coverage under the policy terminates. Portability coverage will be effective on the day after benefits under the policy terminate.

The initial premium rates will be based on the premium rates in effect at the time you apply for portability coverage. You must also pay any portion of the premium previously paid by the policyholder for the coverage.

A grace period of thirty (30) calendar days after the premium due date will be allowed for the payment of each premium. Aetna will not pay benefits under this policy in the absence of payment of the current premium, subject to this grace period.

You'll receive information about portability and continuing coverage from the benefits at Sony Service Center after your employment ends.

Continuation Coverage During Leave Under the FMLA
You're entitled by federal law to up to twelve (12) weeks of unpaid leave under the FMLA for specified family and/or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child, or parent who is seriously ill or for your own illness.

You're entitled to continue your group health coverage under the plan during that leave period, as long as you continue to make payments. If you don't return to covered employment after your leave ends, you're entitled to COBRA continuation coverage, as described above.

If you have questions regarding your entitlement to this leave and the continuation of group health coverage under the plan, speak with a SPE Benefits Center representative.

Note: Coverage continuation rules can vary depending on the type of leave you take and whether or not you're receiving pay during your leave. Go to the https://benefits.spe.sony.com for additional information or call 1-866-941-4773 to speak with a SPE Benefits Center representative.

Military Duty in the United States Armed Forces
If you enter the United States Armed Forces, you'll be offered the opportunity to continue coverage through the plan for yourself and your covered dependents based on the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For up to the first year of your military leave, your coverage and your dependent's coverage will continue at the same cost as if you were an active employee.

If the period of military service is more than one (1) year, you'll be required to pay the COBRA premium to continue coverage for up to an additional eighteen months while on military leave. If you don't choose to continue coverage during the period of military service, you're entitled to have your coverage reinstated on the date you return to employment with SPE. (If the period of service is less than thirty-one days, coverage for you and your dependents continues during military service without additional cost.)

No additional exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably.

Health Care Coverage if You Retire
Refer to the separate "Retiree Health Care" document in the Discover>Health>Medical section of the https://benefits.sonypictures.com Web site.

Health Care Coverage For Your Survivors Can Continue
If you die while an eligible covered employee, your surviving spouse and eligible dependent children, who have medical, dental, and/or vision coverage with SPE when you die, can continue coverage through COBRA. SPE pays the full cost of COBRA for three months.

Information You or Your Dependents Receive
When coverage ends, you and/or your covered dependents will receive:

- COBRA Enrollment Notice, with information about continuing your health care coverage;

COBRA

Continuing Coverage
Special rules apply when you or your dependents lose coverage under SPE's health plans due to a COBRA qualifying event. A federal law known as COBRA requires that you and your dependents must have an opportunity to continue health care coverage for a period of time after coverage would otherwise end for any reason, or be substantially reduced due to a Chapter 11 bankruptcy filing.

If you miss work because of duty in the uniformed services, such as the United States Armed Forces, you and your dependents may be entitled to enhanced continuation coverage under USERRA.

If SPE's health care plan coverage changes during the period that you, your spouse, or your dependents are continuing coverage, then your coverage will change accordingly.

You don't have to show evidence of insurability (EOI) to continue coverage. However, continuation coverage is provided subject to your eligibility for coverage under the plan. SPE may terminate your continuation coverage if it's determined that you're ineligible. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Notification of a Qualifying Event
Bswift, the COBRA Administrator, will notify you, your covered spouse, or your covered dependents of your eligibility to enroll in COBRA coverage within thirty-one (31) days of the date you lose active coverage due to one of the following qualifying events:

- You voluntarily or involuntarily leave the company (except for gross misconduct), including if you retire.

- You're no longer eligible—for example, because your work hours are reduced.
- Your child is no longer eligible due to age.
- You become entitled to Medicare (SPE plan COBRA coverage is the secondary payer to Medicare). (See chart on page 32)
- You die.

You or your covered dependents **must** notify Bswift within sixty (60) days of the date you lose coverage due to one of the following qualifying events to preserve your or their right to enroll in COBRA coverage:

- You get divorced or your marriage is annulled.
- Your child is no longer eligible for coverage.
- You die while continuing coverage under COBRA rules.

If you or your dependents don't provide the required notice, you or your dependents won't be eligible for COBRA coverage.

Note: You must give notification of a second qualifying event in writing to Bswift. Bswift **cannot** accept notification by phone.

COBRA Enrollment Notice
When you or your covered dependents lose coverage due to a COBRA qualifying event, a COBRA Enrollment Notice is sent to your permanent address within fourteen (14) days after Bswift is notified of the qualifying event.

The notice includes information on available coverage and cost. It also includes instructions on how to elect COBRA coverage.

Electing COBRA Coverage
Each qualified beneficiary has the right to choose coverage independently.

You or your covered dependents must call Bswift at 1-866-365-2413 to make your COBRA elections within sixty (60) days of the date the COBRA Enrollment Notice is sent. COBRA coverage is retroactive to the date your active coverage ends.

If you or your covered dependents don't elect COBRA coverage within sixty (60) days, you lose the opportunity to continue coverage under COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Paying for COBRA Coverage
If you or your covered dependents elect COBRA coverage, you or they are required to pay monthly premiums for that coverage retroactive from the date coverage was lost through the last day of the month in which the election was made.

Bswift must receive the first premium payment within forty-five (45) days of the date COBRA coverage is elected. Otherwise, your coverage won't take effect, and any health plan claims that you've submitted will be denied.

Payments are due on the 1st of each month. A thirty(30) day grace period applies. For example, the June payment is due June 1 but will be accepted if it's postmarked by June 30.

You or your dependents are responsible for paying the full cost of the elected coverage (the total of what you and the company were paying for your coverage), plus a 2% administration fee, as allowed by law.

If you or one of your dependents is disabled while covered under COBRA and is eligible to elect COBRA coverage beyond the initial eighteen-month period as a result of the disability, you pay:

102% of the COBRA premium for the first eighteen months of coverage.
150% of the premium for month nineteen and beyond.

Note: If you're covered under USERRA continuation coverage, you continue to pay 102% of the COBRA premium for the duration of that coverage. Your cost doesn't increase after eighteen months.

Costs vary, depending on the coverage elected and the number of dependents covered. When you or your dependents become eligible for COBRA coverage, you'll be notified what the monthly premium will be. The cost for coverage may change at the beginning of a new plan year or whenever there's a change in the cost of coverage for the corresponding active plan.

Changing Your COBRA Coverage
As COBRA coverage participants, you and other qualified beneficiaries have the same rights and restrictions as active plan participants to change your coverage during the year and at annual enrollment. You will need to demonstrate a qualified change in status to change your coverage during the year.

When COBRA Coverage Ends
Your COBRA coverage can continue through the end of the eighteen (18)-, twenty-nine (29) -, or thirty-six (36)- month period from the qualifying date, based on the COBRA qualifying event.

Note: If you're also eligible for continuation coverage under USERRA and your qualifying event was active military leave, your COBRA coverage can continue for up to an additional eighteen (18) months after one year of military leave. After one (1) year of military leave, you'll be requested to pay the COBRA premium to continue coverage for an additional eighteen months.

However, the plan can end your COBRA coverage earlier if:

- You or your covered dependents fail to make the first premium payment within forty-five (45) days of its due date.
- You or your covered dependents fail to make one of the ongoing premium payments within thirty (30) days of its due date.
- The person receiving COBRA benefits becomes covered under another group plan (not maintained by the company) that has no pre-existing condition exclusion or limitation affecting them. You need to call Bswift at 1-866-365-2413 to notify SPE of your enrollment in another group health plan.

- The person receiving COBRA benefits becomes entitled to Medicare. The COBRA beneficiary will need to call Bswift to notify them of their enrollment in Medicare.
- The company ends the plan.
- You or your covered dependents request to cancel the COBRA coverage.
- The disabled status of the person receiving the COBRA coverage ends (applies to eleven (11)- month extension of coverage due to disability).

COBRA coverage will **not** continue for more than thirty-six (36) months, even if multiple qualifying events occur.

Note: If you're eligible for trade adjustment assistance (TAA), you may be eligible for a tax credit or an advance payment for your COBRA premiums. You may also qualify for a second opportunity to elect COBRA coverage if you didn't elect coverage during the regular election period. However, you must elect coverage within sixty (60) days of the first day of the month in which it is determined that you qualify as a TAA recipient. In addition, you must elect coverage within six (6) months after you lost the coverage qualifying you as a TAA recipient. Call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282 for more information.

If you're receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC), you may be eligible for a tax credit or advance payment for your COBRA premiums. Call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282 for more information.

COBRA Qualifying Events

Definition of a Qualifying Event

When You Lose Coverage

You or your dependents have a qualifying event if you lose medical, dental, vision, and/or health care and limited purpose spending account coverage for one of these reasons:

- You voluntarily or involuntarily leave SPE employment (except for gross misconduct), including if you retire.
- You no longer qualify, or you become an ineligible employee—for example, your work hours are reduced.
- You become disabled.
- You die.
- You become entitled to Medicare (see chart on page 32)

When Your Dependents Lose Coverage

Your covered dependents can also have a qualifying event if they lose coverage due to:

- Termination of the employee's employment (for reasons other than the employee's gross misconduct);
- Reduction in the employee's hours of employment;
- Death of the employee;
- Divorce or legal separation of the employee or retiree;
- Loss of eligibility by an enrolled dependent;
- Entitlement of the employee/surviving spouse to Medicare benefits; or
- The Plan Sponsor's commencement of a bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired employee and their enrolled dependents if there is a substantial elimination of no longer eligible for coverage within one year before or after the date the bankruptcy was filed.
- You die while continuing coverage under COBRA.

Continuation Period

The length of time you or your covered dependents can continue coverage under COBRA depends on the qualifying event:

Qualifying Event	Qualified Beneficiaries	Maximum Period of COBRA Coverage
Your work hours are reduced, or you leave the company (unless you're dismissed for gross misconduct)	You, your spouse, and/or your child(ren)	18 months
You or your dependent is determined to be disabled (as defined by the Social Security Act) on or before the COBRA-qualifying event or within the first 60 days of COBRA coverage*	You, your spouse, and/or your child(ren)	29 months total
You get divorced from your spouse	Your spouse and/or your child(ren)	36 months
Your child(ren) lose(s) eligibility	Your child(ren)	36 months
You drop coverage as a result of your enrollment in Medicare	Your spouse and/or your child(ren)	36 months**
You die **Note:** SPE pays to continue medical, dental, and vision (as applicable) coverage through COBRA for the first 3 months if you die while an active employee.	Your spouse and/or your child(ren)	36 months

*You must notify Bswift of a Social Security Award letter or appeal notice within sixty (60) days of receiving the Social Security disability determination and before the end of the eighteen (18) -month COBRA coverage period. You must give notification of the disability extension in writing to Bswift along with a copy of the Social Security Award letter or appeal notice. Bswift cannot accept notification by phone.

**If you become entitled to Medicare within the eighteen-month period before the qualifying event of termination or reduction of hours, your qualified dependents are eligible for COBRA coverage. COBRA coverage ends thirty-six months from when you became entitled to Medicare.

If You Have a Domestic Partner

If you cover a domestic partner and coverage ends for your domestic partner or covered children of your domestic partner due to any of the situations described above, SPE will extend "COBRA-like coverage" on the same basis to your domestic partner and/or eligible covered children of your domestic partner (may not apply to certain HMO options). Note that these covered individuals aren't otherwise eligible under COBRA.

Second Qualifying Event
If your dependents are covered under COBRA because you leave the company or your work hours are reduced and a second qualifying event occurs during their initial eighteen (18) or twenty-nine (29) months of COBRA coverage, they can elect up to a total of thirty-six (36) months of COBRA coverage.

For example, assume that your dependent child has COBRA coverage due to your loss of coverage. When that child turns age 26, they are eligible for up to a total of thirty-six (36) months of COBRA coverage from the original COBRA date.

To qualify for an extension of coverage, you or your dependents must call 1-866-365-2413 and notify Bswift within sixty (60) days of the second qualifying event.

Note: You must give notification of a second qualifying event in writing to Bswift. Bswift **cannot** accept notification by phone.

Qualified COBRA Beneficiaries

Definition of Qualified Beneficiary

A qualified beneficiary is an individual who, **on the day before** the qualifying event, has SPE medical, dental, vision, and/or Health Care, and Limited Purpose Spending Account coverage.

A qualified beneficiary can be:

- The covered employee;
- The covered spouse of a covered employee;
- The covered dependent child of a covered employee; and
- A newborn or newly adopted child or a child placed for adoption who is added to a former employee's COBRA coverage within sixty (60) days of birth, adoption, or placement for adoption.

Each qualified beneficiary can make COBRA elections independent of any other qualified beneficiary's elections.

Nonqualified Beneficiaries

A qualified beneficiary can also add certain nonqualified beneficiaries to their COBRA coverage, subject to the same enrollment rules and restrictions that apply to qualified beneficiaries.

Nonqualified beneficiaries are family members who were eligible for coverage under the company's plans but were not covered on the day before the qualifying event.

Nonqualified beneficiaries also include individuals covered under the company's plans on the day before the qualifying event but not in one of the groups of qualified beneficiaries listed above (for example, domestic partners and their eligible children).

Nonqualified beneficiaries receive the same coverage that the qualified beneficiary elects. They don't have independent coverage election rights under COBRA.

If You Become Disabled

If you can no longer work due to an approved disability, you may be eligible to continue coverage.

In general, your coverage will automatically continue in all of the plans in which you were enrolled at the time of your disability while on out an approved disability leave. If you are approved for LTD benefits, you may be eligible for premium waiver for your Supplemental Life Insurance coverage while you remain disabled (Refer to the Supplemental Life Insurance section).

Your share of the cost of any coverage you continue may be deducted from any company-paid disability or sick-pay benefit plan. (Or you may need to make direct payment to SPE. Direct billing information will be provided to you by the SPE, if needed.)

If your disability continues for more than one (1) year, then you will become eligible for COBRA coverage.

In certain cases, if your job is eliminated while you are out on disability, for example, due to a reduction in force (RIF) or sale of a division or similar business transaction, your employee coverage will terminate on the date such event becomes effective, not the date you are expected to return from leave. In this event, you will become eligible for COBRA coverage at your termination date.

If You Die While Covered Under the Company's Plans

Health Plan Coverage

If you die while employed by SPE or on an approved leave of absence from SPE, your covered dependents will receive continued coverage (medical and or, dental and or, vision coverage at no cost for up to three (3) months through COBRA, if they continue to meet the definition of eligible dependents.

Please note that your spouse/domestic partner and eligible dependent children will be eligible for the coverage only if they were covered the day before you die.

Other Coverage

The following applies if you die:

- Your Basic and Supplemental Life Insurance and AD&D coverage ends. Your beneficiaries will receive payment of the coverage amount in effect at the time of your death, depending on the nature of your death.
- Your Dependent Life insurance ends. However, coverage may be converted to an individual policy.
- Your disability income plans end.
- Your estate can submit spending account claims for eligible expenses incurred before your death. Claims must be submitted by March 31 of the following year.

Coverage During Military Duty

Who's Eligible

If you miss work because of duty in the uniformed services, such as the United States Armed Forces, you can continue medical coverage for yourself and your dependents under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

How Coverage Works

During a military leave that's expected to be thirty (30) days or less, your current employee medical coverage continues uninterrupted. However, if your military leave is expected to be longer than thirty (30) days, you're entitled to continue medical coverage for you and your dependents under both USERRA and COBRA. USERRA enhances your COBRA continuation coverage in the following ways:

- You can continue coverage for yourself and for any dependent who's covered when your active duty begins.
- For up to the first year of your military leave, your coverage and your dependent's coverage will continue at the same cost as if you were an active employee.
- If the period of military service is more than one (1) year, you'll be required to pay the COBRA premium to continue coverage for up to an additional eighteen (18) months while on military leave.

  Note: Coverage may extend beyond twenty-four (24) months under COBRA, depending on the qualifying event.

Coverage costs for disabled dependents can't exceed 102% of the COBRA premium while you're entitled to USERRA continuation coverage.

Your USERRA coverage isn't required to end if you or a covered dependent becomes covered under another group plan.

Paying for Coverage

If you or your covered dependents choose coverage under USERRA, you or they are required to pay monthly premiums for that coverage.

Medical Plan Overview

Common Terms

Many terms used throughout this section are defined in the glossary at the end of the section. Bolded terms are defined in the glossary. Understanding these terms will help you understand how your plan works and provide you with useful information regarding your coverage.

Coverage Categories

When you enroll in a medical plan option, you'll be assigned to a coverage category based on the number of dependents you want to cover. The coverage category affects the price you pay for the coverage:

- Employee Only;
- Employee Plus Spouse/Domestic Partner;
- Employee Plus Child(ren); and
- Employee Plus Family.

Medical Plan Options

Depending on where you live, you may have one or more of these medical plan options available:

Option Name	Plan Type	**Service area** / Network
Sony Consumer Choice	Preferred Provider Organization (PPO)	**Aetna** Choice POS II
Sony EPO	Preferred Provider Organization (EPO)	**Aetna** Select
Sony PPO	Preferred Provider Organization (PPO)	**Aetna** Choice POS II
Kaiser Permanente HMO	Health Maintenance Organization (HMO)	California

Note: Sony employees in Hawaii are eligible for coverage under the BlueCross BlueShield of Hawaii PPO medical plan. Sony employees in California are eligible for coverage under the Kaiser Permanente HMO medical plans. You will receive a separate description of your medical coverage to supplement this SPD information.

Cost of Coverage

You and the company share the cost of coverage. Coverage costs vary based on coverage category, employee salary and coverage option, and are provided with your enrollment materials and are available online during the enrollment process. You pay your portion of the cost with before-tax

deductions paycheck (please note if you cover domestic partner and/or children of a domestic partner, you may be subject to imputed income). The company reserves the right to review and modify the cost of coverage, plan design and eligibility from time to time (generally, annually).

Changing Your Medical Plan Option

After enrolling in a medical plan option, you can only change your option:

- During annual enrollment;
- If you move and your current option is no longer available, or a new option becomes available;
- If your eligibility for the medical plan changes;
- If the option is no longer offered; and
- If you experience certain qualified changes in status.

Schedule of Benefits

Sony Consumer Choice, PPO, EPO Plans

PLAN FEATURE	SONY CONSUMER CHOICE	SONY PPO	SONY EPO
IN-NETWORK			
Annual Deductible **Single** **Family**	 **$1,600*** **$3,200***	 **$700** **$1,400**	 **$250** **$500**
Payment Percentage (What the plan pays after the deductible)	**80%**	**80%**	**90%**
Out-of-pocket maximum (includes copayments, deductible, plan payment percentage and prescription drugs) **Single** **Family**	 **$4,000** **$8,000****	 **$4,200** **$8,200**	 **$3,200** **$6,400**

* Medical and prescription drugs are subject to the deductible under the Consumer Choice plan
** An individual within a family plan will be capped at a maximum out-of-pocket limit of $6,850
*** Inpatient and outpatient charges at out-of-network hospitals and facilities other than hospitals are covered at the FCR Rate

OFFICE VISITS			
Preventive Care	100%	100%	100%
Primary Care Physician (PCP)	80% after deductible	$25	$20
Specialist	80% after deductible	$40	$35
Telemedicine (Teladoc)	$0	$0	$0
CVS MinuteClinics	100% after	$0	$0

	deductible		
Acupuncture (30 visits per year, combined in and out of network)	80% after deductible	$40	$35
Chiropractic (30 visits per year, combined in and out of network)	80% after deductible	$40	$35
Mental Health/Substance Abuse (Outpatient mental health or substance abuse office visits to a physician or behavioral health provider including telemedicine consults)	80% after deductible	$25	$20
Physical / Speech /Occupational Therapy (combined limit of 75 visits per calendar year for physical, occupational, and speech therapy per person. No limit for autism or pervasive developmental delay.)	80% after deductible	$40	$35
HOSPITAL CARE			
Inpatient per admission	80% after deductible	80% after deductible	90% after deductible
Outpatient per admission	80% after deductible	80% after deductible	90% after deductible
Emergency Room (in and out-of-network)	80% after deductible	80% after deductible	90% after deductible
OTHER CARE			
Fertility Benefits (Refer to Progyny Member Guide for more information)	80% after deductible	80% after deductible	90% after deductible
Home Health Care (limited to 120 visits per year, combined in and out of network)	80% after deductible	80% after deductible	90% after deductible
Skilled Nursing (limited to 120 days per year, combined in and out of network)	80% after deductible	80% after deductible	90% after deductible
Private Duty Nursing (unlimited)	80% after deductible	80% after deductible	90% after deductible
Hospice	80% after deductible	80% after deductible	90% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible	90% after deductible
Hearing Aids (one hearing aid per ear every year)	80% after deductible	80% after deductible	90% after deductible
Urgent Care	80% after deductible	$40	$35
Nutritional Counseling (limited to $1,000 per year)	80% after deductible	80% after deductible	90% after deductible

Related Benefits

When you enroll for medical coverage under the Sony Consumer Choice, PPO, or EPO plans, you also will be enrolled in the Sony Prescription Drug plan through Express Scripts.

If you enroll in the Kaiser Permanente HMO, it will provide **prescription drug** coverage.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this section as **covered expenses** that are **medically necessary**.
- This section applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- The following sections apply to the Sony Consumer Choice, PPO, and EPO plans

The plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits.

Network providers have contracted with the plan, an affiliate or third-party vendor to provide health care services and supplies. **Network providers** are generally identified on-line via provider directory at www.aetna.com/dse/custom/sony. With respect to **Fertility Benefits,** please refer to the Progyny Member Guide for access to Network **provider**s. You can call 1-833-404-2011 to obtain a copy of the Progyny Member Guide. **Out-of-network providers** are not listed in the **directory**.

Coverage is subject to all the terms, policies and procedures outlined in this section. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies, and expenses. Refer to the What the Plan Covers, Exclusions, Limitations sections and Schedule of Benefits to determine if medical services are covered, excluded, limited, or subject to prior authorization. **Fertility benefits** are subject to the terms and conditions described in the Progyny Member Guide, which can be accessed by calling 1-833-404-2011. You can also review Progyny's website at www.progyny.com.

The plan will pay for **covered expenses** up to the maximum benefits shown in this section or the Schedule of Benefits.

The Sony Consumer Choice, PPO and EPO plans provide access to covered benefits through a broad network of health care **provider**s and facilities. These plans are designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles**, **copayments**, and **payment percentage** will generally be lower when you use **network providers** and facilities.

The Sony Consumer Choice and PPO plans also provide the choice to access licensed **provider**s, **hospitals,** and facilities outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use **out-of-network providers** because the **deductibles** and **payment percentage** that you are required to pay are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept **Aetna**'s negotiated rates and may balance bill you for charges over the amount the plan pays. The EPO plan does not provide coverage when you use **out-of-network providers** except in the case of an emergency. If you

receive services from an out-of-network provider, all claims must be submitted to Aetna within twelve (12) months of the date of service in order to be processed. **Claims received after twelve (12) months of date of service will be denied.**

Some services and supplies may only be covered through **network providers**. Refer to the Covered Benefit sections and your Schedule of Benefits to determine if any services are limited to network coverage only. With respect to **Fertility benefits**, please refer to the Progyny Member Guide (accessed by calling 1-833-404-2011) to determine applicable **network providers** and the terms and conditions of **Fertility benefits.**

Availability of Providers
The plan cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or the **provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online provider directory. You may also ask contact Aetna to ask for a copy of the directory. Aetna updates the online directory regularly, but the listings can change. Before you get care, we suggest that you call Aetna for current information or to make sure that your provider, their office location, or their provider group is in the network.

Keeping a provider or facility you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** or facility you have now is not in the network
- You are already an Aetna member and your **provider** or facility stops being in our network

However, in some cases, you may be able to keep going to your current **provider** or facility to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels for up to 90 days of the provider or facility ceasing to be in our network. This is called continuity of care. If we know you are under an active treatment plan, we will notify you of the provider's or facility's contract termination and how you can submit a request to keep going to your current **provider** or facility. Contact us for additional information.

Transition of Care

Transition of Care (TOC) coverage is temporary coverage for an out-of-network provider, while receiving an active course of treatment. You can get TOC when you become a new member of a medical benefits plan or change your plan, and you are being treated by a doctor who is not in the plan's network. TOC coverage can also apply when your doctor leaves the plan's network or changes network status or if certain laws or regulations require coverage. Approved TOC coverage allows you or a covered dependent who is receiving treatment to continue the treatment for a limited time at in-network plan benefits level.

An active course of treatment means you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course-of-treatment examples may include, but are not limited to members who:

- Enroll with the plan after twenty (20) weeks of pregnancy, unless there are specific state or plan requirements (Members less than twenty (20) weeks pregnant whom the health plan confirms as high risk are reviewed on a case-by-case basis.)
- Have completed fourteen (14) weeks of pregnancy or more and are receiving care from a plan's participating practitioner whose network status changes.
- Are in an ongoing treatment plan, such as chemotherapy or radiation therapy.

- Have a terminal illness and are expected to live six (6) months or less.
- Need more than one surgery, such as cleft palate repair.
- Have recently had surgery.
- Are being treated for a mental illness or for substance related disorder. (The member must have had at least one treatment session within thirty (30) days before the status of the member or the participating health care provider changed.)
- Have an ongoing or disabling condition that suddenly gets worse.
- May need or have had an organ or bone marrow transplant.

To be considered for TOC coverage, treatment must have started before your Plan enrollment or re-enrollment date, or before the date your doctor left the health plan's network, or before the date a doctor's network status changed.

Under all circumstances, you must apply for TOC services with Aetna in advance of seeking treatment from an out-of-network provider. TOC coverage is only for the requested doctor. Except in New York, TOC coverage does not include health care facilities, durable medical equipment (DME) vendors or pharmaceutical items. If Aetna approves TOC coverage, the doctor must use a health care facility, DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Clinical Policy Bulletin (CPB)
Aetna's Clinical Policy Bulletins (CPBs) explain the medical services they may or may not cover. They are based on objective, credible sources, such as the scientific literature, guidelines, consensus statements and expert opinions. Public access to these CPBs can be found at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Ultimately, coverage is subject to the terms and conditions of **Aetna's provider** agreements which may include **precertification**, utilization management requirements, timely filing limits, requirements around payments for benefits that Aetna may otherwise deny (e.g., when a **provider**'s contract allows **provider** to deem certain treatments as medically necessary or experimental or investigational regardless of the plan's determination), and other requirements to administer the benefits under this plan.

Ongoing Reviews
Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are **covered expenses** under this section. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the Reporting of Claims and the Claims and Appeals sections.

To better understand the choices that you have with your medical plans, please carefully review the following information.

How the Plan Works

The Primary Care Physician:
To access network benefits, you are encouraged to select a **primary care physician (PCP)** from the plan's network of **provider**s at the time of enrollment. Each covered family member may select their own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf. Sony's Consumer Choice, PPO and EPO plans do not require

that you select a **PCP**.

A **PCP** may be a general practitioner, obstetrician/gynecologist, family **physician**, internist, or pediatrician. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or directing you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP
You may change your **PCP** at any time on **Aetna**'s website or by calling the Member Services toll-free number on your identification card.

Specialists and Other Network Providers
You may directly access **specialists** and other health care professionals in the network for covered services and supplies under this section. Refer to the **Aetna provider directory** to locate network **specialists**, **provider**s and **hospitals** in your area. Refer to the Schedule of Benefits section for benefit limitations and out-of-pocket costs applicable to your plan. With respect to **Fertility benefits**, please refer to the Progyny Member Guide (accessed by calling 1-833-404-2011).

Accessing Network Providers and Benefits

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna's** website at www.aetna.com/dse/custom/sony. You can search **Aetna's** online **directory** for names and locations of **physicians**, **hospitals** and other health care **provider**s and facilities. You can choose a **PCP** based on geographic location, group practice, language spoken, or **hospital** affiliation. Aetna's **provider directory** is updated several times a week. You may also request a printed copy of the **provider directory** by contacting Member Services through e-mail or by calling the toll-free number on your ID card.
- With respect to **Fertility benefits**, please refer to the Progyny Member Guide.
- If a service or supply you need is covered under this plan but not available from a **network provider** in your area, your **PCP** may refer you to an **out-of-network provider**. As long as your **PCP** has provided you with a referral that has been approved by **Aetna**, you will receive the network benefit level as shown in your Schedule of Benefits.
- If a service or supply you need is covered under the Sony plans but not available from a **network provider** in your area, please contact Member Services for assistance by email or at the toll-free number, 888-385-1053. This is also located on your ID card.
- Certain health care services such as **hospitalization**, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the **provider**'s responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider's** failure to **precertify** services. Refer to the Understanding **Precertification** section for more information on the **precertification** process and what to do if your request for **precertification** is denied. With respect to **Fertility benefits**, please refer to the Progyny Member Guide (accessed by calling 1-833-404-2011).
- You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your **network provider** will take care of claim submission. The plan will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **payment percentage** and **copayments**, if any.
- You may be required to pay some **network providers** at the time of service. When you pay a

network provider directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from the plan. You must submit a completed claim form and proof of payment to the plan. Note, office visit **copays** will not be reimbursed. Refer to the General Provisions section of this section for a complete description of how to file a claim under this plan.

- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayments**, or **payment percentage** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services at 888-385-1053 if you have questions regarding your statement.

Deductibles and Out-of-Pocket Maximums (Consumer Choice Plan only)

- If you are enrolled in Employee only coverage, you have an individual **deductible**. When covered services are performed by in-network or out-of-network providers, you are required to meet an individual deductible (an in- or out-of-network deductible limit, as applicable) before the Consumer Choice Plan pays any benefits. If you are covering one or more dependent(s), you have a family **deductible**. When covered services are performed by in-network or out-of-network providers for you or your dependents, and your **deductible** limit can be satisfied by a single family member or a combination of family members. Almost all covered services and prescription drugs (other than preventive care) are subject to the deductible. Money paid to meet the deductible also counts toward the out-of-pocket maximum.
- If you are enrolled in Employee only coverage, you have an individual out-of-pocket maximum (in- or out-of-network limit, as applicable). With the Consumer Choice Plan prescription drug expenses count towards the out-of-pocket limit. Once you meet your combined medical-prescription drug out-of-pocket limit, the Consumer Choice Plan pays all remaining expenses for the rest of the calendar year at 100%, except for out-of-network claims that exceed the Plan's maximum allowable charge. If you are covering one or more dependents, your family out-of-pocket maximum and can be satisfied by a family member or a combination of family members. Once the family out-of-pocket limit is met, it is considered met for all family members. In determining if the out-of-pocket limit has been satisfied, only **covered expenses** can be counted.

Deductibles and Out-of-Pocket Maximums (EPO and PPO Plans only)

- If you are enrolled in Employee only coverage, you have an individual **deductible**. When covered services are performed by in-network or out-of-network providers, you are required to meet an individual deductible (in- or out-of-network deductible limit, as applicable) before the EPO and PPO plans pays any benefits. If you are covering one or more dependents, you have a family **deductible**. When covered services are performed by in-network or out-of-network providers, each covered person pays toward their individual **deductible** until the family **deductible** limit is met (with each individual paying no more than the individual **deductible**). When the combined **deductibles** for all individuals equal the family **deductible** limit, no further **deductible** is due for the remainder of the calendar year. Certain benefits, such as in-network office visits (which are subject to a copayment), preventive care, and prescription drugs are not subject to the annual deductible. Money paid to meet the deductible also counts toward the out-of-pocket maximum.
- If you are enrolled in Employee only coverage, you have an individual out-of-pocket maximum (in our out-of-network limit, as applicable). Once you meet your combined out-of-pocket limit, the EPO and PPO plans pay all remaining covered expenses for the rest of the calendar year at 100%, except for out-of-network claims that exceed the Plan's maximum allowable charge. If you are covering one or more dependents, your family out-of-pocket maximum will be met once each covered person pays toward their individual out-of-pocket maximum until the family out-of-pocket maximum limit is met (with each individual paying no more than the individual out-of-pocket maximum). When the combined out-of-pocket maximum for all individuals equals the family out-of-pocket maximum limit, no further out-of-pocket maximum is due for the remainder of the calendar year.

Cost Sharing For Network Benefits

You share in the cost of your in-network benefits. Cost sharing amounts and provisions are described in the Schedule of Benefits.

- **Network providers** have agreed to accept the **negotiated charge**. The plan will reimburse you for a **covered expense**, incurred from a **network provider**, up to the **negotiated charge** and the maximum benefits under this plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits. Note preventive care covered under all plans and office visits covered under the EPO and PPO plans are not subject to the **deductible**.
- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers**.
- For certain types of services and supplies, you will be responsible for any **copayments** shown in your Schedule of Benefits. The PPO and EPO plans have **copayments** for certain office visits. The **copayments** in these plans will vary depending upon the type of service and whether you obtain covered health care services from a **provider** who is a **specialists** or **non-specialists**. You will be subject to the **PCP copayments** shown on the Schedule of Benefits when you obtain covered health care services from any **PCP** who is a **network provider**. If the **provider** is a network **specialist**, then the **specialist copayment** will apply.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the out-of-pocket maximum applicable to your plan.
- Once you satisfy any applicable out-of-pocket maximum, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the out-of-pocket maximum. Refer to your Schedule of Benefits for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific out-of-pocket maximum amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the What the Plan Covers section or the Schedule of Benefits. You are responsible for any expenses incurred over the maximum limits outlined.
- You may be billed for any **deductible**, **copayment,** or **payment percentage** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits (Consumer Choice and PPO Plans only)

- Certain health care services such as **hospitalization**, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your **provider** may **precertify** the services for you. However, you should verify with **Aetna** prior to the service, that the **provider** has obtained **precertification** from **Aetna**. If the service is not precertified, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the Understanding **Precertification** section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **out-of-network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form to **Aetna** for reimbursement up to the **recognized charge**. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** that you paid directly to an **out-of-network provider**.

- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, or **payment percentage** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call 888-385-1053 or e-mail Member Services if you have questions regarding your statement.

Cost Sharing for Out-of-Network Benefits (Consumer Choice and PPO Plans only)
Your share in the cost of your out-of-network benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- **Out-of-network providers** have not agreed to accept the **negotiated charge**. The plan will reimburse you for a **covered expense**, incurred from an **out-of-network provider**, up to the **recognized charge** and the maximum benefits under this plan, less any cost-sharing required by you such as **deductibles** and **payment percentage**. The **recognized charge** is the maximum amount the plan will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, the plan will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **payment percentage** are usually higher when you use **out-of-network providers** than when you use **network providers**.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the out-of-pocket maximum that applies to your plan.
- Once you satisfy any applicable out-of-pocket maximum, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the out-of-pocket maximum. Refer to your Schedule of Benefits for information on what **covered expenses** do not apply to the out-of-pocket maximum and for the specific out-of-pocket maximum amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the What the Plan Covers section or the Schedule of Benefits. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers section or the Schedule of Benefits.
- With respect to **Fertility benefits**, please refer to the Progyny Member Guide (accessed by calling 1-833-404-2011). You can find out more about Progyny at their website at progyny.com.

Understanding Precertification

Precertification
Certain services, such as inpatient **stays**, certain tests, procedures, and outpatient surgery require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your **provider** coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the **provider**'s responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from the plan for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

The Precertification Process
Prior to being hospitalized or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify the plan to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this section in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call the plan at 888-385-1053. This call must be made:

For non-emergency admissions:	You, your **physician,** or the facility will need to call and request **precertification** at least fourteen (14) days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your **physician** should call prior to the outpatient care, treatment, or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, your **physician,** or the facility must call within forty-eight (48) hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**:	You, your **physician,** or the facility will need to call before you are scheduled to be admitted. An **urgent admission** is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least fourteen (14) days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your precertified expenses are approved the approval is good for one hundred eighty (180) days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, the plan will notify you, your **physician** and the facility about your precertified length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the

notification will explain why and how the plan's decision can be appealed. You or your **provider** may request a review of the **precertification** decision pursuant to the Claims and Appeals section of this SPD.

Services and Supplies Which Require Precertification
Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice facility**;
- Outpatient **hospice care**;
- **Stays** in a **residential treatment facility** for treatment of **mental disorders** and **substance related disorder**;
- Partial Confinement Treatment programs for **mental disorders and substance related disorder;**
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for **mental disorders and substance related disorder**;
- Amytal interview;
- Applied Behavioral Analysis;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient **detoxification**;
- Psychiatric home care services;
- Psychological testing.
- Inpatient and Outpatient services and supplies for gene-based, cellular and other innovative therapies (GCIT)
- Complex imaging
- Comprehensive fertility services and ART services
- Obesity surgery (bariatric)
- Cosmetic and reconstructive surgery
- Transportation by airplane
- Injectables (immunoglobulins, growth hormones, multiple sclerosis medication, osteoporosis medications, Botox, hepatitis C medications)
- Gender affirming treatment
- Kidney dialysis
- Sleep studies
- Wrist surgery
- Knee surgery
- Transcranial magnetic stimulation (TMS)
- Outpatient back surgery not performed in physician's office

How Failure to Precertify Affects Your Benefits
A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means the plan will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from the plan prior to receiving services from an **out-of-network provider**. Your **provider** may **precertify** your treatment for you; however, you should verify with the plan prior to the procedure, that the **provider** has obtained **precertification** from the plan. If your treatment is not **precertified** by you or your **provider**, the benefit payable may be significantly reduced, or your expenses may not be covered.

How Your Benefits are Affected
The chart below illustrates the effect on your benefits if necessary, **precertification** is not obtained.

If **precertification** is:	then the expenses are:
▪ requested and approved by the plan.	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered, less $500 penalty
▪ not requested, would not have been covered if requested.	▪ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible** or out-of-pocket maximum.

Emergency and Urgent Care
You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's **service area**, for:
- An **emergency medical condition**; or
- An **urgent condition**.

In Case of a Medical Emergency
When **emergency care** is necessary, please follow the guidelines below:
- Seek the nearest emergency room or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- ▪ **Covered services** include only services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. For those plans that use a network of providers, you can get **emergency services** from network or **out-of-network providers**.
  Your coverage for **emergency services** will continue until the following conditions are met:
  - You are evaluated and your condition is stabilized
  - Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

  If both of the above conditions are met and you continue stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the Schedule of Benefits and Exclusion sections that fits your situation.

- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the Schedule of Benefits for specific details about the plan. No other plan benefits will be paid for non-emergency care in the emergency room unless otherwise specified under the plan.

In Case of an Urgent Condition
Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an urgent care condition if you cannot reach your **physician**.

If it is not feasible to contact your **physician**, please do so as soon as possible after urgent care is provided. If you need help finding an **urgent care provider** you may call Member Services at 888-385-1053, or you may access the plan's online **provider directory** at www.aetna.com/dse/custom/sony.

Non-Urgent Care
If you seek care from an **urgent care provider** for a non-urgent condition (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the plan. Please refer to the Schedule of Benefits for specific plan details.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition
Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered, and you will be responsible for the entire cost of your treatment. Refer to your Schedule of Benefits for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should not be provided in the emergency room but rather by a **physician** in an office setting.

In the Sony Consumer Choice and PPO plans, you may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductible** and **payment percentage** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Requirements For Coverage
To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must:
   - Be included as a **covered expense** in this section;
   - Not be an excluded expense under this section. Refer to the exclusions sections of this section for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this section. Refer to the What the Plan Covers section and the Schedule of Benefits for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this section.
   - With respect to Fertility benefits, please refer to the Progyny Member Guide (accessed by calling 1-833-404-2011) or find out more about Progyny at their website, www.progyny.com.
2. The service or supply must be provided while coverage is in effect.
3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care **provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing, or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:
   (a) In accordance with generally accepted standards of medical practice; and

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
(c) Not primarily for the convenience of the patient, **physician** or other health care **provider**; and
(d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the What the Plan Covers section and the Schedule of Benefits for the plan limits and maximums.

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

What the Plan Covers

Preventive Care

This section on preventive care describes the covered expenses for services and supplies provided when you are well. The recommendations and guidelines of the

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; United States Preventive Services Task Force;
- Health Resources and Services Administration;
- and American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents

as referenced throughout this Preventive Care section, may be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, during the Preventive Care visit, those tests or procedures will not be covered as Preventive Care benefits. Those tests and procedures that are **covered expenses** will be subject to the cost-sharing that applies to those specific services under this plan.

Routine Physical Exams

Covered expenses include charges made by your **primary care physician** (**PCP**) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of

the United States Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/).

- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check up.

Limitations:

Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under their direction;
- Psychiatric, psychological, personality or emotional testing or exams;

Preventive Care Immunizations

Covered expenses include charges made by your **physician** or a facility for:

- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations:

- Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.
- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer.

Well Woman Preventive Visits

Covered expenses include charges made by your **physician**, obstetrician, or gynecologist for:

- a routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**; and
- routine preventive care, breast cancer genetic counseling, and breast cancer (BRCA) gene blood testing. **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/); and
- evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under their direction;
- Psychiatric, psychological, personality or emotional testing or exams.
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive method, sterilization procedures or devices

Routine Cancer Screenings
Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms (including 3D mammograms);
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE)
- Colonoscopies (including pre-procedure **specialist** consultation, removal of polyps performed during a screening procedure, and pathology exam on any removed polyp); and
- Lung cancer screening.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer

Screening and Counseling Services
Additional **covered expenses** include charges made by your **primary care physician** in an individual or group setting for the following:

Obesity and/or Healthy Diet
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Misuse of Alcohol and/or Drugs
Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products
Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, e-cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes:

- preventive counseling visits;
- treatment visits; and
- class visits;
- to aid in the cessation of the use of tobacco products.

Sexually Transmitted Infections
Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risks for Breast and Ovarian Cancer
Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer.

Prenatal Care
Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (Anemia screening, Chlamydia infection, Gonorrhea screening, Hepatitis B screening, Gestational diabetes screening, Rh incompatibility screening, maternal weight, blood pressure, fetal heart rate check, and fundal height).

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer.
- Pregnancy expenses (other than prenatal care as described above).

Comprehensive Lactation Support and Counseling Services
Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support **provider**. **Covered expenses** also include the rental or purchase of breast-feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Limited to six (6) visits per twelve (12) months.

Breast Feeding Durable Medical Equipment
Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump
Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three (3) years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.
- If an electric breast pump was purchased within the previous three (3)-year period, the purchase of another breast pump will not be covered until a three (3) -year period has elapsed from the last purchase.

Breast Pump Supplies
Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

The plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the plan.

Limitations:
Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer.

Family Planning Services - Female Contraceptives
For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting.

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

Voluntary Sterilization
Covered expenses include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the **provider** or because it was not the primary purpose of a confinement.

Contraceptives
Covered expenses include charges made by a **physician** for:

- Services and supplies needed to administer or remove a covered contraceptive **prescription drug** or device;
- Female injectable contraceptives that are generic **prescription drugs**;
- Female contraceptives devices that are generic devices and brand name devices.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer;
- Services and supplies incurred for an abortion;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under their direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services - Other
Covered expenses include charges for certain family planning services, even though not provided to treat an **illness** or **injury** and not considered preventive care.

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Limitations:
Not covered are:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer;
- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges incurred for family planning services while confined as an inpatient in a **hospital** or other facility for medical care.
- Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to family planning services.

Food Items
Covers both amino acid modified preparations and low protein modified food productions for the therapeutic treatment of inherited metabolic diseases, and dietary specialized formulas when a physician prescribes for children (up to age 12), for the treatment of a disease or condition.

Hearing Exam
Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any twelve (12) month period. Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**, are not **covered services**.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **payment percentage** shown in your Schedule of Benefits.

Physician Services

Physician Visits
Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, by way of telemedicine, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Surgery
Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics
Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Alternatives to Physician Office Visits
Walk-In Clinic Visits
Covered expenses include charges made by **walk-in clinics** for:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations administered within the scope of the clinic's

license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:
- In a group setting for screening and counseling services.

Hospital Expenses
Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and board
Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of your medical condition.

Room and board charges also include:
- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies
Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include **hospital** charges for other services and supplies provided, such as:
- **Ambulance** services.
- **Physicians** and surgeons employed by the hospital.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses
Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does not cover private duty nursing services as part of an inpatient **hospital stay**.

The following are not Covered Services for Hospital Expenses:

All services and supplies provided in rest homes or any place considered a person's main residence or providing mainly

custodial or rest care., health resorts, spas, schools or camps.

Hospital admissions need to be precertified by the plan. Refer to How the Plan Works for details about **precertification**.

In addition to charges made by the **hospital**, certain **physicians** and other **provider**s may bill you separately during your **stay**.

Refer to the Schedule of Benefits for any applicable **deductible**, **copay,** and **payment percentage** and maximum benefit limits.

Coverage for Emergency Medical Conditions
Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:
- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Non-emergency services
If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

Coverage for Urgent conditions
Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:
- Use of emergency room facilities when network urgent care facilities are not in the **service area** and you cannot reasonably wait to visit your **physician**;
- Use of urgent care facilities;
- **Physician** services;
- Nursing staff services; and
- Radiologist and pathologist services.

Please contact your **PCP** after receiving treatment of an **urgent condition**.

If you visit an **urgent care provider** for a non-urgent condition, the plan will not cover your expenses, as shown in the Schedule of Benefits.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services
Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:
- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician's** or **dentist's** office.

The following outpatient surgery expenses are covered:
- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations:
Not covered under this plan are charges made for:
- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer;
- The services of a **physician** or other health care **provider** who renders technical assistance to the operating **physician**;
- A **stay** in a **hospital**;
- Facility charges for office-based surgery.

Birthing Center
Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:
- Prenatal care;
- Delivery; and
- Postpartum care within forty-eight (48) hours after a vaginal delivery and ninety-six (96) hours after a Cesarean delivery.

Limitations:
Unless specified above, not covered under this benefit are charges:
- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer;
- In connection with a pregnancy for which pregnancy related expenses are not included as a **covered expense.**

Home Health Care
Covered expenses include charges made by a **home health care agency** in the home, but only when all of the following criteria are met:
- You are homebound;
- Your **physician** orders them;
- The services take the place of a **stay** in a **hospital** or **skilled nursing facility**, or you are unable to receive the same services outside your home;
- The services are part of a **home health care plan**;
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy;
- Home health aide services are provided under the supervision of a registered nurse; and
- Medical social services are provided by or supervised by a physician or social worker.

Home health care expenses include charges for:
- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available;
- Part-time or intermittent home health aide services provided in conjunction with and in direct

support of care by and under the supervision of an **R.N. or L.P.N.**

- Skilled nursing services, home health aide services or medical social services, or short-term speech, physical, or occupational therapy.
- Part-time or intermittent medical social services provided by a social worker or **physician**
- Medical supplies, **prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had a **hospital stay**.
- Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility** or receiving outpatient services outside of the home.
  - You are **homebound** because of **illness** or **injury**.
  - The services provided are not primarily for comfort or convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse, **behavioral health provider** or therapist is 1 visit.

If you are discharged from a **hospital** or **skilled nursing facility** after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Such services are subject to the same conditions and limitations imposed on therapy provided outside the home. *See* the Short-Term Rehabilitation Therapy section, the Habilitation therapy services section and the Schedule of Benefits.

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer.
- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapy section for coverage information.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.

- Services that are **custodial care**.
- The plan does not cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).

Skilled Nursing Care
Covered expenses include charges by an **R.N.**, **L.P.N.**, or nursing agency for outpatient skilled nursing care.

This is care by a visiting **R.N.** or **L.P.N.** to perform specific skilled nursing tasks.

Covered expenses also include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any shifts during a Calendar Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Limitations:
Unless specified above, not covered under this benefit are charges for:
- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility
Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the Schedule of Benefits, including:
- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious **illness** or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and

- Medical supplies.

Limitations:
Unless specified above, not covered under this benefit are charges for:
- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental **illness**; and
- Daily **room and board** charges over the semi private rate.

Hospice Care
Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care** program.

Facility Expenses
The charges made by a **hospital**, hospice, or **skilled nursing facility** for:
- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses
Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:
- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- **Prescription drugs**;
- Dietary counseling; and
- Psychological counseling.

Charges made by the **provider**s below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:
- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Limitations:
Unless specified above, not covered under this benefit are charges for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Inpatient **hospice care** and home health care must be precertified by the plan. Refer to How the Plan Works for details about **precertification**.

Other Covered Health Care Expenses

Acupuncture
The plan covers charges made for acupuncture services provided by a **physician** or an acupuncturist, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure; and
- To treat an **illness**, **injury** or to alleviate:
    - Chronic pain
    - Postoperative and chemotherapy-induced nausea and vomiting
    - Nausea during pregnancy
    - Postoperative dental pain
    - Temporomandibular disorder (TMD)
    - Migraine headache
    - Pain from osteoarthritis of the knee or hip

Ambulance ServiceCovered expenses include charges for Ambulance Service as specified here and in the Exclusions section. Ambulance Service is service provided by a licensed ambulance. An ambulance is a vehicle staffed by medical personnel and is equipped to transport an ill or injured person by ground, air, or water (subject to the conditions below). Covered expenses for Ambulance Service include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency Ambulance Services are limited to transportation by a licensed ambulance to the first facility to provide emergency services and from one facility to another if the first cannot provide the emergency services you need. Covered services may include non-emergency transportation only when an ambulance is the only safe way to transport you and meets certain other conditions under Aetna's policies. Non-emergency services are limited to transportation by a licensed ambulance to the nearest facility able to treat your condition or from a facility to your home by ground ambulance. *Non-emergency ambulance services must be pre-authorized*.

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Air or Water Ambulance
Covered expenses generally include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not medically appropriate; and
- They meet the conditions set forth in Aetna's ambulance policy for air/water ambulance

Limitations:
Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or

- If the type of **ambulance** service provided (e.g. air or water) is not required for your physical condition; or
- By any form of transportation other than a lincensed **ambulance** service; or
- Non-emergency ambulance services that are NOT pre-authorized and/or do not meet Aetna's ambulance policy conditions will not be covered

Autism Spectrum Disorder Applied Behavioral Analysis (ABA)
Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a **physician** or **behavioral health provider**, as part of a Treatment Plan.
Applied Behavior Analysis is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Important Note: Applied behavioral analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

Diagnostic and Preoperative Testing
Diagnostic Complex Imaging Expenses
The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- Computed tomography (CT or C.A.T.) scans;
- Magnetic Resonance Imaging (MRI), including magnetic resonance spectroscopy (MRS), magnetic resonances venography (MRV) and magnetic resonance angiogram (MRA);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations:

- The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan or any other group plans sponsored by your employer.

Outpatient Diagnostic Lab Work and Radiological Services
Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Outpatient Preoperative Testing
Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by

a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations:

- The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan or any other group plans sponsored by your employer.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.

Durable Medical and Surgical Equipment (DME)
Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

The initial purchase of DME if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment, maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Section. The plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the plan.

Clinical Trials

Clinical Trial Therapies (Experimental or Investigational)
Covered expenses include charges made for **experimental** or **investigational** drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a terminal **illness**, and all of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- The plan determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An "approved clinical trial" is a clinical trial that meets these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it **investigational** new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs
Covered expenses include charges made by a **provider** for "routine patient costs" furnished in connection with your participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Limitations:
Not covered under this plan are:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e., protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The **experimental** intervention itself (except **medically necessary** Category B **investigational** devices and promising **experimental** or **investigational** interventions for terminal **illnesses** in certain clinical trials in accordance with the plan's claim policies).

Habilitation therapy services
Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age).

Eligible health services include charges for habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy
Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development. (Speech function is the ability to express thoughts, speak words and form sentences).

Fertility benefits are benefits designed to assist any member wishing to have a child and are provided through the Progyny network. Progyny is designed to provide fertility treatment coverage to assist any member wishing to have a child. Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage. Progyny's program includes a credentialed **provider** network, and a support team (Patient Care Advocates) who offer education, support, and coordinated care. Through Progyny's benefit, members have access to a variety of fertility treatment options which are described in the Progyny Member Guide. Please refer to the Progyny Member Guide, which is incorporated herein by reference, for a complete description of **Fertility benefits** covered under the Plan**.** Progyny's Member Guide can be accessed by calling 1-833-404-2011 and you can find out more about Progyny through their website at www.progyny.com.

Pregnancy Related Expenses
Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits (covered at 100%, excluding certain tests and services), delivery and postnatal visits. Maternity care may include tests and services that are subject to the deductible and coinsurance (e.g., ultrasounds).

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **hospital** for a minimum of:

- Forty-eight (48) hours after a vaginal delivery; and
- Ninety-six (96) hours after a cesarean section.
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital Stays**.

Covered expenses also include services and supplies provided for circumcision of the newborn during the **stay**.

Prosthetic Devices
Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device that your **physician** orders and administers.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or **injury** or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made and fitted for you.

Limitations:
The plan will not cover expenses and charges for, or expenses related to:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the Exclusions section.

Hearing Aids
Hearing aid means any wearable, non-disposable instrument device designed to aid or make up for impaired hearing (parts, attachments, or accessories).

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written during a covered hearing exam. Audiometric hearing visit and evaluation for a hearing aid prescription performed by:

- A **physician** certified as an otolaryngologist or otologist
- An audiologist who is legally qualified in audiology, holds a certificate of Clinical Competence in Audiology from American Speech-Language-Hearing Association in the absence of any licensing requirements, and performs the exam at the written direction of a legally qualified otolaryngologist or otologist

Benefits are payable up to the hearing supply maximum listed in the Schedule of Benefits.

All **covered expenses** are subject to the hearing expense exclusions in this section and are subject to **deductible(s)**, **copayments** or **payment percentage** listed in the Schedule of Benefits, if any.

Benefits After Termination of Coverage
Expenses incurred for hearing aids within thirty (30) days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the thirty (30) days before the date coverage ends:

- The **prescription** for the hearing aid was written; and
- The hearing aid was ordered.

Limitations:
The plan will not cover expenses and charges for, or expenses related to:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Short-Term Rehabilitation Therapy Services
Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your Schedule of Benefits. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifics frequency and duration.

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a **physician**. This course of treatment is limited to a maximum of thirty-six (36) sessions in a twelve (12)-week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of thirty-six (36) hours or a six (6)- week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient **hospital** and **skilled nursing facility** benefits provision in this section.

- Physical therapy is covered for conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions. Physical therapy does not include educational training or services designed to develop or maintain physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost; or impaired, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop or maintain physical function.
- Speech therapy is covered for conditions and acute **illnesses** and **injuries** provided the therapy is expected to restore the speech function or correct a speech impairment; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the Schedule of Benefits for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a twenty-four (24)-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Unless specifically covered above, not covered under this benefit are charges for:

- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-

covered diagnoses include Down syndrome, and cerebral palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders.

- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above;
- Services provided by a **home health care agency**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Musculoskeletal (MSK)

The Plan also covers MSK services through a digital program called Hinge Health Digital Musculoskeletal (MSK) Clinic if you meet the eligibility criteria below.

Eligible participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

(a) Prevention - Program designed to increase education with regards to key strengthening and stretching activities around healthy habits. The prevention program is software based and offered through the Hinge Health app.
(b) Chronic - Program designed to address long term back and joint pain which includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed physical therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.
(c) Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed physical therapist along with software guided rehabilitation and education.

For applicable programs a participant may obtain up to six (6) virtual physical therapy sessions per episode prior to in-person healthcare provider or physical therapy care (additionally, other state laws may limit access without a physician's referral).

To be eligible for the Hinge Health program, you, and your eligible dependents must meet all of the following requirements:

(i) be enrolled in an Aetna medical plan through Sony
(ii) be age 18 or older
(iii) be located in the United States
(iv) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment

If you and/or your eligible dependents are eligible, Hinge Health is offered at no cost. To get started with Hinge Health, visit hingehealth.com/sony to enroll. If you have any questions regarding Hinge Health, email help@hingehealth.com or call 855-902-2777.

Reconstructive or Cosmetic Surgery and Supplies
Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for

reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental **injury**, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original **injury**. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an **injury** that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original **injury**. **Injuries** that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental **injuries**, even if unplanned or unexpected.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an **illness** or **injury**) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment, and the surgery is needed to improve function.

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Gene-based, cellular, and other innovative therapies (GCIT)

Covered services include GCIT provided by a **physician, hospital,** or other **provider**. We designate facilities/providers

Covered services for GCIT include:

- Cellular immunotherapies
- Genetically modified oncolytic viral therapy
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Example include therapies using:
    - Luxturna (Voretigene neparvovec)
    - Zolgensma (Onasemnogene abesparvovec-xioi)
    - Spinraza (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9
- Oligonucleotide-based therapies. Examples include:
    - Antisense. An example is Spinraza
    - siRNA
    - mRNA
    - microRNA therapies

Facilities/providers for gene-based, cellular and other innovative therapies

We designate facilities/**providers** to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:
You must get GCIT **covered services** from the GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your local network, we will arrange for and coordinate your care at a GCIT-designated facility/**provider**. If you do not get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Travel and Lodging
Coverage for Travel and Lodging may be available for participants to obtain **covered services** for **medically necessary** care that is not available from a medical **provider** within a 50-mile radius from your primary residence. This annual travel benefit will cover reasonable transportation and lodging expenses, except where prohibited by law, for the patient and up to one (1) travel companion to obtain medical care.

The following travel and lodging expenses are covered under the plan:

- U.S. domestic travel (from and return to your home) and lodging expenses for you and one (1) companion, to receive the **covered services**
- Total maximum travel and lodging benefit is $10,000 per **year**. To the extent the reimbursement of any travel and lodging expenses exceeds eligible IRS limits, they will be reported as taxable income
    - For individuals enrolled in Sony's Consumer Choice Plan, no travel and lodging benefits are payable until the you have reached the deductible.
- This travel and lodging benefit is not available for **covered services** coordinated through the Institutes of Excellence™, Institutes of Quality, National Medical Excellence® or Gene-based, cellular and other innovative therapies (GCIT) programs.

More information about the travel and lodging benefit under the medical plan options can be found on https://InspiraFinancial.com

Key Terms
To help you understand this section, here are some key terms we use.

Cellular
Relating to or consisting of living cells.

GCIT
Any services that are:

- Gene-based
- Cellular and innovative therapeutics

We call these "GCIT services".

They have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence (IOE) programs.

Gene
A unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular
Relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic
A treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

Radiation Therapy Benefits
Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits
Covered expenses include infusion therapy received from an outpatient setting including but not limited to:
- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in their office or in your home.

The list of preferred infusion locations can be found by logging onto the plan Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card (888-385-1053).

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:
- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:
- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under the Inpatient **Hospital** and **Skilled Nursing Facility** Benefits sections of this document.

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

Specialty Care Prescription Drugs
Covered expenses include **specialty care prescription drugs** when they are:
- Purchased by your **provider**, and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in their office
  - A home care **provider** in your home

Spinal Manipulation Treatment
Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the Schedule of Benefits. However, this maximum does not apply to expenses incurred:
- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Teladoc®
Teladoc provides access to lower cost care for routine common **illnesses** via telephonic and online video consultation. Telephonic consults are available in forty-eight (48) states (not available in AR or ID), and video consults are available in forty-eight (48) states (not available in AR and TX). There is a $0 **copay** for each visit for members enrolled in Sony's PPO Plan and EPO Plan. Members enrolled in the Sony Consumer Choice will pay the full cost of the service as defined in the schedule of benefits above until their **deductible** has been met; after that, there is no cost ($0) for each visit.

Gender Affirming Treatment
Covered expenses include charges in connection with a **medically necessary** -gender affirming (sometimes called sex reassignment) treatment as per **Aetna**'s Clinical Policy Bulletin, which includes the **medical necessity** criteria.

Covered expenses include:
- Charges made by a **physician** for performing the surgical procedure; and pre-operative and post-operative **hospital** and office visits.
- Charges made by a **hospital** for inpatient and outpatient services (including outpatient surgery). **Room and board** charges in excess of the **hospital's** semi-private rate will not be covered unless a private room is ordered by your **physician** and **precertification** has been obtained.

- Charges made by a **skilled nursing facility** for inpatient services and supplies. **Room and board** charges in excess of the **hospital's** semi-private rate will not be covered.
- Charges made for the administration of anesthetics.
- Charges for outpatient diagnostic laboratory and x-rays.
- Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self-donated blood after the surgery has been scheduled.

- Charges made for the following procedures are not considered Cosmetic when an individual is diagnosed with gender dysphoria:
    - Mastoplexy
    - Urethromeatoplasty with partial excision of distal urethral segment
    - Plastic repair of introitus
    - Adjacent tissue transfer of rearrangement for genitalia
    - Vaginoplasty constructed with colon segment
    - Penile skin inversion
    - Construction of vagina with graft
    - Bilateral orchiectomy
    - Coloproctostomy (low pelvic anastomosis)
    - Creation of male chest
    - Colpectomy (removal of vagina)
    - Colpectomy with hysterectomy
    - Second stage phalloplasty
    - Modified abdominoplasty as part of phalloplasty
    - Scrotoplasty, complicated
    - Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir
    - Plastic operation of penis for injury – for glans formation
    - Insertion of testicular expanders
    - Replacement of tissue expander with permanent prosthesis
    - Insertion of penile prosthesis; non-inflatable, semi-rigid
    - Insertion of penile prosthesis; inflatable, self-contained
    - Removal or replacement of non-inflatable or inflatable penile prosthesis
    - Insertion of inflatable (multi-component) penile prosthesis; including placement of pump, cylinders, and/or reservoir
    - Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or cylinders and/or reservoir
    - Formation of direct or tubed pedicle with or without transfer
    - Free skin flap with microvascular anastomosis
    - Free fascial flap with microvascular anastomosis
    - Nerve graft, single strand, arm or leg up to 4 cm length
    - Nerve graft, single strand, arm or leg more than 4 cm length
    - Suture of major peripheral nerve, arm or leg except sciatic including transposition
    - Split graft, trunk, arms, legs, first 100 sq. cm or less
    - Split graft, trunk, arms, legs, each additional 100 sq. cm

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer.
- Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, , liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are not covered. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, Unless otherwise stated above, all other services are considered **cosmetic**. **Cosmetic** expenses are not covered.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; hematopoietic stem cell; bone marrow; CAR-T and T-cell receptor therapy for FDA approved treatments; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be more than one Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

Limitations:

Unless specified above, not covered under this benefit are charges incurred for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells, or other blood cells, without the expectation of transplantation within 12 months from harvesting for an existing **illness**;
- Cornea (Corneal Graft with Amniotic Membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Network of Transplant Specialist Facilities

Through the **Institute of Excellence (IOE)** network, you will have access to a **provider** network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An **Institute of Excellence (IOE)** facility we designate to perform the transplant you need
- A Non-IOE facility

Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a Non-IOE facility, but

your cost share will be higher.

The National Medical Excellence (NME) Program will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

Many pre- and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed though NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

Treatment of Obesity
Covered expenses include charges made by a **physician**, licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and
- **Prescription drugs**.

Morbid Obesity Surgical Expenses
Covered medical expenses include charges made by a **hospital** or a **physician** for the surgical treatment of **morbid obesity** of a covered person.

Coverage includes the following expenses as long as they are incurred within a two-year period:

- One **morbid obesity** surgical procedure including complications directly related to the surgery;
- Pre-surgical visits;
- Related outpatient services; and
- One follow-up visit.

This two-year period begins with the date of the first **morbid obesity** surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

Limitations:
Unless specified above, not covered under this benefit are charges incurred for:

- Charges for services which are covered to any extent under any other part of this plan or any other group plans sponsored by your employer
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the section; and.
- Services which are covered to any extent under any other part of this plan.

Treatment of Mental Disorders and Substance Related Disorders

Treatment of Mental Disorders
Covered expenses include charges made for the treatment of **mental disorders** provided by a **provider hospital**, **psychiatric hospital**, **residential treatment facility, physician**, or **behavioral health provider** as follows:

- Inpatient **room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Other outpatient mental health treatment such as:
    - **Partial Confinement Treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all the following criteria are met:
    - You are homebound
    - Your **physician** orders them
      - The services take the pace of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The services are appropriate for the active treatment of a condition, **illness**, or disease to avoid placing you at risk for serious complications.
    - Electro-convulsive therapy (ECT)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23-hour observation

Treatment of Substance Related Disorders

Covered expenses include charges made for the treatment of **substance related disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician**, or **behavioral health provider** as follows:

- Inpatient **room and board** at the **semi-private room** rate and other services and supplies that are provided during your stay in a **hospital, psychiatric hospital** or **residential treatment** facility.. As used here, "medical complications" include, but are not limited to, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens, and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group and family therapies for the treatment of **substance related disorder**
  - Other outpatient **substance related disorder** treatment such as:
    - Outpatient detoxification
    - **Partial Confinement Treatment** provided in a facility or program for treatment of **substance related disorder** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorder** provided under the direction of a **physician**
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance related disorder**, including administration of medications
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
  - Treatment of withdrawal symptoms
  - Substance use disorder injectables
  - 23-hour observation

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)
Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:
(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut
due to **injury**.

Any such teeth must have been free from decay or in good repair and are firmly attached to the jawbone at the time of the **injury**.

The treatment must be completed in the calendar year of the accident or in the next calendar year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Vision care services and supplies
Covered expenses are limited to keratoconus-related hard contact lenses including those that are prescribed for the first time and those required because of a change in **prescription**.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section or by amendment attached to this section.

- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

- **Ambulance services** for non-emergency transportation or for routine transportation to receive outpatient or inpatient services (except as specifically provided in *What the Plan Covers* above)

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in the Schedule of Benefits.

- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this section. This also includes **prescription drugs** or supplies if:
  - such **prescription drugs** or supplies are unavailable or illegal in the United States; or
  - the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

- Behavioral Health Services:
  - Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the What the Plan Covers section.
  - School and/or education service, including special education, remedial education, treatment in wilderness programs or other similar programs.
  - Services provided in conjunction with school, vocation, work, or recreational activities.
  - Treatment of intellectual disabilities This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Plan Covers.
  - Transportation
  - Sexual deviations and disorders except for gender identity disorder.
  - Specific developmental disorders of scholastic skills (learning disorders/learning disabilities), motor functions, speech and language, and psychological development.

- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered. Blood, blood products, and related services which are supplied to your provider free of charge.

- Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

- Charges for a service or supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

- Charges submitted for services by an unlicensed **hospital**, **physician** or other **provider** or not within the scope of the **provider's** license.

- Contraception, except as specifically described in the What the Plan Covers Section:
  - Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

- **Cosmetic** services and plastic surgery (excluding covered gender affirming services): any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including, but not limited to, the following:
  - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, **cosmetic** eyelid surgery and other surgical procedures;
  - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
  - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
  - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
  - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
  - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
  - Surgery to correct Gynecomastia;
  - Breast augmentation;
  - Otoplasty.

- Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the What the Plan Covers section. Note that marriage or family counseling may be covered when at least one party in the relationship has a diagnosed behavioral health disorder such as an adjustment disorder, alcoholism, anxiety, or depression.

- Court ordered services, including those required as a condition of parole or release.

  - **Custodial Care**

  - Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of **injuries** and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
    - services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
    - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
    - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

- Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

- Drugs, medications, and supplies:
  - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
  - Any services related to the dispensing, injection or application of a drug;
  - Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
  - Immunizations related to work;
  - Needles, syringes and other injectable aids, except as covered for diabetic supplies;
  - Drugs related to the treatment of non-covered expenses;
  - Performance enhancing steroids;
  - Injectable drugs if an alternative oral drug is available;
  - Outpatient **prescription drugs**;
  - Self-injectable **prescription drugs** and medications;
  - Any **prescription drugs**, injectables, or medications or supplies provided by the customer or through a third-party vendor contract with the customer; and
  - Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

- Educational services:
  - Any services or supplies related to education, training or retraining services or testing. This includes: special education, remedial education, wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution), job training and job hardening programs;
  - Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

- Examinations:
  - Any health examinations required:
    - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - by any law of a government;
    - for securing insurance, school admissions or professional or other licenses;
    - to travel;
    - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

- Any special medical reports not directly related to treatment except when provided as part of a covered service.

- **Experimental** or **investigational** drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

- Facility charges for care services or supplies provided in:
  - rest homes;
  - assisted living facilities;
  - similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
  - health resorts;
  - spas, sanitariums; or
  - infirmaries at schools, colleges, or camps.

- **Fertility**: except as specifically covered in the Progyny Member Guide, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception.

- Food items (unless otherwise indicated): Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.

- Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  - Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

- Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

- Hearing:
  - Any hearing service or supply that does not meet professionally accepted standards;
  - Hearing exams given during a **stay** in a **hospital** or other facility;
  - Replacement parts or repairs for a hearing aid; and
  - Any tests for the improvement of hearing (amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under the What the Plan Covers section.

- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;

- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

- Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

- **Maintenance Care**

- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

- Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a **physician's** practice;
  - Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    - Care in charitable institutions;
    - Care for conditions related to current or previous military service;
    - Care while in the custody of a governmental authority;
    - Any care a public **hospital** or other facility is required to provide; or
    - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

- Non-medically necessary services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by the plan, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

- Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the Private Duty Nursing provision in the What the Plan Covers section.

- Services not permitted under applicable state or local laws. Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover

such health care services. For detailed information about these excluded services, contact Member Services at the number on your ID card. See Travel and Lodging section for details regarding travel benefits for covered services that are unavailable within 50 miles of a participant's primary residence.

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member.

- Services of a resident **physician** or intern rendered in that capacity.

- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage.

- Services that are not covered under the What the Plan Covers section.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.

- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the What the Plan Covers section.

- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
  - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
  - Drugs or preparations to enhance strength, performance, or endurance; and
  - Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

- Therapies and tests: Any of the following treatments or procedures:

  - Aromatherapy;
  - Bio-feedback and bioenergetic therapy;
  - Carbon dioxide therapy;
  - Chelation therapy (except for heavy metal poisoning);
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;

- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

- Transplant-The transplant coverage does not include charges for:
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when recipient is not a covered person;
  - Home infusion therapy after the transplant occurrence;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
  - Harvesting and/or storage of bone marrow, tissue or hematopoietic stem cells or other blood cells without the expectation of transplantation within 12 months for an existing **illness**;
  - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by the plan.

- Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services.
- Treatment in a federal, state, or governmental entity:
  Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws.

- Unauthorized services, including any service obtained by or on behalf of a covered person without **precertification** by the plan when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

- Vision-related services and supplies. The plan does not cover:
  - Special supplies such as non-prescription sunglasses and subnormal vision aids;
  - Vision service or supply which does not meet professionally accepted standards;
  - Eye exams during your **stay** in a **hospital** or other facility for health care;
  - Eye exams for contact lenses or their fitting;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;
  - Acuity tests;
  - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
  - Services to treat errors of refraction.

- Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as specifically provided in the What the Plan Covers section, including but not limited to:
  - Liposuction, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling, coaching, training, hypnosis or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

- Wilderness treatment programs, including health resorts, recreational programs, outdoor skills programs, and relaxation/lifestyle programs, including services provided in conjunction with those programs. (See educational services above).

- Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Coordination of Benefits – What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this plan, the amount normally reimbursed under this plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - covers the person as other than a dependent; and
   - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:
   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:
   - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   - If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
   The benefits of a plan which covers the person on whose expenses claim is based as a:
   - laid-off or retired employee; or
   - the dependent of such person.

   Shall be determined after the benefits of any other plan which covers such person as:
   - an employee who is not laid-off or retired; or
   - dependent of such person.

   If the other plan does not have a provision:
   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.
   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.
   If the other plan does not have a provision:
   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this plan and any "other plan" both agree that this plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to the plan for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with the plan's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The medical/**pharmacy** coverage will be coordinated with other medical/**pharmacy** plans.

In order to administer this provision, the plan can release or obtain data. The plan can also make or recover payments.

Other Plan
This means any other plan of health expense coverage under:
- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by law will be counted.

When You Have Medicare Coverage

Effect of Medicare
Health Expense Coverage under this plan will be changed, as listed below, for any person while eligible for Medicare.

A person is "eligible for Medicare" if they:
- Are covered under it;
- Are not covered under it because of:
  - Having refused it;
  - Having dropped it; or
  - Having failed to make proper request for it.

These are the changes:
- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this plan will pay the difference. Otherwise, this plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B **deductible** under Medicare will be applied under this plan in the order received by the plan. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while they are eligible for Medicare. This will be done whether or not they are entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this plan will be applied after this plan's benefits have been figured under the above rules. Any benefits under Medicare will not be deemed to be a "**covered expense**".

Coverage will not be changed at any time when your Employer's compliance with federal law requires this plan's benefits for a person to be figured before benefits are figured under Medicare.

General Provisions

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Type of Coverage

Coverage under the plan is non-occupational. Only non-occupational accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations
The plan will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no

cost to you.

Legal Action
No legal action can be brought to recover payment for any benefit under the plan after 1 year from the date the claim is fully and finally denied.

Additional Provisions
The following additional provisions apply to your coverage:

- This section applies to coverage only and does not restrict your ability to receive health care services that are not, or might not be, covered under this plan.
- You cannot receive multiple coverage under the plan because you are employed by more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact the plan administrator or member services.
- The plan may be changed or discontinued with respect to your coverage.

Assignments
Coverage and your rights under this plan may not be assigned. A direction to pay a **provider** is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements
The plan's failure to implement or insist upon compliance with any provision of this plan at any given time or times, shall not constitute a waiver of the plan's right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Rescission of Coverage
The plan may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and **prescription drug** coverage only, you have the right to an internal appeal with the plan and/or the right to a third-party review conducted by an independent External Review Organization if your coverage under the plan is rescinded retroactive to its effective date.

Subrogation and Right of Recovery Provision
The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an **injury**, **illness** or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

The plan is always secondary to automobile no-fault coverage, personal **injury** protection coverage, or medical payments coverage.

Subrogation
The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an **injury**, **illness** or condition to the full extent of benefits provided or to be provided by the plan. The plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an **injury**, **illness** or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that **injury**, **illness** or condition, up to and including the full amount of your recovery.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any **provider**) you agree that if you receive any payment as a result of an **injury**, **illness** or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the **illness**, **injury** or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any **illness**, **injury** or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the plan.

Assignment
In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting benefits from the plan, you acknowledge that the plan’s recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation
You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your **injury**, **illness** or condition. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in person **injury** litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery you receive may result in the termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan. If you fail to cooperate with the plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you will cease to be entitled to any further plan benefits. The plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You acknowledge that the plan has the right to conduct an investigation regarding the **injury**, **illness** or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/ her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Workers' Compensation
If benefits are paid under the plan medical benefits plan and the plan determines you received Workers' Compensation benefits for the same incident, the plan has the right to recover as described under the Subrogation and Right of Reimbursement provision. The plan, on behalf of the plan, will exercise its right to recover against you.

The Recovery Rights will be applied even though:
- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this plan, you will notify the plan of any Workers' Compensation claim you make, and that you agree to reimburse the plan, on behalf of the plan, as described above.

If benefits are paid under the plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, the plan has a right to recover from you or your covered dependent an amount equal to the amount the plan paid.

Recovery of Overpayments
Health Coverage
If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:
- To require the return of the overpayment;
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan; or
- To reduce future payments to the **provider** by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces future payments to **provider**s by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the **provider**. Payments to **provider**s under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. As a plan participant you should not receive any balance billing by a provider as a result of Aetna's reduction of future payments to providers by the amount of the overpayment.

Such right does not affect any other right of recovery the plan may have with respect to such overpayment.

Reporting of Claims
A claim must be submitted to the plan in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits
Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, the plan has the right to pay any health benefits to the service **provider**. This will be done unless you have told the plan otherwise by the time you file the claim.

The plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

When a **PCP** provides care for you or a covered dependent, or care is provided by a **network provider** (**network services** or supplies), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services** and supplies), you are responsible for filing your own claims.

Involuntary Services and Surprise Billing
A federal law called the No Surprises Act protects you from surprise bills by limiting cost sharing and prohibiting balance billing by out of network providers.

An **out-of-network provider** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and delivered in the emergency room or an independent freestanding emergency department. These services are covered through stabilization and in some cases include admission to the facility.
- Non-emergency services and surgical and ancillary services (defined below) provided by an **out-of-network provider** at an in-network facility by certain types of providers. Providers, other than providers performing the surgical and ancillary services as described below, may balance bill you if the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
  - Signed consent from you to be treated and balance-billed by the **out-of-network provider**
- Out-of-network air ambulance services

Surgical or ancillary services mean any professional services including:
- **Surgery**, including assistants
- Anesthesiology
- Pathology
- Radiology

- Hospitalist services
- Laboratory services
- Neonatology
- Emergency Medicine
- Other provider types as may be added under Federal Law

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation
- Other therapeutic health settings

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the **out-of-network provider** based on the median in-network rate or such other data resources or factors as determined by Aetna.

Your cost share paid with respect to the items and services will be based on the qualifying payment amount, as defined under the No Surprises Act, and applied toward your in-network **deductible** and out-of-pocket maximum, if you have one.

Certain **out-of-network** providers may ask you to sign a consent form to allow them to balance bill you for services above any amounts covered by your plan. In this case, you may be responsible for all charges from that out-of-network provider.

You may request external review if you are seeking to determine if the No Surprises Act applies to your situation.

If you receive a surprise bill or have any questions about what a surprise bill is, contact Aetna.

Records of Expenses
Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:
- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Glossary

A

Aetna
Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with Aetna.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

B

Behavioral Health Provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center
A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

C

Copay or **Copayment**
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts or percentages are specified in the Schedule of Benefits.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this section.

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Deductible
The part of your covered expenses you pay before the plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the Schedule of Benefits.

Dentist
A legally qualified dentist, or a physician licensed to do the dental work they perform.

Detoxification
The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a physician. The process must keep the physiological risk to the patient at a minimum and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory
A listing of all network **provider**s serving the class of employees to which you belong. The contract holder will give you a copy of this directory. Network **provider** information is also available through Aetna's online **provider** directory.

Durable Medical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

E

Emergency Care
Treatment given in a **hospital's** emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An **independent freestanding emergency department** means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

Emergency Medical Condition
A recent and severe medical or mental health condition that comes on suddenly and needs immediate care , including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and mental health, to believe that their condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing their physical or mental health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or **Investigational**
A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:

- drug;
- device;
- procedure; or
- treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

F

FCR Rate – See Recognized Charges below

Fertility benefits are benefits designed to assist a Member with having a child, as described in Progyny's Member Guide.

H

Homebound
This means that you are confined to your place of residence:

- Due to an illness or injury which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Home Health Care Agency
An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one physician and one R.N.) which makes policy.
- Has full-time supervision by a physician or an R.N.
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan
This is a plan that provides for continued care and treatment of an illness or injury. The care and treatment must be:

- Prescribed in writing by the attending physician; and
- An alternative to a hospital or skilled nursing facility stay.

Hospice Care
This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency
An agency or organization that meets all of the following requirements:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:

  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - Physician services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One physician;
  - One R.N.; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
- Assesses the patient's medical and social needs.
- Develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic

services;
- Is supervised by a staff of physicians;
- Provides twenty-four (24) hour-a-day R.N. service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospitalization
A continuous confinement as an inpatient in a hospital for which a room and board charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A hospital or other facility that has contracted with Aetna to give services or supplies to an IOE patient in connection with specific transplants, procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants, procedures for which it has signed a contract.

L

L.P.N.
A licensed practical or vocational nurse.

M

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit
Your plan has a maximum out-of-pocket limit. Your deductibles, payment percentage, **copays** and other eligible out-of-pocket expenses apply to the maximum out-of-pocket limit. Once you satisfy the maximum out-of-pocket limit, the plan will pay 100% of covered expenses for the rest of the calendar year subject to any other plan limits. The maximum out-of-pocket limit applies to both network and out-of-network out-of-pocket expenses.

Medically necessary or Medical necessity
These are health care or dental services, and supplies or prescription drugs that a physician, other health care **provider** or dental **provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury;
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
c) Not primarily for the convenience of the patient, physician, other health care or dental **provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors. Lastly, they must follow the standards set forth in Aetna’s clinical policies and applying clinical judgment.

Important note:
Aetna develops and maintains clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. Aetna uses these bulletins and other resources to help guide individualized coverage decisions under the medical plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact Aetna for more information.

Mental disorder

An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health **provider** such as a psychiatric physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Also included is any other mental condition which requires Medically necessary treatment.

Morbid obesity
This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated charge
The maximum charge a network **provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Network Provider
A health care **provider** who has contracted to furnish services or supplies for this plan; but only if the **provider** is, with Aetna's consent, included in the directory as a network **provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network service(s)
Health care service or supply that is:

- Furnished by a network **provider**; or
- Furnished or arranged by your PCP.

Non-Occupational Illness
A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that illness under such law.

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

Non-Specialist
A physician who is not a specialist.

O

Occupational Illness
An illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full-time basis; or
- Results in any way from an illness that does.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Service(s)
Health care service or supply that is:

- Furnished by an out-of-network **provider**; or
- Not furnished or arranged by your PCP.

Out-of-Network Provider
A health care **provider** who has not contracted with Aetna, an affiliate, or a third-party vendor, to furnish services or supplies for this plan.

P

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, and/or therapeutic services to treat mental disorders and substance abuse. It must meet these tests:

- It is carried out in a hospital; psychiatric hospital or residential treatment facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Payment Percentage
Payment percentage is both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the "plan payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on payment percentage amounts.

Pharmacy
An establishment where prescription drugs are legally dispensed. Pharmacy includes a retail pharmacy, mail order pharmacy and specialty pharmacy network pharmacy.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of their license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where they practice;
- Provides medical services which are within the scope of their license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance related disorder or a mental disorder; and
- A physician is not you or related to you.

Precertification or **Precertify**
A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

Prescriber
Any physician or dentist, acting within the scope of their license, who has the legal authority to write an order for a prescription drug.

Prescription
An order for the dispensing of a prescription drug by a prescriber. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within their capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)
This is the network **provider** who:

- Is selected by a person from the list of primary care physicians in the directory;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on Aetna's records as the person's PCP.

Provider(s)
A physician, other health professional, hospital, skilled nursing facility, home health care agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric Hospital
An institution licensed or certified as a psychiatric hospital by applicable laws to provide a program for the diahnosis, evaluation, and treatment of alcoholism, drug abuse or mental health disorders (including substance related disorders) and meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance related disorder or mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician
This is a physician who:
- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance related disorders or mental disorders.

R

Recognized Charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage (see *Surprise Bills* for more information).

If your ID card displays the National Advantage Program logo (NAP), your cost may be lower when you get care from a NAP **provider** for whom we access NAP rates. Claims for services received from a NAP provider and paid at the NAP contracted rate are not subject to the federal surprise bill law. . Through NAP, the **recognized charge** is determined as follows:

- If your service was received from a NAP **provider**, a pre-**negotiated charge** may be paid. NAP **providers** are **out-of-networks providers** that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP **providers** are not **network providers** (At times Aetna may choose to terminate specific providers from NAP and will notify the provider of such a decision).

- If your service was not provided by a NAP **provider**, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the **recognized charge** for a specific service or supplies will be the out-of-network plan rate, calculated in accordance with the following:

Service or Supply	**Out-Of-Network Plan Rate**
Professional Services	An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical competitive charges and/or payments for a service, adjusted for the **Geographic area** in which the service was provided.
Inpatient and outpatient hospital charges	The Facility Charge Review (FCR)
Inpatient and outpatient charges of facilities other than hospitals	The Facility Charge Review (FCR)

Important note: If the **provider** bills less than the amount calculated using the **out-of-network plan rate** described above, the **recognized charge** is what the **provider** bills.

In the event you receive a balance bill from a **provider** for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances.

If NAP does not apply to you, the **recognized charge** for specific services or supplies will be the **out-of-network plan rate** set forth in the above chart. The **out-of-network plan rate** does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by an **out-of-network provider**, unless that **out-of-network**

provider is an assistant surgeon for your **surgery**
- Not available from a **network provider**
- **Emergency services**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.

Special terms used
"AWP", "FCR Rate" and "Geographic area" are defined as follows:

Average wholesale price (AWP)

The AWP is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Facility Charge Review Rate (FCR)
The Facility Charge Review (FCR) Rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the facility **provider** with a reasonable profit. For **hospitals** and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on what the facilities report to CMS. For facilities which do not report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the **Recognized Charge**. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

Geographic area
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

Reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **Recognized Charge**.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate

- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

Aetna may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help you decide where to get care. Use the "Estimate the Cost of Care" tool on Aetna member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

Residential Treatment Facility (Mental Disorders and Substance Related Disorders)
A facility that provides mental health disorder services or substance related disorder services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed physician for the level of care provided
- Maintains a written treatment plan prepared by a licensed behavioral health provider (RN or master's level) requiring full-time residence and participation
- Has a licensed behavioral health provider (RN or master's level) on-site 24 hours per day 7 days per week and is:
    - Credentialed by Aetna, or
    - Certified by Medicare, or

- Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

R.N.
A registered nurse.

Room and Board
Charges made by an institution for room and board and other medically necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Semi-Private Room Rate
The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by Aetna, in which network **provider**s for this plan are located.

Skilled Nursing Facility
A facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed physician for the level of care provided
- Maintains a written treatment plan prepared by a licensed provider (RN or master's level) requiring full-time residence and participation
- Has a licensed provider (RN or master's level) on-site 24 hours per day 7 days per week and is:
  - Credentialed by Aetna, or
  - Certified by Medicare, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g., acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or

  Part-time care services.

It does not include institutions that primarily provide for the the care and treatment of mental health disorders or substance related disorders.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an R.N. or L.P.N. within the scope of their license.
- The services are not custodial.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a specialist.

Stay
A full-time inpatient confinement for which a room and board charge is made.

Substance Related Disorder
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:
- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

Must have all of the following:
- A physician trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.

- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Surprise Bills

There may be times when you unknowingly receive services or do not consent to receive services from an **out-of-network provider**, even where you try to stay in the network for your **covered services**. You may then get a bill at a rate that you did not expect. This is called a surprise bill.

T

Terminally Ill (Hospice Care)
Terminally ill means a medical prognosis of 12 months or less to live.

U

Urgent Admission
A hospital admission by a physician due to:
- The onset of or change in an illness; or
- The diagnosis of an illness; or
- An injury.
- The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider
This is:
- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Charges for its services and supplies.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
  - Has contracted with Aetna to provide urgent care; and
  - Is, with Aetna's consent, included in the directory as a network urgent care **provider**.

It is not the emergency room or outpatient department of a hospital.

Urgent Condition
This means a sudden illness; injury; or condition; that:
- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;

- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

W

Walk-in Clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near, or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a walk-in clinic:

- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a hospital
- Physician's office
- Urgent care facility

Prescription Drug Plan Overview

Eligibility for Coverage

You and your covered dependents are automatically covered by the Express Scripts Prescription Drug Program if you enroll in the Sony Consumer Choice, PPO or EPO Plan. If you enroll in a Health Maintenance Organization (HMO), the HMOs provide prescription drug coverage directly to you and your covered dependents.

After you enroll, you'll receive your prescription drug program ID card to use when filling retail pharmacy prescriptions as well as Express Scripts by Mail home delivery service information. Also, you can use the program's website to register and access more information or call member services with questions about your prescription drug coverage.

At times, Express Scripts may negotiate rebates or discounts on certain prescription drugs. Any such rebates or discounts will not be used to reduce co-pays, deductibles, coinsurance, OOP maximums and the Company shall have the exclusive right to determine how such rebates or discounts will be used, including applying the amounts toward Company expenses.

Creditable Coverage (Medicare Part D)

If you or a covered dependent is eligible for Medicare or will soon become eligible, you're also eligible for Medicare prescription drug coverage (Part D).

You don't need to enroll in Medicare Part D if your Prescription Drug Program coverage is creditable, which means that your coverage is as good as Medicare Part D standard coverage. Sony provides creditable prescription drug coverage with all its health plans.

For more information about your Prescription Drug Program coverage, refer to the Creditable Prescription Drug Coverage Notice you receive in the mail.

Schedule of Benefits

Sony Consumer Choice, PPO, EPO Plans

PLAN FEATURE	SONY CONSUMER CHOICE*	SONY PPO	SONY EPO
Retail Pharmacy (up to a 30-day supply)			
Generic	$10	$10	$10
Preferred	30% $25 min, $75 max	30% $25 min, $75 max	30% $25 min, $75 max
Non-preferred	40% $40 min, $100 max	40% $40 min, $100 max	40% $40 min, $100 max
Mail Order Pharmacy (up to a 90-day supply)			
Generic	$20	$20	$20
Preferred	30% $55 min, $125 max	30% $55 min, $125 max	30% $55 min, $125 max
Non-preferred	40% $70 min, $150 max	40% $70 min, $150 max	40% $70 min, $150 max

* Combined medical and prescription drug deductible applies first. Please see the preventive medication section below for exceptions.

How the Plan Works

The Prescription Drug Program covers medically necessary drugs and medicines prescribed by your or your covered dependent's doctor on an out-patient basis. Some drugs and medicines are not covered by the program.

The Prescription Drug Program has two parts:

Part 1: For your immediate prescription needs—the retail pharmacy service is available. Simply present your prescription drug ID card with your prescription(s) to the pharmacist at any participating pharmacy. You can receive up to a thirty (30) -day supply of medications (as prescribed by your doctor).
The pharmacist will tell you the appropriate amount to pay. (See the chart above.) You do not have to submit a claim. Note that over-the-counter medications, with a prescription, are not covered but may be reimbursed under your Health Care Spending Account or your Health Savings Account (HSA).

At a participating retail pharmacy, there are no claim forms to complete. You just pay the appropriate amount when you pick up your prescription. At a nonparticipating pharmacy, you must pay the full cost up front and then submit a claim form. Reimbursement is based on the participating pharmacy's discounted cost minus the co-payment. To obtain a form, contact Express Scripts. If your claim is denied, you have the right to appeal.

Part 2: If you have a health condition that requires the use of medication on an ongoing basis, you will need to order your maintenance medications through Express Scripts mail-order services. You will need to contact your doctor to prescribe up to a ninety (90) -day supply for home delivery, plus refills for up to one (1) year. If you do not use the mail order program after three (3) fills at retail, you will pay 100% of the cost of the medication. Note: In this case, none of the cost you pay will be counted toward your annual out-of-pocket maximum (described below) and you will continue to be responsible for this cost, even after your out-of-pocket maximum has been reached.

Ongoing medications are less costly when ordered through the mail and in larger amounts, such as a ninety-day supply. If a prescription costs less than the co-payment, you should pay the cost out-of-pocket rather than filling the prescription through the plan.

You can use your Health Care Flexible Spending Account or Health Savings Account (HSA), as applicable, to receive reimbursement for your share of prescription drug costs

Specialty Drugs

Specialty drugs are prescription medications used to treat complex conditions. These drugs may require special handling (such as refrigeration during shipping) and administration (such as injection or infusion). Specialty drugs are required to be obtained through Express Scripts Mail Order Pharmacy. Please call **1-800-926-1662.**

Generic Substitution

If you buy your prescription at a retail pharmacy and choose a formulary or non-formulary brand drug when a generic equivalent is available, you'll pay coinsurance and the program's cost difference

between the brand and the generic. If you use the Express Scripts by Mail service, your prescription

will automatically be filled with an equivalent generic, if available. Regardless of where you fill your prescription, if your doctor states "no substitutions" on the formulary brand or non-formulary brand prescription, it will be filled as written (no generic substitution), and you will not pay the cost difference between the brand and the generic. Note: if your doctor does not indicate "no substitutions" on your prescription, the cost difference will NOT be counted toward your annual out-of-pocket maximum, and you will continue to be responsible for this cost, even after your out-of-pocket maximum has been reached.

Out of Pocket Maximum

Once you have reached your annual out-of-pocket maximum under the medical plan which includes medical and prescription out of pocket cost, any expenses for a covered prescription drug will be paid by the Plan. The cost of medications that are not covered by the plan will not be counted toward your out-of-pocket maximum. Your annual out-of-pocket maximum is a combined limit that includes both out-of-pocket medical and prescription drug expenses.

Some prescription drug manufacturers offer financial assistance to help you purchase their drugs. This assistance is often provided in the form of a discount, or a program that might be called "copay assistance," "patient assistance," or by some other name. Regardless of how the assistance is provided, amounts paid for your drug by a drug manufacturer will generally not count toward your annual deductible or out-of-pocket maximum.

Coverage Management

Some medications covered by the Plan are limited to certain uses or available only in certain quantities. For example, a medication may not be covered when it is used for cosmetic purposes. Also, the quantity covered may be limited to certain amounts over certain time periods. Your doctor may be required to provide more information to determine if your prescription meets Plan coverage criteria.

Prior authorization is a process by which certain drugs (both at retail and home delivery) are reviewed and approved by Express Scripts before they are covered under the Prescription Drug Program. Certain drugs require prior authorization and clinical management by Express Scripts' pharmacists because the designated drug(s):

- May be used for an inappropriate diagnosis or condition
- Are potent agents that require closer scrutiny of therapeutic approach, dosing duration and/or potential side effects of therapy
- Are used for multiple diagnoses or conditions, some of which are not covered by the plan
- May be prescribed in an excessive amount

Your physician must call Express Scripts at 1-800-753-2851 to begin the coverage review process to obtain approval before prescribing certain drugs including but not limited to anti-obesity agents, central nervous system stimulants, growth hormones, Provigil, and Retin-A. Note: Sony reserves the right to limit coverage for certain prescription drugs for any reason, including, but not limited to, cost management, safety, usage management, or because a drug is prescribed strictly for cosmetic purposes.

Some prescription drug manufacturers offer financial assistance to help you purchase their drugs. This assistance is often provided in the form of a discount, or a program that might be called "copay assistance," "patient assistance," or by some other name. Regardless of how the assistance is provided, amounts paid for your drug by a drug manufacturer will generally not count toward your annual deductible or out-of-pocket maximum.

Preventive Medications

As previously indicated, PPACA requires certain plans to provide enumerated preventive services at no cost to you based on issued guidelines and recommendations. Included in those guidelines and recommendations are certain medications such as aspirin, fluoride, folic acid, immunizations/vaccines, iron supplements, smoking cessation products, HIV prep and women's contraceptives that must also be covered at no-cost when prescribed by your health care **provider**. There are limitations however. For example, the plan retains the flexibility to control costs and may continue to impose cost sharing for branded drugs if a generic version is available and just as effective and safe.

If your health care provider determines that the contraceptives covered standardly as preventive are not medically appropriate for you, you may qualify for an exception that would cover an alternative contraceptive at no cost. To apply for this exception, your health care provider must call Express Scripts at 1-800-753-2851 and provide a copy of the prescription for the contraceptive that is medically necessary for you.

Preventive Medications when enrolled in the Sony Consumer Choice Plans

For the most part, until you reach the deductible under the Sony Consumer Choice Plan, you will pay 100% of the negotiated rate for a prescription. However, many preventive medications that can help you avoid or curtail certain illnesses and conditions are covered at no-cost when you are enrolled in the Consumer Choice Plan. This list includes medications used for prevention or for treatment. Conditions that can be covered include:

- Asthma
- Diabetes
- Heart disease
- Cholesterol
- Side effects of cancer
- High blood pressure

To determine if a specific medication(s) you take are considered preventive, you can check the drug coverage and pricing either by visiting the Express Scripts website at http://www.express-scripts.com/ or by calling Express Scripts member service.

Prescription Drugs and Changes to the Formulary

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, so to get the most up-to-date list go online to www.express-scripts.com. Drugs that are excluded from the Plan's Formulary are not covered

under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is (1) medically necessary and essential to the Covered Person's health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the Covered Person. If approved through that process, the applicable Formulary co-pay would apply for the approved drug based on the Plan's cost share structure. Absent such approval, Covered Persons selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time, including periodically during the plan year. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g., prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

If your prescription is not on the formulary list, your doctor may be able to prescribe a generic or formulary alternative that's equally effective but less costly. To obtain a copy of the formulary at no cost, go to the Express Scripts Web site or call Express Scripts member services.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Drugs that are Limited or Not Covered

Certain drugs and medicines aren't covered by the plan (subject to those preventive medications covered in accordance with PPACA). Also, your payments for excluded medications can't be used to satisfy your medical plan's deductible or out-of-pocket limit.

You can use the Express Scripts website to find participating retail pharmacies near you, get the most recent formulary list, compare drug alternatives and prices, and order home delivery service refills using a credit card for payment; or you can also call member services directly.

Here are examples of drugs and medicines that the plan does **not** cover. This list isn't exhaustive.

- Non-federal legend drugs (i.e., over-the-counter products).
- Mifeprex.
- Therapeutic devices or appliances.
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova, Vaniqa, Tri-Luma, Botox Cosmetic, Avage, Solage, Epiquin).
- Experimental drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.

- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member.

  Medication which is to be taken by or administered to an individual, in whole or in part, while they are a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the refill number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug. Charges for these expenses may be considered under the medical coverage.
- Certain compound medications. (Note: A compound medication is one that requires a licensed pharmacist to combine, mix or alter ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety, and/or effectiveness of compound medications).
- Non-covered, non-preferred drugs under the National Preferred Formulary.

Also, for drugs to treat impotency/erectile dysfunction for men age 18 and over, coverage is limited to:

- Thirty (30) days or twelve (12) units, whichever is less for a retail pharmacy prescription.
- Ninety (90) days or thirty-six (36) units, whichever is less for a mail-order prescription.

If you have any questions about whether a medication is covered, review coverage at www.express-scripts.com and select "Price a medication" from the left hand menu or contact Express Scripts directly at 800-716-2773. The telephone number is also listed on your Prescription Drug Program ID card.

HMO Overview

Kaiser Permanente HMO

If you live or work in California, you may be offered a Kaiser Permanente HMO option in addition to the Sony PPO, Consumer Choice and EPO Plans.

How an HMO Works

A Health Maintenance Organization (HMO) provides services through a select group of doctors, hospitals, and other providers who are under contract with the HMO.

If you live or work within the plan's service area, as defined by your zip code, you're eligible to join that HMO. It is not mandatory that you select a primary care physician during enrollment, but you will need to select a PCP for most HMOs. You can change your PCP at anytime during the year.

You do not need prior authorization from the plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from an HMO network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HMO directly at the contact information provided on the back of your ID card.

For children, you may designate a pediatrician as the PCP.

If you receive medical services outside your PCP's office without being referred by your PCP, you usually won't receive any benefits coverage (with exceptions for emergencies). Contact the HMO directly and/or access its website for participating provider network information and to ask any questions about the benefits it may provide for out-of-network services, including emergency care.

If you have a covered dependent who doesn't live with you but does live in the HMO service area, they should choose a PCP and have that PCP coordinate all care.

If your covered dependent lives outside the HMO service area, call the HMO directly to find out what benefits, if any, are available.

If You're Traveling

If you need medical care while traveling outside the network service area:

- Contact your PCP or HMO as soon as possible after you receive emergency care.
- Contact your HMO before you receive any nonemergency care.

For more details on the Plan coverage refer to the Kaiser Certificate on https://benefits.sonypictures.com.

Filing Medical Plan Claims

Consumer Choice, PPO and EPO Plans

You don't need to file a claim form for in-network services. Your participating provider will submit the expense directly to the Claims Administrator. If you're covered by the PPO or Consumer Choice Plan and use an out-of-network provider, you'll be responsible for filing claims. If you're covered by the EPO, out-of-network services are not covered (except in the case of a medical emergency). Call your plan's member services if you have questions. The telephone number is on your plan ID card. For more information about filing claims and your right to appeal a denied claim, see "Health and Insurance Plans Claims Review Procedures," page 303.

For Prescription Drug Program claims, call Express Scripts Health Solutions to obtain an out-of-network claim form. The telephone number is on your Prescription Drug Program ID card.

Kaiser Permanente HMO

You don't need to file a claim form for in-network services. Your Health Maintenance Organization (HMO) provider will submit the expense directly to the Claims Administrator. If you use an out-of-network provider, the services are not covered (except in the case of a medical emergency). If you have questions, call member services directly. The telephone number is on your plan ID card. For more information about filing claims and your right to appeal a denied claim, see "Health and Insurance Plans Claims Review Procedures," page 303.

How to Appeal Denied Claims

Once you turn in your medical claim, the Claims Administrator will review the claim and make a decision. Claims may be denied in some situations. If you need assistance resolving a claim, you can use Member Services. The phone number to Member Services is located on the back of your medical ID card. You have the right to appeal denied claims by following the claim review process (see "Health and Insurance Plans Claims Review Procedures" on page 303).

Third Party Liability

Subrogation

Under this plan, you or your covered dependent may accept payments of plan benefits that arise from or are related to an illness, injury, or medical condition that was caused by a third party. By accepting any payment of plan benefits, you and/or your covered dependents, agree that the plan will be subrogated to your and/or your covered dependent's right of recovery and entitlement to reimbursement of any plan benefits paid. The plan's subrogation and/or reimbursement rights will include all claims, demands, actions, and rights of recovery of all covered individuals against any third party or insurer, including any Workers' Compensation insurer or governmental agency, and will apply to the extent of any and all payments of plan benefits made or to be made by the plan.

Subrogation and/or Reimbursement Agreement

"Subrogation" means the right of the plan to be substituted in place of a covered person with respect to a covered person's lawful claim, demand, or right of action against a third party who negligently or wrongfully caused the covered person's injury or illness that resulted in a payment of benefits by the plan. The third party who negligently or wrongfully causes the covered person's injury or illness is called the "tortfeasor."

You and your covered dependent(s) must execute and deliver any and all instruments and papers requested by or on behalf of the plan, and must do whatever is necessary to protect all of the plan's subrogation and/or reimbursement rights. As a condition precedent to the payment of benefits by the plan, you or your covered dependent(s) will, upon written request from the plan, execute a subrogation and/or reimbursement agreement in a form to be provided by or on behalf of the plan. However, if you or your covered dependent(s) fail to execute any such subrogation and/or reimbursement agreement, this will not waive, compromise, diminish, release, or otherwise prejudice the plan's subrogation and/or reimbursement rights, as such rights and the plan's lien (as described below) arise through operation of the plan.

Cooperation With the Plan by Covered Persons

The plan may start any legal action or administrative proceeding it deems necessary to protect its right to recover plan benefits that have been paid, and it may try to settle any such action or proceeding in the name of and with full cooperation of you and/or your covered dependent(s). However, in doing so, the plan will not represent or provide legal representation for you or your covered dependent(s) with respect to your damages to the extent those damages exceed any plan benefits paid.

The plan requires you and/or your covered dependent(s) to notify and consult with the plan and the Plan Administrator (or its duly authorized designee) before starting any legal action or administrative proceeding that may relate to or involve recovery of any payments of plan benefits. You must also keep the plan and the Plan Administrator (or its duly authorized designee) informed of all material developments with respect to any such claims, actions, proceedings, or settlement negotiations. The plan may intervene in any such claims, actions, proceedings, or negotiations started by you or your covered dependent(s).

All Recovered Proceeds Are to Be Applied to Reimbursement of the Plan

You and/or your covered dependent(s), jointly and severally, will reimburse the plan for all plan benefits paid on your and/or your covered dependent(s) behalf, out of any amounts paid or payable to you or them by any third party or insurer by way of settlement or in satisfaction of any judgment or agreement, and the plan will have a first priority lien on such amounts until the plan is repaid in full, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of expenses for which plan benefits were paid. The plan's lien will remain in effect until the plan is repaid in full. The plan does not recognize and is not bound by any application of the "make whole" doctrine, common fund doctrine, or any other common law remedies.

In the event that you fail to notify the plan as provided for above and/or if you or your covered dependent(s) fail to reimburse the plan, the plan, in addition to other remedies available to it at law or equity may withhold any amounts that might be due you from the plan for past or future claims until such time as the plan's lien is discharged and/or satisfied.

While the plan requires your cooperation with any actions taken on your or your covered dependent(s) behalf to recover the amounts not reimbursed to the plan, as set forth above, the plan does not require you to seek any recovery against a third party. If you or your covered dependent(s) do not receive any recovery from a third party, you or your covered dependent(s) are not obligated to reimburse the plan for benefits that are applied for and approximately received.

Coordination of Benefits

Definition of Coordination of Benefits

Some people are covered under multiple health plans. For instance, if you're married and your spouse works for a different company, each of you can choose to cover the other under your respective company plans.

Most health plans have coordination of benefits rules to ensure that, when multiple plans are involved, the health plan administrators don't overpay or duplicate payments for covered health care services.

When Coordination Is Needed

Coordination of benefits is needed when you and/or your dependents have coverage under:

- More than one company-provided health plan—for example, if both spouses are working;
- A university-sponsored student plan and a company plan;
- Medicare or other government plans and a company plan; and
- An individually purchased plan and a company plan.

Also, you have certain obligations to coordinate benefits if you receive payments in third party liability situations.

How Coordination Rules Work

If a health care expense is covered by two plans, one plan is the "primary" plan and has first responsibility for the expense. When the primary plan has paid its normal benefits, the other, or "secondary," plan may make an additional payment based on its provisions.

When SPE pays benefits as the secondary plan, SPE's Claims Administrator determines whether any additional benefit is payable by comparing the primary plan's benefit with the amount SPE would have paid as your only source of coverage. SPE makes up the difference (if any) between the amount you've already received and the amount SPE would have paid if the SPE plan had been the primary plan.

For example, assume your spouse is covered as a dependent under the Sony PPO Plan but they also have coverage with their employer. In this case, your spouse's plan is primary—pays benefits for their expenses first. Assume on a $1,000 covered expense, your spouse's plan pays 70% or $700. Next, you submit the claim to SPE's plan as the secondary coverage. Assuming your spouse has met the deductible under SPE's plan and your spouse used a participating provider, SPE's plan would have paid 80% or $800. However, since you've already received $700 from the primary plan, SPE pays only the difference—$100 ($800 - $700).

Coordination of Benefits and In-Network Coverage

When a Sony plan that's secondary offers in-network and out-of-network benefit levels, SPE's benefit is based on the amount the company would have paid if you received in-network benefits.

If a family member is covered under SPE's Medical Plan as well as another plan (with your spouse's employer, for example), the network discount doesn't apply if another plan pays benefits first. You may want to evaluate whether coverage under two plans is cost-effective.

Other employers' plans may have different rules about how much they pay when they're not the primary plan. You should learn the provisions of other plans that might cover your medical expenses.

If the Expense Is for You
SPE's plan is the primary plan for you (the company employee or eligible retiree under age 65) and pays benefits without regard to other coverage. In addition, Sony's plan remains primary for you until the end of the month in which you are terminated.

If the Expense Is for a Dependent
If a child is covered under both parents' plans, the primary plan is that of the parent who has the earlier birthday during the calendar year. If the primary plan can't be determined by the parents' birthdays, then it is determined to be the plan under which the dependent has been covered for the longest time.

If a covered dependent is an employee of another company and is covered by that company's plan, the other company's plan is primary.

If you're a SPE employee and your dependent is covered under Medicare and the company's Medical Plan, SPE's plan is primary, although certain Medicare exceptions may apply, as described below.

If you and your spouse both work at SPE, the SPE plan will be primary for both you and your spouse. It will not also act as a secondary plan.

If the Other Plan Has No Coordination Rules
If the other plan has no provision regarding coordination of benefits, that plan is primary.

If You or Your Dependent Are Eligible for Medicare or Other Government Plans
Medical Coverage
Generally, you're eligible for Medicare coverage when you reach age 65. If you or your covered dependent become eligible for Medicare while you're still working and covered by the company's plan, the company's plan is the primary plan, and Medicare is the secondary plan, except as described below.

Note: If you're under age 65 but entitled to a Social Security disability income benefit, you're also eligible for Medicare coverage after a waiting period. If you or your covered dependent becomes covered by Medicare because of age or disability, you may continue or cancel your coverage under SPE's plan.

If You or Your Dependent Become Eligible for Medicare Due to a Disability or End Stage Renal Disease
If you become eligible for Medicare because of disability and you continue to be a participant in SPE's plan, Medicare pays benefits first and SPE's plan pays benefits second, if applicable.

However, SPE's plan still pays benefits first for a covered dependent entitled to Medicare because of disability, as long as you maintain your current employment status and the dependent remains enrolled in the plan.

If, while you're actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease, SPE's plan pays benefits first and Medicare pays benefits second for a limited time.

Motor Vehicle No-Fault Coverage Required by Law
In general, this plan excludes coverage if benefits are available under motor vehicle no-fault insurance.

If you're covered for medical benefits by both this plan and other motor vehicle no-fault coverage required by law, the motor vehicle no-fault coverage pays first and SPE's plan pays second.

If you're covered for loss of earnings by both this plan and motor vehicle no-fault coverage required by law, the benefits payable by SPE's plan on account of disability will be reduced by the benefits available to you for loss of earnings based on the motor vehicle no-fault coverage.

Other Coverage Provided by State or Federal Law
If you're covered by both this plan and any other coverage provided under any other state or federal law, that coverage pays first and SPE's plan pays second.

Workers' Compensation
SPE's plan doesn't provide benefits for medical or dental expenses covered by Workers' Compensation or occupational disease law.

If SPE contests the application of workers' compensation law for the sickness, illness, or injury for which expenses are incurred, SPE's plan will pay benefits subject to its right to recover those payments if and when it's determined that they're covered under a Workers' Compensation or occupational disease law.

However, before payment will be made, you or your covered dependent must execute a subrogation and reimbursement agreement acceptable to the plan or its designee in its sole and absolute discretion.

Administration in Duplicate Coverage Situations
To administer duplicate coverage situations, the SPE plan (or its authorized designee, which may include the applicable plan insurer) reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that you or your health care provider furnish any necessary information (which may include, but isn't limited to, information regarding the nature and scope of coverage available and/or received, and the cause or origin of the sickness, illness, injury, or condition);
- Reimburse any plan that made payments this plan should have made; and
- Recover any overpayment from you or your covered dependent, your hospital, physician, dentist, other health care provider, or other insurance company.

If this plan should have paid benefits that were paid by any other plan, this plan may pay the party that made the other payments in the amount that the Plan Administrator (or its designee) determines to be proper under the terms of the plan. Any amounts paid in this way will be considered to be benefits through this plan, and Sony's plan will be fully discharged from any liability it may have to the extent of the payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the health care expenses that were incurred. However, any person who claims benefits through Sony's plan must provide the plan with all the information the plan needs to apply the coordination of benefits rules or otherwise administer plan benefits where duplicate coverage is available.

Employee Assistance Plan (EAP) Overview

SPE has established an Employee Assistance Program with Spring Health. The program is designed to assist benefits eligible employees and their dependents in personal issues that may be adversely impacting their performance at work or home. The EAP functions as a single front door to any type of care - from digital exercises to coaching and therapy.

The EAP is designed to help with a broad array of concerns including the areas listed below:

- General mental health concerns
- Depression, sadness or irritability
- Feelings of extreme highs and lows
- Excessive fears, worries and anxieties
- Social withdrawal
- Inability to cope with daily problems or activities
- Suicidal thoughts
- Numerous unexplained physical ailments
- Substance use
- Prolonged negative mood
- Difficulties focusing at work
- Work/life referrals such as child or elder care resource and referrals

SPE provides 8 coaching or therapy sessions for all benefits eligible employees and their dependents each calendar year. Unused sessions will not rollover into the next year

Accessing Care

You can obtain assistance in one of the following ways:

- Self Referral: Employees and/or dependents can go online at sonypictures.springhealth.com (work-life access code: sonypictures) or call the Spring Health Employee Assistance Program number at 1-855-629-0554. There is a brief clinical assessment that helps to direct you to the right services. Masters level clinicians (Care Navigators) are available 24 hours a day, 7 days a week, 365 days a year.

- Consultations with a clinician are available for managers when a previously reliable employee begins to exhibit absenteeism, tardiness, a failure to meet project deadlines, or other performance problems. These behavior changes may indicate a need for personal support outside of the workplace, and Spring Health is here to help. The manager should also work with their Human Resources Department to ensure that standard performance improvement and documentation policies are followed.

- A Management Referral to Spring Health may be a way to promote performance improvement, and managers or HR can call for a consultation first, if unsure about proceeding with a more formal referral to the

EAP. A formal manager referral to EAP should be presented to an employee as a voluntary but highly encouraged means of support towards meeting performance expectations, not as a disciplinary measure. Any employment disciplinary steps or consequences should be applied based on meeting company conduct and performance standards, not upon participation with Spring Health's mental health support.

- When meeting with an employee, we recommend focusing on specific examples to identify how performance has declined, in addition to explaining expectations and identifying the impact and consequences for not meeting standards. The focus should stay on work, and it's best to avoid making any statements that might sound like a diagnosis or directive to complete a specific type or amount of mental health care treatment services, without obtaining specific Human Resource and Legal guidance.

After informing you of the referral request, the manager will notify a People & Organization Representative of this action.

The People & Organization Representative will provide you with the information needed to contact the EAP and ask for the appropriate release of information. The Care Navigator will only indicate (to the People & Organization Representative) the fact that an appointment was or was not made and if it was kept by you.

The People & Organization Representative will notify the manager only of the initial Employee Assistance Program contact. No other subsequent information will be obtained or disclosed by the People & Organization Department to the manager without your written consent (except if required by federal, state, or local laws).

Instructions for the manager: Managers may contact Spring Health at managersupport@springhealth.com or by calling 1-855-629-0554, option 4, to notify the Care Navigation team that they are initiating a formal manager referral, or to discuss options if unsure that a direct referral is appropriate.

Confidentiality

The EAP is a confidential program and no data is shared outside of the EAP unless there has been a signed release of information (management referral only) or there is risk to self or others. All records are maintained by an external third-party Employee Assistance Program service provider. Records are strictly confidential and will not be disclosed unless (1) a court order requiring disclosure is received, or (2) an Employee Assistance Program counselor believes disclosure is in compliance with federal, state or local laws (e.g., child abuse situations).

Job Performance

Your participation in the Employee Assistance Program will not affect your at-will status. Managers are prohibited from considering in any manner Employee Assistance Program participation itself in evaluating your performance (whether oral or written) or as grounds for termination.

Dental Plan Overview

Common Terms

Many terms used throughout this section are defined in the glossary at the end of the section. Bolded terms are defined in the glossary. Understanding these terms will help you understand how your plan works and provide you with useful information regarding your coverage.

Coverage Categories

When you enroll in a dental option, you'll be assigned to a coverage category based on the number of dependents you want to cover. The coverage category affects the price you pay for the coverage:

Employee Only;
Employee Plus Spouse/Domestic Partner;
Employee Plus Child(ren); and
Employee Plus Family.

Dental Plan Options

Option Name	Plan Type	Service Area
High Plan	Preferred Provider Organization (PPO)	Nationwide
Standard Plan	Preferred Provider Organization (PPO)	Nationwide

How the Options Vary

The options vary in these ways:

- **Deductible**;
- Benefit percentage amounts (i.e., coinsurance);
- Annual maximums; and
- Coverage provided for certain dental services.

Cost of Coverage

You and the company share the cost of coverage.
You pay your portion of the cost with before tax deductions from your paycheck.
Costs are subject to review and updating annually by Sony. You will be notified of any changes in plan costs during annual enrollment.

Changing Your Dental Plan Option

After enrolling in a dental option, you can only change your option:

- During annual enrollment;
- If your eligibility for the Dental Plan changes;
- If the option is no longer offered;
- If the Dental Plan ends; and
- If you experience a qualified status change.

Schedule of Benefits

PLAN FEATURE	HIGH PLAN		STANDARD PLAN	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Deductible Individual	$50	$50	$25	$25
Family	$150	$150	$50	$50
Annual Maximum	$3,000*		$1,500	
DIAGNOSTIC AND PREVENTIVE				
Oral Exams (3 per calendar yr.)	100%	100%	100%	100%
Cleanings (3 per calendar yr.)	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%
Sealants	100%	100%	100%	100%
BASIC SERVICES				
Fillings	90%	80%	80%	80%
Oral Surgery	90%	80%	80%	80%
Periodontics	90%	80%	80%	80%
Endodontics	90%	80%	80%	80%
Anesthesia	90%	80%	80%	80%
MAJOR SERVICES				
Restorations	85%	50%	60%	50%
Crowns	85%	50%	60%	50%
Bridges	85%	50%	60%	50%
Dentures	85%	50%	60%	50%
Implants	85%	50%	60%	50%
ORTHODONTIA (ADULT AND CHILDREN)**				
Coverage	50%		Not Covered	
Orthodontia Annual Maximum	$3,000*		N/A	

Notes:
Diagnostic and Preventive services do not apply toward the annual maximum.
You do not need to meet the **deductible** before diagnostic and preventive services are covered
Two periodontal cleanings are covered in addition to three covered routine cleanings and exams.
* Annual Maximum and Orthodontia Annual Maximum are combined.
Out of network charges are subject to the **maximum plan allowance

How the Plan Works

Locating a Delta Dental PPO Provider

There are two ways in which you can locate a **PPO Provider** near you:

- You may access information through our website at www.deltadentalins.com/sony. **Providers** in Delta's PPO Network are preferable to the **providers** in the Premier Network as their deeper discounts allow members to receive services for lower costs. This website includes a **provider** search function allowing you to locate PPO and **Premier Providers** by location, specialty and network type; or

You may also call our Customer Service Center toll-free at 800-471-7059 and one of our representatives will assist you. We can provide you with information regarding a **provider's** network, specialty and office location.

Family Deductible

Each covered person pays toward their individual **deductible** until the family **deductible** limit is met (with each individual paying no more than the option's individual **deductible**). When the combined **deductibles** for all individuals equal the family **deductible** limit, no further **deductible** is due for the remainder of the **calendar year**.

Maximum Plan Allowance Limits

Maximum plan allowance limits apply to coverage for services under the Dental Plan. The Plan covers expenses only up to the **maximum plan allowance** limit. It doesn't cover the portion of any expense **over** the limit. However, when you use a participating dentist, you're assured that all charges will be within the **maximum plan allowance** limits.

Pretreatment Estimate of Benefits

A pretreatment estimate allows you to find out, before you incur any expenses:

- Estimated cost for treatment;
- Estimated benefit payment; and
- Possible alternative treatments that may be more cost-effective.

A pretreatment estimate doesn't guarantee **benefits** from the plan. However, it can help you understand more about how the plan works for your specific need so you can make an informed decision about treatment.

When to Request an Estimate

You should request a pretreatment estimate in either of these situations:

- A procedure is expected to cost more than $200; and
- You don't know if the procedure is covered under the plan.

If you don't get a pretreatment estimate of **benefits** or your dentist does not follow the correct procedure, in some cases the plan may not pay for all or part of the treatment.

How to Get an Estimate

To request a pretreatment estimate, you and your dentist need to complete a pretreatment estimate form and submit it to your plan. Your dentist will indicate the diagnosis, the cause of recommended treatment, and estimated cost. The insurance company may also ask for additional material such as X-rays.

If your dentist doesn't have a form, call the Dental Plan to get a form and filing instructions. Forms can also be downloaded on Delta Dental's website.

Alternate Procedures

Sometimes there's more than one way to treat a dental problem (for example, repairing a tooth with a silver or composite filling instead of gold or porcelain). The plan bases its definition of eligible charges on the less costly procedure that treats the condition and meets acceptable dental standards.

If you and your dentist decide that you want to pursue a more costly covered treatment, you pay the additional charges. If the plan does not cover the service you choose but covers a less costly alternate procedure, the plan doesn't pay **benefits** for the more expensive, non-covered treatment.

Work in Progress

Procedures with dates of service prior to the effective date of Delta Dental coverage are considered to be the responsibility of the previous carrier.

Orthodontia Work in Progress

Delta Dental takes into account the date that treatment began and the amount already paid toward the treatment. The orthodontist should submit a claim with the treatment plan, an explanation of the status of the treatment plan, and evidence of the amount paid to date by the enrollee and/or the prior insurance carrier(s). Delta Dental will review the treatment plan and determine its liability in the absence of other coverage. In the event there is other coverage, Delta Dental will then coordinate **benefits** by reducing its payment by the amount covered by any previous carriers.

Orthodontia New Cases

If less than $500, Delta Dental will pay in one lump sum at date of banding. If greater than $500, Delta Dental will pay 50% at date of banding. Following the initial payment, orthodontic payments will be made on a quarterly basis throughout the scheduled treatment plan until the annual plan allowance has been met regardless of your **providers** billing practice. You must be enrolled in the high plan at the time of each payment to receive benefits.

How Claims are Paid

Payment for Services — PPO Provider

Payment for covered services performed for you by a **PPO Provider** is calculated based on the **maximum plan allowance**. **PPO Providers** have agreed to accept the Delta Dental **PPO Contracted Fee** as the full charge for covered services. Providers in the PPO network are the most favorable from a cost perspective for members as their deep discounts allow services to be provided at a lower out of pocket cost.

The portion of the **maximum plan allowance** payable is limited to the applicable Schedule of Benefits. Delta Dental's Payment is sent directly to the **PPO Provider** who submitted the claim. You will be advised of any charges not payable for which you are responsible. These charges are generally your share of the **maximum plan allowance**, as well as any **deductibles**, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Premier Provider

Payment for covered services performed for you by a **Premier Provider** is calculated based on the **maximum plan allowance**. **Premier Providers** have agreed to accept the Delta Dental Premier **Contracted Fee** as the full charge for covered services.

The portion of the **maximum plan allowance** payable is limited to the applicable Schedule of Benefits. Delta Dental's Payment is sent directly to the **Premier Provider** who submitted the claim. You will be advised of any charges not payable for which you are responsible. These charges are generally your share of the **maximum plan allowance**, as well as any **deductibles**, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Delta Dental Provider

Payment for services performed for you by a **Non-Delta Dental Provider** is also calculated based on the **maximum plan allowance**. The portion of the **maximum plan allowance** payable is limited to the applicable Schedule of Benefits. **Non-Delta Dental Providers** have no agreement with Delta Dental and are free to bill you for any difference between what Delta Dental pays and the submitted fee.

When dental services are received from a **Non-Delta Dental Provider**, Delta Dental's Payment is sent directly to the primary enrollee. You are responsible for payment of the **Non-Delta Dental Provider's** submitted fee. **Non-Delta Dental Providers** will bill you for their normal charges, which may be higher than the **maximum plan allowance** for the service. You may be required to pay the **provider** yourself and then submit a claim for reimbursement. The portion of the **maximum plan allowance** payable is limited to the applicable Schedule of Benefits. Since payment for services you receive may be less than the **Non-Delta Dental Provider's** actual charges, your out-of-pocket cost may be significantly higher. You will be advised of any charges for which you are responsible. These charges are generally your share of the **maximum plan allowance**, as well as any **deductibles**, charges where the maximum has been exceeded, and/or charges for non-covered services.

How to Submit a Claim

Delta Dental does not require special **claim forms**. However, most dental offices have **claim forms** available. PPO and **Premier Providers** will fill out and submit your claims paperwork for you. Some **Non-Delta Dental Providers** may also provide this service upon your request. If you receive services from a **Non-Delta Dental Provider** who does not provide this service, you can submit your own claim directly. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the **claim form**. Fill out the **claim form** completely and send it to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-6999

What the Plan Covers

The plan will pay the amount shown in the Schedule of Benefits for services.

The following list shows examples of what's covered by the Standard and High Plans but may not include all covered services. If you have questions about what's covered, contact the Claims Administrator.

Diagnostic and Preventive Services

- Diagnostic: procedures to aid the **provider** in determining required dental treatment.
- Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars resulting from the process of decay.
- Palliative: emergency treatment to relieve pain.
- Specialist Consultations: opinion or advice requested by the general dentist.

Basic Services

- Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay). Composite fillings on posterior & anterior teeth.
- Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
- General Anesthesia or IV Sedation: when administered by a **provider** for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Endodontics: treatment of diseases and injuries of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth. Periodontal Maintenance Cleanings are limited to twice in any **calendar year**.
- Night Guards/ Occlusal Guards: intraoral removable appliances provided for treatment of harmful oral habits associated with periodontal disease. Replacement is limited to once every sixty (60) months. The repair, relining, or adjustment of appliances is limited to once every six (6) months.
- Note: If a tooth can be restored with amalgam, synthetic porcelain or plastic, but you and the Dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental Treatment excluded from coverage.

Major Services

- Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implants surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

- Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five (5)-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five (5) -year period shall be measured from the date on which the restoration was last supplied in all cases.
- Temporomandibular Joint (TMJ) Dysfunction Services
    - Intra-oral services provided by a **provider**, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofacial plan dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).

Orthodontia Services *(Available to Enrollees in the High Plan)*

- Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits. Procedures performed by a **provider** using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

*Limitation on Orthodontic **Benefits***: Orthodontic **benefits** are limited to devices and procedures for the correction of malposed teeth of you, your spouse/domestic partner, and dependents up to age twenty-six (26), through the completion of the procedures; or to the date eligibility terminates. The obligation of Delta Dental to make payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure.

Note on additional benefits during pregnancy

- When an enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the enrollee during the pregnancy. The additional services each **calendar year** while the enrollee is covered under the plan include one (1) additional oral exam and one (1) additional routine cleaning and/or one (1) additional periodontal scaling and root planning per quadrant. Written confirmation of the pregnancy must be provided by the enrollee or her **provider** when the claim is submitted.

Limitations

Benefits to Enrollees shall be limited as follows:

- Limitation on Optional Treatment Plan. In all cases in which there are optional plans of Treatment carrying different Treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the enrollee. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.
- Limitation on Major Restorative **Benefits**. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the enrollee and the Dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan. Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five (5) -year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five (5) -year period shall be measured from the date on

which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care plan, or by the enrollee.

- Limitation on Diagnostic Aids. Full mouth x-rays and panorex x-rays accompanied by bitewing x-rays are limited to once in any three (3) -year period. Bitewing x-rays are limited to twice in any **calendar year**. Periodic examinations of the full mouth are limited to three in any **calendar year**.
- Limitation on Prophylaxes and Fluoride. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to three in any **calendar year**. Fluoride applications as a benefit are limited to twice in any **calendaryear** up to age 19.
- Limitation on Prosthodontic **Benefits**. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided in accordance with the plan. Prosthodontic appliances and abutment crowns will be replaced only after five (5) years have elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

    - Implants provided under any Delta Dental plan will be replaced only after five (5) years have passed. Replacement of an implant supported prosthesis not provided under a Delta Dental program will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to once for each tooth during the enrollee's lifetime.

- Limitation on Orthodontic **Benefits**. Orthodontic **benefits** are limited to devices and procedures for the correction of malposed teeth of enrollees, spouses and dependents up to age 26, through the completion of the procedures; or to the date eligibility terminates or the plan terminates, whichever occurs first. Delta Dental shall pay quarterly orthodontic payments. The obligation of Delta Dental to make payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances furnished pursuant to the plan.

    - Note: Orthodontic **benefits** are available only to enrollees in the High Plan.

- Limitation on Periodontal Surgery. **Benefits** for periodontal surgery in the same quadrant are limited to once in any five (5) -year period. The five (5) -year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental plan, or by the enrollee.
- Limitation on Sealants. Treatment with sealants as a covered service is limited to applications to eight posterior teeth to age 14. Applications to deciduous teeth or teeth with caries are not covered services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.
- Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve (12) months, and two or three surface restorations within six (6) months, which include occlusal surfaces on which sealants have been placed are not covered services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six (36) months after a sealant has been applied to that tooth, the obligation of Delta Dental.

shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

- Limitations on Night Guard/Occlusal Guard Services. The replacement of appliances for Night Guard/Occlusal Guard Services is limited to once every five (5) years. The repair, relining, and adjustment of appliances for Night Guard/Occlusal Guard Services is limited to once every six (6) months.

- Limitation on Periodontal Maintenance. Periodontal prophylaxes (cleanings) are limited to twice in any **calendar year**.

Dental Plan Exclusions

Certain dental services and supplies aren't covered by the plan. Your payments for excluded expenses can't be used to satisfy your **deductible**. Keep in mind, however, you may be able to use your Health Care Flexible Spending Account (FSA) or Health Savings Account (HSA), as applicable, for some expenses that are not covered by the Dental Plan.

- Treatment or materials which are **benefits** to an enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.
- Treatment or materials with respect to congenital skeletal malformation or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children so long as such dependent children continue to be eligible. When services are not excluded under this provision as to dependent children who continue to be eligible, other limitations and exclusions shall specifically apply.
- Treatment that restores or increases the vertical dimension of an occlusion including but not limited to dentures, crowns, inlays, or onlays, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury and directly attributable thereto.
- Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes and charges for personalization or characterization of dentures; except as part of a treatment dentally necessary due to accident or injury and directly attributable thereto. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected ones is excluded.
- Treatment or materials for which the enrollee would have no legal obligation to pay.
- Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan unless the treatment was a year in duration and was completed after the enrollee became eligible except insofar as the limitations in the second and fifth bulleted items above do not apply.
- Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
- Preventive plaque control programs, including oral hygiene instruction programs.
- Myofunctional therapy, unless covered by the exception in the second bulleted item in this section.

- Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication and analgesias.
- Experimental procedures which have not been accepted by the American Dental Association.
- Services provided or materials furnished after the termination date of coverage.
- Treatment or materials provided in a hospital or any other surgical treatment facility.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
- Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for **benefits** provided under the plan, will be the responsibility of the enrollee and not a covered Benefit.
- Expenses for treatment of a job-related illness or injury whether or not covered by Workers' Compensation;
- Expenses for which you are covered under a Sony Medical Plan;
- Expenses for services for which you aren't required to pay or for which you are reimbursed;
- Expenses for treatment by someone other than a dentist or doctor, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of a dentist or doctor;
- Expense for replacement of any prosthetic device (including bridges and crowns) within five years of its last replacement, for duplication of any appliance to be used as a spare, or for the replacement of any lost or stolen prosthetic device;
- Expenses for the adjustment of prosthetic appliances within six months of their initial installation if these expenses are not included in the cost of the appliance;
- Expenses for occlusal equilibration, except to the extent necessary to treat periodontal disease;
- Bonding, unless medically necessary and the tooth would otherwise require a crown;
- Expenses for restorative crowns, inlays, onlays, or gold fillings unless they are for the restoration of teeth which, as result of extensive cavities or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material;
- Treatment that does not have a reasonably favorable prognosis;
- Expenses for prosthetic devices (including bridges and crowns and the fitting) that were ordered while the covered individual was not covered under this plan, or devices that were ordered while the individual was covered but are installed or delivered to the individual more than sixty days after termination of this coverage.

If you have any questions about whether an expense is covered, contact the plan directly by calling Delta Dental at 800-471-7059.

Coordination of Benefits

We coordinate the **benefits** under the plan with an enrollee's **benefits** under any other group or pre-paid plan or Benefit plan designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce **benefits**. If this plan is the "secondary" plan, we may reduce **benefits** otherwise payable under the plan so that the total **benefits** paid or provided by all plans do not exceed 100 percent of this plan's **maximum plan allowance** limit.

Determining which plan is "primary":

- The plan covering you as an employee is primary over a plan covering you as a dependent.
- The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - secondary to the plan covering the insured person as a dependent and
  - primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the **benefits** of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
- Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
  - The **benefits** of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
  - If both parents have the same birthday, the **benefits** of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
  - However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of **benefits**, the rule in the other plan will determine the order of **benefits**.
- In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e., step-parent) will be primary over the plan covering the enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the **benefits** of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the **benefits** of any other policy which covers the child as a dependent child.
- If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined above.
- The **benefits** of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of **benefits**, this rule is ignored.

- If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
    - First, the **benefits** of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
    - Second, the **benefits** under the continuation coverage.
- If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of **benefits**, this rule is ignored.
- If none of the above rules determine the order of **benefits**, the **benefits** of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.
- When determination cannot be made in accordance with the above, the **benefits** of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

General Provisions

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining **provider**, or from hospitals in which a **provider's** care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at our expense, in or near your community or residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your **provider**, on request, a **claim form** to make claim for **benefits**. To make a claim, the form should be completed and signed by the **provider** who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within fifteen (15) days after requested by you or your **provider**, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your **provider** may download a **claim form** from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within twelve (12) months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

Time of Payment

Claims payable under the plan for any loss other than loss for which the plan provides any periodic payment will be processed no later than thirty (30) days after written proof of loss is received. We will notify you and your **provider** of any additional information needed to process the claim within this thirty (30) day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or **Premier Provider** will be made directly to the dentist. Any other payments provided by the plan will be made to you. When **benefits** are payable to you, the primary enrollee, or dependent enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, **benefits** may be payable to their parent, guardian or other person actually supporting him or her.

Legal Actions

No action at law or in equity will be brought to recover **benefits** under the plan prior to expiration of sixty (60) days after proof of loss has been filed in accordance with requirements of the plan, nor will an action be brought at all unless brought within one (1) year from expiration of the time within which proof of loss is required by the plan.

Claim Appeals

Delta Dental will notify you and your **provider** if **benefits** are denied for services submitted on a **claim form**, in whole or in part, stating the reason(s) for denial. You have the right to appeal denied claims by following the Plan's claims review procedures. See "Health and Insurance Plans Claims Review Procedures" on page 303 for more information on filing claims and appeals under the Plan.

Glossary

A

Accepted Fee:

The amount the attending Provider agrees to accept as payment in full for services rendered.

B

Benefits:

The amounts that the plan will pay for covered dental services.

C

Calendar Year:

The 12 months of the year from January 1 through December 31.

Claim Form:

The standard form used to file a claim or request pre-treatment estimate.

D

Deductible:

A dollar amount that an enrollee and/or the enrollee's family (for family coverage) must pay for certain covered services before the plan begins paying benefits.

Delta Dental Premier® Provider (Premier Provider):

A Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee:

The fee for a Single Procedure covered under the contract that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPO Provider (PPO Provider):

A Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO contracted fee as payment in full for covered services provided under a PPO Dental Plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee:

The fee for a Single Procedure covered under the contract that a PPO Provider has contractually agreed to accept as payment in full for covered services.

M

Maximum Plan Allowance:

The reimbursement under the enrollee's benefit plan against which Delta Dental calculates the plan's payment and the enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Plan Allowance for services provided:

- by a PPO Provider is the lesser of the provider's submitted fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the provider's submitted fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the provider's submitted fee or the Delta Dental Premier Contracted Fee.

N

Non-Delta Dental Provider:

A Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

P

Program Allowance:

The amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider:

A person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Vision Plan Overview

Coverage Categories
If you enroll in the Vision Plan, you'll be assigned to a coverage category based on the number of dependents you cover. The coverage category affects the price you pay for the coverage:

- Employee Only;
- Employee Plus Spouse/Domestic Partner;
- Employee Plus Child(ren); and
- Employee Plus Family.

Vision Plan Options
You can choose No Coverage or Coverage.

Cost of Coverage
You pay the cost of coverage with before-tax deductions from your paycheck

Costs are subject to review and updating annually by Sony. You'll be notified of any changes to cost during annual enrollment.

How the Plan Works
Vision Plan coverage is provided through Vision Service Plan (VSP), which has a network of participating optometrists and ophthalmologists that provide vision care services at negotiated rates. You can get a list of VSP network doctors in your area by using their website at **www.vsp.com** (or calling VSP's member services at 1-800-877-7195). If you choose coverage, your benefits depend on whether you use in-network or out-of-network provider. You can seek vision care from any licensed optometrist, ophthalmologist, or optician. However:

- If you use a VSP in-network provider, you receive the highest level of benefits.
- If you use an out-of-network provider:
    - You receive limited benefits according to a fixed schedule.
    - You need to file a claim with the Vision Plan administrator to be reimbursed.

While covered by the plan, you have certain rights and protections, including privacy of your health information (see page 312).

Changing Your Option
After enrolling in the Vision Plan, you can only change your option:

- During annual enrollment;
- If you have a qualified status change; or
- If the contract between Sony and VSP ends.

Vision Plan Benefits

The amount the plan pays for expenses relating to eye exams, glasses, and contact lenses depends on whether or not you use a VSP in-network doctor.

If you or a covered dependent has a vision care expense that is also covered by another plan, coordination of benefits may apply.

If You Use VSP In-Network Providers

If you use a VSP in-network doctor, here's what the plan covers each calendar year for each covered person:

Plan Feature	Coverage
Annual co-payment	$10 annual co-payment per person per calendar year. This $10 co-payment applies to materials only (frames or lenses) each year.
Coverage after $10 annual** co-payment **for materials (frames or lenses)	
Annual eye exams	The plan pays 100%; $0 copay
Eyeglasses, if needed (new or replacement lenses and frame)*	The plan pays: For frames, up to $200, $220 Featured Frames, $110 allowance at Costco and Walmart Optical retail allowance once per calendar year; you pay additional cost of frame that exceeds the plan allowance—generally, with a 20% discount**
Lenses	Single Vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children
Lens enhancements	UV Protection $ 0 copay Standard Progressive $50 copay Premium progressive lenses $80-$90 copay Custom progressive lenses $120-$160 copay Average savings 35%-40% for lens enhancements
Elective contact lenses (instead of eyeglasses—lenses and frame)	The plan pays up to $200. There is a 15% discount on the contact lens exam (fitting/evaluation), which is performed in addition to the routine eye exam; limited to once per calendar year.
Medically necessary contact lenses (with prior VSP authorization)	The plan pays 100%
Laser vision correction surgery	Available to plan participants at a reduced rate when performed by a participating provider. Go to **www.vsp.com** for details. After surgery, use your Frame benefit (if eligible) for non-prescription sunglasses from any VSP doctor.
Low vision benefit (special aid for people with severe visual problems and who are referred to as "partially sighted" must be approved by VSP)	You pay 25% of the cost of any approved low vision program subject to a $1,000 benefit maximum every 2 years

*Contact lenses benefit is instead of eyeglasses (lenses and frame).
**VSP provides cost savings off retail pricing that is generally about 35-40% less than reasonable and customary charges.

Computer Vision Care (employee only)

Plan Feature	Coverage
Computer Vision Exam	$0 for exam every calendar year to evaluates your need related to computer use
Annual eye exams	The plan pays 100%, $0 copay
Frames	$10 copay for glasses every calendar year. The plan pays: • $90 allowance for a wide selection of frames • $110 allowance for featured frame brands • 20% savings on the amount over your allowance •
Lenses	Single Vision, lined bifocal, lined trifocal, occupational lenses and anti-reflection coatings are covered in full.

If You Use Out-of-Network Services

If you use an out-of-network doctor or other vision care provider, here's what the plan pays for covered services each calendar year per covered person:

Plan Feature	Coverage
Annual eye exams	The plan pays up to $50 after you pay an annual $10 co-payment
Eyeglasses, if needed (new or replacement lenses and frames)*	The plan pays up to these scheduled amounts: Frames—$70 Lenses —(per pair): Single vision $50 Lined bifocal $75 Lined trifocal $100 Progressive $75 Lenticular $125
Elective contact lenses (instead of eyeglasses—lenses and frames)	The plan pays up to $105
Medically necessary contact lenses	The plan pays up to $210 ($105 per eye)

***Note:** Contact lens benefit is instead of eyeglasses (lenses and frames).

You need to file a claim to be reimbursed for your covered out-of-network expenses based on the plan's reimbursement schedule.

Additional Benefits

Cosmetic Options

The following cosmetic options can be ordered whether you use a VSP network provider or a nonparticipating provider. You pay the additional charge for these options. Using a VSP provider, you'll generally save 35-40%.

- Photochromic or tinted lenses other than Pink 1 or 2;
- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Coated or laminated lenses;
- Cosmetic lenses;
- Any other optional cosmetic process; and
- The portion of any frame cost to the extent it exceeds the limit provided under the plan. (The limit is designed to cover the cost of the majority of frames currently in use.)

Laser Vision Correction Surgery Discount
VSP has arranged for plan participants to receive laser vision correction surgery at a discounted fee. Go to VSP's website at **www.vsp.com** or call VSP for additional information about the procedure. Consult with your eye doctor to determine if laser vision makes sense for you.

You pay the full cost of the surgery but at a reduced rate. Also, if you contribute to your Health Care Spending Account or HSA, as applicable, you can claim laser vision correction surgery expenses through your account and receive a tax-free reimbursement of these expenses.

Low Vision Benefit
The low vision benefit provides special aid for people who have severe visual problems and who are often referred to as partially sighted. If you or a covered dependent fall within this category, you'll be entitled to low vision services and associated materials subject to certain limitations.

The treatment plan and charges must be approved before services are rendered. VSP doctors have the forms to submit for approval. You're required to pay 25% of the cost of any approved low vision program. The plan has a $1,000 benefit maximum (excluding co-payments) every two (2) years. The maximum includes the cost for supplementary testing.

Supplemental Primary Eyecare Program

The Supplemental Primary Eyecare Program ("PEC") is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the program, Eyecare Professionals provide treatment and management of urgent and follow-up services. PEC also involves management of conditions that require monitoring to prevent future vision loss.

Symptoms
Examples of symptoms which may result in a covered person seeking services on an urgent basis under the PEC may include, but are not limited to:

- Ocular discomfort or pain
- Transient loss of vision
- Flashes or floaters
- Ocular trauma
- Diplopia
- Recent onset of eye muscle dysfunction
- Ocular foreign body sensation
- Pain in or around the eyes
- Swollen lids
- Red eyes

Conditions
Examples of conditions that may require management under the PEC may include, but are not limited to:

- Ocular hypertension
- Macular degeneration

- Retinal nevus
- Glaucoma
- Cataract
- Pink-eye
- Corneal dystrophy
- Corneal abrasion
- Blepharitis
- Sty

Procedures For Obtaining Supplemental Primary Eyecare Services

The PEC provides coverage for certain vision-related medical services as a supplement to each covered person's group medical plan. The provider should first submit a claim to the covered person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB."

When a covered person does not have a group medical plan, the PEC provides plan benefits as follows:

- Covered person contacts an in-network doctor and makes an appointment.
- Covered person pays the applicable Copayment at the time of each PEC visit and amounts for any additional services not covered by the Plan.

Referrals

If covered services cannot be provided by a covered person's in-network doctor, the doctor will refer the covered person to another in-network doctor or to a physician whose offices provide the necessary services.

If the covered person requires services beyond the scope of the PEC Program, the in-network doctor will refer the covered person back to a physician.

Referrals are intended to ensure that each covered person receives the appropriate level of care for their presenting condition, covered persons do not require a referral from a doctor in order to obtain plan benefits.

Supplemental Primary Eyecare Services Covered Services

- **Eye Examinations, Consultations, Urgent/Emergency Care:** Covered in full after a Copayment of $20.00.
- **Special Ophthalmological Services:** Covered in full
- **Eye and Ocular Adnexa Services:** Covered in full

Supplemental Primary Eyecare Limits and Exclusions

The PEC provides coverage for limited vision-related medical services as a supplement to each covered person's group medical plan.

The following services are not covered under the PEC:

- Services and/or materials not specifically included in this SPD as covered plan benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.

- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where the Plan is required by law to pay.

Supplemental Primary Eyecare Plan Definitions

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.

Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition or problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

What's Not Covered

Certain vision services and supplies are excluded expenses under the plan.

The vision plan is designed to cover your basic vision needs. If you want to purchase certain optional services and materials, such as types of lenses that are considered cosmetic, you'll be responsible for the cost.

Here are examples of expenses that the plan doesn't cover. This list isn't exhaustive.

- Preventive or diagnostic exams as well as medical or surgical treatment of the eye. (**Exception:** You can receive a discount on fees for laser vision correction surgery at participating providers. Also, certain medical treatment may be covered by your medical plan.)
- An eye exam or corrective eye wear required as a condition of employment.
- More than one (1) pair of prescription lenses (either eyeglasses or contacts) and frames and more than one vision exam annually.
- The extra charge for lenses that are blended bifocals, coated, scratch-coated, oversized, photochromic, progressive multifocal, laminated, UV-protected, or tinted (other than Pink 1 or 2).
- Two (2) pairs of glasses instead of bifocals.
- Replacement of lost or broken lenses, unless the replacement would otherwise be paid for as part of your annual services.
- Orthoptics or vision training and any associated supplemental testing.
- Plano or lenses with a prescription of less than .50 diopter (flat surface lenses).

If you have any questions about whether an expense is covered, contact the Claims Administrator or call VSP Customer Care at 1-800-877-7195.

Computer VisionCare Program

This component of the Vision Plan provides covered employees with enhanced coverage to address vision strain related to the use of computers. Coverage includes enhancement to our prescription lenses which are especially designed to optimize vision when viewing content on screens.

This program is <u>not</u> available to covered dependents under the Vision Plan.

Computer VisionCare Program Features

If you use a VSP in-network doctor, the Vision Plan

Program Feature	Coverage	Frequency
Eye Examination	Covered in full*	Available once each calendar year
A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs of computer use.		

Computer VisionCare Program Services

Program Feature		
	In-Network Benefit	**Frequency**
Lenses	**Available only when the Covered Person has been diagnosed by an eye care professional as having a vision condition affecting computer use**.	
Lens Options	Anti-reflective coating Covered in full	Available once each calendar year
Frames	Covered up to Plan Allowance*	Available once each calendar year
Single Vision	Covered in full *	Available once each calendar
Bifocal	Covered in full *	
Trifocal	Covered in full *	
Near Variable Focus	Covered in full *	
Occupational Progressive	Covered in full *	
Associated Vision Therapy** (specific to computer use)	Up to $200.00 per year (includes any supplemental testing)	Available once each calendar year

Plan Benefits for lenses are per complete set, not per lens.

VSP reserves the right to limit the cost of the frames provided by a VSP in-network doctor under this Plan. The current allowance shall be published periodically by VSP to its in-network doctors and will be set at a level to cover a sufficient number of frames in common use.

*Less any applicable Copayment, as shown on pages 174 and 175.
** **This benefit is limited to Covered Persons who are eligible for Computer VisionCare Program Coverage and who are diagnosed as having one of the following conditions:**

- **Accommodative Infacility –** The inability (or inefficiency) to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period of time. (Primarily when looking at things up close.)
- **Convergence Insufficiency –** The occasional problem with the eye muscles' ability to point the eyes straight when working up close.

Computer VisionCare Program Exclusions And Limitations

Some brands of eyeglasses frames may be unavailable for purchase under the Computer VisionCare Program, or may be subject to additional limitations. It is recommended that you obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195 in advance of making a purchase.

The Computer VisionCare Progrma is designed to cover visual needs rather than cosmetic materials. When select-any of the following extras, the Vision Plan will pay the basic cost of the allowed lenses or frames, and you will pay the additional costs for the options. Optional cosmetic processes include:

- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

Additionally, the following items are excluded under the Computer VisionCare Program and no benefits for professional services or materials connected with:

- Subnormal vision aids.
- Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Photochromic or tints greater than 20%.
- Laminated lenses.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Vision Plan Benefits.

KidsCare Program

The KidsCare Program ("KidsCare") provides for additional benefits for covered dependents up to age 26. The program allows for an additional exam each calendar year (up to 2 total per year). The program also provides coverage for one (1) additional pair of lenses or Necessary Contact Lenses, or Elective Contact Lenses, if:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder, or
- There is a change in the axis of 15 degrees or more, or There is a .5 prism diopter change in at least one eye.

KIDSCARE PROGRAM SERVICES

You must seek an in-network provider to access the KidsCare Program. When you seek services in-network:

- No copayment is required for the additional examination.
- A $10 copayment is due for a retinal screening.
- If materials (lenses and frames) are provided, a copayment of $10.00 will be due at the time the materials are ordered. However, the copayment for materials shall not apply to elective contact lenses.

The following services are covered under this KidsCare program in addition to the services covered under the Vision Plan:

- **EYE EXAMINATION: Covered in full* once every 12 months****

Comprehensive examination of visual functions and prescription of corrective eyewear.

- **LENSES: Covered in full* once every 12 months****

Eyeglasses Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26

*Less any applicable Copayment.
**Available once every plan year beginning on January 1st. (in addition to the Vision Plan's 1 year allotment).

- **CONTACT LENSES**

Elective

Elective Contact Lenses (materials only) are covered up to $ 200.00 once every 12 months.

Necessary

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

Contact Lenses are provided in place of eyeglasses lens and frame benefits. The KidsCare benefit will cover either spectacle lenses or contact lenses in a given year, not both.

*Less any applicable Copayment.
**Available once every plan year beginning on January 1st. (in addition to the Vision Plan's 1 year allotment).

- **FRAMES: Refer to the Schedules on pages 174 and 175**

- **KidsCare Program Exclusions and Limitations**

In addition to the exclusions in the "What's Not Covered" section on page 184, the following services are not covered under the KidsCare Program:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter),
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Services and/or materials provided by someone other than a VSP Network Provider

KidsCare Program Vision Therapy Services

Covered dependents eligible under the KidsCare Program are covered professional services and associated ophthalmic materials (or other aids) as prescribed by the doctor for individuals who have visual problems as diagnosed by an in-network VSP provider. Services and materials covered can include supplementary testing, evaluations, and training. Coverage is subject to the limitations described in "What's Not Covered Section" below.

For the KidsCare Vision Therapy Program, vision therapy is defined as the science of developing and remediating visual abilities for those persons who have severe visual problems associated with sensory and/or muscular deficiencies of the visual system. Some conditions which may lead to the need for vision therapy are as follows:

- Near point visual difficulties ranging from eye strain, blurred and double vision; to headaches and constant loss of place;
- Strabismus or misalignment of the eyes;
- Amblyopia or lack of normal vision, also known as "lazy eye";
- Inability to read for normal amounts of time after working on a Video Display Terminal.

COPAYMENT - 75% of the cost being paid by VSP and 25% of the cost being paid by the Covered Person. The total maximum allowable charge for purposes of this copayment is $50 per session at a Member doctor.

MAXIMUM BENEFIT - VSP will pay a maximum annual benefit of $750.00, excluding Copayment, for approved vision therapy care. The maximum reimbursement that a Member doctor will receive for sensorimotor exam is $85.

Vision therapy benefits under the KidsCare Vision Therapy Program rendered by a Non-Member doctor are subject to the same time limits and Copayment arrangements described above. The Covered Person will pay the Non-Member Provider his full fee. Covered Persons will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. However, there is no assurance that this amount will be 75% of the provider's full fee.

KidsCare Program Vision Therapy Services Exclusions And Limitations

In addition to the exclusions in the "What's Not Covered" section on page 184, the following is not covered under the Vision Therapy Program:

The furnishing of corrective eyewear (lenses and frames) (may be covered under core vision benefits);

- Medical or surgical treatment of the eyes;
- Perceptual training for a learning disability;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

What's Not Covered

Certain vision services and supplies are excluded expenses under the plan.

The vision plan is designed to cover your basic vision needs. If you want to purchase certain optional services and materials, such as types of lenses that are considered cosmetic, you'll be responsible for the cost.

Here are examples of expenses that the plan doesn't cover. This list isn't exhaustive.

- Preventive or diagnostic exams as well as medical or surgical treatment of the eye. (**Exception:** You can receive a discount on fees for laser vision correction surgery at participating providers. Also, certain medical treatment may be covered by your medical plan.)
- An eye exam or corrective eye wear required as a condition of employment.
- More than one (1) pair of prescription lenses (either eyeglasses or contacts) and frames and more than one vision exam annually.
- The extra charge for lenses that are blended bifocals, coated, scratch-coated, oversized, photochromic, progressive multifocal, laminated, UV-protected, or tinted (other than Pink 1 or 2).
- Two (2) pairs of glasses instead of bifocals.
- Replacement of lost or broken lenses, unless the replacement would otherwise be paid for as part of your annual services.
- Orthoptics or vision training and any associated supplemental testing.
- Plano or lenses with a prescription of less than .50 diopter (flat surface lenses).

If you have any questions about whether an expense is covered, contact VSP at 1-800-877-7195.

Filing Vision Plan Claims

For In-Network Expenses

When you have in-network vision care expenses, identify yourself as a Vision Service Plan (VSP) member. You pay the $10 annual co-payment for glasses (lenses and frames) as well as any additional cost for cosmetic lens options, the portion of the frame cost in excess of your allowance or elective contact lenses in excess of your allowance. Your VSP provider will submit claims for you.

For the low vision benefit, VSP in-network doctors will submit claim forms for approval.

For Out-of-Network Expenses

When you have out-of-network vision care expenses, you need to pay the entire bill. You should request an itemized bill that shows the amount of the eye exam, lens type, and frame. Also include employee's name, last four digits of the employee's Social Security number and mailing address, patient's name, relationship to employee, and date of birth. Then file a claim for reimbursement.

Call VSP to get a claim form and filing instructions. You can also print the form from VSP's website at **www.vsp.com**.

The instructions on the claim form should be followed carefully. Be sure all questions are answered fully and any required statements and bills are submitted with the claim form. Mail the original claim form and itemized bills to:

Vision Service Plan, Attention Out-of-Network Claims

PO Box 495918
Cincinnati, OH 45249

VSP allows coordination of benefits for patients eligible for coverage by more than one vision plan.

Primary and Secondary Plans

When coordinating benefits, it must be determined which plan is billed first.

- The plan that covers the member as an employee is "primary".
- The plan that covers the member as a dependent is "secondary".

If the patient is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

Primary Plan
The primary plan must pay or provide benefits as if the secondary plan does not exist.

Secondary Plan

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

Services from Non-VSP Providers
VSP will reimburse the patient according to each benefit's out of network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear. For more information, please contact VSP Customer Care at 800-877-7195.

How to Appeal Denied Claims

Once you turn in your vision claim, the Claims Administrator will review the claim and make a decision. Claims may be denied in some situations. If you need assistance resolving a claim, you can use Participant Advocacy Services, which are available through the SPE Benefits Center. Call 1-833-976-6901 and speak with a SPE Benefits Center representative. You have the right to appeal denied claims by following the claim review process (see page 303).

Right of Recovery

If any claim or benefit is overpaid, the plan reserves the right to recover the overpayment or to reduce any future payments. The person receiving the benefit must produce any instruments or papers necessary to ensure this right of recovery.

Life and AD&D Insurance Overview

Available Coverage

The life and accident insurance plans offer you and your family the opportunity to have financial protection when you may need it most. The life insurance plans are administered by Securian.

- Life Insurance provides your beneficiary with a benefit in the event of your death.
- **Accidental Death and Dismemberment (AD&D) Insurance** provides an additional benefit if you die or suffer a serious injury as result of an accident (e.g., lose a limb, become paralyzed, lose your hearing, speech or sight).
- **Dependent Life and Dependent AD&D Insurance** provides coverage for your spouse, domestic partner and eligible dependent children.

Company-Provided Life and AD&D Insurance

SPE provides Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to you equal to one times your base salary, up to a maximum benefit payment of $1,000,000 rounded to the next higher $1,000, if not already a multiple thereof.

Supplemental Life and AD&D Insurance

You can choose to purchase Supplemental Life and AD&D Insurance up to eight (8) times your base salary rounded to the next higher $1,000, if not already a multiple thereof, then multiplied, up to a maximum benefit payment of $1,500,000. The cost of Supplemental Life Insurance coverage is based on your age, salary, and the amount of coverage you have selected. Deductions will be withheld from your paycheck on an after-tax basis.

Evidence of Insurability

You must submit an Evidence of Insurability (EOI) form and receive insurance company approval under the following circumstances (or if you have previously been declined by Securian while at SPE):

Newly eligible:

- You may elect Supplemental Life coverage up to a maximum benefit payment equal to the lesser of five (5) times annual earnings or $1,000,000. Any election that exceeds this will require Evidence of Insurability.

Annual Enrollment:

- You may elect coverage for the first time or increase your Supplemental Life coverage by one times annual earnings, provided the resulting benefit payment does not exceed the lesser of five (5) times annual earnings or $1,000,000. Any election that exceeds this will require Evidence of Insurability.

Qualified Status Change (Marriage, Divorce, Birth of a Child):

- You may elect coverage for the first time or increase your Supplement Life coverage by one times annual earnings, provided the resulting benefit payment does not exceed the lesser of five (5) times annual earnings or $1,000,000. Any election that exceeds this will require Evidence of Insurability. Must elect coverage within 31 days of a Qualified Status Change.

For this purpose, the following events are considered a qualified status change:

- Birth or adoption or otherwise acquiring a newly eligible child
- Death of a dependent (spouse, domestic partner, or child)
- Divorce, legal separation, or annulment
- Termination of a dependent spouse's employment
- A change in the dependent spouse's benefit plan
- A change in the employment status for the employee or dependent spouse that affects eligibility for benefits
- Dissolution of a domestic partnership
- Marriage or creation of domestic partnership
- Child losses or gains eligibility for coverage

Contact SPE Benefits Center if you have questions about EOI.

Mid-Year Salary and Contribution Rate Changes

If your base salary increases during the year, changes to your benefit payment amount for Basic Life, Supplemental Life, and AD&D Insurance coverage and your employee contribution for supplemental coverage will be updated on the 1st of the month following the salary increase. The benefit payment amount and employee contributions will be reduced in a similar fashion if your earnings decrease. Your premiums will be based on your age as of 1/1 of the benefit plan year.

Continuation of Life & AD&D Benefits

Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff per Sony Pictures' practices and procedures. Continuation is contingent upon premiums being paid and is subject to the following maximum time frames:
If you are on non-medical leave of absence or temporary layoff, insurance can be continued up to 24 months from the last day you were actively at work.
If you are on a medical leave of absence but not considered totally disabled, insurance cannot be continued beyond the later of 24 months from the last day you were at work or attained age 65.

If You Become Totally Disabled

Basic and Supplemental Life Insurance
If you are approved for the Sony Pictures Long Term Disability (LTD) plan, you are eligible for Waiver of Premium for the Basic and Supplemental Life Insurance amount in force just prior to your disability. To qualify for Waiver of Premium, you must meet the following criteria:

- You meet the definition of total disability or are receiving LTD benefits under the Sony Pictures Long Term Disability (LTD) plan, and
- Your disability commenced while your Sony Pictures Group Life Insurance was in force.

If you do not return to active employment when your Basic and Supplemental Life Insurance benefits would otherwise end, you may have the right to convert your coverage to an individual policy (see Conversion Privilege for Basic and Supplemental Life).

Accelerated Benefits
If you become terminally ill while covered under Basic Life Insurance (and, if applicable, Supplemental Life Insurance) you may apply to have all or a portion of your coverage amount paid to you while you are living. If approved by Securian, Accelerated Benefits benefit payments can be between $10,000 up to a maximum of $1,000,000 (not to exceed your in-force coverage amount). You may choose to accelerate only a portion of your benefit payment amount, providing

the remaining amount of insurance benefit payment is at least $25,000. You may reapply for the payment of the remaining amount of insurance at any time. However, the total amount of the death benefit for all accelerated benefit payments for an insured cannot exceed $1,000,000. On your death, the benefits that would otherwise have been payable will be reduced by the amount of the Accelerated Benefits proceeds. For purposes of this benefit, terminally ill means a life expectancy of twelve (12) months or less as certified by a doctor. To apply for Accelerated Benefits, contact SPE Benefits Center. Payment of Accelerated Benefits is subject to approval by Securian.

Beneficiary Designation

You must name a beneficiary at the time you become a plan participant. You may name a new beneficiary at any time online at https://benefitscenter.spe.sony.com. If you do not name a beneficiary or if your beneficiary is not living at the time of your death and there is no contingent (secondary) beneficiary, benefits will be paid in the following order:

- Your spouse;
- Your child(ren) in equal shares;
- Your surviving parents in equal shares;
- Your siblings in equal shares;
- Your estate.

Assignment Rights

The rights provided to you by the Life and AD&D Insurance Plan are owned by you, unless:

- You have previously assigned these rights to someone else (called the “assignee”); or
- You assign your rights under the plan to an assignee.

The plan will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing, signed by you, and acceptable to Securian; and
- A signed or certified copy of the written assignment has been received and registered by Securian

SPE or Securian assumes no responsibility for the validity of any assignment. You are responsible to see the assignment is legal in your state and that it accomplishes the goals that you intend.

Imputed Income

The value of Basic and Supplemental Life Insurance coverage in excess of $50,000, which is paid by SPE, is taxable income to you. This tax liability is called “imputed income” and is included as taxable income on your paycheck and is reported on your W-2 form at the end of the year.

The amount of your imputed income (if any) is based on your age, amount of coverage in excess of
$50,000 and the value of such coverage, as determined in accordance with the IRS Imputed

Income Schedule.

Suicide Exclusion for Supplemental Life Insurance

Supplemental Life Insurance benefits will not be paid to your beneficiary if you commit suicide within two (2) years after the effective date of your Supplemental Life Insurance coverage and/or the effective date of any increase in the amount of your Supplemental Life benefits. If this exclusion applies, your beneficiary will be reimbursed an amount equal to any contributions you paid for the excluded coverage, without interest.

Conversion Privilege for Basic and Supplemental Life

Upon termination of your coverage, you may be eligible to convert your Basic and Supplemental Life Insurance coverage to an individual policy by completing a conversion application (available from SPE Benefits Center). You may convert the full amount of your coverage or a portion thereof, without having to furnish EOI. Securian will determine the type of individual policies (such as whole life) available to you and the cost; term life insurance is not offered. The application must be submitted to the Claims Administrator within the thirty-one (31)-day period from the date coverage ends, or if later, fifteen (15) days from the date the conversion notice is given if the notice was given fifteen (15) days prior to the date coverage was terminated. In no event will the conversion period extend beyond ninety (90) days from the date coverage was terminated. If you die during this thirty-one (31)-day period, your Basic Life Insurance and, if applicable, your Supplemental Life Insurance amount will be paid, whether or not you have applied for an individual policy.

Portability Option for Basic and Supplemental Life Insurance

The portability option allows you to continue the full amount of your Supplemental Life Insurance or a portion thereof, on a group basis through Securian following termination of your coverage. If you choose this option, you will be required to complete a Portability Application, subject to approval from the insurance company. Your Ported Policy will terminate at age 70, at which time you will be provided an option to apply for Conversion. Rate information is provided on the portability application form (available from SPE Benefits Center). Application for portability must be made within the thirty-one (31)-day period from the date coverage ends.

Schedule of AD&D Benefits

Depending on the nature of your injury, you or your beneficiary will receive a percentage of the AD&D coverage amount. For benefits to be payable:

- Death or the loss suffered must be the direct result of the accidental injury and from no other cause; and
- Death or the loss must occur within 365 days of the accident.

You or your beneficiary will receive a percentage of your total AD&D benefit for these losses:

Loss	Percentage of the AD&D Coverage Amount Paid
Life	100%*

Coma	1% of principal sum for 11 months; 100% of principal sum at the beginning of the 12th month
Both hands or both feet	100%
Sight in both eyes	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Speech and hearing	100%
Quadriplegia	100%
Paraplegia	75%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Hemiplegia	50%
Thumb and index finger of the same hand	25%
All 4 fingers on one hand	25%
Uniplegia	25%
Loss of all toes on the same foot	20%

*Paid in addition to Employee Life Insurance.

Loss of a hand or foot means that the hand or foot is completely severed at or above the wrist or ankle joint.

Loss of sight means total irrevocable loss of sight.
The maximum benefit the plan will pay for any combination of covered losses is the full amount (100% of core benefit, not including any amounts under Additional Benefits section of the certificate).

Situations Not Covered by AD&D Insurance
AD&D Insurance benefits are paid for losses caused only by accidents. Also, your AD&D Insurance does not cover any accidental loss caused by:

Basic AD&D:
- Intentionally self-inflicted injury, suicide, or attempted suicide whether sane or insane; or
- Your commission of or attempt to commit a felony, or your being engaged in an illegal occupation; or
- Your being legally intoxicated as defined by the jurisdiction in which injury or loss occurred; or
- The voluntary use of prescription drugs, non-prescription drugs, illegal drugs, or medications, unless prescribed or administered by a physician and taken in accordance with the physician's instructions; or
- Poisons, gases, fumes or other substances voluntarily taken, absorbed, inhaled, ingested or injected, unless as a direct result of an occupational accident; or
- Aviation, other than as a fare-paying passenger on a charter flight operated by a scheduled airline; or War or any act of war, whether declared or undeclared.

Voluntary AD&D:
- Self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
- Suicide or attempted suicide, whether sane or insane; or
- Your participation in, or attempt to commit, a felony or your engagement in an illegal occupation; or

- Your being legally intoxicated as defined by the jurisdiction in which injury or loss occurred; or
- The voluntary use of prescription drugs, non-prescription drugs, illegal drugs, and medications, unless prescribed or administered by a physician and taken in accordance with the physician's instructions; or
- Poisons, gases, fumes or other substances voluntarily taken, absorbed, inhaled, ingested or injected, unless as a direct result of an occupational accident; or
- Aviation, other than as a fare-paying passenger on a charter flight operated by a scheduled airline; or War or any act of war, whether declared or undeclared

Dependent Life Insurance

You can also choose to purchase Dependent Life Insurance coverage for your spouse and eligible children.

Eligible Dependents

You can elect Dependent Life Insurance coverage for:

- Your spouse or domestic partner
- Your dependent child(ren) from live birth to age 26. Children aged 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on you for more than one-half of their support and maintenance.

Dependents may be asked to provide proof of dependent eligibility during SPE's dependent audit and/or at the time of a claim. Failure to provide proof may result in a claim denial.

Coverage Options

You may choose Dependent Life coverage for your spouse/domestic partner and /or your dependent children.

Spouse/domestic partner life insurance is available in the following amounts:

- $10,000
- $25,000
- $50,000
- $100,000
- $250,000

You may elect child life insurance in the amount of $10,000 or $20,000.

Cost of Coverage

Contributions are made on an after-tax basis, based on the rates established each plan year. Spouse rates are determined based on the age of your spouse/domestic partner coverage and the amount of coverage you select. Child Life coverage has a flat rate for each option regardless of the number of children covered. You pay the full cost of Dependent Life Insurance coverage with after-tax deductions.

Evidence of Insurability

Spouse/Domestic Partner Life:

You must submit an Evidence of Insurability (EOI) form and receive insurance company

approval under the following circumstances:

Newly eligible:
- You may elect Spouse/Domestic Partner Life coverage up to $50,000. Any election that exceeds this will require Evidence of Insurability.

Annual enrollment:
- You may elect coverage for the first time or increase your Spouse/Domestic Partner Life coverage by one increment, provided the resulting amount of insurance does not exceed
- $50,000. Any election that exceeds this will require Evidence of Insurability.

Qualified status change (e.g., see below):
- You may elect coverage for the first time or increase your Spouse/Domestic Partner Life coverage by one increment, provided the resulting amount of insurance does not exceed
- $50,000. Any election that exceeds this will require Evidence of Insurability.

For this purpose, the following events are considered a Qualified Status Change:
- Birth or adoption or otherwise acquiring a newly eligible child
- Death of a dependent (spouse, domestic partner, or child)
- Divorce, legal separation, or annulment
- Termination of a dependent spouse's employment
- A change in the employment status for the employee's eligibility for benefits
- Dissolution of a domestic partnership
- Marriage or creation of domestic partnership

Accelerated Death Benefits
If you have elected Spouse or Child Dependent Life Insurance and your spouse or child becomes terminally ill while covered, you may apply to have a portion of the coverage amount paid to you while your spouse or child is living.

If approved by Securian, Accelerated Benefits proceeds can be between $10,000 up to a maximum of $1,000,000, or the amount of life insurance in force on the date the Claims Administrator receives proof of terminal illness. You may choose to accelerate only a portion of your coverage amount, providing the remaining amount of insurance is at least $25,000. Upon death, the benefits that would otherwise have been payable will be reduced by the amount of the Accelerated Benefits proceeds.For purposes of this benefit, terminally ill means a life expectancy of 12 months or less as certified by a doctor.

To apply for Accelerated Benefits, contact SPE Benefits Center. Payment of Accelerated Benefits is subject to approval by Securian.

Suicide Exclusion
If an insured dependent, whether sane or insane, commits suicide within two (2) years from the effective date of any contributory life insurance, our liability with respect to that coverage will be limited to an amount equal to the premiums paid for the coverage.

If there has been an increase in an insured dependent's amount of contributory life insurance for which you were required to apply or for which we required evidence of insurability, and if the dependent dies by suicide within two (2) years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

The suicide exclusion does not apply to an insured child.

Beneficiary Designation
Under SPE's Dependent Life Insurance Plan, you as the employee will be the sole beneficiary. You may also designate a contingent beneficiary in the event that you are not living at the time of the dependent's death.

Filing a Claim
Claim forms needed to file for benefits can be requested from SPE Benefits Center. The instructions on the claim form should be followed carefully to expedite the processing of the claim. Completed claim forms accompanied by an original certified death certificate should be submitted to Securian. When the claim has been processed, you or, if applicable, your beneficiary will be notified of the benefits paid. If any benefits have been denied, you or, if applicable, your beneficiary will receive a written explanation.

Imputed Income
Under the Internal Revenue Code, the value of Dependent Life Insurance, in the amounts offered by SPE, may be taxable income to you. This tax liability is called "imputed income" and is included as an addition to your paycheck and reported on your W-2 form at the end of the calendar year. The amount of imputed income (if any) is equal to the difference between the deemed cost of the dependent life insurance coverage, as determined by the IRS Imputed Income Schedule and the amount that you pay for the insurance (if less).

Conversion
If you cease to cover your dependent(s) due to termination of your employment, your loss of eligibility for benefits, your death, your retirement, or your dependents' loss of eligibility (e.g., a non-handicapped child who turns age 26), your dependent may convert this coverage to an individual life insurance policy without providing EOI. A conversion application can be obtained from SPE Benefits Center. Securian will determine the type of individual policies (such as whole life) available to you and the cost; term life insurance is not offered. The application must be submitted to the Claims Administrator within the thirty-one (31)-day period from the date coverage ends, or if later, fifteen (15) days from the date the conversion notice is given if the notice was given fifteen (15) days prior to the date coverage was terminated. In no event will the conversion period extend beyond ninety (90) days from the date coverage was terminated.

Portability Option
The portability option allows you to continue Dependent Life Insurance for your spouse/domestic partner and/or children on a group basis through Securian following eligible termination of coverage due to your:

- Voluntary termination of employment
- Retirement
- Dismissal from employment
- Change in employee class resulting in a termination of benefits.
- Divorce

An insured spouse is eligible to continue insurance under this supplement if he or she no longer meets the eligibility requirements of the certificate due to legal separation, divorce or the employee's death.

An insured child aged 19 or older is eligible to continue insurance under this supplement if he or she no longer meets the eligibility requirements of the certificate due to attaining an age limit or otherwise ceases to be an eligible dependent.

An insured will not be eligible to request coverage under this supplement if they:

- Have attained the age of 70; or
- Have converted their insurance to an individual life policy under the terms of the certificate's conversion right section; or
- Is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
- Is a spouse and is totally disabled. A spouse will be considered totally disabled only if they are unable to engage in any full time or part time occupation for which they are reasonably suited by education, training, or experience; or
- Loses eligibility due to termination of the group policy. Applications must be submitted to Securian within thirty-one (31) days after the coverage ends.

Business Travel Accident Insurance

How the Plan Works

SPE provides a Business Travel Accident Insurance benefit equal to three times your annual compensation, up to a maximum benefit of $1,000,000, in the event you suffer certain accidental injuries or if you die in an accident while traveling on company business. Spouses are covered for $25,000 and dependent children for $5,000. That means you have protection while traveling on SPE business away from your ordinary place of work. Your beneficiary designation for Life and Accidental Death and Dismemberment (AD&D) Insurance applies to this coverage as well.

The plan also pays you a benefit if you should suffer a severe physical loss while traveling on company business. You'll receive a percentage of your coverage as follows if the loss is suffered as a direct result of and within three hundred and sixty-five (365) days of the accident:

Loss	Percentage of the Coverage Amount Paid
Life	100%
Two or more hands or feet	100%
Sight in both eyes	100%
One hand or one foot and the sight in one eye	100%
Speech and hearing (in both ears)	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
One hand or one foot	50%
Sight in one eye	50%
Speech	50%
Hearing (in both ears)	50%
Thumb and index finger on the same hand	25%
Coma	1% of the Principal Sum payable for 11 months; lump sum 100% payable in 12th month

Note:

Loss of a hand or foot means completely severed at or above the wrist or ankle joint.
Loss of sight means total irrevocable loss of sight of one eye.

The plan covers any accident that occurs while you're traveling or making a short stay away from your normal work location and in the course of authorized business for the company. A short stay is an authorized business trip lasting less than 60 days.

Additional AD&D coverage includes:

- Seatbelt coverage equal to an additional 10% of the benefit (principal sum) to a maximum of $25,000, payable if you die as the result of a covered accident which occurs while you are driving

or riding in a private passenger car and it is determined that a seat belt was worn (certification must be provided via police report);

- Air bag benefit equal to an additional 5% of the benefit (principal sum) to a maximum of $10,000, payable in the event you die on a business trip and it was determined that the vehicle was equipped with and an air bag was deployed (certification must be provided via police report);
- Coma benefit equal to 1% of the benefit monthly up to 11 months, with the remainder of principal sum paid in the 12th month; payable in the event you lapse into a coma as a result of an accident that occurred while you were on a business trip;
  - Permanent Total Disability – monthly benefits payable, in accordance with conditions and limitations, if the covered person remains totally and permanently disabled as a result of a covered accident.
  - Exposure and Disappearance Coverage – payable when following the forced landing, sinking, stranding or wrecking of a conveyance in the course of a covered trip, the covered person suffers a covered loss that causes unavoidable exposure to the elements or disappears and is not found within one year
  - Owned Aircraft – a covered loss that results from a covered accident the occurs during travel or flight in, including getting in or out of, any aircraft that is owned, leased, operated or controlled by the policyholder or any of its subsidiaries or affiliates.
  - Relocation – covered accident during relocation from prior place of residence or employment to a new place of residence or employment necessitated by a covered person's change in assigned place of employment for the policyholder
  - War Risk – a covered loss that occurs during war or acts of war that occur worldwide; exclusion of certain countries in addition to the United States and the country of citizenship or permanent residence may apply.

The maximum aggregate benefit is $20,000,000 per accident.

The Business Travek Accident program includes travel assistance services through New York Life Group Benefit Solutions (NYL GBS) Secure Travel, including pre-trip planning, assistance while traveling and emergency medical transportation (benefits for covered persons traveling 100 miles or more from home). Below is a list of services and benefits available through NYL GBS Secure Travel.

- Pre-trip Planning
  - Immunization requirements
  - Visa and passport requirements
  - Embassy/consular referrals
  - Foreign exchange rates
  - Travel advisories and weather conditions
  - Cultural information
- Traveling Assistance
  - 24-hour multilingual assistance and referral to interpretation and translation services
  - Referrals to physicians, dentists, medical facilities and legal assistance providers
  - Arrangements for payment of medical expenses up to $10,000 if required prior to treatment
  - Assistance with lost or stolen items, including luggage and prescription replacement services
  - Emergency cash advances, up to $1,500
  - Advancement of bail
- Emergency Assistance
  - Emergency evacuation and repatriation, when medically necessary; arrange and cover the cost of transportation to the nearest adequate medical facility
  - Travel arrangements for the return of a travel companion or children under age 18

who are left unattended due to the covered person's medical emergency

- Cover round-trip transportation as well as accommodations, up to $150 per day for up to seven days, for a family member or friend to visit a covered person who is hospitalized more than 100 miles away from home for more than seven days
- Arrange and cover the costs associated with returning a deceased covered person's remains to his or her place of residence for burial
- Emergency message relay, toll-free

- Assistance with making emergency travel arrangements

The coverage does not apply while commuting between home and place of work, or while on company premises. Coverage for personal deviations applies only during or within 7 days before or after covered business travel and for a maximum of 7 days.

Coverage starts at the actual start of a trip, whether your trip starts at home, where you work, or another place, and ends when you arrive at home or work (whichever happens first) or you make a covered personal deviation.

Note: If you travel to another city and expect to work there for more than 60 consecutive days, this is considered a change of your permanent assignment.

Exclusions

The following exclusions apply:

- 1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
- 2. Commission or attempt to commit a felony or an assault;
- 3. Commission of or active participation in a riot or insurrection;
- 4. Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
- a. except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
- b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
- c. being used for:
- i. crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky
- writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or
- exploration, racing, endurance tests, stunt or acrobatic flying; or
- ii. any operation that requires a special permit from the FAA, even if it is granted (this does not
- apply if the permit is required only because of the territory flown over or landed on);
- d. designed for flight above or beyond the earth's atmosphere;
- e. an ultra-light or glider;
- f. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
- g. being used for the purpose of parachuting or skydiving;
- 5. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- 6. Travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Policyholder if

the Aircraft may be used as the Policyholder wishes for more than ten (10) straight days, or more than fifteen (15) days in any year;

- 7. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
- 8. A covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond thirty-one (31) days;
- 9. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.
- In addition, benefits will not be paid for services or treatment rendered by any person who is:
  - 1. employed or retained by the Policyholder;
  - 2. living in the Covered Person's household;
  - 3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
  - 4. The Covered Person.

Other limits and exclusions may apply. Please see the full policy for more information.

Filing Life Insurance, AD&D Insurance and Business Travel Accident Claims

Life Insurance Claims

If you die, a family member or your beneficiary should notify the SPE Benefits Center of your death. Call the SPE Benefits Center1-833-976-6901.

If your covered dependent dies, you should notify the SPE Benefits Center by calling the number above.

Securian will be notified by the SPE Benefits Center, and information will be mailed to your beneficiary (or you, if applicable) outlining the steps to take to claim benefits, including providing a certified copy of the death certificate and in the case of the death of a dependent, proof of eligibility as your dependent at the time of death. You or your beneficiary should submit a claim within ninety days after the death or as soon as reasonably possible.

If your beneficiary (or you, for Accidental Death and Dismemberment (AD&D) or Dependent Life Insurance claims) files a claim, and it's partially or totally denied, your beneficiary (or you, if applicable) can appeal the decision by writing to the Claims Administrator.

AD&D Insurance Claims

If you're injured or die as a result of an accident, a family member or your beneficiary should notify the SPE Benefits Center.

Securian will be notified by the SPE Benefits Center and will outline the steps to take to claim benefits. You or your beneficiary should submit a claim within ninety (90) days after the accident, unless extenuating circumstances warrant an extension of up to a year.

How to Appeal Denied Life and AD& D Claims

Once you or your beneficiary files a claim, the Claims Administrator, Securian, will review the claim and make a decision. Claims may be denied in some situations. You have the right to appeal denied claims by following the claim review process (see page 303).

Business Travel Accident Claims

If you're injured or die while traveling on company business, the company will automatically initiate the claim on your behalf. Benefits will be coordinated with other coverage, and your beneficiary will be contacted by the Claims Administrator.

How to Appeal Denied Business Travel Accident Claims

If you file a claim under the New York Life Travel Accident policy, the claims department will send you a decision letter. If the claim is denied, the letter will include instructions in how to appeal the denial.

Disability Plans Overview

You have various income replacement programs available that are designed to provide income protection in case you can't work due to an illness or injury. Programs that SPE provides or contributes toward include (but are not limited to):

- Short term disability/sick pay benefits for non-work related disability;
- State disability benefit plans (California, Colorado, Washington DC, Hawaii, Massachusetts, New Jersey, New York, Oregon, and Washington);
- State Workers' Compensation programs for work-related injuries; and
- Long Term Disability (LTD) Plan Coverage.

If you're eligible, your disability benefits can work together to replace a portion of your income during periods of approved disability. Refer to the Employee Handbook on SPE's intranet, mySPE, for more information on Leaves and Time Off to get more details about disability income benefits.

The remainder of this section provides details of the LTD Plan, which is part of the SPE Benefits Plan.

Long Term Disability (LTD) Plan

How the Plan Works

The Long-Term Disability (LTD) Plan, administered by RelianceMatrix, provides a monthly benefit if you become disabled due to injury or illness and remain disabled for more than one hundred and eighty (180) days.

If you qualify for LTD coverage after one hundred and eighty (180) days of short-term disability, the LTD Plan will provide you with 60% of your covered monthly earnings, for a maximum benefit amount of $20,000 per month. For information on the SPE Short-Term Disability Plan, go to the Employee Handbook on SPE's intranet, mySPE.

You can also elect to purchase an enhanced long-term disability option. The supplemental option provides an additional 10% of long-term disability coverage for a total of 70% of your covered monthly earnings, for a combined (Company-paid and supplemental coverage) maximum of $20,000 per month. The total monthly benefit payable to you from all benefits provided under the LTD Plan cannot exceed 100% of your covered monthly earnings.

Certain reductions, limitations, or exclusions may apply. This SPD contains only a summary of your LTD coverage. Please refer to the LTD Policy for further details.

Earnings

Basic monthly earnings is your gross monthly rate of earnings in effect immediately prior to the date disability begins. Covered monthly earnings does not include bonuses, commissions, overtime pay or extra compensation.

Effect of Changes in Earnings on Benefit Coverage

Once your coverage begins, any increased coverage due to a change in your insured earnings will take effect **on the date of the change**, as long as you are an active employee at the time of the increase. If you are not an active employee at the time of a salary and/or coverage increase, the coverage amount will increase upon your return to active employment. If your salary is decreased, a

decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Cost of Coverage

SPE provides basic long-term disability coverage at no cost to you. You pay for supplemental long-term disability coverage on an after-tax basis. As per LTD policy "Premium contributions will be included in your gross income" and "this means that under the law as of the date to policy was issued your monthly benefit might be treated as non-taxable. It is recommended that you contact your personal tax advisor.

Note: Imputed income may apply.

Changing Your Coverage Option

After enrolling in the LTD Plan, you **cannot** change your options, except:

- During open enrollment; or
- If you have a qualified change in status.

Income From Other Sources

Your LTD benefit is reduced by the amount of any other disability income you're eligible to receive from these other income sources, such as:

(1) disability income benefits you are eligible to receive because of your total disability under any group insurance plan(s);
(2) disability income benefits you are eligible to receive because of your total disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total Disability under:
    (a) Workers' Compensation Laws;
    (b) occupational disease law;
    (c) any other laws of like intent as (a) or (b) above; and
    (d) any compulsory benefit law;
(4) any of the following that you are eligible to receive from the participating unit:
    (a) any formal salary continuance plan;
    (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
    (c) commissions or monies from you, including vested renewal commissions, but, excluding commissions or monies that the insured earned prior to total disability which are paid after total disability has begun;
(5) that part of disability benefits paid for by the participating unit which you are eligible to receive because of your total disability under a group retirement plan; and
(6) that part of retirement benefits paid for by the participating unit which you are eligible to receive under a group retirement plan; and
(7) disability or retirement benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
    (a) an insured is eligible to receive because of his/her total disability or eligibility for retirement benefits; and
    (b) an insured's dependents are eligible to receive due to (a) above.

Eligibility for Benefits

If you have LTD coverage when you become disabled and expect to be unable to work for one hundred and eighty (180) days or longer, you will be eligible to begin receiving a benefit under the LTD Plan. RelianceMatrix will reach out to you around the 4th month of disability to begin the approval process. When you apply for benefits, you may be required to provide proof that your disability has continued, and you are under the regular care of a **physician**. RelianceMatrix determines if you qualify for benefits.

Note:

RelianceMatrix, the disability Claims Administrator, reserves the right to request that you undergo periodic physical exams or provide medical evidence to confirm your disability. An independent medical exam performed by a **physician** of their choice may also be required.

Qualification for Social Security disability benefits does not ensure eligibility for LTD benefits.

Definition of Disability

The LTD Plan defines disability as:

- During the Elimination Period and for the first twenty-four months thereafter You must be unable to perform each of the material duties of your regular occupation due to injury or sickness; [and]

- After twenty-four (24) months of benefits: You must be unable to perform the material duties of an occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience.

When Benefits End

Benefits continue until the earliest of the date you:

- Are no longer Totally Disabled.

- Fail to furnish the required proof of Total Disability

- Cease to be under the regular care of a **physician**

- Refuse to undergo, at RelianceMatrix's request and expense, an examination, diagnostic study, or testing performed by a **physician**, vocational expert, rehabilitation specialist, or other health care professional.

- Decline treatment options recommended by your **physician** and within generally accepted medical standards, for a Sickness or Injury for which you are claiming benefits.

- Refuse to return to work with the assistance of:

    - Modification made to your work environment, functional occupational

requirements, or work schedule, or

- Adaptive equipment or devices

- Reside outside the United States or Canada for a total period of 3 months or more during any 6 consecutive months of receipt of Monthly Benefits

- Reach the maximum Duration of Benefits, as shown below (or if later, the date you reach your Social Security Normal Retirement Age as shown below).

- Die.

Your maximum benefit period is the longer of the Duration of Benefits, or until you reach your Normal Retirement Age, specified below:

Age of Disablement	Duration of Benefits
61 or less	to age 65
62	3 1/2
63	3
64	2 ½
65	2
66	1 ¾
67	1 ½
68	1 ¼
69 or older	1

OR

Year of Birth	Normal Retirement Age
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 thru 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

LTD—Additional Plan Rules

Two or More Disabilities

Special rules apply if you're disabled, recover, and return to work full time, and then become disabled again:

- If the second disability is due to the same or a related cause, it will be considered a continuation of the first disability if it starts less than six months after you return to work. In this case, LTD

benefits begin again immediately.

- If the second disability starts six (6) months or more after you return to work, or if it's due to a different cause, it's considered a separate disability. In these cases, LTD benefits begin again after you satisfy a new one hundred eighty (180) day waiting period.

Disabilities Due to a Mental or Nervous Disorder

Monthly benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the maximum Duration of Benefits. Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:

(1) bipolar disorder (manic depressive syndrome);
(2) schizophrenia;
(3) delusional (paranoid) disorders;
(4) psychotic disorders;
(5) depressive disorders;
(6) anxiety disorders;
(7) somatoform disorders (psychosomatic illness);
(8) eating disorders; or
(9) mental illness.

If you were confined in a Hospital or Institution as a result of your Mental Disorder diagnosis and:

(1) Total Disability continues beyond discharge;

(2) the confinement was during a period of Total Disability; and

(3) the period of confinement was for at least fourteen (14) consecutive days;

then upon discharge, Monthly Benefits will be payable for the greater of:

(1) the unused portion of the twenty-four (24) month period; or

(2) ninety (90) days; but in no event beyond the maximum Duration of Benefits, as shown on the Schedule of Benefits page

Disabilities Due to Substance Abuse

Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while you are a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.

If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, you are able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) you are performing all the material duties of your regular occupation on a fulltime basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied,

whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:

(1) Impairments in social and/or occupational functioning;

(2) Debilitating physical condition;

(3) Inability to abstain from or reduce consumption of the Substance; or

(4) The need for daily Substance use for adequate functioning.

"Substance" means alcohol and those drugs included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

"Substance Abuse Rehabilitation Program" means a program supervised by a **physician** or a licensed rehabilitation specialist approved by RelianceMatrix.

If You Die While Receiving LTD Benefits

If you die after one hundred eighty (180) days of disability and while receiving a monthly benefit, your eligible survivors will receive special benefits from the LTD Plan. These benefits are in addition to amounts that may be payable through other company benefit plans. The benefit will be an amount equal to six times your last Monthly Benefit. The last Monthly Benefit is the benefit you were eligible to receive right before your death. It is not reduced by wages earned while in Rehabilitative Employment.

Eligible survivors your spouse; or a civil union partner or domestic partner where legally recognized under applicable state law. If the spouse, civil union partner or domestic partner dies before the insured, or if you were legally separated or the civil union or domestic partnership was no longer in effect, then your natural, legally adopted children, step-children, or children of a civil union or domestic partnership who are under age twenty-five (25) will be the Survivors. If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with RelianceMatrix.

Partial Disability

"Partial Disability" means you are capable of performing the material duties of your Regular Occupation on a part-time basis or some of the material duties on a full-time basis. Please see the Rehabilitation Benefit section for details of how much of your income may be replaced during a Partial Disability.

Rehabilitation Benefit

"Rehabilitative Employment" means work in Any Occupation for which your training, education or experience will reasonably allow. The work must be approved by a p**hysician** or a licensed or certified rehabilitation specialist approved by the insurer. Rehabilitative Employment includes work performed while Partially Disabled but does not include performing all the material duties of your Regular Occupation on a full-time basis.

If you are receiving a Monthly Benefit because you are considered Totally Disabled under the terms

of this Policy and are able to perform Rehabilitative Employment, the insurer will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If you are able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, the insurer will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

You will be considered able to perform Rehabilitative Employment if a **physician** or licensed or certified rehabilitation specialist approved by the insurer determines that you can perform such employment. If you refuse such Rehabilitative Employment or have been performing Rehabilitative Employment and refuse to continue such employment, even though a **physician** or licensed or certified rehabilitation specialist approved by the insurer has determined that you are able to perform Rehabilitative Employment, the Monthly Benefit will be reduced by 50%, without regard to the Minimum Monthly Benefit.

Work Incentive Benefit

During the first twenty-four (24) months of Rehabilitative Employment during which a Monthly Benefit is payable, Reliance will not offset earnings from such Rehabilitative Employment until the sum of:

(1) the Monthly Benefit prior to offsets with Other Income Benefits; and

(2) earnings from Rehabilitative Employment; exceed 100% of the i Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

Child Care Benefit

Reliance will allow a Child Care Benefit to an insured if:

(1) the insured is receiving benefits under the Work Incentive Benefit;

(2) the insured's Child(ren) is (are) under 14 years of age;

(3) the childcare is provided by a non-relative; and

(4) the charges for childcare are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twenty-four (24) month period in which the insured is eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for childcare, up to a maximum of $250.00 per month, will be added to the insured's Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: The insured's unmarried child(ren), including any foster child, adopted child, step-child, or child of a civil union or domestic partnership where legally recognized under applicable state law who resides in the insured's home and is financially dependent on the insured for support and maintenance.

Applying for Social Security and Other Disability Income

Because LTD benefits are reduced by disability income from other sources, it's important to apply for these other benefits as soon as possible. Social Security disability benefits are payable after approximately five and a half months of disability. It typically takes several months to process a Social Security claim, so it's important to get this claim process started as soon as possible. RelianceMatrix may offer help to you in applying for Social Security Disability Income Benefits. In order to be eligible for assistance you must be receiving a Monthly Benefit from RelianceMatrix. Such assistance will be offered only if RelianceMatrix determines that assistance would be beneficial.

What If Your Claim Is Denied?

RelianceMatrix's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;

2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal;

4. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration;

7. A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and

8. Notice in a culturally and linguistically appropriate manner.

What Do You Do To Appeal A Claim Denial?

You, or your authorized representative, may appeal a denied claim within 180 days after you receive RelianceMatrix's notice of denial. You have the right to:

1. Submit to RelianceMatrix, for review, written comments, documents, records, and other information relating to the claim;

2. Request, free of charge, reasonable access to, and copies of, all documents, records and

other information relevant to your claim;

3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;

4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate;

5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual;

6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

7. A review and reasonable opportunity to respond to any new or additional evidence considered relied upon, or generated, or any new or additional rational in support of an adverse decision, before an adverse decision is rendered.

RelianceMatrix will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless RelianceMatrix determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which RelianceMatrix expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period. The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period. RelianceMatrix's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim;

3. A statement describing any voluntary appeal procedures offered by RelianceMatrix and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA; including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires;

4. Either the specific internal rules, guidelines, protocols, standards or other similar criterion of the Plan relied upon in making the adverse decision, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criterion of the Plan do not exist; and was relied upon and a copy thereof will be provided free of charge upon request;

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Exclusions

This plan will not cover any Disability due to:

1. war, declared or undeclared, or any act of war;

2. intentionally self-inflicted injuries;

3. the committing of a felony;

4. an injury or Sickness that occurs while you are confined in a penal or correctional institution.

Pre-Existing Condition limitations:

This LTD Plan will not cover any Disability or Partial Disability caused by, contributed to by, or resulting from a Pre-Existing Condition unless you have been actively at work for one (1) full day following the end of twelve (12) consecutive months from the date you became an insured.

"Pre-Existing Condition" means any Sickness or Injury for which you received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to your effective date of insurance.

Flexible Spending Accounts and Health Savings Account Overview

How Flexible Spending Accounts (FSA) Work

The FSA benefit includes both the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account. These accounts allow you to set aside money from your pay on a before-tax basis to pay for your eligible health care and dependent care expenses.

The accounts work like this:

- When you enroll, you choose how much to contribute to the accounts, up to the Health Care Spending Account maximum and the Dependent Care Spending Account maximum allowed for the year. If you participate in the Sony Consumer Choice Plan, the Health Care Spending Account is limited to dental and vision expenses, until your deductible is met.
- Your contribution is deducted from your pay before federal, Social Security, and most state taxes are calculated. This reduces your taxable income and, therefore, the amount of your income tax for the year.
- When you incur an eligible expense, you file a claim.
- You're then reimbursed for eligible expenses according to the rules of the plan. You don't pay taxes on the payments you receive from the spending account.

You can't deduct expenses that are reimbursed through the spending accounts from your federal income taxes.

How the Health Savings Account (HSA) Works

If you participate in the Consumer Choice Plan, you may also open a health savings account (HSA) provided you meet the eligibility criteria (as described below) to help you pay for certain out-of-pocket health care costs. In general, your account will be automatically established for you when you enroll in the Consumer Choice Plan; however, if you can't satisfy the eligibility criteria or you do not respond to any requests for information from our HSA provider in a timely manner, your account opening may be delayed or denied.

Once your account has been set up, SPE will make contributions to it while you remain actively employed. In addition, you can contribute your own money to the HSA on a pre-tax basis, but you are not required to do so in order to receive company contributions.

You can use the funds in your HSA as soon as they have been deposited. Funds used for eligible health care expenses may be withdrawn tax-free. If you have unused funds remaining in your HSA at the end of the year, they will roll over to the following year, so you never lose them. If you leave the company or retire, you can continue to access the unused balance in the HSA because you own the account and all the funds in it.

Any unused balances in the HSA will earn interest like a savings account. Once your balance reaches $1,000, you also have the option to invest the balance over $1,000 among a diverse window of mutual funds (though additional account maintenance and investment fees may apply). As with your contributions and withdrawals for eligible expenses, account earnings are also tax-free.

It is your responsibility to ensure you're eligible to enroll in an HSA. To qualify you must:

- Be covered under the Consumer Choice Plan
- Have no other health coverage (except what is permitted under IRS rules)
- Not be enrolled in Medicare (including Part A)
- Not be claimed as a dependent on someone else's tax return.
- Not be enrolled in a health care Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) including through a spouse's plan. Unless the health FSA and/or HRA is limited to vision/dental or post-deductible
- Use your HSA only for health care expenses incurred by your spouse or by dependents you claim on your federal tax return.

Planning How Much to Contribute to your FSA

The Health Care Flexible Spending Account and Dependent Care Flexible Spending Account are separate accounts and have different limits on how much you can contribute.

Before you enroll, you should estimate what your expenses will be during the year, and then decide how much to contribute, up to the maximum amount allowed by the plan. You can use the Spending Account Estimator on Your Benefits Resources Web site when you enroll. It's important to plan carefully because:

- You must incur the expenses or receive the services in the same calendar year in which you contribute to the account.
- If you contribute more to the accounts than you claim in expenses during the year, federal law requires you to forfeit the leftover money in your accounts. All reimbursement requests for expenses incurred during the calendar year must be filed (or postmarked) by March 31 of the following year.
- You can't start or stop contributing or change your contribution amounts in either account during the year unless you have a qualified change in status.
- You can't use extra funds in your Health Care Spending Account to fund your Dependent Care Spending Account, or vice versa.
- If you leave SPE before the end of the calendar year, only the expenses you incurred while working at the company are eligible for reimbursement. **(Exception:** You may choose to continue Health Care Spending Account contributions on an after-tax basis under COBRA for the remainder of the calendar year.)

After you enroll, you can use the Inspira Financial Web site for personalized account service to:

- Submit your claims and review claim status.
- Learn more about eligible expenses.
- Check your account balances.

You can link to the Inspira Financial site from https://benefits.sonypictures.com/.

Planning How Much to Contribute to your HSA

The IRS imposes annual limits on how much the company, and you can contribute, on a combined basis, to your HSA each year. If you wish to contribute, you make an annual election and the money you contribute is taken from your paycheck in equal installments over the remaining pay periods in the year before income tax applies (state tax treatment may vary, for example, HSA contributions are subject to state taxes in CA and NJ). Because the money you put into your HSA isn't taxed, the pay on which your income is calculated is less, so you pay less taxes. You can start or stop contributing

or change your contribution amounts at any time during the year. You may also rollover money from a previous employer HSA account into the SPE HSA account.

SPE also makes a discretionary contribution into your account. For 2024, SPE will contribute up to $750 (for employee only coverage) and $1,500 (for family coverage*) to your account. This discretionary contribution amount may change in future years. SPE's full contribution to your account will be deposited as soon as administratively possible in January. Employees hired and actively enrolled after March 31 or having a mid-year status change will receive a pro-rated amount deposited as soon as administratively possible (based on your date of hire or status change date). You must be actively employed and enrolled in the Sony Consumer Choice Plan and have opened your HSA at the time of SPE's quarterly contribution in order to receive the funds in your account.

*"Family coverage" means any of the following coverage levels: "Employee + Spouse/Domestic Partner," "Employee + Child(ren)," or "Employee + Family." SPE's Contribution is discretionary.

SPE's contributions are included in the maximum annual HSA contribution limit.

After you enroll, you can use the Inspira Financial Web site for personalized account service to:

- Submit your claims and review claim status.
- Learn more about eligible expenses.
- Check your account balances.
- Find information about the debit card program for eligible health care expenses.
- Invest your HSA balance (if over $1,000) in one or more mutual funds.

You can visit Inspira Financial at Inspirafinancial.com

Effect of Before-Tax Contributions

Before-tax contributions from your pay reduce your income for tax purposes only. They don't affect the pay used to determine your benefit levels or coverage under any company-sponsored plans. However, since you may be paying lower Social Security taxes, you should be aware that any future Social Security benefits you may be eligible to receive could be slightly reduced.

The potential impact on your Social Security benefit depends on how much you contribute to your Flexible Spending Accounts and/or HSA and for how long, but it's likely to be very small—less than 1%. Also, the reduction in your eventual Social Security benefit can be more than offset by your tax savings over the years.

Situations That Can Affect Participation

Your participation in the Flexible Spending Accounts could be affected in the following ways:

- If you elect not to make contributions to your accounts, you'll have to pay for any out-of-pocket expenses you incur with after-tax dollars.
- Once you decide how much to contribute to a spending account during annual enrollment, you generally can't change your decision until the next annual enrollment. The only exception is if you have a qualified change in status.
- If you don't properly file a claim for reimbursement or if you don't provide adequate proof of your expenses, reimbursements from your Flexible Spending Accounts may be delayed or denied. The Claims Administrator may request additional proof of your claim.

If you do not incur enough eligible expenses to receive reimbursement for all of the money in your Flexible Spending Accounts during the year, the remaining balances will be forfeited. (You have until March 31 to submit claims for eligible expenses incurred during the previous calendar year.)

Health Care Flexible Spending Account

How the Account Works

If you participate in the Sony PPO, EPO or HMO plan, you are eligible to contribute to the Health Care Spending Account. The Health Care Flexible Spending Account allows you to set aside money on a before-tax basis to pay for eligible out-of-pocket health care expenses incurred by you and your eligible dependents. The account works like this:

When you incur a health care expense that isn't fully paid for by your Medical, Dental, or Vision Plan, you can file a claim with your account for the unpaid amount. **Note:** Not all expenses are eligible for reimbursement.

You're then reimbursed for the eligible expense, up to the amount you've chosen to contribute for the year or the remaining balance if you've received previous reimbursement from the account that year.

You don't pay taxes on the reimbursements you receive from the account.

While participating in the Health Care Flexible Spending Account, you have certain rights and protections, including the privacy of your health information.

How Much You Can Contribute

You can contribute up to $3,200 to your Health Care Flexible Spending Account in 2024. There is no minimum annual contribution.

Plan carefully and be conservative with your estimates. If you contribute more in the plan year than you claim for reimbursement, any amount left in your account is forfeited—you are not allowed to carry over remaining contributions to the next year.

Eligible Health Care Expenses

Eligible Expenses

The Health Care Flexible Spending Account can be used to receive reimbursement for eligible out-of-pocket health care expenses that aren't reimbursed by your SPE or other health care coverage, such as your co-payments, deductibles, coinsurance, and amounts over reasonable and customary limits or plan limits. The expenses can be incurred by you, your spouse, or your dependents that you claim on your income tax return.

Note: Your spouse and dependents do not have to be covered under SPE's plans to claim their eligible expenses under the account. (You can't be reimbursed for expenses incurred by your domestic partner or children of your domestic partner unless they qualify as dependents on your income tax returns.) Examples of eligible expenses are:

- Acupuncture (performed by a licensed practitioner)
- Alcohol or chemical dependency payments to a treatment center
- Ambulance services
- Birth control pills
- Car controls for the handicapped
- Chiropractor
- Condoms
- Contact lenses (excluding insurance)
- Crutches (purchase or rental)
- Dental treatment
- Doctor's fees
- Eyeglasses, lenses, frames, and exams
- Fertility treatments
- Founder's fee—monthly lump-sum fee to a retirement home (covers portion specifically for medical care)
- Guide dog for the blind or deaf
- Halfway house care to help individual adjust from life in a mental hospital to community living
- Health care equipment—furniture or household appliances for non-general use
- Health or fitness club dues (with a letter of medical necessity)
- Hearing aids
- Laboratory fees
- Laetrile (if legally qualified as a drug where purchased)
- Laser eye surgery
- Learning disabilities—tutoring by a licensed school or therapist for a child with severe learning disabilities
- Medical services
- Medical care provided in a nursing or retirement home (custodial care is not covered)
- Menstrual Care Products
- Nursing services
- Oxygen or oxygen equipment
- Over-the-counter (OTC) drugs (allergy medicines, antacids, cold medicine, pain relievers)
- Personal protective equipment (e.g., hand sanitizer and face masks)
- Prescription drugs prescribed and legally obtained by a doctor's prescription (including prescribed over-the counter (OTC) medications) to treat a medical condition
- Psychiatric care
- Psychologist's services within scope of license
- Routine physical exams
- Schools—special schooling to relieve a handicap
- Sterilization
- Stop-smoking programs
- Surgery, excluding experimental and cosmetic procedures (unless performed as a medical necessity to correct a deformity)
- Syringes, needles, and injections
- Telephone—special equipment for the deaf

- Television—audio display equipment for the deaf
- Therapy—physical or occupational therapy by a licensed therapist
- Transplants
- Vaccinations and immunizations
- Vitamins and mineral supplements prescribed for the treatment of illness
- Weight loss programs (prescribed by a doctor to treat a specific ailment)
- Wheelchairs
- X-ray fees

Ineligible Expenses

Some expenses are **not** eligible for reimbursement. They include:

- Cosmetic surgery, treatments or prescribed drug and medicines (unless medically necessary)
- Custodial care in a nursing or retirement home
- Exercise equipment (even if recommended or approved by a health care provider)
- Funeral or burial expenses
- Household or domestic help (even if recommended by a doctor because of an inability to perform household work)
- Marriage or family counseling
- Maternity clothing or diaper service
- Nursing expenses for a licensed practical nurse (L.P.N.) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother during childbirth)
- Premiums for health care coverage
- Sending a child to a special school to improve discipline
- Social activities even if recommended by a doctor for general health improvement
- Transportation expenses to and from work even if a physical condition requires special means of transportation
- Vacation or travel, even when taken for health purposes
- Vitamins without a doctor's prescription

For More Information

For more information on the Health Care Spending Account, go to Inspirafinancial.com or contact Inspira Financial at 1-888-678- 8242.

Dependent Care Flexible Spending Account

How the Account Works

The Dependent Care Flexible Spending Account allows you to set aside money from your pay on a before-tax basis to pay for your eligible dependent care expenses. The account works like this:

- When you incur an eligible expense, you file a claim.
- You're then reimbursed for the amount of each claim as long as you have enough money in the account. If the claim amount is more than the balance in your account, you'll be reimbursed for the remainder of the claim once enough money has been credited to your account through future contributions.
- You don't pay taxes on the reimbursements you receive from the account.

If you're married and want to participate in the Dependent Care Flexible Spending Account, your spouse must either:

- Work (either full time or part time);
- Be actively looking for work;
- Be a full-time student; or
- Be incapacitated.

Eligible Dependents

You can use the Dependent Care Flexible Spending Account to pay for child and adult dependent care expenses that would otherwise qualify for the child and dependent care tax credit on your federal income tax return.

Specifically, your expenses must be for the care of **either**:

- A dependent child under age 13 who lives in your home and is claimed as a dependent on your federal income tax return.; or
- A dependent who is mentally or physically disabled and incapable of self-care. This dependent must live in your home at least eight hours a day. They can be your spouse, parent, brother, sister, or any other family member, as long as you provide at least half of his or her financial support.

How Much You Can Contribute

In general, you can contribute up to $5,000 per year to your Dependent Care Flexible Spending Account. However, if you're married and you and your spouse file separate tax returns, you can each contribute up to $2,500, as limited by federal law. Also, if you are considered a highly paid employee (for example, for 2023 plan year, you earned $150,000 or more) according to Internal Revenue Service (IRS) participation rules, your contribution amount may be subject to a lower limit (for 2024, the limit is $2,800). You'll be notified if your contribution is limited. This limit may change from year to year.

Your annual contribution to your account can't be more than your earned income or that of your spouse, whichever is less. For example, if you earn $25,000 and your spouse earns $4,000, you can put only up to $4,000 into your Dependent Care Spending Account.

Different limits apply if your spouse is a full-time student or is physically or mentally incapable of self-care. In these cases, you may be able to contribute up to an amount deemed earned based on the number of eligible dependents you have (but not to exceed the account limit of $5,000 per year):

- $3,000 a year if you have one eligible dependent; or
- $5,000 a year if you have two or more eligible dependents.

By making an election to contribute, you're representing to SPE that your contributions are not expected to exceed these limits. Also, the maximum reimbursement you can receive during a calendar year from this account or any similar account with another employer is also subject to the above limits as well.

Plan carefully and be conservative with your estimates. You can use the Spending Account Estimator available on the Inspira Financial site at the time you enroll. Keep in mind that if you contribute more in the plan year than you claim for reimbursement, any amount left in your account is forfeited—you are not allowed to carry over remaining contributions to the next year.

If you're considering using the Dependent Care Flexible Spending Account, you should also take the federal dependent care tax credit into consideration.

The Dependent Care Flexible Spending Account allows you to save taxes by paying for eligible dependent care expenses with before-tax dollars.

The federal dependent care tax credit reduces the amount of federal income tax you pay.

If you use the Dependent Care Flexible Spending Account, you cannot claim the federal dependent care tax credit for the same expenses and vice versa.

For more information on the dependent care tax credit, see IRS Publication 503, available at **www.irs.gov**. You may want to discuss these options with your tax advisor.

Eligible Dependent Care Expenses

Eligible Expenses

The following expenses paid for the care of an eligible dependent qualify for reimbursement from your Dependent Care Flexible Spending Account after services have been rendered:

- Day care services provided in your home; and
- Dependent care services provided outside your home, such as:
    - Care in an adult or child day care center;
    - Nursery school;
    - Summer or school break camps that don't include overnight stays; and
    - Before and after school care programs.

Keep the following in mind:

- If a dependent care center provides services for more than six people, it must comply with all state and local laws.
- Certain household services may be reimbursable if such services are at least partly for the well-being and protection of an eligible dependent. Household services that may be eligible include ordinary and usual services done in and around your home that are necessary to run your home.
- You may be considered the employer of the caregiver in your home and responsible for withholding and paying employment taxes. (For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees.")
- When you file your federal income tax return, you must provide the tax ID number for the care provider.

Ineligible Expenses

The following are examples of expenses that do **not** qualify for reimbursement from your account:

- Child care for an evening or weekend out babysitting when you're not working.
- Expenses for overnight camp.
- Ongoing twenty-four (24) hour institutional care (for example, a nursing home). **Note:** Some expenses may be reimbursable under the Health Care Flexible Spending Account.
- Care provided by someone whom you claim as a dependent on your income tax return or by your child if they are under age 19.
- Any expenses reimbursed by another Dependent or dependent care type account (for example, through your spouse's employer).
- Payments for schooling in kindergarten or higher.
- Transportation expenses.

For More Information

For more information on expenses that qualify for reimbursement, refer to the instructions for filing Federal Income Tax Form 1040 and IRS Publication 503, available at **www.irs.gov**. You can also refer to Inspira Financial site for more information. Go to "Return to the Main Window" at the top of the page and choose the Inspira Financial Web site under Tools.

Health Savings Account

How the Health Savings Account (HSA) Works

An HSA is a tax-deferred account that can be used to pay for qualified out-of-pocket health care expenses, such as your and your family's deductibles, copays and coinsurance (as applicable) under the Consumer Choice Plan or the Dental or Vision Plan.

If you participate in the Consumer Choice Plan, you can establish an HSA, and SPE will contribute funds to your account to help you defray your health care costs. You may also elect to contribute to this account on a pre-tax basis although it is not required to do so in order to receive SPE's contribution. As long as you use your HSA funds to pay for eligible expenses, withdrawals from your account are also tax-free. If you have unused funds in your account at year-end, they will roll over to the following year. You never lose the funds in your account.

Any unused balances in the HSA will earn interest like a savings account. Once your balance reaches $1,000, you also have the option to invest the balance over $1,000 among a diverse window of mutual funds (though additional account maintenance and investment fees may apply). As with your contributions and withdrawals for eligible expenses, account earnings are also tax-free.

Inspira Financial Card

The Inspira Financial card, which is available through Inspira Financial, works like a debit card. You use it to pay for your eligible health care expenses without filing a claim to be reimbursed. As you use your Inspira Financial card, your eligible expenses will be deducted automatically from your HSA account.

Although you do not need to submit your receipts to be reimbursed, you are strongly encouraged to keep your receipts from your services or purchases as proof that you actually incurred the expenses.

How Much You Can Contribute

You can contribute up to $4,150 (employee only) and $8,300 (family) to your HSA account in 2024. There is no minimum annual contribution. This amount includes contributions made by Sony to your account. If you are age 55 or older, you may save an additional $1,000 in catch-up contributions.

HSA type	Your Contribution	SPE's Contribution*	Contribution Limit***
Employee only	$3,400	$750	$4,150
Family**	$6,800	$1,500	$8,300

* Sony Pictures' discretionary contribution amount may change in future years. Sony Pictures' contribution will be pro-rated and deposited quarterly as soon as administratively possible after the first business day of each calendar quarter.

** For purposes of this chart, "Family" means any of the following coverage levels: "Employee + Spouse/Domestic Partner," "Employee + Child(ren)," or "Employee + Family." Sony Pictures' Contribution is discretionary.

*** Note that funding of both your contributions and Sony's will not begin until the required banking vetting process is

completed, which could take between 1 and 3 pay periods. If vetting is passed after the end of the calendar year, you will not receive company funding for that year.

Eligible Health Care Expenses

Eligible expenses for purposes of the HSA means amounts paid for medical care, as defined in Section 213(d) of the Internal Revenue Code for you, your spouse or your tax dependents, but only to the extent such amounts are not compensated by insurance or otherwise. A full list of expenses can be found on www.IRS.gov, under Publication 969. Most medical expenses are covered, such as medical, prescription, dental and vision plan deductibles, copays and coinsurance.

HSA Fees and Expenses

Inspira Financial, as the HSA administrator, may charge fees for certain transactions and services, including a monthly maintenance fee. A full list of fees is available on the Inspira Financial website and they may change at any time for any reason at Inspira Financial's discretion.

As a benefits-eligible employee enrolled in the Consumer Choice Plan, Sony will pay the full cost of the monthly maintenance fee during the months you are enrolled in coverage. You will be responsible for any other fees or expenses incurred, other than the monthly maintenance fee.

If were enrolled in the Consumer Choice Plan and you later i) decline medical coverage, ii) enroll in the EPO, PPO or Kaiser HMO and/or iii) you terminate from Sony, Inspira Financial will transfer your HSA to a retail account. Your debit card will remain active and you can continue to access to any remaining HSA account balance. However, you will be responsible for the monthly maintenance fee as well as any other fees or expenses incurred.

Questions regarding any fees should be addressed to the Inspira Financial Customer Service number at 1-888-678-8242.

For More Information

For more information on the Health Savings Account, contact Inspira Financial at www.inspirafinancial.com or call 1-888-678- 8242.

Filing Claims for FSA Reimbursement

Health Care Flexible Spending Account Claims

If you have an expense that's covered by the SPE Medical, Dental, or Vision Plan or other coverage you have elsewhere, submit a claim to that plan first. You'll receive an Explanation of Benefits (EOB) from the plan showing what was covered and what wasn't. You can then submit a claim for reimbursement for the expenses your health care plan didn't pay.

When you have eligible health care expenses to submit, you can file your claim using the Inspira Financial website accessed from a link on this site under the Topics menu. You can also request a claim form by calling 1-888-678-8242 and be connected to the Inspira Financial Service Center.

Complete the form and mail, fax or scan it to the Inspira Financial Claims Administrator at the address on the form, along with the EOB, if any, and copies of your receipts. Please remember to keep a copy of all documents that you submit. If the claim amount is an eligible expense and doesn't exceed the total amount you chose to contribute for the year, minus previous reimbursements, you'll be reimbursed for the full amount.

You have until March 31 of the next year to submit claims for expenses incurred in the prior calendar year. Once you're reimbursed for the total amount of your annual contribution for the year, no more reimbursements are made.

Dependent Care Flexible Spending Account Claims

When you have eligible dependent care expenses to submit, you can file your claim on the Inspira Financial website. You can also request a claim form by calling 1-888-678-8242.

Complete the form and send it to the Inspira Financial Claims Administrator at the address on the form, along with copies of your receipts.

You'll be reimbursed for your eligible expenses unless they're for more than your account balance at the time you submit your claim.

If your claim amount is greater than your account balance, you receive the amount of your balance.

As your future contributions are deposited to your account, you'll receive additional amounts until your full reimbursement is paid.

Once you're reimbursed for the total amount of your annual contributions, no more reimbursements are made.

You have until March 31 of the next year to submit claims for expense incurred in the prior calendar year.

How to Appeal Denied Claims

Once you turn in your Inspira Financial claim, the Claims Administrator will follow the benefit review process for the Health Care or Dependent Care Flexible Spending Account and make a decision. Claims may be denied in some situations—for example, if the expense isn't eligible for reimbursement or if the expense exceeds your annual contribution to your account. You have the right to appeal denied claims by following the claim review process (see page 303).

For More Information

For more information on expenses that qualify for reimbursement, refer to the instructions for filing Federal Income Tax Form 1040 and IRS Publication 503, available at **www.irs.gov**. You can also refer to the Inspira Financial website for more information.

Filing Claims for HSA Reimbursement

Health Savings Account (HSA) Claims

Once your HSA is active, you may use it at any time to pay for eligible health care expenses (with your Inspira Financial card) or reimburse yourself for eligible expenses that you previously incurred to the extent your account is funded (if your claim is for more than the balance if your HSA, you will need to pay your claim out of pocket and reimburse yourself once the funds are available). There are no claim forms to submit. It is your responsibility to verify that any expenses are eligible.

You are strongly encouraged to save your health care receipts together with our other important tax documents. While you are not required to submit your receipts to be reimbursed from your account, because the HSA is a tax-favored vehicle, you may be required to substantiate your claim at a later date by the IRS. In addition, at the end of each year, you'll receive a tax form (Form 8889) from our HSA provider to show you the amount of contributions to and qualified distributions from your account during the year. You'll need to submit this form along with your tax return each year. If you take a distribution from your HSA for an ineligible expense, you'll receive a separate tax form (Form 1099-SA) showing the amount of the distribution and the reason. You'll need to file this form with your tax return as well. Finally, our HSA provider will also make available a form (Form 5498-SA) showing you the contributions made to your account during the year. You do not need to file this form, but you'll want to keep this together with you other tax forms.

For More Information
For more information on expenses that qualify for reimbursement review the IRS rules on HSAs at www.irsgov , IRS Publication 969. You can also refer to the Inspira Financial website for more information.

Legal Plan Overview

MetLife Legal Plans, Inc. ("MetLife Legal Plans") has been selected to provide legal benefits (the "Legal Plan") under the Plan. Services are generally provided through a panel of carefully selected participating law firms. Lawyers in this network are called Plan Attorneys. These arrangements are described in detail in this summary. The actual provisions of the Plan are set out in a written document maintained by SPE. All statements made in this summary are subject to the provisions and terms of that document, which control in the event of conflict with this summary.

If you have any questions about the Legal Plan that are not answered in this summary or on the MetLife Legal Plans website at https://members.legalplans.com, please call MetLife Legal Plans directly at 1-800-821-6400.

Enrolling in the Plan

For the Legal Plan, you can change your enrollment decision **only** during the open enrollment period. (Even if you have a qualified change in status that allows you to make changes to some Benefits coverage during the year, you cannot change your Legal Plan enrollment decision until the next open enrollment period.)

Initial Enrollment for a Newly Eligible Employee
You have thirty (30) days to enroll in the Legal Plan from the date your enrollment information is sent to you to enroll in the Legal Plan once you become eligible. As long as you enroll by your deadline, the coverage you choose will automatically be retroactive to your date of hire.

As part of the enrollment process, you'll choose whether or not you want to participate in the Legal Plan. The decision you make during your initial enrollment period cannot be changed until the next open enrollment period. If you don't enroll within thirty (30) days, you're assigned no coverage automatically for the Legal Plan for the current Plan year.

Open Enrollment
Each fall, you can enroll for coverage for the next Plan year. For current employees making new coverage choices during open enrollment, your new Legal Plan choice takes effect on the next January 1. **Note:** If you're on a leave of absence on January 1, special rules apply.

You must enroll during the open enrollment period if you want to be covered by the Legal Plan and you do not currently have coverage.

If you do not make an election during the open enrollment period, your Legal Plan coverage election in effect in the current year will carry over to the next Plan year. If you are currently enrolled for coverage, this coverage will be automatically carried over to the following year unless you elect otherwise.

Who's Eligible to Use the Plan
As an eligible SPE employee enrolled in the Legal Plan, you and your eligible family members can use the Legal Plan for covered services. There are two tiers of coverage (basic and Parent Plus). In the basic plan eligible family members include the following (whether or not you choose to cover them for other Benefits plans such as medical coverage):

- Your spouse or domestic partner
- Your dependent children

In addition to the standard level of coverage (which covers you, your spouse/domestic partner and dependent children), you may also elect the **Enhanced Parents Plus** coverage option. This option provides coverage for certain select services for your parents and in-laws, including access to consultations and document review with participating attorneys for estate planning (wills, health care directives, etc.), nursing home agreements, and more.

When Coverage Ends
Your eligibility and family members' eligibility to receive legal services under the Legal Plan ends if you are no longer an eligible active employee or if you are currently enrolled and choose to decline coverage during the next open enrollment period. Your current coverage will end on the day in which your employment terminates. If you chose to decline coverage during open enrollment, your coverage will end on December 31st of the current year.

If you are no longer eligible to participate in the Legal Plan or your employment with Sony ends, the Legal Plan will cover the eligible legal fees for you and covered family members for those covered services that were opened and pending during the period you were enrolled in the Legal Plan. No new matters will be covered after you become ineligible.

Coverage is portable for twelve (12 months). To continue coverage on your own, you must contact MetLife Legal Plans' Client Service Center at **800-821-6400** within thirty (30) days of your employment termination date and request to continue coverage. (While the term for portability is currently a set period of thirty (30) months, this term is subject to change by MetLife for new enrollees without notice.) You would be required to pay MetLife the full twelve (12) months of premium upfront.

If the employee dies while actively enrolled, the surviving spouse is eligible to continue coverage for a 3-month period at no cost.

How to Get Legal Services
To use your Legal Plan, visit our website at www.members.legalplans.com or call MetLife Legal Plans' Client Service Center at 1-800-821-6400. Employees enrolled in the plan must remain in the plan for the benefit plan year.

If you call the Client Service Center, the Client Service Representative who answers your call will:
- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number that is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about your Legal Plan.

Then call the Plan Attorney and identify yourself as a Legal Plan member referred to them by MetLife Legal Plans. You should request an appointment for a consultation. You should be prepared to give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. Evening and Saturday

appointments are available. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, MetLife Legal Plans will reimburse you for these non-Plan attorneys' fees based on a set fee schedule.

What Services Are Covered
You and your eligible dependents are entitled to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions that must be met. Please take time to read the description of benefits carefully. All benefits are available to you and your spouse and dependents, who are referred to below as participant(s), unless otherwise noted or you are enrolled in a Single or Employee Only plan.

ADVICE AND CONSULTATION

Office Consultation and Telephone Advice
This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the participant's rights, point out his or her options and recommend a course of action. The plan attorney will identify any further coverage available under the Legal Plan, and will undertake representation if the participant so requests. If representation is covered by the Legal Plan, the participant will not be charged for the Plan attorney's services. If representation is recommended, but is not covered by the Legal Plan, the Plan Attorney will provide a written fee statement in advance. The participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a participant may use this service; however, for a non-covered matter, this service is not intended to provide the participant with continuing access to a Plan Attorney in order to seek advice that would allow the participant to undertake his or her own representation.

CONSUMER PROTECTION

Consumer Protection Matters
This service covers the participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Personal Property Protection
This service covers counseling the participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits, and demand letters.

Small Claims Assistance
This service covers counseling the participant on prosecuting a small claims action; helping the participant prepare documents; advising the participant on evidence, documentation and witnesses; and preparing the participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

DEBT MATTERS

Debt Collection Defense
This service provides participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Identity Restoration Services
This service provides the participant with access to Identity Restoration Services provided by IdentityForce, a TransUnion Brand. This includes identity restoration services from U.S.-based Certified Protection Specialists. Specialists assist with more than identity restoration; they help recover if wallets and information are ever lost or stolen and can save the participant hundreds of hours by completing all the paperwork, making calls, and doing all the heavy lifting to make sure your identity is restored.

Identity Theft Defense
This service provides the participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Personal Bankruptcy or Wage Earner Plan
This service covers the Legal Plan member and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or wage earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the sponsor or employer, even if the Legal Plan member or spouse chooses to reaffirm that specific debt.

Tax Audits
This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the participant's tax return; negotiating with the agency; advising the participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

DEFENSE OF CIVIL LAWSUITS

Administrative Hearing Representation
This service covers participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense
This service covers the participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense
This service covers the participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the participant incompetent.

DOCUMENT PREPARATION

Affidavits
This service covers preparation of any affidavit in which the participant is the person making the statement.

Deeds
This service covers the preparation of any deed for which the participant is either the grantor or grantee.

Demand Letters
This service covers the preparation of letters that demand money, property or some other property interest of the participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the participant. Negotiations and representation in litigation are not included.

Document Review
This service covers the review of any personal legal document of the participant, such as letters, leases or purchase agreements.

Elder Law Matters
This service covers counseling the participant over the phone or in the office on any personal issues relating to the participant's parents as they affect the participant. The service includes reviewing documents of the parents to advise the participant of the effect on the participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the participant is either the grantor or grantee; and preparing promissory notes involving the parents when the participant is the payor or payee.

Mortgages
This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes
This service covers the preparation of any promissory note for which the participant is the payor or payee.

FAMILY LAW

Adoption and Legitimization (Contested and Uncontested)
This service covers all legal services and court work in a state or federal court for an adoption for the Legal Plan member and spouse. Legitimization of a child for the Legal Plan member and spouse, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested and Uncontested)
This service covers establishing a guardianship or conservatorship over a person and their estate when the Legal Plan member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.

Name Change
This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement
This service covers representation of the plan member and includes the negotiation, preparation, review and execution of a Prenuptial Agreement between the plan member and their fiance/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiance/partner must either have separate counsel or waive their right to representation.

Protection from Domestic Violence
This service covers the Legal Plan member only, not the spouse or dependents, as the victim of domestic violence. It

provides the Legal Plan member with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Reproductive Assistance Law Coverage - Twenty Hour Maximum
This service covers the Participating Employee and/or spouse for the first twenty hours of legal services and court work related to reproductive assistance matters. Reproductive assistance matters may include, but shall not be limited to, as permitted by law, surrogacy, egg donation, sperm donation, gamete donation, embryo donation and embryo adoption. This service includes reviewing and preparing any necessary agreements or documents, the preparation and filing of any pleadings or other documentation to obtain any necessary orders or decrees, and representation at any hearing or other proceeding related to the matter as may be required by law. This service does not include representation of any party other than the Participating Employee and/or spouse, even if the Participating Employee and/or spouse may be required to pay that party's legal fees or expenses. It is the Participating Employee and/or spouse's responsibility to pay fees beyond the first twenty hours.

IMMIGRATION

Immigration Assistance
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the participant prepare for hearings.

PERSONAL INJURY

Personal Injury (25% Network Maximum)
Subject to applicable law and court rules, Legal Plan attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant's responsibility to pay this fee and all costs.

REAL ESTATE MATTERS

Boundary or Title Disputes
This service covers negotiations and litigation arising from boundary or real property title disputes involving a participant's residence, where coverage is not available under the participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction and Tenant Problems (Tenant Only)
This service covers the participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Home Equity Loans
This service covers the review or preparation of a home equity loan on the participant's residence.

Property Tax Assessment
This service covers the participant for review and advice on a property tax assessment on the participant's residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Residence
This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a participant's residence.

The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a property that is held for any rental, business, investment or income purpose.

Sale or Purchase of Residence
This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a participant's residence or of a vacant property to be used for building a residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a rental property, property held for business or investment or leases with an option to buy.

Security Deposit Assistance (Tenant only)
This service covers counseling the Participant as a tenant in recovering a security deposit from the participant's residential landlord; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the participant for the small claims trial. This service does not include the Legal Plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Zoning Applications
This service provides the participant with the services of a lawyer to help get a zoning change or variance for the participant's residence. Services include reviewing the law, reviewing the surveys, advising the participant, preparing applications, and preparing for and attending the hearing to change zoning.

TRAFFIC AND CRIMINAL MATTERS

Juvenile Court Defense
This service covers the defense of a participant and a participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the participant and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Legal Plan member only, including services for parental responsibility.

Restoration of Driving Privileges
This service covers the participant with representation in proceedings to restore the participant's driving license.

Traffic Ticket Defense (No DUI)
This service covers representation of the participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

WILL AND ESTATE MATTERS

Advanced Healthcare Directive
This service covers the preparation of a living will for the participant.

Powers of Attorney
This service covers the preparation of any power of attorney when the participant is granting the power.

Probate (10% Network Discount)
Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the participant's responsibility to pay this reduced fee and all costs.

Trusts
This service covers the preparation of revocable and irrevocable living trusts for the participant. It does not include tax planning or services associated with funding the trust after it is created.

Wills and Codicils
This service covers the preparation of a simple or complex will for the participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

MISCELLANEOUS

Attorney Services for Non-Covered matters- 4 hours
For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The participant is responsible to pay fees beyond the four (4) hours. No more than a combined maximum total of four (4) hours of attorney time and service are provided for the member.

What's Not Covered

Excluded services are those legal services that are not provided under the Plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits;
- Matters involving the employer, SPE, MetLife, or their respective parents, subsidiaries, affiliates, and Plan attorneys;
- Matters in which there is a conflict of interest between the Sony employee and his/her spouse/domestic partner or dependents in which case services are excluded for the spouse/partner and dependents;
- Appeals and class actions;
- Farm and business matters, including rental issues when the participant is the landlord;
- Patent, trademark, and copyright matters;
- Costs or fines;
- Frivolous or unethical matters; and
- Matters for which an attorney-client relationship exists prior to your becoming eligible for Plan benefits.

Additional exclusions and/or conditions apply as referenced under covered services. The list above is not all inclusive.

Additional Plan Provisions

Administration and Funding
The Legal Plan is provided for and administered through a contract with MetLife Legal Plans, Inc. MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to MetLife Legal Plans, Inc.

Plan Confidentiality, Ethics, and Independent Judgment
Your use of the Legal Plan and the legal services is confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Sony will not receive, nor will it have access to, information about your legal problems or the services you use under the Legal Plan; it will have access only to limited statistical information needed for orderly administration of the Legal Plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Legal Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Legal Plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Legal Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife Legal Plans, Inc., or the law firm providing services under the Legal Plan, is responsible for all services provided by their attorneys.

You should understand that the Legal Plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous, or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at 1-800-821-6400. Your complaint will be reviewed, and you will receive a response within 2 business days of your call.

Other Special Rules
In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

If other coverage is available to you. If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Legal Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Legal Plan, so long as you meet the eligibility requirements.

If you are involved in a legal dispute with your dependents. You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the Plan Attorney. Your dependent will not be covered under the Legal Plan.

If you are involved in a legal dispute with another employee. If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

If the court awards attorneys' fees as part of a settlement. If you are awarded attorneys' fees as a part of a court settlement, the Legal Plan must be repaid from this award to the extent that it paid the fee for your attorney.

Denial of Benefits and Appeal Procedures

Denials of Eligibility
MetLife Legal Plans verifies eligibility using information provided by Sony. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact Sony for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal, see page 301 for the Appeals section.

Denials of Coverage
If you are denied coverage by MetLife Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

MetLife Legal Plans, Inc.

Director of Administration Eaton Center
1111 Superior Avenue
Cleveland, Ohio 44114-2507

The Director will issue MetLife Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Legal Plan provisions on which the denial is based and a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, an explanation of the review procedure, and notice of the right to bring a civil action under Section 502(a) of ERISA.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Legal Plan and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits and benefit payments. However, the Plan Administrator, pursuant to its authority, has delegated most administrative functions under the Plan MetLife Legal Plans. As the Plan Administrator's delegate, MetLife Legal Plans has the authority to review and decide on all claims and appeals for benefits under the Legal Plan.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Legal Plan (including, but not limited to, eligibility for benefits, Legal Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

Funding Information and Source of Contributions
Costs for participation in the Legal Plan are paid by SPE employees by after-tax payroll deductions.

The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

IF YOU HAVE ANY QUESTIONS, PLEASE VISIT OUR WEBSITE AT WWW.LEGALPLANS.COM OR CALL METLIFE LEGAL PLANS AT 1-800-821-6400.

Voluntary Group Accident Plan Overview

Aetna Life Insurance Company ("Aetna") has been selected as the insurer of group accident insurance benefits under the Plan. This category of coverage is designed to provide, to persons insured, benefits for certain losses resulting from a covered accident only, subject to any limitations contained in the certificate. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

The actual provisions of the Plan are set out in a written Policy document maintained by SPE. All statements made in this summary are subject to the provisions and terms of that document, which control in the event of conflict with this summary.

Schedule of Benefits

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Accidental Follow-up Benefit	$100
Maximum Visits per **Accident**	3
Maximum Visits per **Plan Year**	9
Ground Ambulance Benefit	$300
Maximum Trips per **Accident**	1
Air Ambulance Benefit	$1,500
Maximum Trips per **Accident**	1
Appliances Benefit	$100
Maximum Appliances per **Accident**	1
Blood/Plasma/Platelets Benefit	$400
Maximum Transfusions per **Accident**	1
Burn Benefit	
Burn Classifications:	
Second Degree Burn, greater than 5% of total body surface	$1,000
Third Degree Burn, less than 5% of total body surface	$1,500
Third Degree Burn, 5-10% of total body surface	$6,000
Third Degree Burn, greater than 10% of total body surface	$18,000

Burn Skin Graft Benefit	50% of Burn Benefit
Maximum Skin Grafts per **Accident**	1
	$25
Chiropractic Treatment Benefit	
Maximum Visits per **Accident**	10
Maximum Visits per **Plan Year**	30
Coma Benefit	$10,000
Maximum Coma per **Accident**	1
Concussion Benefit	$150
Maximum Concussion per **Accident**	1

Dental Treatment Benefit

Extractions	$75
Crown	$225

Dislocation Benefit

Closed Reduction	
Hip	$4,000
Knee	$2,500
Ankle - Bone or Bones of the foot (other than toes)	$1,500
Collarbone (Sternoclavicular)	$1,200
Lower Jaw (or associated bone joints)	$1,200
Shoulder (Glenohumera)	$1,200
Elbow	$1,000
Wrist	$1,000
Bone or Bones of the hand (other than fingers)	$1,000
Collarbone (Acromiociociavicular and separation)	$500
Rib	$250
One toe or one finger	$250
Open Reduction	2.0 x Closed Reduction
Maximum Dislocations per **Accident**	1

Eye Injury Benefit	$300
Maximum Visits per **Accident**	1

Fracture Benefit
Closed Reduction

Skull (except bones of the face or nose), depressed	$4,125
Skull (except bones of the face or nose), non-depressed	$4,125
Hip, Thigh (Femur)	$3,000

Vertebrae, Body of (excluding Vertebral Processes)	$2,000
Pelvis (inc. Ilium, Ishicum, Pubis, Acetabulum except Coccyx)	$2,000
Leg (Tibia and/or Fibula Malleolus)	$2,000

Bones of the Face or Nose (except Mandible or Maxilla)	$1,500
Upper Jaw (or associated bone joints), Maxilla (except Alveolar Process)	$1,500
Upper Arm between Elbow and Shoulder (Humerous)	$1,500
Lower Jaw (or associated bone joints), Mandible (except Alveolar Process)	$1,000
Collarbone, (Clavicle, Sternum)	$1,000
Shoulder Blade (Scapula)	$1,000
Vertebral Process	$1,000
Forearm (Radius and/or Ulna)	$1,000
Kneecap (Patella)	$1,000
Hand/Foot (except fingers and toes)	$1,000
Ankle/Wrist	$1,500
Rib	$250
Coccyx	$250
Finger, Toe	$250

Open Reduction	2.0 x Closed Reduction
Maximum Fractures per **Accident**	3

Hospital Stay - Admission Benefit	
Hospital Admission	$2,000
Maximum Admissions per **Accident**	1
Intensive Care Unit (ICU) Admission	$4,000
Maximum Admissions per **Accident**	1

Hospital Stay - Daily Benefit

Hospital Daily	$200
Maximum Days per **Stay**	365
Maximum **Stays** per **Accident**	1
Intensive Care Unit (ICU) Daily	$400
Maximum Days per **Stay**	365
Maximum **Stays** per **Accident**	1
Rehabilitation Unit Daily	$200
Maximum Days per **Stay**	30
Maximum **Stays** per **Accident**	1

Initial Treatment Benefit - Emergency Room	$300
Maximum Visits per **Accident**	1
Maximum Visits per **Plan Year**	3

Initial Treatment Benefit - Physician's Office or Urgent Care Center

Maximum Visits per **Accident**	**1**
Maximum Visits per **Plan Year**	$250

1

3

Laceration Benefit

Repair Classifications:	
Without stitches	$25
With stitches, less than 7.5 centimeters	$75
With stitches, 7.6 - 20.0 centimeters	$300
With stitches, greater than 20.0 centimeters	$600
Maximum Repairs per **Accident**	1

Lodging Benefit	$200
Maximum Days per **Accident**	30

Medical Imaging Benefit	$200
Maximum Imaging Tests per **Accident**	1

Observation Unit Benefit	$100
Maximum Observations per **Accident**	1

Pain Management (Epidural Anesthesia) Benefit	$100
Maximum Administrations per **Accident**	1

Paralysis Benefit

Paraplegia	$5,000
Quadriplegia	$10,000

Prosthetic Device/Artificial Limb Benefit

One Limb	$750
Multiple Limbs	$1,500

Ruptured Disc Benefit	$750
Maximum Repairs per **Accident**	1

Surgery Benefit (with repair)

Cranial, Open Abdominal & Thoracic	$1,000
Hernia	$150
Maximum Surgeries (with repair) per **Accident**	1

Surgery Benefit (with no repair)

Exploratory or Arthroscopic	$250
Maximum Surgeries (with no repair) per **Accident**	1

Tendon/Ligament/Rotator Cuff Benefit

Surgery for Single Repair	$750
Surgery for Multiple Repairs	$1,500
Maximum Surgeries per **Accident**	1

Therapy Services Benefit - Speech Therapy, Occupational Therapy and Physical Therapy)
$50

Maximum Visits per **Accident**
10

Torn Knee Cartilage Benefit	$750
Maximum Repairs per **Accident**	1
Transportation Benefit	$250
Maximum Round Trips per **Accident**	1

X-ray Benefit	$50/100
Maximum X-rays per **Accident**	1

Benefits Under the Group Accident Plan

If an **insured person** has an **accidental injury**, **Aetna** will pay the applicable benefits shown on the Schedule of Benefits subject to the following:

1. The benefit maximums, if any, shown on the Schedule of Benefits;
2. A charge must be incurred for the **care** of an **insured person** due to an **accidental injury**;
3. The service or supply must be rendered or received due to an **accidental injury**;
4. The **accidental injury** must occur while coverage for the **insured person** is in force;
5. The service or supply must be rendered or received while coverage for the **insured person** is in force;
6. The service or supply must be rendered or received in the United States or its territories; and
7. The **accident** must take place in the United States or its territories.

Aetna reserves the right to request that a **physician** of **Aetna's** choice review any **diagnosis** in the event of a dispute or disagreement regarding the appropriateness or correctness of a **diagnosis**. **Aetna** also reserves the right to require that an **insured person** submit to an examination to confirm a disputed **accidental injury**. **Aetna** reserves the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed **diagnosis**. **Aetna** will pay for any such requested examination or review.

Accident Follow-up Benefit

Aetna will pay the Accident Follow-up Benefit shown on the Schedule of Benefits if an **insured person** receives follow- up treatment in a **physician's** office, **urgent care center** or **emergency room** for an **accidental injury** within one year of the **accident**.

Aetna will pay either, the Accident Follow-up Benefit, the Initial Treatment Benefit – Emergency Room or the Initial Treatment Benefit – Physician's Office or Urgent Care Center if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Aetna will pay either, the Accident Follow-up Benefit or the Therapy Services Benefit if those visits occur on the same day for the same **accidental injury**. When the visits occur on the same date, the benefit with the greatest amount is payable.

Ground Ambulance Benefit

Aetna will pay the Ground Ambulance Benefit shown on the Schedule of Benefits if a licensed

professional ambulance company transports any **insured person** by ground to or from a **hospital** or between medical facilities where treatment is received as the result of an **accidental injury**.

The ground ambulance transportation must take place within twenty-four (24) hours after **accidental injury**.

Aetna will pay either, the Ground Ambulance Benefit or the Air Ambulance Benefit if both ground and air transportation takes place on the same date for the same **accidental injury**. When both transports take place on the same date, the benefit with the greatest amount is payable.

Air Ambulance Benefit

Aetna will pay the Air Ambulance Benefit shown on the Schedule of Benefits if a licensed professional air ambulance company transports any **insured person** by air to or from a **hospital** or between medical facilities where treatment is received as the result of an **accidental injury**.

The air ambulance transportation must take place within forty-eight (48) hours after the **accidental injury**.

Aetna will pay either, the Air Ambulance Benefit or the Ground Ambulance Benefit if both ground and air transportation takes place on the same date for the same **accidental injury**. When both transports take place on the same date, the benefit with the greatest amount is payable.

Appliances Benefit

Aetna will pay the Appliances Benefit shown on the Schedule of Benefits if a **physician** prescribes the use of an **appliance** as an aid in personal locomotion or mobility as a result of an **accidental injury**. The use of an **appliance** must begin within ninety (90) days after of the **accidental injury**.

Blood/Plasma/Platelets Benefit

Aetna will pay the Blood/Plasma/Platelets Benefit shown on the Schedule of Benefits if an insured person receives the transfusion of blood, plasma and/or platelets due to an accidental injury.

The transfusion must take place within ninety (90) days after the

accidental injury. **Burn Benefit**

Aetna will pay the applicable Burn Benefit shown on the Schedule of Benefits if an **insured person** receives a **second degree burn** or **third degree burn** as a result of an **accidental injury**.

Treatment must be received by a **physician** within seventy-two (72) hours after the

accidental injury.

The Burn Benefit is payable for one of the burn classification amounts shown on the Schedule of Benefits per accident. If the insured person sustains more than one burn classification, the benefit payable is the greater amount.

Burn Skin Graft Benefit

Aetna will pay the Burn Skin Graft Benefit shown on the Schedule of Benefits if an **insured person** receives a skin graft for a burn as a result of an **accidental injury**.

Treatment must be received by a **physician** within seventy-two (72) hours after the

accidental injury. **Chiropractic Treatment Benefit**

Aetna will pay the Chiropractic Treatment Benefit shown on the Schedule of Benefits if an **insured person** suffers a structural imbalance due to an **accidental injury** and receives **chiropractic care services** by a chiropractor in a chiropractor's office.

Treatment must begin within ninety (90) days after the **accidental injury** and must be completed within 365 days after the **accidental injury**.

Coma Benefit

Aetna will pay the Coma Benefit shown on the Schedule of Benefits if an **insured person** is in a **coma** as a result of an **accidental injury**. Benefits will not be paid for a medically induced **coma**.

If Aetna pays the Coma Benefit then the insured person dies as a result of the same accidental injury, the Accidental Death Benefit payable or the Accidental Death Common Carrier Benefit payable, whichever applies, will be reduced by the amount paid under this Coma Benefit.

Concussion Benefit

Aetna will pay the Concussion Benefit shown on the Schedule of Benefits if an **insured person** sustains a concussion as the result of an **accidental injury**.

A **physician** must **diagnose** the concussion within 72 hours after the **accidental injury**.

Dental Treatment Benefit

Aetna will pay the applicable Dental Treatment Benefit shown on the Schedule of Benefits if an insured person sustains a broken tooth as the result of an accidental injury and the tooth is repaired by a dental crown and/or dental extraction.

The dental services must begin within sixty (60) days after the **accidental injury**.

Regardless of the number of broken teeth, only one dental crown benefit and one dental extraction benefit will be paid per accident.

Dislocation Benefit

Aetna will pay the applicable Dislocation Benefit shown in the Schedule of Benefits if an **insured person** sustains a **dislocation** as the result of an **accidental injury**.

A **physician** must **diagnose** the **dislocation** within ninety (90) days after the **accidental injury** and correct it by open reduction or closed reduction.

Aetna will pay the applicable Dislocation Benefit only for the first dislocation of a joint after the insured person's effective date of coverage. This benefit will not be paid for subsequent dislocations of the same joint after the effective date of coverage.

Aetna will pay either the applicable Dislocation Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

If the **insured person**:

Sustains more than one joint dislocation, Aetna will pay for each dislocation, but no more than two times the applicable Dislocation Benefit for the joint involved which has the greatest benefit amount.

1. Receives reduction by a **physician** without anesthesia, **Aetna** will pay 25% of the applicable Dislocation Benefit.

shown in the Schedule of Benefits for a Closed Reduction of the joint involved.

2. Is **diagnosed** by a **physician** with an incomplete dislocation, **Aetna** will pay 25% of the applicable Dislocation Benefit shown in the Schedule of Benefits for a Closed Reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

3. Sustains a **dislocation** and a **fracture** as a result of the same **accident**, both benefits are payable. However, **Aetna** will pay no more than two times the amount for the joint or bone involved which has the greatest amount.

Eye Injury Benefit

Aetna will pay the Eye Injury Benefit shown on the Schedule of Benefits if an **insured person** sustains an **accidental injury** to the eye.

The eye injury must require surgery or the removal of a foreign object by a physician within ninety (90) days after the accidental injury. An examination with anesthesia will not be considered surgery.

Fracture Benefit

Aetna will pay the applicable Fracture Benefit shown in the Schedule of Benefits if an **insured person** sustains a **fracture** as the result of an **accidental injury**.

A **physician** must **diagnose** the **fracture** within ninety (90) days after the **accidental injury** and correct it by open reduction or closed reduction.

Aetna will pay this benefit only for the first **fracture** of any bone after the **insured person's** effective date of coverage. If there are multiple **fractures** to the same bone, **Aetna** will pay only one Fracture Benefit.

Aetna will pay either the applicable Fracture Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same accidental injury. When treatment occurs on the same date, the benefit with the greatest amount is payable.

If the **insured person**:

Sustains a fracture of more than one bone, Aetna will pay for each fracture, but no more than two times the applicable Fracture Benefit for the bone involved which has the highest benefit amount.

1. Is **diagnosed** by a **physician** with a chip fracture, **Aetna** will pay 25% of the applicable Fracture Benefit shown in the Schedule of Benefits for the Closed Reduction for the bone involved. A chip fracture is a **fracture** in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

2. Sustains a **fracture** and a **dislocation** as a result of the same **accident**, both benefits are payable. However, **Aetna** will pay no more than two times the amount for the bone or joint involved which has the greatest amount.

Hospital Stay - Admission Benefit

Hospital Admission:

Aetna will pay the Hospital Admission Benefit shown on the Schedule of Benefits if an **insured person** has a **stay** in a **hospital** due to an **accidental injury**.

The **stay** must begin within one hundred eighty (180) days after an **accidental injury**. Intensive Care Unit (ICU) Admission:

Aetna will pay the ICU Admission Benefit shown in the Schedule of Benefits if an **insured person** is admitted directly to **ICU** due to an **accidental injury**.

The **stay** must begin within thirty (30) days after an **accidental injury**.

Aetna will only pay either the Hospital Admission Benefit or the ICU Admission Benefit once per accidental injury. If admitted directly:

Into the hospital, then the Hospital Admission Benefit is payable.

- Into the **ICU**, then the ICU Admission Benefit is payable.

Hospital Stay - Daily Benefit

Hospital Daily:

- **Aetna** will pay the Hospital Daily Benefit shown on the Schedule of Benefits if an **insured person** has a **stay** in a **hospital** due to **accidental injury**.

- The **stay** must begin within one hundred eighty (180) days after

an **accidental injury**. Intensive Care Unit (ICU) Daily:

- **Aetna** will pay the ICU Daily Benefit shown in the Schedule of Benefits if an **insured person** has a **stay** in an **ICU** due to an **accidental injury**.

- The **stay** must begin within thirty (30) days after the **accidental injury**.

Rehabilitation Unit Daily:

Aetna will pay the Rehabilitation Unit Daily Benefit shown in the Schedule of Benefits if an **insured person** is transferred to a **rehabilitation unit** immediately after a **stay** in a **hospital** due to an **accidental injury**.

Aetna will pay either the Hospital Daily Benefit or the ICU Daily Benefit if treatment occurs on the same date for the same accidental injury. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Aetna will pay either the Hospital Daily Benefit or the Rehabilitation Unit Daily Benefit if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Initial Treatment Benefit – Emergency Room

Aetna will pay the Initial Treatment Benefit – Emergency Room shown on the Schedule of Benefits if an **insured person** requires initial examination and treatment in an **emergency room** as the result of an **accidental injury**.

Such initial examination and treatment must be received within seventy-two (72) hours after the accidental injury. Aetna will pay either the Initial Treatment Benefit - Emergency Room or the Initial Treatment Benefit -
Physician's Office or Urgent Care Center for the same **accidental injury**, whichever occurs first.

If follow-up treatment is prescribed by a **physician**, the Accident Follow-up Benefit is payable if the follow-up visit for the same **accidental injury** occurs on a different date as the initial examination and treatment in an **emergency room**.

Initial Treatment Benefit - Physician's Office or Urgent Care Center

Aetna will pay the Initial Treatment Benefit - Physician's Office or Urgent Care Center on the Schedule of Benefits if an **insured person** requires initial examination and treatment in a **physician's** office or **urgent care center** as the result of an **accidental injury**.

Such initial examination and treatment must be received within seventy-two (72) hours after the accidental injury.

Aetna will pay either the Initial Treatment Benefit **-** Physician's Office or Urgent Care Center or the Initial Treatment Benefit - Emergency Room for the same **accidental injury**, whichever occurs first.

If follow-up treatment is prescribed by a **physician**, the Accident Follow-up Benefit is payable if the follow-up visit for the same **accidental injury** occurs on a different date as the initial examination and treatment in a **physician's** office or **urgent care center**.

Laceration Benefit

Aetna will pay the applicable Laceration Benefit shown on the Schedule of Benefits if an **insured person** receives a **laceration** as the result of an **accidental injury**.

The **laceration** must be repaired by a **physician** within seventy-two (72) hours after the **accidental injury**.

If the laceration is severe enough to require stitches but the physician chooses to repair it in another way, Aetna will pay the benefit amount that corresponds to "with stiches".

The Laceration Benefit is payable for one of the repair classification amounts shown on the Schedule of Benefits per **accident**. If the **insured person** sustains more than one repair classification, the benefit payable is the greater amount.

If the Laceration Benefit is paid then the **insured person** who received a **laceration** on a hand, foot or eye and later loses that hand, foot or eye as the result of the same **accidental injury**, the applicable Accidental Dismemberment Benefit payable will be reduced by the amount paid under this Laceration Benefit.

Lodging

Aetna will pay the Lodging Benefit shown on the Schedule of Benefits for one motel/hotel room for a companion to accompany an **insured person** who has a **hospital stay** as the result of an **accidental injury**.

This benefit is payable only for motel/hotel stays during the period of time the **insured person** has a **hospital stay**. In order for this benefit to be payable, the **hospital** must be more than fifty (50) miles from the residence of the **insured person**. **Aetna** will measure the mileage for the most direct route from the **insured person's** residence to the motel/hotel.

Medical Imaging Benefit

Aetna will pay the Medical Imaging Benefit shown on the Schedule of Benefits if an insured person receives a medical imaging test due to an accidental injury. Medical imaging tests include only the following:

- Positron Emission Tomography (PET)
- Computed Tomography Scan (CT)
- Computed Axial Tomography (CAT)
- Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)

The test must be ordered by a **physician** and performed in a medical facility on an inpatient or outpatient basis within one hundred eighty (180) days after the **accidental injury**.

Observation Unit Benefit

Aetna will pay the Observation Unit Benefit shown on the Schedule of Benefits if an **insured person** requires services in an **observation unit** as the result of an **accidental injury**. The Hospital Stay Admission Benefit will not be payable if the Observation Unit Benefit is payable.

Observation services must begin within seventy-two (72) hours after the **accidental injury**.

Aetna will pay the Observation Unit Benefit, or the Initial Treatment Benefit – Emergency Room, or the Initial Treatment Benefit – Physician's Office or Urgent Care Center for the initial treatment of an accidental injury, whichever occurs first.

Pain Management (Epidural Anesthesia) Benefit

Aetna will pay the Pain Management Benefit shown on the Schedule of Benefits if an **insured person** receives **epidural anesthesia** as the result of an **accidental injury**.

The **epidural anesthesia** must be administered within sixty (60) days after the **accidental**

injury. **Paralysis Benefit (Quadriplegia/Paraplegia)**

Aetna will pay the applicable Paralysis Benefit shown on the Schedule of Benefits if an insured person sustains **paralysis** as a result of an **accidental injury**. A **physician** must:

1. **Diagnose paralysis** within sixty (60) days after the **accidental injury**; and

Confirm the paralysis continued for a period of ninety (90) consecutive days.

If **Aetna** pays the Paralysis Benefit then the **insured person** dies as a result of the same **accidental injury**, the Accidental Death Benefit payable or the Accidental Death Common Carrier Benefit payable, whichever applies, will be reduced by the amount paid under this Paralysis Benefit.

Prosthetic Device/Artificial Limb Benefit

Aetna will pay the Prosthetic Device/Artificial Limb Benefit shown on the Schedule of Benefits if an **insured person** receives one or more prosthetic device(s)/artificial limb(s) when the **insured person** loses a hand, foot or one eye as the result of an **accidental injury**.

The prosthetic device(s)/artificial limb(s) must be received within one year of the **accidental injury**.

Aetna will not pay a benefit for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs, or for joint replacement such as artificial hip or knee.

Ruptured Disc Benefit

Aetna will pay the Ruptured Disc Benefit shown on the Schedule of Benefits if an **insured person** sustains a ruptured disc in the spine as the result of an **accidental injury**.

A **physician** must**:**

- Treat the ruptured disc within sixty (60) days after the **accidental injury**; and
- Repair it through surgery within one (1) year after the **accidental injury**.

If exploratory or arthroscopic surgery is performed and no repair is done, Aetna will pay the Surgery Benefit (with no repair) shown in the Schedule of Benefits once per accidental injury.

Aetna will pay either the Ruptured Disc Benefit or the Surgery Benefit (with no repair) for the same **accidental injury** if treatment occurs on the same date. When treatment occurs on the same date, **Aetna** will pay the benefit with the highest benefit amount.

Surgery Benefit (with repair)

Cranial, Open Abdominal & Thoracic:

- **Aetna** will pay the Surgery Benefit for Cranial, Open Abdominal & Thoracic shown on the Schedule of Benefits if an **insured person** undergoes cranial, open abdominal or thoracic surgery, and repair is done, within seventy-two (72) hours of the **accidental injury**.

Hernia:

- **Aetna** will pay the Surgery Benefit for Hernia shown on the Schedule of Benefits if an **insured person** undergoes hernia surgery as the result of an **accidental injury**.

A physician must:

- **Diagnose** the hernia within thirty (30) days after the **accidental injury**; and
- Perform surgery within sixty (60) days after the **accidental injury**.

If an insured person has open abdominal and hernia surgery, or thoracic and hernia surgery, on the same date for the same accidental injury, only the Surgery Benefit for Cranial, Open Abdominal & Thoracic is payable.

Aetna will pay either the Surgery Benefit (with repair) or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Surgery Benefit (with no repair)

Aetna will pay the Surgery Benefit (with no repair) shown on the Schedule of Benefits if an **insured person** undergoes exploratory or arthroscopic surgery, and no repair is done, within sixty (60) days of the **accidental injury**.

Aetna will pay either the Surgery Benefit (with no repair) or the Surgery Benefit (with repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Aetna will pay either the Surgery Benefit (with no repair) or one of the following benefits if treatment occurs on the same date for the same **accidental injury**:

- Dislocation Benefit;
- Fracture Benefit;
- Ruptured Disc Benefit;

- Surgery Benefit (with repair);
- Tendon/Ligament/Rotator Cuff Benefit; or
- Torn Knee Cartilage Benefit.

When treatment occurs on the same date, the benefit with the greatest amount is payable.

Tendon/Ligament/Rotator Cuff Benefit

Aetna will pay the applicable Tendon/Ligament/Rotator Cuff Benefit shown on the Schedule of Benefits if an **insured person** sustains a torn, ruptured or severed tendon, ligament or rotator cuff as the result of an **accidental injury**.

Aetna will pay the Surgery for Single Repair Benefit or the Surgery for Multiple Repairs Benefit if a **physician**:

- Treats the tear, rupture or sever within sixty (60) days after the **accidental injury**; and
- Repairs it through surgery within one hundred eighty (180) days after the **accidental injury**.

If exploratory or arthroscopic surgery is performed and no repair is done, Aetna will pay the Surgery Benefit (with no repair) shown in the Schedule of Benefits once per accidental injury.

Aetna will pay either the Tendon/Ligament/Rotator Cuff Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Therapy Services Benefit – Speech Therapy, Occupational Therapy and Physical Therapy

Aetna will pay the Therapy Services Benefit shown on the Schedule of Benefits if an **insured person** receives **speech therapy**, **occupational therapy** or **physical therapy** as the result of an **accidental injury**. The therapy must be:

- prescribed by a **physician**;
- rendered by a **speech therapist**, **occupational therapist** or **physical therapist**; and

performed in an office or in a hospital on an inpatient or outpatient basis.

The therapy must begin within ninety (90) days after the **accidental injury** and must be completed within one year after the **accidental injury**.

Aetna will pay either the Therapy Services Benefit or the Accident Follow-up Benefit if those visits occur on the same day for the same accidental injury. When the visits occur on the same date, the benefit with the greatest amount is payable.

Torn Knee Cartilage Benefit

Aetna will pay the Torn Knee Cartilage Benefit shown on the Schedule of Benefits if an **insured person** sustains a torn knee cartilage (meniscus) as the result of an **accidental injury**.

A **physician** must:

- Treat the torn knee cartilage within sixty (60) days after the **accidental injury**; and
- Repair it through surgery within one hundred eighty (180) days after the **accidental injury**.

If exploratory or arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), Aetna will pay the Surgery Benefit (with no repair) shown in the Schedule of Benefits once per accidental injury.

Aetna will pay either the Torn Knee Cartilage Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Transportation Benefit

Aetna will pay the Transportation Benefit shown in the Schedule of Benefits for an **insured person** who must travel from their residence more than fifty (50) miles one way on **physician's** advice for treatment as the result of an **accidental injury**.

The Transportation Benefit will be paid for:

- A **hospital stay**;
- Outpatient surgery; or
- A **physician's** office visit.

Aetna will pay this benefit when the injured **insured person** travels to and from the **insured person's destination via:**

- Commercial travel (plane, train or bus); or
- Non-commercial travel (use of a personal car).

Aetna will measure the mileage for the most direct route from the **insured person's** residence to the facility where treatment is received.

This benefit is not payable if the **insured person** is transported by taxi, ground ambulance or air ambulance.

X-ray Benefit

Aetna will pay the X-Ray Benefit shown on the Schedule of Benefits if an **insured person** receives an X-ray due to an **accidental injury**.

The X-ray(s) must be prescribed by a **physician** and performed by a licensed facility within 30 days after the **accidental injury**.

Limits and Exclusions

Benefits under the Policy will not be payable for any loss or accidental injury caused in whole or in part by or resulting in whole or part from the following:

- Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a **diagnosed** disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
- Engaging in felony crimes;
- Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection;
- Operating, learning to operate or serving as a crewmember of an aircraft, whether motorized or not;
- Engaging in hang gliding, bungee jumping, parachuting, sail gliding, parasailing, mountaineering using ropes and/or other equipment, or motor-driven vehicle racing;
- Participating in any semi-professional or professional competitive athletic contest, including officiating or

coaching, for which the **insured person** receives any compensation or remuneration;

- Services ordered or performed by a **physician**, or supplies purchased from a provider, who is an **insured person**, the **insured person's immediate family member**, or someone who resides with or is employed by or who employs an **insured person**;

Any form of intentional asphyxiation;

- Elective or cosmetic surgery;
- Bacterial infection that was not caused by a cut or wound from an **accidental injury**.

Aetna will not pay any benefits for a service or supply rendered or received that are not specifically covered or not related to an accidental injury.

General Provisions

Independent, Non-Coordinated Benefits. Each benefit under the Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under the Policy is payable with respect to any event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under the Policy will not be reduced on account of any other health insurance coverage or health plan.

Complaints. If the **insured person** is dissatisfied with the service received from this plan, the **insured person** must call or write Member Services within thirty (30) calendar days of the incident. The complaint must include a detailed description of the matter and include copies of any records or documents that are relevant to the matter. **Aetna** will review the information and provide a written response to the **insured person** within thirty (30) calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will explain what the **insured person** needs to do to seek an additional review.

Assignments of Your Coverage. Coverage may not be assigned. An assignment is the transfer of **your rights under this policy to a person you name.**

Overpayments. Aetna has the right to recover any overpayments due to fraud and any error **Aetna** makes in processing a claim. **You** must reimburse **Aetna** in full. **Aetna** will determine the method by which the repayment is to be made.

Unpaid Premium. Any unpaid premium due for an **insured person's** coverage under the Policy may be recovered by **Aetna** by offsetting against amounts otherwise payable under the Policy.

Notice of Claim. Written notice of claim must be given to Aetna within twenty (20) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the covered person or the beneficiary to the covered person at Aetna Voluntary, P.O. Box 14079, Lexington, KY, 40512-4079, or to any of Aetna's authorized agents, with information sufficient to identify the covered person, shall be deemed notice to Aetna.

Claim Forms. Aetna, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss. Written proof of loss must be furnished to **Aetna** at its said office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Proof of loss includes a completed and signed claim form and any supporting documentation from the **insured person's physician**.

Time of Payment of Claims. Indemnities payable under the Policy for any loss will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss.

Payment of Claims. Accrued indemnities unpaid at the **covered person's** death may, at **Aetna's** option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the **covered person**.

If any indemnity of the Policy shall be payable to the estate of the covered person, or to a covered person or beneficiary who is a minor or otherwise not competent to give a valid release, Aetna may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the covered person or beneficiary who is deemed by Aetna to be equitably entitled thereto. Any payment made by Aetna in good faith pursuant to this provision shall fully discharge Aetna to the extent of such payment.

Physical Examination and Autopsy. At **Aetna's** own expense shall have the right and opportunity to examine the person of the **covered person** when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Change of Beneficiary. Unless the **covered person** makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the **covered person** and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

Workers' Compensation. The Policy is not a Workers' Compensation policy. It does not satisfy any requirement for coverage by Workers' Compensation insurance.

Conformity With State Statutes. Any provision of this plan which, on or after the Group Policy Effective Date, is in conflict with the statutes of the state in which **you** reside on such date, is hereby amended to conform to the minimum requirements of such state.

Appeal Procedure

If **Aetna** gives notice of an **adverse benefit determination**, the **insured person** may submit an **appeal**. This plan provides for one level of **appeal**.

The **insured person** has ninety (90) calendar days after the receipt of notice of an **adverse benefit determination**
to request an **appeal** orally or in writing. The **appeal** must include:

- The **insured person's** name.
- The **policyholder's** name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.

The reasons for making the appeal.

- Any other information the **insured person** would like to have considered.

The **insured person** may choose to have another person (an authorized representative) make the **appeal** on their behalf. The **insured person** must provide written consent to **us**.

A review of an **appeal** of an **adverse benefit determination** shall be provided by **Aetna's** personnel. They shall not have been involved in making the **adverse benefit determination**.

Aetna shall issue a decision within 60 calendar days of receipt of the request for an **appeal**. **Exhaustion of Process.** The **insured person** must exhaust the applicable Appeal Procedure before:

Contacting the California Department of Insurance to request an investigation of a complaint or appeal at:

Consumer Services Division 300 Spring Street South Tower Los Angeles CA 90013 1-800-927-HELP 1-800-927-4357

- Filing a complaint or **appeal** with the California Department of Insurance; or
- Establishing any:

- litigation;
- arbitration; or
- administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Definitions

In this section, insured persons will find the definitions for the words and phrases that appear in bold type throughout the text of this section of the SPD.

Accident means an unforeseen event, which occurs on or after the effective date of coverage for the **insured person** and while this Policy is in force, that is the direct cause of an **accidental injury** to an **insured person**.

Accidental injury means bodily injury to an **insured person** that is the proximate cause of an **accident** and is the proximate cause of an injury or loss sustained on or after the **insured person's** effective date of coverage and while this Policy is in force, which is not excluded under the Policy.

Active-at-work; **actively-at-work**; **active work**; **available-to-work: You** will be considered to be **active-at-work**, **actively-at-work**, **available-to-work** or performing **active work** if, **you** are **available to work** or performing the regular duties of **your** job.

Adverse benefit determination (decision) means a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit. Such **adverse benefit determination** may be based on the **insured person's** eligibility for coverage or coverage determinations, including plan exclusions.

Aetna means Aetna Life Insurance Company for the purposes of this section of the SPD.

Appeal means an oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Appliance means a walking boot that extends above the ankle, brace for the neck, arm, back or leg, cane, crutches, walker and wheelchair.

Care means medical treatment or attention received in an **emergency room**, **hospital**, **rehabilitation unit**, **urgent care center** or by a **physician** or other licensed health care provider.

Chiropractic care services means spinal manipulation services conducted by a licensed chiropractor to correct a structural imbalance caused by an accidental injury. Benefits are not payable for massage therapy or for treatment of chronic conditions or other injuries not related to structural imbalance.

Civil union means a legal relationship between two people of the same or opposite sex that gives them some of the same rights and responsibilities that married people have.

Closed reduction means manipulative, non-surgical, repair of a **fracture** or **dislocation**.

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance.

Common carrier means a commercial airlines, train, bus, boat, ferry or ship, subway or streetcar, operated on a regularly scheduled basis between pre-determined ports or cities. Taxis and privately chartered vehicles are not common carriers.

Complaint means any oral or written expression of dissatisfaction about quality of care or the operation of this plan.

Custodial care means services and supplies that are primarily intended to help an **insured person** meet their personal needs. **Care** can be custodial even if it is prescribed by a **physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. **Custodial care** includes; but is not limited to; the following services:

- Changing dressings and bandages; periodic turning and positioning in bed; administering oral medication; watching or protecting an **insured person**.
- Care of a stable tracheostomy (this includes intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or constant) feeding.
- Care of a stable indwelling bladder catheter (this includes emptying/changing containers and clamping tubing).
- Respite care; adult (or child) day care; or convalescent care.
- Helping an **insured person** perform an activity of daily living, such as: walking; grooming; bathing; dressing; getting in and out of bed; toileting; eating or preparing food.
- Any services that an insured person without medical or paramedical training can perform or be trained to perform.

Diagnosis/diagnosed means a **physician**, specializing in a particular field of medicine, where applicable, has definitively identified an **accidental injury** in an **insured person**. Such **diagnosis** must:

Be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the insured person's medical records; and

- Meet all diagnostic requirements stated in the Policy for the particular **accidental injury** being **diagnosed**.

Dislocation means a completely separated joint.

Emergency room means a specified area within a **hospital** that is designated for the emergency **care** of **accidental injuries**. This area must:

Be staffed and equipped to handle trauma;

- Be supervised and provide **care** by a **physician**;

Provide care seven (7) days per week, twenty-four (24) hours per day.

Employee means a person listed as an employee on the books of the **employer** and who is enrolled under the Policy.

Employer means the **policyholder**.

Epidural anesthesia means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to an accidental injury and does not include epidural steroid injections or treatment for childbirth.

Fracture means a break, rupture or crack in a bone that can be **diagnosed** by X-ray.

Hospital means an institution that:

Is operated pursuant to law and is licensed as a hospital by the responsible state agency;

- Is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the **hospital** on a prearranged basis and under the supervision of a staff of duly licensed **physicians**, medical, diagnostic and major surgical facilities for the **care** of sick or injured persons on an inpatient basis for which a charge is made; and

- Provides twenty-four (24)-hour nursing services by or under the supervision of registered graduate professional nurses (RNs).

Hospital does NOT mean or include:

Convalescent, assisted living, extended care, hospice, rest or nursing facilities;

- Facilities primarily affording custodial, educational or rehabilitative **care** or facilities primarily for the aged or for substance abusers; or

- A private monitored room.

Immediate family member means a person who is related to the **insured person** in any of the following ways: spouse, child (including a legally adopted child, foster child, grandchildren, stepchild, son-in-law and daughter-in-law), parents (including stepparent, mother-in-law and father-in-law), and brother or sister (including stepbrother, stepsister, brother-in-law or sister-in-law).

Intensive care unit (ICU) means a place which:

Is a specifically designated area of the hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;

- Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient not requiring intensive care;

- Is permanently equipped with special lifesaving equipment for the **care** of the critically ill or injured;

- Is under close observation by a specially trained nursing staff assigned exclusively to the **ICU** on a twenty-four (24)-hour basis; and
- Has a **physician** assigned to the **ICU** on a full-time basis.

An **intensive care unit** that meets the definition above may include **hospital** units with the following names:

Intensive Care Unit;

- Coronary Care Unit;
- Neonatal Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

Insured child(ren) means **your** dependent child(ren) who are enrolled for coverage under the Policy. **Insured dependents** means **your insured spouse/civil union partner/domestic partner** and **insured child(ren)**. **Insured person** means **you** and any **insured dependents**.

Insured spouse/civil union partner/domestic partner means **your** spouse, **civil union** partner or domestic partner who is enrolled for coverage under the Policy.

Laceration means a cut or tear in skin or flesh.

Observation unit means a specified area or room within a **hospital**, apart from the **emergency room**, where a patient can be monitored by a **physician** and which:

Is under the direct supervision of a physician or registered nurse (R.N.);

- Is staffed by nurses assigned specifically to that unit; and
- Provides **care** seven days per week, twenty-four (24) hours per day.

Occupational injury means an **accidental injury** that arises out of (or in the course of) any activity in connection with the **insured person's** employment or self-employment whether or not on a full-time basis or results in any way from an **accidental injury** that does.

Occupational therapist means a person, other than an **insured person** or an **immediate family member who:**

- Possesses the designation "Occupational Therapist Registered (OTR)";
- Is licensed by the State to practice **occupational therapy**;

Performs services which are allowed by his or her license; and

- Performs services for which benefits are provided under the Policy.

Occupational therapy means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. **Occupational therapy** does not include diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts).

Open reduction means the surgical repair of a **fracture** or **dislocation**.

Paralysis means injury resulting in paraplegia or quadriplegia (complete, total and permanent loss of use of two or more limbs) confirmed by the insured person's attending physician.

Physical therapist means a person, other than an **insured person** or an **immediate family member who:**

1. Is licensed by the State to practice **physical therapy**;

Performs services which are allowed by his or her license;

2. Performs services for which benefits are provided under the Policy; and

3. Practices according to the Code of Ethics of the American Physical Therapy Association.

Physical therapy means treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio- mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following injury to or loss of a body part.

Physician means a licensed medical provider, other than the **insured person**, an **immediate family member** or anyone living at the **insured person's** residence, who acts within the scope of his or her license and provides **care** necessary for an **accidental injury**.

Plan year means the period during which benefit maximums accumulate. Each new plan year, these maximums reset.

Policyholder means the **employer** who holds the Master Policy.

Rehabilitation unit means an appropriately licensed facility that provides rehabilitation **care** on an inpatient basis. Rehabilitation **care** consists of the combined use of medical, social, educational and vocational services to enable patients disabled by an **accidental injury** to achieve the highest possible functional ability. Services must be provided by or under the supervision of an organized staff of **physician**. The **rehabilitation unit** may be part of a **hospital** or a freestanding facility. A **rehabilitation unit** is not:

A nursing home;

- An extended care facility;
- A skilled nursing facility;
- A rest home or home for the aged;

- A hospice care facility;
- A place for alcoholics or drug addicts; or
- An assisted living facility.

Second degree burns, also called partial-thickness burns, means the epidermis (outer layer of skin) has been burned through and part of the dermal (second layer of skin) has been burned by heat, electricity, radiation, friction or chemicals. **Second degree burns** do not include burns that result from the skins exposure to the sun.

Sickness means a disease, bodily infirmity, illness, infection or any other physical condition that affects the **insured person**.

Specialist or **subspecialist** means a **physician** whose practice is limited to a particular specialty (or sub-specialty) of medicine or surgery. The **physician** would not routinely provide primary **care** or general **care** for patients.

Speech therapist or **speech pathologist** means a person other than the **insured person** or an **immediate family member** who:

- Is licensed by the State to practice **speech therapy**;

Performs services which are allowed by his or her license;

- Performs services for which benefits are provided under the Policy; and
- Practices according to the Code of Ethics of the American Speech-Language-Hearing Association.

Speech therapy means treatment and assistance for disorders related to speech, language, cognitive-communication, voice, swallowing and fluency.

Stay means a period during which an **insured person** is confined as an inpatient in a **hospital**, **intensive care unit** or **rehabilitation unit**. **Stay** does not include any period of such a confinement due to **custodial care** or personal needs that do not require medical skills or training. A **stay** excludes time in an **observation unit** or in the **emergency room** unless this leads to a **stay**. Two or more separate **stays** count as one **stay** if they are due to the same **accident**; and they are separated by less than 90 days. **Otherwise, they count as separate stays.**

Third degree burns, also called full-thickness burns, means an area of tissue damage in which there is destruction of the entire epidermis (outer layer of skin) and the dermal (second layer of skin) that is caused by heat, electricity, radiation or chemicals.

Urgent care center means a facility operated pursuant to law and licensed by the responsible State agency. Such center is dedicated to the delivery of unscheduled, walk-in care outside of an **emergency room**. The center must be under the supervision of a **physician**.

You, your or **yourself** means the **employee**.

Voluntary Hospital Indemnity Plan Overview

Aetna Life Insurance Company ("Aetna") has been selected to provide hospital indemnity insurance. This benefit that supplements your medical insurance and offers financial protection in case of a covered hospitalization. It provides you with payments when you are admitted to a hospital due to an accident or illness. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

The actual provisions of the Plan are set out in a written Policy document maintained by SPE. All statements made in this summary are subject to the provisions and terms of that document, which control in the event of conflict with this summary.

Schedule of Benefits

Benefit maximums apply to each **plan year**. During the **plan year**, the benefit maximums accumulate. Each new **plan year**, these maximums reset.

Benefit	**Benefit amount**
Inpatient benefits	
Hospital stay – admission (initial day) Non-ICU admission or **ICU** admission Maximum per **plan year**	 $1,000 for the initial day of your **stay** 1 admission
Hospital stay – daily Non-ICU daily **ICU** daily Maximum days per **plan year**, combined days for all **stays**	 $100 per day, beginning on day two of your **stay** $200 per day, beginning on day two of your **stay** 30
Newborn routine care	$100 per **stay** per newborn
Rehabilitation unit stay – daily Maximum days per **plan year**, combined days for all **stays**	$50 per day 30
Mental disorders stay – daily Maximum days per **plan year**, combined days for all **stays**	$100 per day 30

Substance abuse stay – daily Maximum days per **plan year**, combined days for all **stays**	$100 per day 30
Additional benefits	
Observation unit Maximum observations per **plan year**	$100 per initial day of observation 1
Benefit	**Benefit amount**
Outpatient benefits	
Health screening Maximum days per **plan year**	$75 per day 1

Benefits under your plan

In this section Aetna helps you understand your benefits under this plan. Covered benefits must meet all of these requirements:

- Your **stay** and other services
  - Must appear in this section.
  - Are not listed in the *What your plan doesn't cover – exclusions* section.
  - Are not beyond any benefit maximums shown in the *Schedule of benefits* section.
  - Must be advised by a **physician**.
  - Must be **necessary**.
- For **stays**, the initial day of your **stay** must be on or after your **effective date of coverage**, and other services must be given or received on or after your **effective date of coverage**.
- You must have been billed for your **stay** and other services.
- Your **stay** must take place or other services must be given or received, in the United States or its territories.
- Your **accidental injury** must take place in the United States or its territories.

Care to prevent **illnesses** are covered under the applicable benefit as listed in the *Schedule of benefits* section, to the same extent as for treatment of an **illness**.

Inpatient benefits

Hospital stay – admission (initial day)

Non-intensive care unit (non-ICU) admission

Aetna will pay the *Non-ICU admission* benefit amount shown in the *Schedule of benefits* section for the initial day of your **stay** in a non-ICU room of a **hospital** due to an **illness**, **accidental injury**, or labor and delivery.

This benefit will not be paid for your newborn's routine post-natal care. See the *Newborn routine care* benefit below for details on what benefits are payable for your newborn child.

If you have an **accidental injury**, you must be admitted to the **hospital** within one hundred eighty (180) days after your accident for this benefit to be payable.

Intensive care unit (ICU) admission

Aetna will pay the *ICU admission* benefit amount shown in the *Schedule of benefits* section for the initial day of your **stay** in an **ICU** room due to an **illness**, **accidental injury**, or labor and delivery.

If you have an **accidental injury**, you must be admitted to the **hospital** within thirty (30) days after your accident for this benefit to be payable.

This benefit is not payable for your **stay** in a **mental disorder treatment facility** or **substance abuse treatment facility**. This benefit is payable for **hospital stays** due to **mental disorders** or **substance abuse**.

Hospital stay – daily

Non-Intensive care unit (Non-ICU) daily

Aetna will pay the *Non-ICU daily* benefit amount shown in the *Schedule of benefits* section beginning on day two of your **stay** in a non-ICU room of a **hospital** due to an **illness**, **accidental injury**, or labor and delivery.

This benefit will not be paid for your newborn's routine post-natal care. See the *Newborn nursery care* benefit below for details on what benefits are payable for your newborn child.

If you have an **accidental injury**, your **stay** must begin within one hundred eighty (180)

days after your **accident**. **Intensive care unit** (**ICU**) **daily**

Aetna will pay the *ICU daily* benefit amount shown in the *Schedule of benefits* section beginning on day two of your **stay** in an **ICU** room due to an **illness**, **accidental injury**, or labor and delivery.

If you have an **accidental injury**, your **stay** must begin within thirty (30) days after your accident.

This benefit is not payable for your **stay** in a **mental disorder treatment facility** or **substance abuse treatment facility**.

This benefit is not payable for **hospital stays** due to **mental disorders** or **substance abuse**.

If you have a stay in both a non-ICU room of a hospital and an ICU room on the same day, Aetna will pay either the *Non-ICU daily* benefit amount or the *ICU daily* benefit amount, whichever is the greatest amount.

This plan has a shared maximum number of days for all **stays** as shown in the *Schedule of benefits*. Each day of your **stay** in a **hospital**, **mental disorder treatment facility**, **rehabilitation unit** and **substance abuse treatment facility**, are all counted against the total.

Newborn routine care

This provision explains what benefit amounts are payable after the birth of your newborn children.

- If after delivery, your newborn has a **stay** in the **hospital** for routine post-natal care until the newborn is discharged, then:

  - The *Newborn routine care* benefit amount shown in the *Schedule of benefits* section is payable once for the duration of the newborn's **stay**.

  - The *Hospital stay – admission* and the *Hospital stay – daily* benefit amounts are not payable for the newborn.

If after delivery, your newborn has a stay in the ICU before being discharged from the hospital, then:

- The applicable *Hospital stay – ICU admission* and the *Hospital stay – ICU daily* benefit amounts shown in the *Schedule of benefits* section are payable.

- The *Newborn routine care* benefit amount is not payable, even if the newborn also had a **stay** in the **hospital** nursery before or after the **stay** in the **ICU**.

Important note:
If the birth mother is a **covered person**, benefits and maximums associated with the birth mother's **hospital stay** are the same as those for an **illness**. See the *Hospital stay – admission (initial day)* and *Hospital stay – daily* benefits above for details.

Rehabilitation unit stay – daily

Aetna will pay the *Rehabilitation unit stay - daily* benefit amount shown in the *Schedule of benefits* section for each day you have a **stay** in a **rehabilitation unit** immediately after your **hospital stay** due to an **illness** or **accidental injury**.

You must be transferred to the **rehabilitation unit** within seventy-two (72) hours for treatment after your **hospital stay**.

Aetna will not pay the *Rehabilitation unit stay - daily* benefit amount for the same days that the *Hospital stay - daily* benefit amount is paid. Aetna will pay the highest eligible benefit.

This plan has a shared maximum number of days for all **stays** as shown in the *Schedule of benefits*. Each day of your **stay** in a **hospital**, **mental disorder treatment facility**, **rehabilitation unit** and **substance abuse treatment facility**, are all counted against the total.

Mental disorders stay – daily

Aetna will pay the *Mental disorders stay – daily* benefit amount as shown in the *Schedule of benefits* section for each day you have a **stay** in a **hospital** or **mental disorder treatment facility** for the treatment of **mental disorders**.

This plan has a shared maximum number of days for all **stays** as shown in the *Schedule of benefits*. Each day of your **stay** in a **hospital**, **mental disorder treatment facility**, **rehabilitation unit** and **substance abuse treatment facility**, are all counted against the total.

Substance abuse stay – daily

Aetna will pay the *Substance abuse stay – daily* benefit amount as shown in the *Schedule of benefits* section for each day you have a **stay** in a **hospital** or **substance abuse treatment facility** for the treatment of **substance abuse**.

This plan has a shared maximum number of days for all **stays** as shown in the *Schedule of benefits*. Each day of your **stay** in a **hospital**, **mental disorder treatment facility**, **rehabilitation unit** and **substance abuse treatment facility**, are all counted against the total.

Additional benefits Observation unit
Aetna will pay the *Observation unit* benefit amount as shown in the *Schedule of benefits* section for the initial day of observation you have in an **observation unit** as the result of an **illness** or **accidental injury**.

If you have an accidental injury, the initial day of observation must begin within seventy-two (72) hours after your accident. If your period of observation leads to a hospital stay, then:

- The *Observation unit* benefit amount will not be paid.
- The applicable *Hospital stay – admission* and *Hospital stay – daily* benefit amounts are payable.

Outpatient benefits

Health screening

Aetna will pay the *Health screening* benefit amount as shown in the *Schedule of benefits* section for each day you receive any of the following health screenings:

• Lipoprotein profile (serum plus HDL, LDL and triglycerides) • Fasting blood glucose test • Doppler screenings for peripheral vascular disease (also known as arteriosclerosis) • Carotid Doppler Ultrasound • Electrocardiogram (EKG, ECG) • Echocardiogram (ECHO) • Chest x-ray (CXR) • Thermography • Ultrasound screening for abdominal aortic aneurysms • Bone marrow screening • Adult and child immunizations • HPV vaccine (Human Papillomavirus) • Bone mass density measurement (DEXA, DXA)	• Skin cancer screening • Serum protein electrophoresis (blood test for myeloma) • Prostate Specific Antigen (PSA) Test • Flexible sigmoidoscopy • Digital rectal exams (DRE) • Hemoccult stool analysis • Colonoscopy • Virtual colonoscopy • Carcinoembryonic Antigen (CEA) • Cancer Antigen (CA) Test 15-3 (breast cancer) • Mammography • Breast Ultrasound • Cancer Antigen (CA) Test 125 (ovarian cancer) • Pap smears • Cytologic Screening • ThinPrep Pap Test • Any other generally medically accepted cancer screening tests

Cancer screening tests are payable on the same basis as other screenings.

What your plan doesn't cover – exclusions

Aetna calls stays and other services that are not covered "exclusions." In this section Aetna tells you about exclusions.

And just a reminder, you'll find benefit maximums in the *Schedule of benefits* section.

Exclusions

Benefits will not be paid for any **stay** or other service for an **illness** or **accidental injury** related to the following:

Activities and contests

Competitive or recreational activities:

- Ballooning
- Boarding (including the use of self-balancing boards or hover boards)
- Bungee jumping
- Gliding (including sailplaning or sail gliding, hang gliding, paragliding)
- Mountaineering using ropes and/or other equipment
- Parachuting
- Paramotoring
- Parasailing or parakiting
- Parascending
- Racing a motor-driven vehicle
- Scuba diving
- Skydiving

- Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment.

Act of war, riot, war

- Any act of war, whether declared or not
- Terrorism
- Voluntary participation in a riot
- Rebellion or civil insurrection

Aircraft (pilot and crew member)

Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by, for, or under the direction of, any military authority.

Care provided by family members

Care provided by a:

Spouse, civil union partner, or domestic partner

- Parent (including stepparent, mother-in-law and father-in-law)
- Child (including a legally adopted child, foster child, grandchildren, stepchild, son-in-law and daughter-in-law)
- Sibling (including brother, sister, stepbrother, stepsister, brother-in-law or sister-in-law)
- Any household member

Cosmetic services and plastic surgery

Surgery (**cosmetic** or plastic) to alter, improve or enhance the shape or appearance of the body, even for psychological or emotional reasons, except to the extent needed to:

- Improve the function of a part of the body that is not a tooth or structure that supports the teeth
- Repair of an **accidental injury** that occurs while you are covered under this Plan

This exclusion does not apply to reconstructive **surgery** in these events:

- When a **necessary** mastectomy is performed:

Your surgery reconstructs the affected breast.

  - Your **surgery** makes a healthy breast look like the reconstructed breast.

- When you have a gross anatomical defect present at birth and:

  - Your **surgery** corrects a severe facial disfigurement or major functional impairment of a body part.
  - Your **surgery** improves function.

When you had an illness that resulted in severe facial disfigurement or major functional impairment of a body part and your surgery improves function.

Custodial care

Examples are:

- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.

- Any services that a person without medical or paramedical training can perform or could be trained to perform.

Dental and orthodontic care and treatment

- Routine/general dental **care**
- Dental conditions or problems related to:
  - Bridges
  - Cavities
  - Crowns
  - Gum care
  - False teeth and dentures
  - Implants
  - Replacement teeth
  - Root canal
  - Wisdom teeth, impacted or not
- Orthodontics

Educational services

Education, training or retraining services or testing. This includes special education, remedial education, job training, and job hardening programs.

Exams

Except as specifically provided in the *Benefits under your plan* section, benefits will not be paid for:

Routine physical, eye, dental, and hearing exams

- Preventive services and supplies
- Any health exams needed:
  - Because a third party requires the exam. Examples are, exams to get or keep a job, or exams required under a labor agreement or other contract
  - To buy insurance or to get or keep a license
  - To travel
  - To go to a school, camp, or sporting event
  - To join in a sport or other recreational activity

Experimental or investigational

Experimental or investigational drugs, devices, treatments, or procedures.

Family planning services

A voluntary abortion

- Complications resulting from a voluntary sterilization procedure
- Any follow-up after a voluntary sterilization procedure
- Any contraceptive methods, devices, material or sterilization procedures
- The reversal of voluntary sterilization procedures, including any related follow-up **care**

Felony

Felony crimes

Fertility

Any **care**, **prescription drugs**, and medicines related to:

In vitro fertilization

- Zygote or gamete intrafallopian transfer

Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection or ovum microsurgery)

Hospice services

Except as specifically provided in the *Benefits under your plan* section, benefits will not be paid for:

- Hospice facility stays
- Hospice care

Funeral arrangements

- Pastoral counseling
- Financial or legal counseling, including estate planning and the drafting of a will
- Homemaker or caretaker services which are solely related to **care** received in your home
- Homemaker or caretaker services which are not solely related to your **care** which include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Nutritional supplements

Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Outpatient rehabilitation and therapy services

Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason.

Self-harm, suicide

Except when resulting from a **diagnosed** disorder, benefits will not be paid:

- In connection with suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self- inflicted injury.
- For any form of intentional asphyxiation.

Substance abuse and use

Except when resulting from a **diagnosed** disorder, benefits will not be paid for:

- Any **accidental injury** sustained while you were/are under the influence of a stimulant, depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a **physician** that are misused by you.

Violation of cellular device use laws

Violating any cellular device use laws, of the state in which the accident occurred, while operating a motor vehicle.

Vision

Vision-related **care**

Claim decisions and appeal procedures for when you disagree

When a claim comes in, Aetna reviews it and decides if a benefit is payable or not. In this section, Aetna explains the claim decision process and what you can do if you think Aetna got it wrong.

Action	Requirement	Timeframe

Notice of claim	When you have a loss, you must let Aetna know so that Aetna can begin the claim payment process. When you let Aetna know you have a loss, this is called a *Notice of claim*. You or your representative must give Aetna written *Notice of claim*. When you give Aetna your *Notice of claim*, you should include your name and **policy** number. The *Notice of claim* should be mailed to Aetna at the company address appearing on the face page of this certificate or to one of Aetna's agents.	Your *Notice of claim* must be given to Aetna, or any authorized agent, within 20 days after a loss occurs or starts or later, as soon as it's reasonably possible.
Claim forms	When Aetna receives your *Notice of claim*, Aetna will provide you with a form for sending Aetna your proof of loss. This form is called a *Claim form*.	If Aetna does not provide you with the *Claim form* within 15 days, you can give Aetna a written statement of what happened. This statement should include the type and extent of the loss incurred.
Submitting your *Claim form* and *Proof of loss* When you have a **stay** or other service you will be charged. The information you receive for that **stay** or other service is your *Proof of loss*.	To give Aetna your *Claim form*, or written statement, and *Proof of loss*, you can choose from one of these two options: • Use the online claim process by logging into www.aetnavoluntaryforms.com • Complete the *Claim form* and submit it to Aetna with any required information by fax or the postal service.	You must send Aetna your *Claim form*, or written statement, and *Proof of loss* within 90 days after the loss. If it was not reasonably possible to send Aetna the required information, Aetna will not reduce or deny the claim for this reason. However, your *Claim form*, or written statement, and *Proof of loss* must be filed as soon as reasonably possible. Except in the absence of legal capacity, your *Claim form*, or written statement, and *Proof of loss* must be given no later than one year from the time specified above.

Claim decision	Aetna will review your *Claim form*, or written statement, and *Proof of loss* and promptly decide to either: • Pay benefits • Request additional information, or • deny payment	If a benefit is payable, it will be paid immediately after *Proof of Loss* is received. All benefits are payable to you. If Aetna needs additional info, you have 45 days from the date of request to send Aetna the additional information. If your claim is denied entirely or in part, this is called an "adverse claim decision." If Aetna makes an adverse claim decision, Aetna will tell you in writing in 30 days. If you disagree, you can ask Aetna to re-review the adverse claim decision. This is called an appeal. See the *Appeal procedures for when you disagree section* below.

Appeal procedures for when you disagree

If you want to appeal, send it to Aetna within 180 calendar days from the time you receive the adverse claim decision. You can appeal by either:

- Calling Aetna toll-free at 888-772-9682
- Sending Aetna a written appeal to the address on the notice of adverse claim decision

When you send Aetna a written appeal, be sure to include:

- Your name
- The **policyholder's** name

A copy of the adverse claim decision

- Your reasons for making the appeal
- Any other details you would like Aetna to know

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell Aetna if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling Aetna that you are allowing someone to appeal for you. You can get this form on Aetna's website or by calling Aetna toll-free at 888-772-9682. The form will tell you where to send it to Aetna.

When Aetna receives your appeal, it will be handled by someone who was not involved in making the adverse claim decision.

Timeframe for deciding your appeal

Aetna will give you an appeal decision within sixty (60) calendar days of Aetna's receipt of your request for an appeal.

Exhaustion of appeals process

Aetna recommends that you complete the appeal process with Aetna before you can take these actions:

- Contact the California Department of Insurance to request an investigation of an appeal.

  Consumer Services Division 300 Spring Street South Tower
  Los Angeles CA 90013 1-800-927-HELP (4357)
  TDD: 1-800-482-4TDD (4833)
- File a complaint or appeal with the California Department of Insurance.
- Pursue arbitration, litigation or other type of administrative proceeding.

Do you have a complaint?

If you are not happy about a **provider** or an operational issue, you may want to complain. You can call Aetna toll- free at 888-772-9682 or write Member Services to tell Aetna about your complaint.

When you complain in writing, you should include:

- A description of the issue
- Copies of any records or documents that you think are important

Aetna will review the information and provide you with a written response within thirty (30) calendar days of receiving the complaint**.** Aetna will let you know if they need more details to make a decision.

Fees and expenses

Aetna does not pay any fees or expenses incurred by you in pursuing an appeal or complaint.

Coordination of benefits

This plan does not coordinate benefits with any other plan. That means it pays benefits regardless of any other coverage you may have.

General provisions – other things you should know

Administrative provisions Transfer of your rights

You may not transfer your rights under this plan to a person you name.

Your coverage can change

Your coverage is defined by the **policy**. This document may have amendments and riders too. Aetna, the **policyholder**, or the law may change your plan. Only Aetna may waive a requirement of your plan. No other person, including the **policyholder**, can do this without Aetna's approval.

Legal action

You cannot take any action at law or in equity until sixty (60) days after Aetna receives written proof of loss.

No legal action can be brought to recover payment under any benefit after three (3) years from the time written proof of loss is required.

Physical examinations, evaluations and autopsy

At Aetna's expense, Aetna has the right to have a **physician** examine you. Aetna also has the right to require an autopsy unless prohibited by law. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of services

You should keep complete records of the **care** you receive because Aetna may need them to pay a claim. Records that you should keep are:

- Names of **physicians** and others who give you **care**

Dates your expenses are incurred

- Copies of all bills and receipts

Your health information

Aetna will protect your health information. Aetna will use it and share it with others to help Aetna process your claims. Aetna needs your consent to distribute your information. You can get a free copy of Aetna's Notice of Privacy Practices at www.aetna.com.

When you accept coverage under this plan, you agree to let your **providers** share your information with Aetna. Aetna will need information about your physical and mental condition and care.

Workers' Compensation

The **policy** is not a Workers' Compensation policy. It does not satisfy any requirement for coverage by Workers' Compensation insurance.

Mistakes and intentional deception

Honest mistakes

You or the **policyholder** may make an honest mistake when you share facts with us. When Aetna learns of the mistake, Aetna may make a fair change in **premium** contribution or in your coverage. If Aetna does, Aetna will tell you what the mistake was. Aetna won't make a change if the mistake happened more than two (2) years before Aetna learned of it.

Any statement you or the **policyholder** make is considered a representation and not a warranty.

Intentional deception

If Aetna learns that you defrauded Aetna or you intentionally misrepresented material facts, Aetna can take actions that can have serious effects on your coverage. Examples of serious effects include:

- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts Aetna already paid
- Reduced benefits

Aetna also may report fraud to law enforcement.

Some money issues

Assignments of your coverage

Coverage may not be assigned.

Benefits unpaid at death

Benefits unpaid at death may be paid, at Aetna's option, to either your beneficiary or estate. If benefits are payable to your estate or a beneficiary who cannot execute a valid release, Aetna can pay benefits up to $1,000 to someone related to you or your beneficiary by blood or marriage whom Aetna considers to be entitled to the benefits. Aetna will be discharged to the extent of any such payment made in good faith.

Change of beneficiary

Aetna will use the most recently signed or electronic beneficiary designation on file with the **policyholder** or Aetna. You can change your beneficiary information at any time by completing a beneficiary designation form. A beneficiary change will be effective on the date you sign the beneficiary designation form, provided it's on file with the **policyholder** or Aetna or if mailed, postmarked prior to your death.

Financial sanctions exclusions

If benefits provided under this plan violate or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, Aetna cannot pay group benefits if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

If Aetna overpays benefits, Aetna can:

- Require you or the person Aetna paid to return the money
- Stop paying benefits until the money is paid back

- Take legal action to get the amount owed
- Reduce the amount of a benefit owed by the amount of the overpayment

Unpaid premium

If you owe past-due **premiums** for your coverage under the **policy**, Aetna can recover them by offsetting what you owe against what Aetna would otherwise pay under the **policy**.

Glossary

Aetna or Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with Aetna. Accidental injury

A sudden, unforeseen trauma that is proximate cause of an injury and that:

- Is caused by an identifiable event that is definite as to a time and place
- Occurs on or after your **effective date of coverage**

Occurs while this policy is in force

Active work, actively at work, active at work, available to work

An **employee** is **actively at work** or performing **active work** on any of the **policyholder's** scheduled workdays if on that day, the **employee** is **available to work** or performing the regular duties of their job on a full-time basis for the normally scheduled number of work hours.

Ambulatory surgical center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Behavioral health provider

An individual professional who is licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where they practices.

Care

Medical treatment, health care services or supplies, or attention received by a **health professional**.

Chiropractic visits

An office visit for the manipulative (adjustive) treatment, or other physical treatment for any condition caused by or related to biomechanical, nerve conduction, or disorders of the spine.

Cosmetic

Services, drugs, or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered dependent

The **employee's** spouse, civil union partner, or domestic partner, and any children who are covered under this policy.

Covered person

An **employee** or an **employee's** dependent for whom all of the following applies:

The person is eligible for coverage as defined in this policy.

- The person has enrolled for coverage and paid any required **premium**.
- The person's coverage has not ended.

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it prescribed by a **physician** or given by trained medical personnel.

Diagnosis/diagnosed

A **physician**, specializing in a particular field of medicine, where applicable, has definitively identified your **accidental injury** or **illness**. Such **diagnosis** must:

Be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by your medical records and

- Meet all diagnostic requirements stated in the **policy** for the particular **accidental injury** or **illness** being **diagnosed**.

Effective date of coverage

The date the employee and their eligible dependents coverage begins under this policy.

Emergency medical condition

A recent and severe medical condition, **illness**, or **accidental injury** that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **accidental injury** is of a severe nature. And that if immediate **care** is not received, it could result in:

Placing your health in serious danger

- Serious loss to bodily function
- Serious loss of function to a body part or organ

- Serious danger to the health of a fetus

Employee

A person listed as an **employee** on the books of the **policyholder**.

Experimental or investigational

A drug, device, procedure, or treatment that is **experimental or investigational** because:

There is not enough outcome data available from controlled clinical trials published in the peer- reviewed literature to validate its safety and effectiveness for the illness or accidental injury involved

- The needed approval by the U.S. Food and Drug Administration (FDA) has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes

It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services

- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide **care**, such as **physicians**, podiatrists, chiropractors, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable laws to provide home health care services such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** or other **health professional** to be provided in your home. The services are usually provided after you're discharged from a **hospital** or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** focused on comfort and quality of life, rather than cure.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital

An institution licensed as a **hospital** or birthing center by applicable laws and accredited as a **hospital** by The Joint Commission.

Hospital does not include a:

Convalescent facility

- Extended care facility
- Facility for the aged
- **Hospice facility**
- Intermediate care facility
- **Mental disorder treatment facility**
- Nursing facility
- **Psychiatric hospital**
- **Rehabilitation unit**
- Rest facility
- **Skilled nursing facility**
- **Substance abuse treatment facility**

Illness

Poor health resulting from disease of the body or mind. **Illness** includes pregnancy.

Intensive care unit (ICU)

Is an area of the **hospital** that:

Is for patients who:

- Are critically ill or injured, and
- Need intensive, comprehensive observation and **care**.

- Is separate from:
  - The surgical recovery room
  - Rooms, beds, and wards customarily used for patients not requiring intensive care.
- Is equipped with special lifesaving equipment for the **care** of the critically ill or injured.
- Is under close observation by specially trained staff assigned exclusively to the **ICU** on a 24-hour basis.
- Has a **physician** assigned to the **ICU** on a full-time basis.

An **intensive care unit** that meets the definition above may include **hospital** units with the following names:

- Burn unit
- Coronary care unit or CCU
- Intensive care nursery or ICN
- Intensive care unit or ICU
- Neonatal Intensive care unit or NICU
- Pulmonary care unit or PCU
- Transplant unit

Mental disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a psychiatrist, a psychologist or a psychiatric social worker. **Mental disorders** include disorders related to **substance abuse** or use.

Mental disorder treatment facility

A licensed institution that:

- Mainly provides a program to **diagnose**, evaluate, and treat **mental disorders**

Is not mainly a school or a custodial, recreational, or training institution

- Provides infirmary-level medical services
- Is staffed and supervised full-time by a psychiatrist who is responsible for patient care
- Has a psychiatrist present during the whole treatment day
- At all times:
    - Provides psychiatric social work and nursing services
    - Provides **skilled nursing services** by licensed nurses who are supervised by a full-time registered nurse (R.N.)

Provides, or arranges with a hospital in the area, for any other required care

- Maintains a written treatment plan, supervised by a psychiatrist, for each patient based on medical, psychological, and social needs
- Makes charges

Necessary Care that your treating **provider** recommends to you to prevent, evaluate, **diagnose**, or treat an **illness** or **accidental injury** or its symptoms

Observation unit

A specified area or room within a hospital where a patient can be monitored by a physician and which:

- Is under the direct supervision of a **physician** or registered nurse (R.N.).
- Is staffed by nurses assigned specifically to that unit.
- Provides **care** seven days per week, 24 hours per day.

Physician

A person who:

- Is a doctor of medicine or osteopathy,
- Is licensed or certified to provide **care** under the laws of the state where they practice, and
- Provides **care** within the scope of their license or policy. A **physician** also includes a **health professional**.

Plan Year

The period from January 1st through December 31st of the calendar year.

Policy

The **policy** consists of several documents taken together. These documents are:

- The **policyholder's** application
- The **policy**

The certificate

- Any amendments and riders to the **policy** or this certificate

These documents are the entire contract between Aetna and the **policyholder**.

Policyholder

The employer and entities associated with it for purpose of coverage under the policy. Premium
The amount you and/or the **policyholder** is required to pay to **Aetna** to continue coverage.

Prescriber

Any provider acting within the scope of their license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription

A written order for the dispensing of a **prescription drug** by a **prescriber**.

Prescription drug

An U.S. Food and Drug Administration approved drug or biological which can only be dispensed by prescription.

Provider

A **physician** or other **health professional**, **hospital**, **skilled nursing facility**, or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Rehabilitative Services

The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining if you are disabled by **illness** or **accidental injury**.

Rehabilitation unit

A free-standing facility or part of a **hospital** that provides **rehabilitative services**.

Room and board

A facility's charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospital**s, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include institutions that provide only:

- Ambulatory care
- **Custodial care**
- Minimal care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance abuse**.

Skilled nursing services

Services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) within the scope of his or her license.

Stay

A period during which you are confined as an inpatient in a:

- **Hospital**
- **Mental disorder treatment facility**
- **Rehabilitation unit**
- **Substance abuse treatment facility**

Stay excludes:

any period of such a confinement due to custodial care or personal needs that do not require medical skills or training

- a period of observation in an **observation unit** or in the emergency room unless this leads to a **stay**

newborn routine care

- any period of such a confinement in a:
    - **Hospice facility**
    - **Skilled nursing facility**

Substance abuse

A physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment, or an addiction to nicotine products, food, or caffeine.

Substance abuse treatment facility

A licensed institution that:

- Mainly provides a program to **diagnose**, evaluate, and treat **substance abuse**

Maintains a written treatment, supervised by a physician, for each patient based on medical, psychological, and social needs

- Provides, or arranges with a **hospital** in the area, for any other required **care**
- Provides, on the premises, at all times:
    - Detoxification services and an effective treatment program
    - Infirmary-level medical services
    - Supervision by a staff of **physicians**
    - **Skilled nursing services** by licensed nurses who are supervised by a full-time registered nurse (R.N.)

Makes charges

Surgical procedure or surgery

Cutting into the skin or other organ to:

- Implant mechanical or electronic devices
- Make a **diagnosis**

Redirect channels

- Remove an obstruction, diseased tissue, or diseased organ(s)
- Repair an area that has been injured or affected by trauma, overuse, or disease

- Repair an area to restore proper function
- Reposition structures to their normal position
- Take a biopsy of tissue
- Transplant tissue or whole organs

Under this policy, these procedures are not a **surgical procedure**:

Venipuncture (drawing blood)

- Lumbar puncture
- Epidural steroid injections
- Removal of skin tags
- Foreign body removal from the ear, eye, or other cavity unless cutting of the skin is required
- Episiotomy during routine vaginal delivery
- Endoscopy/colonoscopy without biopsy

Telemedicine

A telephone or internet-based consult with a **provider** through an authorized internet service vendor who conducts **telemedicine** consultations.

Terminal illness

A medical prognosis that you are not likely to live more than twelve (12) months.

Urgent Care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

An **illness** or **accidental injury** that requires prompt medical attention. An **urgent condition** is not an **emergency medical condition**.

Walk-in clinic

A free-standing health care facility that is not an emergency room or the outpatient department of a hospital.

Expatriate Benefits

How the Medical, Dental and Vision Plan Works

The Expat Benefits plan provides Continuous worldwide medical, dental care coverage to eligible employees virtually anywhere you may travel while residing overseas. While in the US, you have access to the nation's largest provider network – the Aetna U.S. Healthcare Preferred Provider Network with more than 400,000 participating physicians and hospitals.

Eligibility Provision			
Employee	Regular full-time employees of Sony participating in this plan, working a minimum of 20 hours per week.		
Dependent	Wife or husband; same or opposite sex domestic partner; children up to age 26, regardless of student status.		
PPO			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$0 per calendar year	$0 per calendar year	$150 per calendar year
Family Deductible	$0 per calendar year	$0 per calendar year	$450 per calendar year
Prior Plan Credit	Prior plan credit accrued within the last calendar year from previous carrier applies to the current ye		
Individual Coinsurance Limit	$0 per calendar year	$0 per calendar year	$1,000 per calendar year
(Does not include deductibles, copays, benefit penalties and 50% items)			
Family Coinsurance Limit	$0 per calendar year	$0 per calendar year	$3,000 per calendar year
(Does not include deductibles, copays, benefit penalties and 50% items)			
Lifetime Maximum	Unlimited		
Hospital Services			
Inpatient	No charge	No charge	20% after deductible
Outpatient	No charge	No charge	20% after deductible
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	$400
To avoid penalties and/or benefit reductions for non-preferred benefits received in the U.S., contact the service center to determine if precertification is needed for a procedure.			
Non-Emergency Use of the Emergency Room	No charge	20%	20% after deductible
Emergency Room	No charge	No charge	No charge
Urgent Care	No charge	No charge after $10 copay	20% after deductible
Physician Services			
Physician Office Visit	No charge	No charge after $10 copay	20% after deductible
Specialist Office Visit	No charge	No charge after $10 copay	20% after deductible
Telemedicine consultation by a Physician	No charge	No charge after $10 copay	20% after deductible
Telemedicine consultation by a Specialist	No charge	No charge after $10 copay	20% after deductible
Allergy Testing and Treatment	No charge	No charge after $10 copay	20% after deductible
Virtual Care and Virtual Primary Care	Not covered	No charge	Not covered
Allergy Serum and Allergy Injections	No charge	No charge	20% after deductible
Mental Health Services *			
Mental Health Inpatient Coverage	No charge	No charge	20% after deductible

Unlimited days per calendar year

Mental Health Outpatient Coverage (*Includes Telemedicine consultation)*	No charge	No charge	20% after deductible
Unlimited visits per calendar year			
Alcohol/Drug Abuse Services *			
Substance Abuse Inpatient Coverage	No charge	No charge	20% after deductible
Unlimited days per calendar year			
Substance Abuse Outpatient Coverage (*Includes Telemedicine consultation)*	No charge	No charge	20% after deductible
Unlimited visits per calendar year			

	PPO		
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Other Services			
Skilled Nursing Facility *(60 Days per calendar year)*	No charge	No charge	20% after deductible
Hospice Care Facility Inpatient *(Unlimited lifetime maximum)*	No charge	No charge	20% after deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	No charge	No charge	20% after deductible
Home Health Care *(120 visits per calendar year)*	No charge	No charge	20% after deductible
Private Duty Nursing *(70 shifts per calendar year)*	No charge	No charge	20% after deductible
Spinal Disorder Treatment *(Unlimited visits per calendar year)*	No charge	No charge after $10 copay	20% after deductible
Short-Term Rehabilitation	No charge	No charge after $10 copay	20% after deductible
(Includes coverage for Speech Therapy; 60 Visits per calendar year; and Occupation and Physical Therapy; unlimited visits per calendar year)			
Diagnostic Outpatient X-ray	No charge	No charge	20% after deductible
Diagnostic Outpatient Lab	No charge	No charge	20% after deductible
Base Fertility Services	No charge	No charge	20% after deductible
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			
Comprehensive Fertility Services	No charge	No charge	20% after deductible
(6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction)			
ART Fertility Services	No charge	No charge	20% after deductible
(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).			
Durable Medical Equipment	No Charge	No Charge	20% after deductible
Acupuncture *($ 1,500 calendar year maximum)*	No Charge	No Charge	20% after deductible
Repatriation of Mortal Remains *($ 20,000 maximum)*	No Charge	No Charge	No Charge
International Employee Assistance Program (IEAP)	Included	Included	Included
Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.			

	PPO	
		In the U.S.

PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Wellness Benefits			
Routine Children Physical Exams	No charge	No charge	20% after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22 (includes immunizations)			
Routine Adult Physical Exams	No charge up to $1,000 calendar year maximum (Includes immunizations, x-rays and labs)	No charge	20% after deductible
Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	No charge	No charge	20% after deductible
Includes 1 exam and pap smear per calendar year			
Mammograms *(Unlimited visits per calendar year)*	No charge	No charge	20% after deductible
Prostate Specific Antigen (PSA)	No charge	No charge	20% after deductible
(Unlimited visits per calendar year)			
Digital Rectal Exam (DRE)	No charge	No charge	20% after deductible
(Unlimited visits per calendar year)			
Cancer Screening	No charge	No charge	20% after deductible
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 10 years			
Hearing Aids	No charge	No charge	20% after deductible
1 hearing aid per ear to $1,000 maximum per ear every 3 years for covered persons through age 25			

PPO			
		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Vision Care			
Routine Eye Exam	No charge	No charge	20% after deductible
(Covered under medical) Includes one routine exam per calendar year			
Vision Supplies (not subject to deductible or copay, per calendar year)			
Frames	100% up to $200 maximum		
Single Lenses (Includes Computer Glasses)	100% up to $200 maximum		
Bifocal Lenses (Includes Computer Glasses)	100% up to $200 maximum		
Trifocal Lenses (Includes Computer Glasses)	100% up to $200 maximum		
Lenticular Lenses (Includes Computer Glasses)	100% up to $200 maximum		
Contact Lenses (In lieu of Eyeglasses)	100% up to $200 maximum		
Prescription Drug Coverage			
Generic Drugs *(365-day maximum supply)*	No charge	$10 copay per month supply (includes Mail Order Drugs)	20% after deductible
Brand Name Drugs *(365-day maximum supply)*	No charge	$20 copay per month supply (includes Mail Order Drugs)	20% after deductible

PPO Dental			
		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)

Individual deductible	$50 per calendar year	$50 per calendar year	$50 per calendar year
Family deductible	$150 per calendar year	$150 per calendar year	$150 per calendar year
Type A Expense *(Diagnostic & Preventive)*	No Charge	No Charge	No Charge
Type B Expense *(Basic Restorative)*	20% after deductible	20% after deductible	20% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum (Includes Orthodontic and Type B and Type C Expenses)	$3,000	$3,000	$3,000
Orthodontic Treatment Dependent adults and children	50%	50%	50%
Please refer to the Dental Plan Caveats below for additional benefit coverages for Types A, B and C			

Services and Programs included in Quote

Informed Health Line (24-hour nurse line)
International Disease Management
International Maternity Management Program
Simple Steps To A Healthier Life®
Wellness Checkpoint
On-Line Global Health and Travel Information through HTH Worldwide (http//www.aetnainternational.com)
red24*- Includes security, political & natural disaster coverage *(Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd.)*

Medical Plan Caveats

**This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018.*

This plan includes coverage for women's preventive health benefits to the extent required under U.S. federal law effective beginning with plan years starting on or after August 1, 2012.

Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. Deductibles, copays, benefit penalties and 50% items are excluded from the payment limit.

There is cross-application between calendar year deductible, out of pocket maximum and lifetime maximum across overseas, in-network and out of network level of benefits.

Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).

Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and all female family members Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.

For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.

Benefit maximums per Calendar year are calculated between 01/01/2024 and 12/31/2024.

Other Aetna Programs
When you enroll in the Aetna Medical, Dental and Vision Expat Benefits you and your covered dependents have access to several resources administered by Aetna. These programs are designed to provide you with personalized information, additional support and help coordinating your care. Participation is voluntary and completely confidential.

How the Life and Accidental Death and Dismemberment (AD&D) Plan Works
The life and accident insurance plans offer you and your family the opportunity to have financial protection when you may need it most. The life insurance plans are administered by Zurich.

Life Insurance provides your beneficiary with a benefit in the event of your death
AD&D Insurance provides an additional benefit if you die or suffer a serious injury as result of an accident (e.g., lose a limb, become paralyzed, lose your hearing, speech or sight)

Company-Provided Life and AD&D Insurance
SPE provides the following Life and AD&D Insurance at no cost to you. Life and AD&D Insurance coverage is equal to one times your base salary to a maximum of $1,000,000. Guarantee Issue Amount is $500,000, any amounts in excess requires Evidence of Insurability.

Supplemental Life and AD&D Insurance
You can choose to purchase Supplemental Life and AD&D Insurance from 1, 2, 3 or 4 times your annual base salary up to $1,000,000 (combined basic and supplemental coverage). All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

Evidence of Insurability
You must submit an Evidence of Insurability (EOI) form and receive insurance company approval under the following circumstances:
You enroll for coverage for the first time and your basic coverage exceeds the Guarantee Issue Amount;

- You re-enroll for coverage after your coverage ends for any reason;
- You enroll for an increase in your coverage above the Guarantee Issue Amount.

Contact your employer if you have questions about EOI.

Accelerated Death Benefit Option
The Accelerated Death Benefit option allows you to receive a one-time partial life insurance benefit if, while covered under the Plan, you are diagnosed with a Terminal Illness and not expected to survive more than 12 months. The Accelerated Death Benefit is subject to the terms and conditions of the Policy.

This benefit option does not apply to any Terminal Illness resulting from an intentionally self-inflicted injury or suicide attempt.

You may request and receive an Accelerated Death Benefit under this Plan only once on your own behalf.

The amount of the Accelerated Death Benefit available is a percentage of the amount of employee term life insurance that you elected under the Plan. You may request up to 50% of the term life insurance that is currently in effect for you or the person for whom you are making the request on the date we receive proof that you are terminally ill. But the amount you request may not be:
Less than $5,000; or

- More than $150,000.

Accidental Death and Dismemberment (AD&D) Benefits

How the Plan Works
The Accidental Death and Dismemberment benefit covers losses you suffer solely and as a direct result of an Accidental Bodily Injury that occurs while coverage is in effect. The Accidental Death and Dismemberment benefits are payable in addition to any other coverage you may have from Your Employer.

Covered Loss Schedule

Loss	Percentage of the AD&D Coverage Amount Paid
Life	100%*
Both hands or both feet	100%
Sight in both eyes	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Speech and hearing	100%
Quadriplegia	100%
Triplegia	75%
Paraplegia	75%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing	50%
Hemiplegia	50%
Thumb and index finger from one hand	25%
Uniplegia	25%

When Coverage Ends

- Your coverage under this Plan ends on the earliest of:
- the date the Policy or a Plan is cancelled;
- You voluntarily stop Your coverage;
- the date You are no longer in an Eligible Class;
- the date You are no longer eligible for coverage;
- the date Your Eligible Class is no longer covered;
- the last day of the period for which You made any required contributions;
- the last day You are in Active Employment;
- Your return to the U.S.A. or your country of residence for more than 180 days;
- Your employment stops for any reason, including job elimination, or being placed on severance. This will be either the date you stop Active Employment, or the day before the first premium due date that occurs after you stop active employment;

- the date on which You are age 70;
- the date on which You retire;
- the date of Your death; or
- the date on which You begin active duty in the armed forces of any country.

Conversion Benefit
A Life Conversion option may be available without a medical exam if you apply for it within 31 days of your loss of coverage under this Plan.

Long-Term Disability (LTD) Plan

How the Plan Works
Long Term Disability Plan provides financial protection for you by paying a portion of your income if you become disabled due to an Illness or Injury while covered under this Plan. The amount you receive is based on the amount you earned before your disability began.

Cost of Coverage
SPE provides basic LTD coverage at no cost to you.

Premium Waiver
If you become disabled, no premium payments are required for your coverage while you are receiving benefits under this Plan, provided the premium was paid during the Elimination Period.

Monthly Benefit
Monthly Benefit Percentage: 60% of covered monthly earnings to a maximum benefit up to $12,500 per month.

Your benefit may be reduced by Deductible Sources of Income and Disability Earnings. Some disabilities may not be covered or may have limited coverage under this Plan.

Minimum monthly benefit is $100 per month. Maximum benefit period is to age 65.

Definition a Long Term Disability
During the Elimination Period, you are disabled when Zurich determines that:
- you are unable to perform limited from performing the material and substantial duties of your regular occupation due solely to your sickness or injury; and
- you are under the regular care of a physician; and
- you are not working at any job for compensation or profit;

After the Elimination Period, you are disabled when they determine that:
you are unable to perform the material and substantial duties of your regular occupation due solely to your sickness or injury; and
- you are under the regular care of a physician; and
- you have a 20% or more loss in your indexed monthly earnings due to that sickness or injury.

After 24 months benefits have been payable, you are disabled when Zurich determines that due to the same sickness or injury:
you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and

- you are under the regular care of a physician; and
- you have a 40% or more loss in your indexed monthly earnings due to the same sickness or injury.

Zurich will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from your physicians and physicians and medical practitioners or vocational experts of our choice.

Zurich may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. They will pay for this examination and can require an examination as often as it is reasonable to do so. They may also require you to be interviewed by our authorized representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Eligibility for Benefits
You must be continuously disabled through your elimination period. The days that you are not disabled will not count toward your elimination period. Zurich will treat your disability as continuous if your disability stops for fifteen (15) days or less during the elimination period. No benefit is payable for or during the elimination period.

Your Elimination Period is one hundred eighty (180) days.

When Does Your Coverage End?
Your coverage under this Plan ends on the earliest of:
- the date the Policy, the Master Policy or a Plan is cancelled;
- the date on which your employer ceases to be a Participating Employer;
- You voluntarily stop Your coverage;
- the date you are no longer in an Eligible Class;
- the date you are no longer eligible for coverage;
- the date your Eligible Class is no longer covered;
- the last day of the period for which you made any required contributions;
- the last day you are in Active Employment except as provided under the covered Layoff
- or Leave of Absence provision;
- You return to the U.S.A or your Country of Residence for more than one hundred eighty (180) days;
- Your employment stops for any reason, including job elimination, or being placed on severance. This will be either the date you stop Active Employment, or the day before the first premium due date that occurs after You stop Active Employment;
- The date on which you are age sixty-five (65);
- the date on which you retire;
- the date on which you voluntarily or involuntarily lose your professional license; or
- the date on which you begin active duty in the armed forces of any country.

SEVERANCE PAY & BENEFITS

Employees classified by SPE as Regular, full-time, at-will, non-union employees with at least twelve (12) months of continuous service, who are not eligible for another severance pay plan, including without limitation a Sony Pictures Imageworks severance pay plan, and who meet the eligibility and other requirements of the SPE Severance Benefits Policy ("Severance Policy") are eligible to receive severance pay and benefits under the terms and conditions of the Severance Policy in the event of a termination without cause, lay-off or job elimination.

In the event of a termination without cause, lay-off or job elimination, are not eligible for severance pay or benefits under this Severance Policy, including by way of example, terminations for any of the following reasons:

- performance of duties in a manner deemed by the Company to be in any way unsatisfactory;
- theft, fraud or illegal conduct;
- sexual or other unlawful harassment or discrimination;
- violation of any Company policy;
- willful misconduct or gross negligence in connection with employment;
- refusal or unwillingness to perform duties;
- termination for exhaustion of or failure to return from a leave of absence;
- employee's voluntary resignation or retirement;
- employee's decision to decline an offer of, or transfer to, comparable employment within the Company or with any subsidiary or affiliate;
- employee's termination from the Company as a result of the sale or other disposition of all or part of the Company, where the employee is offered comparable employment by the purchaser or new owner; or
- any other termination of employment that does not constitute a layoff or job elimination, as determined in the sole and absolute discretion of SPE.

To be eligible for receipt of severance pay and benefits, an eligible employee who has been notified of their layoff or job elimination must work satisfactorily up to the scheduled termination date as set by Company management.

SEVERANCE PAY

In the event of a layoff or job elimination, an eligible employee is eligible to receive a "severance payment" in an amount equal to the number of weeks of the employee's base earnings as set forth in the schedule below:

Organization Level	Number of Weeks of Base Earning per Year of Service	Minimum Number of Weeks of Base Earnings	Maximum Number of Weeks of Base Earnings
1-3	2 weeks	4 weeks	52 weeks
4		8 weeks	
5		16 weeks	
6-7		20 weeks	
8-10		26 weeks	

An employee's Organization Level is determined at the sole discretion of SPE.

Severance Payments are paid in a lump sum, less applicable deductions, and withholdings.

For purposes of the Severance Policy, "continuous service" means the employee's most recent period of employment with SPE. "Adjusted service date" is not used for purposes of calculating Years of Service under the Severance Policy. Any portion of an employee's first year of service will be considered one year for the purpose of calculating the amount of severance pay. Beyond an employee's first year of service, completion of six (6) or more months of service in the employee's last employment year will be considered a full year for the purpose of calculation the amount of severance pay.

In addition to the above severance payment, eligible employees who timely elect to continue their (and, if applicable, their eligible family members') coverage in one or more of SPE's medical (including prescription drug), vision, and/or dental plans, in which the employee or any eligible family members are enrolled on the Employee's date of termination, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), the Company will subsidize the cost of COBRA coverage (the "COBRA Benefit") for such plans for the equivalent number of weeks as the employee's severance entitlement set forth above (the "COBRA" Benefit Period). During the COBRA Benefit Period, the employee's cost for COBRA coverage will be the same as it would be if the employee had remained an active employee electing the same coverage (as such costs may be adjusted from time to time), and the Company will pay the remaining portion of the employee's COBRA cost, commencing on the first day of the full month following the employee's termination date. If the COBRA Benefit Period ends in the middle of the month, the COBRA Benefit will be extended to the end of the month in which the COBRA Benefit Period Ends.

The COBRA Benefit does not apply to any deductibles, copayments, co-insurance or other out of pocket costs. In no event will the Company pay the COBRA Benefit directly to an eligible employee.

The COBRA Benefit will terminate automatically with respect to each covered individual upon the earliest of (i) the expiration of the COBRA Benefit period (as described above), (ii) the date on which the covered individual becomes covered under another group health plan, including a spouse's or domestic partner's employer's health plan (employees shall promptly notify SPE in the event any covered individual obtains such coverage) or (iii) loss of eligibility for COBRA coverage. Once the COBRA Benefit terminates, each covered individual may continue COBRA coverage for the remainder of the COBRA continuation coverage period provided that he/she remains eligible for such coverage and timely remits all required premiums associated with such coverage.

* Note that the COBRA Benefit also applies to your eligible same-sex spouse or domestic partner and his/her children who are not otherwise eligible for COBRA continuation coverage. Although same-sex spouses/domestic partners and their children (who are not also your natural-born or adopted children) are not generally eligible for COBRA continuation coverage, SPE offers continuation coverage for such individuals on a voluntary basis.

Receipt of severance pay and COBRA Benefit is expressly conditioned on the employee timely signing an Acknowledgement and Release Form ("Release") which waives all legal claims that the employee may have against SPE and its parents, subsidiaries, affiliates, successors, assigns, and employee benefits plans, and its and their directors, officers, trustees, administrators, agents and employees, including but not limited to claims arising from the employee's employment or termination. The Release must be signed by the employee within forty-five (45) days of the employee's termination date and returned to SPE and not revoked during the applicable revocation period, if any, for the employee to be eligible for severance pay and COBRA

Benefit. The Severance Payment will be paid within thirty (30) calendar days after the effective date of the Release.

Interpretation of the applicability of this Policy or any term of provision of the Policy shall be made by the EVP & Chief People Officer (or their designee) in their sole discretion.

SPE reserves the right to change or terminate the Severance Policy at any time. The Severance Policy as set forth herein shall be effective as of April 1, 2021 and shall not apply to any termination, layoff or job elimination occurring prior to such date. For the avoidance of doubt, neither the Severance Policy as set forth herein, or any prior version of this Severance Policy shall apply with respect to any termination, layoff or job elimination occurring prior to April 1, 2017.

Important Plan Information

Plan Identification
When dealing with or referring to the plan in benefit appeals or other correspondence, you'll receive help more quickly if you identify the plan fully and accurately. To identify the plan, use the official plan name, employer identification number (EIN), and the plan number (PN).

The name of the plan is the Sony Pictures Entertainment Inc. Health & Welfare Benefits Plan. The EIN is 13-3265777 and Plan Number is 501.

Please note that neither the Dependent Care Flexible Spending Account ("DCFSA") nor the Health Savings Account ("HSA") are covered under the Sony Pictures Entertainment Inc. Health & Welfare Benefits Plan as they are not considered to be health benefit plans under ERISA. Instead, they are tax-favored accounts that are operated pursuant to certain sections of the Internal Revenue Code. Accordingly, the information below does not apply to the DCSA or HSA. If you have questions about either of those benefits, you should contact SPE Benefits Center at 1-833-976-6901.

Plan Year
Records for each plan are maintained on a calendar-year basis, starting each January 1 and ending each December 31.

Service of Legal Process
Legal process on the plans may be served on the Plan Administrator.

Benefit Plans Sponsor and Administrator
SPE sponsors the SPE Benefits Plans. The plans are administered by the Plan Administrator.

Plan Sponsor:
Sony Pictures Entertainment Inc.
10202 W. Washington Blvd
Culver City, CA 90232

Other companies within the Sony organization may also participate. To find out whether your employer participates in the plans, refer to "Eligibility for Coverage."

You may direct any questions about your rights under the plans to the Plan Administrator at any time by writing to this address:

Sony Pictures Entertainment Inc.
c/o Plan Administrator for the
Sony Pictures Entertainment Health & Welfare Benefits Plan
10202 W. Washington Blvd.
Culver City, CA 90232

Without limiting any other plan provisions for the discontinuance of coverage, your coverage under a plan (or a portion of a plan) shall terminate when SPE terminates such plan (or portion thereof), when your company ceases to be a participating employer in the plan(s), or when you're no longer

eligible to receive benefits under such plan, whichever comes first. Neither you, your beneficiaries, nor any other person have or will have a vested or non-forfeitable right to receive benefits under a plan. Any amendment or termination could apply to only active employees, retired employees, or both. If such an amendment or termination occurs, you will be notified. Any such change may affect the benefits payable to you or your family.

In general, the Plan Administrator is the sole judge of the application and interpretation of the plans, and has the discretionary authority to construe the provisions of the plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits and benefit payments. However, the Plan Administrator has the authority to delegate certain power and duties to a third party, such as the Claims Administrator. SPE has delegated certain administrative functions under some plans to the insurance companies and other third-party providers. As the Plan Administrator's delegate, these parties have the authority to make certain decisions under the plans relating to benefit claims.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the plans (including, but not limited to, eligibility for benefits, plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law unless they are determined to be arbitrary and capricious.

Note: This summary is supplied solely for the purpose of helping you to understand the plans, not to replace, amend, or add to the plans. To the extent that any of the information is inconsistent with any official plan documents, the provisions set forth in the official plan documents will govern in all cases. Please note, for some plans, this summary plan description is considered to be the plan's official plan document.

Self-Insured and Insured Plans

Self-Insured Plans

The Medical, Prescription Drug, and Dental Plan with the exception of certain Health Maintenance Organizations (HMOs), see below, Vision Care Plan, and the Wellness Plan are all self-insured plans. Benefits are funded from the general assets of Sony and from employee contributions.

All benefits provided under these plans are fully guaranteed by SPE, which has full responsibility and liability for the payment of benefits by these plans. You can contact the Plan Administrator if you have questions. Where there is a contract administrator indicated in the Plan Identification chart, the administrator is solely a provider of administrative services under the relevant plan. Administrative services include the payment of benefits, maintenance of provider networks, and processing of claims.

Insured Plans

The Business Travel Accident Plan, Employee Assistance Plan, the Basic, Supplemental and Dependent Life Insurance Plans, the Accidental Death and Dismemberment Insurance Plan, the Legal Plan, the Voluntary Group Accident Insurance, the Voluntary Hospital Indemnity Insurance, the Long Term Disability Plan, and the Kaiser Permanente HMO are all insured plans.

These plans are fully insured by the insurance companies listed as Claims Administrators. All benefits are provided through insurance policies and are fully guaranteed by the applicable insurance company, which has full financial responsibility and liability for the payment of benefits by these plans. The premiums for these insurance policies are funded by employer and employee contributions.

These insurance companies also provide certain administrative services to the plans such as processing and paying your claims for benefits. You may contact these insurance companies if you have questions.

Situations Affecting Your Benefits

Here are a few situations that may affect your benefits from the plans:

- No benefits are paid for services or supplies received before coverage begins or after coverage ends.
- You, your provider, or your beneficiary may need to file a claim before benefits are paid.
- If you, your provider, or your beneficiary file a claim for benefits but do not complete all of the necessary information, benefits could be delayed.
- Benefits may be delayed if you don't keep your most current address on file and the company can't locate you.
- If you fail to designate a beneficiary to receive a life insurance benefit payment, payment will be made according to plan provisions.

Please also refer to each benefit plan section within this SPD for additional rules and exclusions that may apply to your benefits.

Changes to the Health and Insurance Plans

While the company expects to continue the SPE Benefits Plan indefinitely, it reserves the right to amend, modify, or terminate the plans at any time in its sole discretion, by action of the Plan Administrator. The company also reserves the right to change the amount of required employee contributions for coverages under the plans.

Important: An amendment or termination of the plan(s) may affect not only the coverage of active employees (and their covered dependents) but also of COBRA participants and former employees who retired.

Health and Insurance Claims Administrators and Insurance Companies

The following are the Claims Administrators and insurance companies for the health and insurance plans. For your Medical Plan, the Claims Administrator depends on the plan in which you enroll. (The information is also on your plan ID card.) The Claims Administrator for **Fertility benefits** is Aetna Life Insurance Company.

Each Claims Administrator has full discretion and authority to make claim and appeal determinations. The Claims Administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, the Claims Administrator has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the plan option with respect to benefits. The Claims Administrator's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

All categories of medical claims are administered by the Claims Administrator listed below. See "Health and Insurance Plan Claims Review Procedures" on page 303 for details.

Medical Plans

Aetna Life Insurance Company
PO Box 981106
El Paso, TX 79998-1106
www.aetna.com
1-888-385-1053

For prescription drug program, see below.

Kaiser Permanente Southern California HMO
Kaiser Permanente Foundation Health Plan, Inc.
P.O. Box 7004
Downey, CA 90242-7004
www.kp.org
1-800-464-4000

Kaiser Permanente Northern California HMO
Kaiser Permanente Foundation Health Plan, Inc.
P.O. Box 12923
Oakland, CA 94604-2923
www.kp.org
1-800-390-3510

Prescription Drug Program

For all Medical Plan coverage except HMOs (HMO members should contact their HMO Claims Administrator for drug claims):

Express Scripts
P.O. Box 14711
Lexington, KY 40512

www.express-scripts.com
1-800-716-2773

Dental Plans
Delta Dental of New York Dental Plan
Delta Dental claims
P.O. Box 2105
Mechanicsburg, PA 17055-6999
www.deltadentalins.com/sony
1-800-471-7059

Vision Care Plan
Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105
www.vsp.com
1-800-877-7195

Employee Assistance Program
Spring Health
245 Fifth Avenue, Floor 21
New York, NY 10016
https://benefits.springhealth.com/sonypictures
1-240-558-5796

Employee Life and AD&D Insurance Plans
Securian Life Insurance Company
400 Robert Street North
St. Paul, MN, 55101-2098

Business Travel Accident
New York Life Travel Accident (Life Insurance Company of North America)
1600 West Carson Street, Suite 300
Pittsburgh, PA 15219
1-800-238-2165

Long Term Disability Plan
RelianceMatrix Life Insurance Company
1700 Market Street Suite 1200 Philadelphia, PA 19103
1-800-351-7500

Flexible Spending Accounts (including Health Savings Accounts)*
Inspira Financial
PO Box 400
Richmond, KY 40476
www.inspirafinancial.com1-888-238-3539
* Note: Inspira Financial also administers the Dependent Care Flexible Spending Account and Health Savings Account; however, these options are not ERISA plans and is not subject to the Claims and Appeals procedure or the ERISA rights described below. If you have questions about the Dependent Care Flexible Spending Account and/or the Health Savings Account, please contact

Inspira Financial directly.

Legal Plan

MetLife Legal Plans,
Inc. 1111 Superior
Avenue
Cleveland, OH 441141-
800-821-6400
www.members.legalplans.com

Voluntary Group Accident Insurance

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
http://myaetnasupplemental.com
855-703-5585

Voluntary Hospital Indemnity Insurance

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
http://myaetnasupplemental.com
855-703-5585

Expat Life, AD&D and Disability

Zurich American Life Insurance Company
1400 American Lane
Schaumburg, Illinois 60196
Policy 2010-1TR

Severance Pay Plan

Sony Pictures Entertainment
Attn: People & Organization
10202 W. Washington Blvd
Culver City, CA 90232
1-310-244-4748

Health and Insurance Plans Claims Review Procedures

Categories of Claims

Under health and insurance plans, there are three categories of claims:

- Health plan claims including medical, prescription drug, Employee Assistance plan (EAP), and Health Care Spending Account, which are subdivided into four categories:
  - Urgent care decisions—An urgent care claim decision is one where failing to make a determination quickly could seriously jeopardize your (or your covered dependents) life, health, or ability to regain maximum function, or in the opinion of your physician, could subject you to severe pain that could not be managed without the requested treatment. Any claim that a physician (with knowledge of your condition) considers an urgent care claim is an urgent care claim under these rules.
  - Concurrent care decisions—A concurrent care decision is any reduction or termination of your course of treatment before a previously approved time period expires or number of treatments is completed. This is a claim that is made during the time you are receiving treatment. You must be notified of any decision to reduce or terminate your course of treatment before the previously approved time period expires or treatments are completed. Time frames for adjudication of concurrent care decisions and appeals follow the time frames for the type of claim (i.e., urgent, pre-service, or post-service).
  - Pre-service claims—A pre-service claim is a claim that is filed prior to obtaining care or treatment.
  - Post-service claims—A post service claim is a claim that is filed after obtaining treatment. (**Note:** A post-service claim is never an urgent care claim.)
- Disability claims.
- All other claims, including Vision plan, Dental plan, Employee Life and Accidental Death and Dismemberment (AD&D) Insurance, Long Term Care plan, and Dependent Care Spending Account.

To make a claim under a plan, you must follow certain procedures. Failure to follow these procedures may substantially delay or otherwise impact your claim. There may be timing considerations as well, for example, you may be required to submit your claim to the appropriate claims administrator within one year after it is incurred. Contact the appropriate claims administrator for additional details.

Health and Disability Plans Claims Review

Step 1: File Initial Claim

You need to file your initial claim with the appropriate claims administrator for your plan. (**Exception:** If you use network providers for a health care claim, your participating provider will generally file your claim for you.) Review this section for more information and contact the appropriate claims administrator with questions:

- Medical plan claims;
- Prescription drug program claims;
- Long-term disability plan claims;
- Employee assistance plan claims; and
- Health care spending account claims.

Note:

See the chart below entitled "Claims Review Periods" for information on the claim filing and response deadlines applicable to all claims filed under the plans.

If you do not receive a response to your initial claim within the required time frames, you should immediately notify the claims administrator responsible for handling your claim.

If a claim for benefits is denied or reduced, in whole or in part, you or your beneficiary will receive a written notice (notice may be provided verbally for an urgent care claim) of the adverse benefit determination.

Any reference to "you" in this Health and Insurance plans claims review procedures section includes you, and your authorized representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health professional with knowledge of your condition may always act as your authorized representative.

The Claims Administrator for **Fertility benefits** is Aetna Life Insurance Company.

Claims Review Periods

	Urgent Health Claims	Pre-Service Health Claims	Post-Service Health Claims	Disability
Who handles the claim?	The health plan claims administrator	The health plan claims administrator	The health plan claims administrator	The long term disability (LTD) plan claims administrator
Initial Claim decision Process				
After you file a claim under the plan:				
If applicable, the plan must provide you with a Notice of Improper or Incomplete Pre-Service Claim within:	72 hours after receiving your improper or incomplete claim notice	N/A	N/A	N/A
After you receive a Notice of Improper or Incomplete Claim, you **must** complete or correct your urgent claim within:	48 hours after receiving notice	N/A	N/A	N/A
For a non-urgent claim, if the plan needs more information to decide your claim, it must make this within:	N/A	30 days after receiving your initial claim	30 days after receiving your initial claim	N/A
For a non-urgent claim, you must provide additional information to the plan, if requested, within:	N/A	45 days after receiving a request for additional information from the plan	45 days after receiving a request for additional information from	N/A

			the plan	
The plan must provide you with a plan Notice of Initial Claim decision within:	48 hours (i) after receiving your completed or corrected claim or, (ii) after your 48-hour deadline (above) ends, whichever is earlier 72 hours after receiving your initial claim, if it was originally proper and complete	**Initial:** 15 days after receiving your initial claim (runs concurrently with the 15-day period above) **Extension:** The plan is allowed a 15-day extension (for a total of 30 days), provided the plan furnished you with an extension notice or a request for additional information during the initial 15-day period If you have received a request for additional information from the plan (see above), the 15-day extension period does not begin to run until you respond to the plan's request, or until the 45-day deadline was expired, whichever is earlier	**Initial:** 30 days after receiving your initial claim (runs concurrently with the 30-day period above) **Extension:** The plan is allowed a 15-day extension (for a total of 45 days), provided the plan furnished you with an extension notice or a request for additional information during the initial 30-day period If you have received a request for additional information from the plan (see above), the 15-day extension period does not begin to run until you	**Initial:** 45 days after receiving your initial claim **Extension:** The plan is allowed up to 2 30-day extensions (for a total of 105 days), provided the plan furnished you with an extension notice or a request for additional information during the initial 45-day period (or for purposes of a second 30-day extension, during the initial 30-day extension period)

			respond to the plan's request, or until the 45-day deadline was expired, whichever is earlier	

Manner and Content of Notification of Adverse Benefit Determination
The plan administrator must provide you with written (or electronic) notification of an adverse benefit determination (with the exception of verbal notification of urgent care claims). The notification must contain the following items:

The specific reason(s) for the adverse determination:

- Reference to the specific plan provisions on which the determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents relating to the claim.
- A description of the plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's rights to bring a civil action under Section 502 (a) of ERISA following an adverse benefit determination on review.
- If an internal rule or guideline was relied upon in making the adverse determination, either the specific rule or guideline or a statement that such a rule or guideline was relied upon in making such determination and that a copy of such rule or guideline will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request.
- In the case of an urgent care claim, a description of the expedited review process applicable to such claims (may be provided verbally).

Step 2: File an Appeal
You may appeal a denial or adverse determination on your claim for benefits under certain conditions.

Timing of Your Appeal
If you want to appeal an adverse benefit determination under any of the plans, you should notify the claims administrator, in writing, that you want a review of the determination. You must file an appeal of the claim within one hundred eighty (180) days after you receive notice of the adverse benefit determination.

Note: Failure to timely file an appeal within this time frame will result in a waiver of your rights to have your claim reconsidered on appeal. This applies to all types of claims.

See the chart below entitled "Appeal Review Periods" for information on the appeals deadlines applicable to all appeals filed under the plans.

Information to Include With Your Request for Appeal
In connection with your appeal, you should provide all relevant information that may be necessary to resolve your claim. You are encouraged to send written evidence rather than relying solely on verbal communication with the claims administrator. You are responsible for procuring information from your health care provider and ensuring that such information is properly communicated to the claims

administrator for appeals.

Where to Send Your Appeal
For urgent care appeals, you can make the appeal by telephone. The claims administrator for appeals for each of the plans and the telephone number can be found under Health and Insurance claims administrators.

Your Rights During Review of Your Appeal
You may call 1-866-941-4773 and speak with a SPE Benefits Center Service Center representative for copies of the relevant plan documents in preparing your appeal.

You may have anyone you choose represent you during the appeals procedure. However, you may be asked to submit written notice that you have designated a third party to act on your behalf. You may also be asked to sign an authorization allowing that third party to have access to your private health information in connection with your appeal resolution.

You have the right to submit in writing any comments, documents, records, and other information relating to the appeal, for consideration by the claims administrator during its review of your appeal.

You also have the right to find out the identity of the medical or vocational experts, if any, consulted as a part of the claims or appeals procedure.

Review of Your Appeal
The claims administrator has full discretion to grant or deny your appeal in full or in part upon its review. During its review of your appeal, the claims administrator will:

- Take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim or appeal without regard to whether such information was previously submitted or considered by the claims administrator in the initial decision regarding your claim.
- Review your appeal in a manner that does not afford deference to the initial decision to deny your claim.
- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, if the initial decision on your claim was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate.

Notice of Decision on Appeal
The claims administrator must notify you of its decision on the first level of appeal as follows:

- For urgent care claims, within seventy- two (72) hours after receiving your appeal.
- For pre-service health claims, within fifteen (15) days after receiving your appeal.
- For post-service health claims, within thirty (30) days after receiving your appeal.

The claims administrator will notify you of its decision about your appeal. If the claims administrator denies your appeal (in whole or in part), you will receive a written notice explaining the decision in detail.

This notice will include the content described above in connection with the initial claim determination, plus a statement regarding your right to seek a second level of appeal. See “Manner and Content of Notification of Adverse Benefit Determination on Appeal” below.

See the chart below entitled “Appeals Review Periods” for information on the appeals deadlines applicable to all appeals filed on or after under the plans.

Appeals Review Periods

Medical/Prescription Drug/EAP/Health Care Spending Account Claims				
	Urgent Health Claims	**Pre-Service Health Claims**	**Post-Service Health Claims**	**Disability Claims**
Who handles the claim?	The health plan claims administrator	The health plan claims administrator	The health plan claims administrator	The long term disability (LTD) plan claims administrator
First Level Appeal Process				
Who handles the claim?	Same as above for all plans	Same as above for all plans	Same as above for all plans	Same as above
If you wish to appeal the Initial Claim decision, you **must** do so within:	180 days after you receive a claim denial	180 days after you receive a claim denial	180 days after you receive a claim denial	180 days after you receive a claim denial
The plan must inform you of the Appeal decision within:	72 hours after receiving your appeal	15 days after receiving your appeal	30 days after receiving your appeal	45 days after receiving your appeal
Second Level Appeal Process				
Who handles the appeal?	Same as above for all plans except prescription drug program claim, handled by the plan administrator	Same as above for all plans except prescription drug program claim, handled by the plan administrator	Same as above for all plans except prescription drug program claim, handled by the plan administrator	Same as above for all plans except prescription drug program claim, handled by the plan administrator
If your first appeal is denied, and you want to take your claim to a second level of appeal you must do so within:		60 days after receiving your second appeal (prescription drug: 90 days after you receive a first level appeal denial)	60 days after receiving your second appeal (prescription drug: 90 days after you receive a first level appeal denial)	45 days after receiving your second appeal
The plan must inform you of the Second Appeal decision within:	N/A	15 days after receiving your second appeal	30 days after receiving your second appeal	

Manner and Content of Notification of Adverse Benefit Determination on Appeal
If you don't agree with the plan administrator's decision, you can appeal. Upon review of your appeal, the plan administrator must provide you with written (or electronic) notification of an adverse benefit determination (with the exception of verbal notification of urgent care claims). The notification must contain the following items:

The specific reason(s) for the adverse determination:

- Reference to the specific plan provisions on which the determination is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents relating to the claim.
- A statement of your right to seek a second level of appeal (See "File a Second Appeal" below).
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA Section 502(a).
- If an internal rule or guideline was relied upon in making the adverse determination, either the specific rule or guideline or a statement that such a rule or guideline was relied upon in making such determination and that a copy of such rule or guideline will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request.
- The following statement, "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Decision on Medical Care
The benefits provided under the health plans (medical, prescription drug, EAP, and Health Care Spending Account) provide solely for the payment of certain health care benefits. All decisions regarding health care, including decisions regarding whether to obtain health care, will be solely the responsibility of each covered individual in consultation with the health care providers selected by an individual.

The health plans only govern decisions as to the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense, may be disputed by the covered individual in accordance with the above claims procedure.

Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the plan nor the company shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the plan for the payment of benefits.

Step 3: File a Second Appeal
You may submit the denial of your appeal for a second level appeal to the same entity for appeals identified on page 301.

If you want the denial of your appeals reviewed, you must file for a second level of appeal within the time frame indicated in the chart on 211 after you receive denial of your first appeal. Failure to file an appeal within the time frame will result in a waiver of your rights to have your appeal reconsidered. This applies to all types of appeals under the plans. The process and timing of this second appeal is the same as the first appeal. See the sections entitled "Your Rights During Review of Your Appeal," "Review of Your Appeal," "Notice of Decision on Appeal," and "Appeals Review Periods" on page 301. If your second appeal is also denied, you will receive "Notice of Final Internal Benefit Determination". You will also be informed of your right to seek an external voluntary review of your appeal.

Step 4: Health Claims – external reviews

Request for External Review
The external review process under this plan gives you the opportunity to receive review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to applicable law. Your request will be eligible for external review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based upon your eligibility is not eligible for external review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the plan unless otherwise allowed by law.

Preliminary Review
Within five (5) business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless deemed exhaustion applies), and you have provided all paperwork necessary to complete the external review and you are eligible for external review.

Within one (1) business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for external review within the one hundred twenty-three (123) calendar

days filing period or within the forty-eight (48)-hour period following the receipt of the notification, whichever is later.

Referral to ERO
Aetna will assign an ERO accredited as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for external review and will provide an opportunity for you to submit in writing within ten (10) business days following the date of receipt additional information that the ERO must consider when conducting the external review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

(i) Your medical records;
(ii) The attending health care professional's recommendation;
(iii) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, you, or your treating provider;
(iv) The terms of your plan to ensure that the ERO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
(vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the external review decision within forty-five (45) days after the ERO receives the request for the external review. The ERO must deliver the notice of final external review decision to you, Aetna and the plan.

After a final external review decision, the ERO must maintain records of all claims and notices associated with the external review process for six (6) years. An ERO must make such records available for examination by the claimant, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review
The plan must allow you to request an expedited external review at the time you receive:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal;or
(b) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency care, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard external review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO
Upon a determination that a request is eligible for external review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the plan.

Important Note: In the event of your death, any claims payable to your estate may be paid to the administrator or executor of the estate. If claims are payable to a minor or individual who is incompetent to give a valid release, the plan may pay such benefit either to any relative or person whom Sony determines accepted competent responsibility for the care of such individual or as otherwise required by law. Any payment made by the plan in good faith pursuant to this provision fully discharges the plan and the company to the extent of such payment.

Claims for Benefits Under the Long-Term Disability (LTD) Plan

For the LTD plan:

- For information regarding the claims process, see the above chart entitled "Claims Review Periods" for the timing of the claims process.
- For information regarding the appeals process, see the above chart entitled "Appeals Review Process" for the timing of the appeals process.

You can file a claim for benefits and/or appeal a claim by contacting the LTD plan Claims Administrator.

Claims for Benefits Under All Other Health and Insurance Plans (Dental, Vision, Life and AD&D Insurance, and Dependent Care Spending Account)

You can file a claim or file an appeal of a claim with the plan's Claims Administrator.

If a claim for a benefit is denied or reduced, in whole or in part, you or your beneficiary will receive written notice of the denial. The notice will describe the specific reasons for the denial and the plan provisions on which they are based. The notice will also describe how claims are reviewed and explain the steps for an appeal. If completion of the claim requires additional information or documents from you, those will be noted.

If you do not receive an approval or a denial notice within ninety (90) days after your claim is reviewed, special circumstances may have required an extension of review, and you will receive an extension notice. The Claims Administrator is allowed an additional ninety (90)-day extension to review your claim.

If a claim is denied, you, your beneficiary, or your legal representative may ask for a full review of the decision by writing to the Plan Administrator. The request for this review must be made within sixty days of the date you receive the denial. You may review any documents related to the claim, and you may submit issues and comments in writing.

Generally, the final decisions on your claim will be made promptly, usually within sixty (60) days after your request for review is received. However, the final decision will be made and communicated to you no later than one-hundred-twenty (120) days after the request for review was received.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted your remedies under the Plan's internal claims review process; provided, however, that you do so within one year of exhausting your remedies (or as otherwise provided in any notice of adverse benefit determination sent to you by the applicable plan's Claims Administrator). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Medical Child Support Order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to

pay these costs and fees—for example, if it finds your claim is frivolous.

Your Legal Rights Under the Plans

Plans Subject to ERISA

As a participant in the Sony Pictures Entertainment Inc. Health & Welfare Benefits Plan, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as described below.

Non-ERISA Benefits

Any other benefits described in this SPD are included as a convenience only and aren't subject to ERISA. These other descriptions aren't considered part of the summary plan description (SPD), and none of the rights under ERISA described in this SPD apply to other non-ERISA benefits.

Receive Information About Your Plan and Benefits

As a plan participant, you're entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

As a plan participant, you're entitled to continue health care coverage for yourself, your spouse, or your dependents if there's a loss of coverage under a plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage rights.

If you have creditable coverage from another plan, any exclusionary periods of coverage for pre-existing conditions under your group health plan may be reduced or eliminated. You should be provided a Certificate of Group Health Coverage (creditable coverage), free of charge, from your group health plan or health insurance issuer:

- When you lose coverage under the plan;
- When you become entitled to elect COBRA continuation coverage;
- When your COBRA continuation coverage ends, if you request the certificate before losing coverage; and
- If you request the certificate up to twenty-four (24) months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after the enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your remedies under the Plan's internal claims review process; provided, however, that you do so within one year of exhausting your remedies (or as otherwise provided in any notice of adverse benefit determination sent to you by the applicable plan's Claims Administrator). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

U.S. Department of Labor
Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
200 Constitution Avenue N.W.
Washington, D.C. 20220

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Health Information Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group health plans protect the confidentiality of your private health information. The plans and the Company will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the plans' business associates are also required to also observe HIPAA's privacy rules. In particular, the plans will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Sony or any company.

You have certain rights under HIPAA with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the plans' Privacy Officer or with the Secretary of the U.S. Department of Health.

Also, the plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. The privacy notice was updated as of -January 1, 2021. You can view or print the revised notice from the Plan Information section on https://benefits.sonypictures.com Web site, or you can obtain a copy of the plan's privacy notice from the Plan Administrator. Among other information, the plan's privacy notice will tell you whom to contact if you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48)-hour (or ninety-six (96)-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, you may be required to obtain precertification for any days of confinement that exceed forty-eight (48) hours (or ninety-six (96) hours). For information on precertification, contact your plan administrator.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits coverage will be provided in a manner determined in consultation with the attending

physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- **Surgery** and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information on the deductibles and coinsurance that may apply please contact your health plan's member services department. To request a copy of this notice, call benefits at Sony at 1-833-654-7669 and ask to speak with a Benefits Service Center representative.

Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at

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www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, **2022. Contact your State for more information on eligibility –**

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus(CHP+**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

ARKANSAS Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa

Phone: 1-800-862-4840

INDIANA Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

MINNESOTA Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

IOWA Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

MISSOURI Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

KANSAS Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

MONTANA Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

LOUISIANA Medicaid

NEVADA Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE Medicaid	**NEW HAMPSHIRE Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY Medicaid and CHIP	**SOUTH DAKOTA Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

RHODE ISLAND Medicaid and CHIP	WISCONSIN Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone 800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
1-877-267-2323, Menu Option 4, Ext.61565
www.cms.hhs.gov

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)