2025 MEDICAL PLANS AT A GLANCE

This table is an overview of your medical plan options and the coverage available under each plan. For details, see the applicable Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) on **benefits.sonypictures.com**.

PLAN FEATURE	SONY CONSUMER CHOICE	SONY PPO	SONY EPO	KAISER HMO (CA ONLY)
Type of plan	PPO	PPO	EPO	HMO
Payroll contribution	Lowest	Highest	Moderate	Moderate
	IN-NETWORK	IN-NETWORK	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual deductible	$1,650 individual[1] $3,300 family[1]	$700 individual $1,400 family	$250 individual $500 family	None
Annual out-of-pocket maximum (includes deductibles, copays & prescriptions)	$4,000 individual $8,000 family[3]	$4,200 individual $8,200 family	$3,200 individual $6,400 family	$1,500 individual $3,000 family
	YOU PAY			
Preventive care	0% (free)	0% (free)	0% (free)	0% (free)
Office visits (primary care)	20% coinsurance[2]	$25 copay	$20 copay	$20 copay
Office visits (specialists)	20% coinsurance[2]	$40 copay	$35 copay	$35 copay
Teladoc	$56 copay[5]	$0 (free)	$0 (free)	N/A
Coverage for most services	20% coinsurance[2]	20% coinsurance[2]	10% coinsurance[2]	$20 copay
Emergency room	20% coinsurance[2]	20% coinsurance[2]	10% coinsurance[2]	$150 copay
Inpatient hospital	20% coinsurance[2]	20% coinsurance[2]	10% coinsurance[2]	$250 per admission
Outpatient testing	20% coinsurance[2]	20% coinsurance[2]	10% coinsurance[2]	$50 per procedure
Diagnostic X-ray and laboratory	20% coinsurance[2]	20% coinsurance[2]	10% coinsurance[2]	No charge
Inpatient mental health & substance misuse	20% coinsurance[2]	20% coinsurance[2]	10% coinsurance[2]	$250 per admission
Outpatient services copay/coinsurance	20% coinsurance[2]	$25 office visit copay	$20 office visit copay	$20 copay
Physical, occupational, and speech therapy[4]	20% coinsurance[2] up to 75 visits per year in- and out-of-network combined[4]	20% coinsurance[2] (other outpatient services); $40 copay for doctor visit; up to 75 visits per year in- and out-of-network combined[4]	10% coinsurance[2] (other outpatient services); $35 copay for doctor visit; up to 75 visits per year in- and out-of-network combined[4]	$20 copay
	OUT-OF-NETWORK			
Annual deductible	$3,300 individual[1] $6,600 family[1]	$1,400 individual $2,800 family	No coverage	No coverage
Your coinsurance after deductible	40%	40%	No coverage	No coverage
Annual out-of-pocket limit ***Note:*** *Any amount over maximum allowable charge is not included.*	$8,000 individual $16,000 family	$8,400 individual $16,400 family	No coverage	No coverage
Preventive care; you pay:	20% coinsurance	20% coinsurance	No coverage	No coverage

1 *All services, including prescriptions, are subject to the annual deductible except for certain preventive care services defined under the plan as being covered at 100%.* ***Note:*** *You may pay a copay for some medications on the preventive list. Out-of-network expenses in excess of "reasonable and customary" charges under the plan will not count toward the annual out-of-network deductible.*

2 *After deductible.*

3 *Family out-of-pocket maximum has an embedded per-member out-of-pocket maximum of $6,850 for in-network services.*

4 *Visit limit does not apply to habilitative treatment for autism and development delays, however exclusions may apply.*

5 *The cost for Sony Consumer Choice Plan Teladoc behavioral health service is $215 for the first consultation with a psychiatrist and $100 for all subsequent consultations with a psychiatrist. Consultations with a master's level therapist are $90 each. Dermatology consultations are $85 each. Once you meet the deductible, Teladoc services are free.*

Note: *If you meet the in-network deductible in an Aetna plan, it counts toward the out-of-network deductible, and vice versa. Example: If you're in the Sony PPO and meet the $700 in-network deductible, you've met half of the $1,400 out-of-network deductible.*