Sony Pictures Entertainment Inc.
Health and Welfare Benefits Plan
Summary Plan Description
January 2019

This summary plan description (SPD) provides a summary of your benefits updated as of January 1, 2019. 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 www.KENKOatSPE.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. 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.

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 27).

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 his or her 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 132.)

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 27).

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

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

- Supplemental Life Insurance
- Dependent Life Insurance; and
- Supplemental LTD coverage.

Payroll deductions 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 16.

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 Term Deal II or 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 Creative Services 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) a Term Deal II or 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"; (ii) a Creative Services Production Hire or working in the State of California or New York who has received the open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; 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 • A Creative Services 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 employee's employment with the Employer (except as otherwise specifically provided)

	(iv) a Term Deal II or 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"; (ii) a Creative Services Production Hire or working in the State of California or New York who has received the open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; or	• 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) a Term Deal II or 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	• 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.

	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) a Creative Services Production Hire or working in the State of California or New York who has received the open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; or (iv) 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; or	
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) a Term Deal II 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	• 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"; (ii) a Creative Services Production Hire or working in the State of California or New York who has received the open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; or	
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) a Term Deal II 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) a Creative Services Production Hire or working in the State of California or New York who has received the open enrollment materials for a given Plan Year or a personalized Certificate of Coverage and employment with a "B3 Employer"; or (iv) 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; 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) • 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 Term Deal II or SPA Term Deal • An intern • A trainee • A temporary employee • A consultant or independent contractor (or their employees) • A Production Hire • A Creative Services 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 (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 that you are eligible to participate in this Plan (iv) A Term Deal II or 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 Creative Services 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 in the United States.	• Eligible to participate in another health and welfare plan sponsored by the Employer • Employed pursuant to a Term Deal, or Term Deal II or SPA Term Deal • A Show Hire • An intern • A trainee • A temporary employee

		• A consultant or independent contractor (or their employees) • A Production Hire • A Creative Services 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.
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 Creative Services 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 Aetna/Payflex at 1-888-678-8242 or online at www.aetna.com or www.payflex.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, 2019 are:

Component Benefits	Participating Employers
PPO and HDHP with HSA (includes medical, prescription drugs); Vision, Dental PPO (Group Dental)	Adelaide Prod., Inc., Col. Pic. Industries, Inc, Col. TS Marketing Group., Columbia TriStar TV, Inc., CPE Holdings, Inc., CPE US Networks, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc. CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, FUNimation Prod., LLC, Global Mastering & Servicing, Screen Gems, Inc., SET Brazil, LLC, SET Distribution, LLC., Sony Pic. TV Intl Ad Sales, Sony Pic. Animation Inc., Sony Pic. Imageworks Inc., Sony Pic. Releasing Corp., Sony Pic TV de Mexico, Sony Pictures Classics, Sony Pictures Ent. Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services Inc., Sony Pictures Studios Inc., Sony Pictures Tech, Inc., Sony Pictures TV Inc., SP Releasing Int'l. Corp., SPE Corporate Services, SPT Networks Games Inc., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
HMO and EPO (includes medical, vision, prescription drugs); Vision, DMO	Adelaide Prod., Inc., Col. Pic. Industries, Inc, Col. TS Marketing Group., Columbia TriStar TV, Inc., CPE Holdings, Inc., CPE US Networks, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc. CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, FUNimation Prod., LLC, Global Mastering & Servicing, Screen Gems, Inc., SET Brazil, LLC, SET Distribution, LLC., Sony Pic. TV Intl Ad Sales, Sony Pic. Animation Inc., Sony Pic. Imageworks Inc., Sony Pic. Releasing Corp., Sony Pic TV de Mexico, Sony Pictures Classics, Sony Pictures Ent. Inc., Sony

	Pictures Home Ent., Sony Pictures Post Production Services Inc., Sony Pictures Studios Inc., Sony Pictures Tech, Inc., Sony Pictures TV Inc., SP Releasing Int'l. Corp., SPE Corporate Services, SPT Networks Games Inc., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition.
Flex Benefits (FSAs & premium pay; HSA)	Adelaide Prod., Inc., Col. Pic. Industries, Inc, Col. TS Marketing Group., CPE Holdings, Inc., CPE US Networks, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc. CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, FUNimation Prod., LLC, Global Mastering & Servicing, Screen Gems, Inc., SET Brazil, LLC, SET Distribution, LLC., Sony Pic. TV Intl Ad Sales, Sony Pic. Animation Inc., Sony Pic. Imageworks Inc., Sony Pic. Releasing Corp., Sony Pic TV de Mexico, Sony Pictures Classics, Sony Pictures Ent. Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services Inc., Sony Pictures Studios Inc., Sony Pictures Tech, Inc., Sony Pictures TV Inc., SP Releasing Int'l. Corp., SPE Corporate Services, SPT Networks Games Inc., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
Life Insurance, AD&D	Adelaide Prod., Inc., Col. Pic. Industries, Inc, Col. TS Marketing Group., Columbia TriStar TV, Inc., CPE Holdings, Inc., CPE US Networks, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc. CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, FUNimation Prod., LLC, Global Mastering & Servicing, Screen Gems, Inc., SET Brazil, LLC, SET Distribution, LLC., Sony Pic. TV Intl Ad Sales, Sony Pic. Animation Inc., Sony Pic. Imageworks Inc., Sony Pic. Releasing Corp., Sony Pic TV de Mexico, Sony Pictures Classics, Sony Pictures Ent. Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services Inc., Sony Pictures Studios Inc., Sony Pictures Tech, Inc., Sony Pictures TV Inc., SP Releasing Int'l. Corp., SPE Corporate Services, SPT Networks Games Inc., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
LTD	Adelaide Prod., Inc., Col. Pic. Industries, Inc, Col. TS Marketing Group., CPE Holdings, Inc., CPE US Networks, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc. CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, FUNimation Prod., LLC, Global Mastering & Servicing, Screen Gems, Inc., SET Brazil, LLC, SET Distribution, LLC., Sony Pic. TV Intl Ad Sales, Sony Pic. Animation Inc., Sony Pic. Imageworks Inc., Sony Pic. Releasing Corp., Sony Pic TV de Mexico, Sony Pictures Classics, Sony Pictures Ent. Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services Inc., Sony Pictures Studios Inc., Sony Pictures Tech, Inc., Sony Pictures TV Inc., SP Releasing Int'l. Corp., SPE Corporate Services, SPT Networks Games Inc., TriStar Pictures, Inc., TriStar Television, Inc., Worldwide SPE Acquisition
EAP	Same as medical plans
BTA	As determined by Employer in its discretion
Component Benefits	**Participating Employers**
Severance	Adelaide Prod., Inc., Col. Pic. Industries, Inc, Col. TS Marketing Group., Columbia TriStar TV, Inc., CPE Holdings, Inc., CPE US Networks, Inc., CPE US Networks II, Inc., CPE US Networks III, Inc. CPT Holdings, Inc., Crackle, Inc., Embassy Row, LLC, FUNimation Prod., LLC, Global Mastering & Servicing, Screen Gems, Inc., SET Brazil, LLC, SET Distribution, LLC., Sony Pic. TV Intl Ad Sales, Sony Pic. Animation Inc., Sony Pic. Imageworks Inc., Sony Pic. Releasing Corp., Sony Pic TV de Mexico, Sony Pictures Classics, Sony Pictures Ent. Inc., Sony Pictures Home Ent., Sony Pictures Post Production Services Inc., Sony Pictures Studios Inc., Sony Pictures Tech, Inc., Sony Pictures TV Inc., SP Releasing Int'l. Corp., SPE Corporate Services, SPT Networks Games Inc., 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.

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 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 after this date you will have thirty-one 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 www.KENKOatSPE.com Web site if you are eligible to participate in the Retiree Medical Plan.

Eligibility Rules for Survivors

If you die while employed by SPE, your surviving spouse 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 41.

Dependents You Can Cover

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

- Medical;
- Dental;
- Vision; and
- Dependent Life Insurance
- Accidental Death & Dismemberment Insurance

Your eligible dependents may include:

- Your spouse or domestic partner—see below for definitions (if you wish to enroll a domestic partner, see below for eligibility rules); and
- Your children and/or children of your domestic partner up to age 26 (see page 19).

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 21).

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 21). 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.

Domestic Partner Eligibility Rules

Definition of Eligible Domestic Partner

Health care (medical, dental, and vision) and dependent 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 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.

If your domestic partner is also an eligible company employee, special rules apply—see page 21.

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.

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.

Rules for Disabled Children
In general, a disabled child age 26 or older is eligible for coverage if he or she is 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 his or her 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 he or she actually

becomes covered under the other person's plans. See "If Your Child Loses Eligibility" in the chart on page 29.

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 Dependent Life Insurance when both you and your spouse/domestic partner 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.
- Either you or your spouse/domestic partner (not both) can purchase Dependent Life Insurance for your eligible children.

Flexible Spending Account Coverage

These rules apply to coverage under the Flexible Spending Accounts 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 his/her 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 if later, eligibility date to enroll for coverage. To facilitate efficient operation of the plan, the plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means. As long as you enroll by your deadline, the coverage you choose will automatically be retroactive to your date of hire.

During the year, you can only change your coverage if you have a qualified change in status (see page 27).

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 log on to Alex Does Health Care Reform at www.alexdoeshcr.com/SPE or 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 (link from www.KENKOatSPE.com **or logging into the website at https://benefitscenter.spe.sony.com**, or by calling 1-866-941-4773and 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

* *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 Aetna/Payflex at 1-888-678-8242 or online at www.aetna.com or www.payflex.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. If you wish to increase you will be required to provide Evidence of Insurability (EOI). You'll learn when you're making your coverage choices if restrictions or EOI requirements apply.

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 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 27 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 21).

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.

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 29.) They must also mirror any changes your spouse, domestic partner, or child makes to his or her 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
- Your 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.

- You or your family member's benefits eligibility changes because of a change in his or her eligibility or coverage under another employer's plans:
    - He or she gains or loses eligibility as a result of a change in work schedule or status.
    - He or she gains a benefit option or loses coverage.
    - His or her cost for coverage increases or decreases significantly.
    - He or she 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 or Medicaid.
- 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 coverage under his or her 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 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 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.

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.

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 38.

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
You Get Married			
Under the Medical Plan, you can change your 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 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
You Get Divorced			
Under the Medical Plan, you can change your 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 his or her 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 38) 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 Employee Life and AD&D Insurance You can enroll in, increase, decrease or drop 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 Dependent Care Spending Account
Your Spouse Dies			
Under the Medical Plan, you can change your option. In addition, under the Medical, Dental, and Vision Plans: If you lose coverage under your spouse's plan as result of his or her 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 his	You can enroll in, increase, decrease or drop coverage in any of these plans: Employee Life and AD&D Insurance 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

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
or her coverage; this may result in a change in coverage category			
You Have or Adopt a Child			
Under the Medical Plan, you can change your 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 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
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, 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	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 any Life and AD&D Insurance coverage or Dependent Life Insurance	You can't make any changes to your LTD Plan coverage ***If the Child Will Be Covered Due to a QMCSO*** You can't change your LTD Plan coverage	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*** You can start or increase your Health Care Spending Account contributions. However, you can't change your Dependent Care Spending Account contributions.
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 38) ***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	You can't change Employee Life and AD&D coverage. You can change Dependent Life coverage if the child losing coverage is the only dependent covered. ***If the Child's Coverage Will Be Dropped Due to a QMCSO*** You can't change Employee Life or	You can't increase or, decrease your LTD Plan coverage ***If the Child's Coverage Will Be Dropped Due to a QMCSO*** You can't change your LTD Plan coverage	You can stop or decrease your contributions to the: Health Care Spending Account 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

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
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	AD&D coverage. You can change Dependent Life coverage if the child losing coverage is the only dependent covered.		. However, you can't change your Dependent Care Spending Account contributions
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 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. Dependent Care Spending Account
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 Your current plan option is no longer available at your new location (if your current option remains available, you can't make a change until the next annual 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 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 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 a different zip code that affects access to participating **provider**s under your current coverage Your current plan option is no longer available at your new location (if your current option remains available, you can't make a change until the next annual enrollment)	You can't change your coverage in the following plans: Employee Life and AD&D Insurance 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

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
You cannot change the dependents you cover under the plans			
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 Dependent Life Insurance	You can enroll in LTD Plan coverage	You can start contributing to the: Health Care Spending Account Dependent Care Spending Account
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 38)	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

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
Your Family Member Gains Benefits Eligibility Due to a Work Situation Change			
He or She: Starts a job Has a change in work schedule (for example, from part-time to full-time employment) Is 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 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 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.

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
Your Family Member Loses Benefits Eligibility Due to a Work Situation Change			
He or She: Leaves a job Has a change in work schedule (for example, from full-time to part-time employment) Is 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 he or she lost coverage Add coverage for any affected children	You can enroll in, increase, decrease or drop 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.
Your Family Member Gains a Benefit Option			
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 Dependent Life Insurance	You can decrease 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
Your Family Member Loses Coverage Under Another Employer's 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			

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
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: Employee Life and AD&D Insurance Dependent Life Insurance	You can increase 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
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 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
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 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	You can't change coverage in any of these plans: Employee Life and AD&D Insurance Dependent Life Insurance	You can't change your LTD Plan coverage	You can't change Health Care Spending Account contributions 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 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 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

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
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 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 he or she 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 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 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 or Your Family Member Becomes Entitled to or Loses Medicare or Medicaid			
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 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 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
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	You can't change your coverage in any of these plans: Employee Life and AD&D Insurance 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

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
coverage (your spouse, domestic partner, or child) You can't change any other family member's medical, dental, or vision coverage			
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 Dependent Life Insurance	You can't change LTD Plan coverage	You can't change your contributions to the: Health Care Spending Account Dependent Care Spending Account
Your Domestic Partner Is Eligible for Coverage			
If you're covered, you can change your medical 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 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
You End a Domestic Partnership			
If you're covered, you can change your medical 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 his or her 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 If your eligible children lose coverage under a domestic partner's plan, you can add coverage for them	You can enroll, increase, decrease or drop your 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.
Your Domestic Partner Dies			

Health Care Coverage	Life and AD&D Insurance	LTD Coverage	Spending Accounts
If you're covered, you can change your medical 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 qualify as your dependents, you must enroll them as your eligible children	You can enroll, increase, decrease or drop your Employee Life and AD&D Insurance 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

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 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 Spending Account;
- Dependent Care Spending Account;
- Supplemental LTD (buy up option);
- Supplemental Life Insurance (for unpaid leave only);
- Dependent Life Insurance; and

SPE will continue to pay for Basic Life Insurance and Basic LTD while you are on an approved leave of absence up to one year.

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 his or her 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.

You may add or stop coverage in any or all of the following plans:

- Medical;
- Dental;
- Vision;
- Health Care Spending Account
- Dependent Care Spending Account;
- Supplemental LTD (buy up option);
- Supplemental Life Insurance (for unpaid leave only); and
- Dependent Life Insurance (same option reinstated).

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 he or she loses 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 he or she loses 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 219 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 Spending Account/Health Savings Account;
- Dependent Care Spending Account
- Legal Plan

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 38). 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 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 conversion provisions.
- If you have LTD coverage, coverage ends on your last day of eligibility under the plan.

Continuing Group Life Insurance as an Individual Life 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 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 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.

Continuation Coverage During Leave Under the FMLA

You're entitled by federal law to up to twelve 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 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 www.KENKOatSPE.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 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 36)
- You die.

You or your covered dependents **must** notify Bswift within sixty 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 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 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 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 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 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-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, twenty-nine, or thirty-six 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 months after one year of military leave. After one 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 days of its due date.
- You or your covered dependents fail to make one of the ongoing premium payments within thirty 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 him or her. 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 his/her 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 month extension of coverage due to disability).

COBRA coverage will **not** continue for more than thirty-six 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 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 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 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 30)

When Your Dependents Lose Coverage
Your covered dependents can also have a qualifying event if they lose coverage when:

- You get divorced or your marriage is annulled.
- Your child is no longer eligible for coverage.
- 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 60 days of receiving the Social Security disability determination and before the end of the 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 or twenty-nine months of COBRA coverage, they can elect up to a total of thirty-six 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, he or she is eligible for up to a total of thirty-six 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 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 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 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 his or her 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 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 months through COBRA, if they continue to meet the definition of eligible dependents.

Please note that your spouse 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 coverage ends. Your beneficiaries will receive payment of the coverage amount in effect at the time 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 days or less, your current employee coverage continues uninterrupted. However, if your military leave is expected to be longer than thirty 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 year, you'll be required to pay the COBRA premium to continue coverage for up to an additional eighteen months while on military leave.

  Note: Coverage may extend beyond twenty-four 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 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 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 from your paycheck (please note if you cover a 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 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	 $1,350* $2,700*	 $600 $1,200	 $150 $300
Plan **Payment Percentage** (what the plan pays after **deductible**)	80%	80%	90%
Out-of-Pocket Maximum (includes **copayments**, **deductible**, plan **payment percentage** and **prescription drugs**)			
Single Family	$3,750 $7,500**	$4,000 $8,000	$3,000 $6,000
* 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)	$40 (80% after deductible)	$25	$20
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 /Occupation Therapy ((combined limit of 60 visits per calendar year for physical, occupational, and speech therapy per person.)	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**
PLAN FEATURE	SONY CONSUMER CHOICE	SONY PPO	SONY EPO
IN-NETWORK			
OTHER CARE			
Infertility 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 three calendar years)	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**
Other Outpatient Mental Health and Substance Abuse Treatment (including skilled behavioral health services in the home;	80% after **deductible**	80% after **deductible**	90% after **deductible**

partial confinement treatment and intensive outpatient programs)			
OUT-OF-NETWORK			
Annual **Deductible** Single Family	 $2,700* $5,400*	 $1,200 $2,400	No coverage
Plan **Payment Percentage** (what the plan pays after **deductible**)	60%	60%	No coverage
Out-of-pocket maximum (includes **copayments**, **deductible**, plan **payment percentage** and **prescription drugs**) Single Family	 $7,500 $15,000	 $8,000 $16,000	No coverage
Note: Any amount over the **recognized charge** is not included * 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 subject to Recognized Charge.			

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 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 DocFind at www.aetna.com/dse/custom/sony. With respect to **Infertility 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. **Infertility 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.

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 **Infertility 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 **Infertility 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.

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 his or her 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**.

You may search online for the most current list of participating **provider**s in your area by using DocFind, **Aetna's** online **provider directory** at www.aetna.com/docfind/custom/sony. You can choose a **PCP** based on geographic location, group practice, language spoken, or **hospital** affiliation. DocFind 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.

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 **Infertility 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 change your **PCP** at any time. With respect to **Infertility 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 **Infertility 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.

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 **specialists**, 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 **Infertility 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 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 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 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 60 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 abuse**;
- Partial Confinement Treatment programs for **mental disorders** and **substance abuse**;
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for **mental disorders** and **substance abuse**;
- Amytal interview;
- Applied Behavioral Analysis;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient **detoxification**;
- Psychiatric home care services;
- Psychological testing.

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.
- 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 Infertility 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 Plans 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, 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 his or her 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 his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

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 (removal of polyps performed during a screening procedure is a **covered expense**); 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 (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 6 visits per 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 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 year period, the purchase of another breast pump will not be covered until a three 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 his or her 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.

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 12-month period.

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, 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 a contagious **illness** or immune system problem.

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.
- 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**.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, the plan will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

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.

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 48 hours after a vaginal delivery and 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** for home health care, and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**.

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 aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**
- 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.

In figuring the Calendar Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is 1 visit and
- **behavioral health provider**, of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

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. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation Therapies section of 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 Therapies section for coverage information.
- Services for infusion therapy.
- 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.

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.

Ambulance Service
Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance
Covered expenses include charges for transportation:
- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.

- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulanc**e is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance
Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:
- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; and the two conditions above are met.

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 is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or
- By fixed wing air **ambulance** from an **out-of-network provider**.

Autism Spectrum Disorder Applied Behavioral Analysis (ABA)
Covered expenses include charges made by a **physician** or **behavioral health provider** for the 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 an educational service that 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:
- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);

- 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).

Covered expenses 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**.

Infertility 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 **Infertility 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%), delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **hospital** for a minimum of:
- 48 hours after a vaginal delivery; and
- 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.

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
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.

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 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 30 days before the date coverage ends:

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

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:

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 36 sessions in a 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 36 hours or a six 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 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 ~~pervasive developmental disorders (including autism),~~ 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.

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.

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 his/her 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 his/her 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 48 states (not available in AR or ID), and video consults are available in 48 states (not available in AR and TX). The **primary care physician** (**PCP**) **copay** will be charged for each visit for members enrolled in the Sony PPO or EPO plans. 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, member cost share applies up to the out-of-pocket maximum.

Transgender Reassignment Surgery

Covered expenses include charges in connection with a **medically necessary** Transgender Reassignment (sometimes called Sex Reassignment) Surgery 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.

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, breast augmentation, 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, 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 Abuse

Treatment of Mental Disorders
Covered expenses include charges made for the treatment of **mental disorders** provided by **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 Abuse

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

- 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. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**. 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 abuse**
  - Other outpatient **substance abuse** treatment such as:
    - Outpatient detoxification
    - **Partial Confinement Treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, 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 jaw bone 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**.

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.

- 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.
  - Treatment of a covered health care **provider** who specializes in the mental health care field and who receives treatment as a part of their training in that field.
  - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
  - Treatment of antisocial personality disorder.
  - Treatment in wilderness programs or other similar programs.
  - Treatment of mental retardation, defects, and deficiencies. 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.

- 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.

- 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: 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:
  - 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.

- 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, including: special education, remedial education, job training and job hardening programs;
  - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
  - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

- 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.

- Food items: 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.

- **Infertility**: 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

- **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 provided by a spouse, domestic partner, parent, child, step-child, 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.

- 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 (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

- 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 he or she:
- Is covered under it;
- Is 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 he or she is eligible for Medicare. This will be done whether or not he or she is 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 an "**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

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.

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.

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 he or she performs.

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, DocFind®.

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
This means the treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your 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

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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.

Infertility benefits are benefits designed to assist a Member with having a child, as described in Progyny's Member Guide.

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 mostly 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.

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 his or her 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 he or she practices;
- Provides medical services which are within the scope of his or her 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 abuse 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 his or her 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 his or her 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
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse 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 abuse 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.

If your ID card displays the National Advantage Program logo (NAP), your cost may be lower when you get care from a NAP **provider**. Through NAP, the **recognized charge** is determined as follows:

- If your service was received from a NAP **provider**, a pre-**negotiated charge** will 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**.

- 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
"FCR Rate" and "Geographic area are defined as follows:

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.

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)
This is an institution that meets all of the following requirements:
- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health **provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:
- A behavioral health **provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a **behavioral health provider** or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An R.N. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a physician.

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
An institution that meets all of the following requirements:
- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

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.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental 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 his or her 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 Abuse
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.

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
Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of:
- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither:

- An emergency room; nor
- The outpatient department of a hospital; shall be considered a Walk-in Clinic.

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 web site to register and access more information or call member services with questions about your prescription drug coverage.

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

* Medical 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 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 day supply for home delivery, plus refills for up to one year. If you do not use the mail order program after three 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 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 **1-800-716-2773.**

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.

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.

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, 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.

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

For a complete list of covered prescriptions, go to www.expressscripts.com

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. 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 Web site 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 he or she is 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 days or twelve units, whichever is less for a retail pharmacy prescription.
- Ninety days or thirty-six 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. For most HMOs, you need to choose a primary care physician (PCP) or facility from a list of providers in the service area when you enroll.

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 Web site 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, he or she 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 www.KENKOatSPE.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 206.

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 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 206.

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 206).

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 "tort feasor."

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 he or she also has coverage with his or her employer. In this case, your spouse's plan is primary—pays benefits for his or her 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

Purpose of the EAP

The Employee Assistance Plan (EAP) helps you and your eligible family members deal with a wide range of life issues.

Counselors provide confidential support to help you handle both small problems and major issues in your life. There's no charge to you for this service.

How the EAP Works

For advice or counseling, call the EAP and speak to an EAP counselor. The counselor evaluates the situation with you and recommends a course of action. Recommendations can include:

- On-the-phone discussion with an EAP counselor; and
- A series of face-to-face counseling sessions with an EAP counselor in your area.

Eight (8) face-to-face counseling sessions per family member, per issue, per year are available at no cost to you.

If you're eligible for one-on-one counseling, you need to consider whether to seek additional assistance outside the EAP when you reach the benefit limit. If you seek assistance outside the plan, you pay the cost for additional counseling on your own. Certain expenses may be covered through your health plan.

Any psychiatric counseling services that the Medical Plan doesn't pay for may be reimbursable from the Health Care Spending Account or the HSA, as applicable depending upon your medical plan enrollment (if you're contributing).

The cancellation policy will vary by EAP counselor and SPE will never be charged per sessions.
Note: While covered by the plan, you have certain rights and protections, including the privacy of your health information.

EAP Benefits

You and your eligible family members are entitled to receive up to eight counseling sessions per family member per incident each calendar year.

The EAP can help you with:

- Marital and family problems;
- Relationship issues;
- Job pressures;
- Grief and loss;
- Alcohol abuse;
- Drug dependency;
- Financial and credit concerns;
- Emotional problems and stress;
- Child care;
- Elder care;
- Pre-retirement planning;
- Federal taxpayer problems;
- Legal issues and questions; and
- Interpersonal conflicts.

EAP services are provided by ComPsych, an independent firm retained by SPE to administer the Plan. ComPsych has a network of psychologists, social workers, and marital and family therapists who are trained to deal with a wide variety of personal and emotional problems.

The EAP is completely confidential. No information about the identity of the caller or the nature of his or her problem is shared with SPE, unless you provide a written authorization for the EAP to do so. As indicated above, SPE will not find out about a problem addressed through the EAP unless you either authorize the EAP to disclose the problem to SPE or independently notify SPE that such a problem exists.

The FinancialConnect® program offers you unlimited telephone access to certified public accountants, certified financial planners, and other financial professionals who are trained and experienced in handling personal financial issues and can offer consulting on issues such as family budgeting, credit problems, tax questions, investment options, money management and retirement programs.

The LegalConnect® program provides you with unlimited telephone consultation with attorneys who are trained and dedicated to providing legal information and assistance to clients with such issues as divorce, bankruptcy, family law, real estate purchases and wills.

If you need legal representation or extended assistance that cannot be provided by phone, LegalConnect professionals can provide referrals to local attorneys. You or your family member will receive a free 30-minute consultation and, thereafter, a 25% reduction in fees for representation if you choose one of ComPsych's network attorneys.

ComPsych's FamilySource® Guidance Specialists offer practical advice through telephonic consultation, accurate and timely referral information, and educational literature. Specialists are available to provide assistance on issues such as:

- Finding and evaluating quality daycare
- School selection for the relocating employee
- Planning for your child's college education
- Understanding programs such as Medicare and Medicaid
- Planning events or vacations
- And More

Callers receive detailed resource packages containing accurate referral information on community resources, available openings in programs, and guidelines for evaluating:

- Daycare centers and after school programs
- Public and private schools and tuition assistance
- Geriatric assessment clinics
- Assisted living and other housing options for the elderly
- And more

ComPsych will follow-up to make sure callers have received all the information necessary to meet their specific needs.

Treatment Not Covered by the EAP

Note: Coverage may be provided by your SPE health plan or other health care coverage. In addition, expenses not covered may be eligible for reimbursement through the Health Care Spending Account or HSA, as applicable.

The following treatments aren't covered by your EAP:

- Treatment for mental retardation (defined as an IQ of 70 or below, measured by the Weschler scales);
- Treatment for autism or learning disabilities;
- Treatment for any condition paid for by Workers' Compensation or treatment that is obtained through or required by a government agency; and
- Physical or medical treatment for medical, endocrine, metabolic, or other physiological disorders including, but not limited to, Pick's disease, Down syndrome, Parkinson's disease, epilepsy, Huntington's chorea, brain tumor, and Alzheimer's disease.

Even though the medical treatment of a condition is not included under EAP coverage, the counseling related to your ability or your dependent's ability to handle the situation is covered by the EAP.

Also, counseling is not covered in these situations, and you'll be responsible for payment (unless coverage is provided by your medical plan) for:

- Counseling by a provider who is not in the EAP network;
- Counseling that exceeds the benefit limits paid for by SPE;
- In-patient counseling, while a patient is hospitalized in a general acute care or acute psychiatric hospital or other licensed health facility; and
- Involuntary counseling requirements based on the orders of a state or federal judicial officer or another government official.

How to Contact the EAP

You can reach your EAP by logging into www.KENKOatSPE.com and choose Employee Assistance Plan or you can call EAP member services directly at 1-855-327-7669 (855-EAP-SONY). You can also call the SPE Benefits Center at 833-976-6901 if you have any questions about your EAP benefits.

Use of the EAP is entirely voluntary. It begins with a phone call to ComPsych. Their phone number is 855-327-7669 (855-EAP-SONY) and they are open 24 hours a day, seven days a

week. You can also utilize the service online by going to www.guidanceresources.com. If you are a first time visitor to the site, you will be asked to enter the company Web ID which is EAPSONY.

After contact has been made with ComPsych, they will make a preliminary assessment of the problem based on information provided to them by the caller. ComPsych will then either recommend that the caller meet with an EAP counselor in person or refer the caller to another source or agency for assistance.

Note: The description of the EAP is a general summary. If you have a question, you should call your EAP directly. Also, in the case of a conflict between this description and the plan document, the provisions of the EAP plan document will control.

Additional Points

If You Have Comments About Your EAP Administrator

You're encouraged to provide comments on the services the EAP provides. You can submit comments to the EAP at the address indicated in the ERISA Information section and/or to the SPE Benefits Department at KENKO@spe.sony.com. You may also call the EAP dedicated toll-free number to voice complaints.

If a Benefit Is Denied

If you or an eligible family member requests EAP services and benefits are partially or totally denied, you can appeal your claim (see page 146).

When Coverage Ends

Your SPE-provided coverage in your EAP ends at the earliest of last day of the month in which :

- You leave SPE employment;
- You're no longer eligible for coverage due to your employment status;
- You transfer to a position that is not eligible for coverage, or you transfer to a SPE company that does not offer coverage; and
- The EAP ends.

Your family members' coverage ends when your coverage ends or, if earlier, when your family member no longer qualifies as a dependent.

All Other Situations

In situations other than retirement when coverage would otherwise end, you can continue EAP coverage through COBRA as part of your COBRA medical continuation coverage.

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**;
- Payment percentage amounts;
- Annual maximums;
- Coverage provided for certain dental services; and
- Process for filing claims.

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		100%	100%	100%	100%
Cleanings		100%	100%	100%	100%
X-Rays		100%	100%	100%	100%
BASIC					
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					
Restorations		85%	50%	60%	50%
Crowns		85%	50%	60%	50%
Bridges		85%	50%	60%	50%
Dentures		85%	50%	60%	50%
ORTHODONTIA (ADULT AND CHILDREN)**					
Coverage		50%		Not Covered	
Orthodontia Annual Maximum		$3,000*		N/A	

Notes:
Diagnostic and Preventive services are applied 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.
* 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 his or her 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 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 payment.

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 by us is limited to the applicable Schedule of Benefits. Delta Dental's Payment is sent directly to the **PPO Provider** who submitted the claim. We advise you of any charges not payable by us 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 by us is limited to the applicable Schedule of Benefits. Delta Dental's Payment is sent directly to the **Premier Provider** who submitted the claim. We advise you of any charges not payable by us 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 by us 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 to us for reimbursement. The portion of the **maximum plan allowance** payable by us is limited to the applicable Schedule of Benefits. Since our 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. We advise you of any charges not payable by us 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 to us. 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. 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 60 months. The repair, relining, of appliances is limited to once every 6 months. The adjustment of appliances is limited to once every 12 months. 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-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-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 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-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-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-year period. Bitewing x-rays are limited to

twice in any **calendar year**. Periodic examinations of the full mouth are limited to twice 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 **calendar year** 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-year period. The five-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 months, and two or three surface restorations within six 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 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 5 years. The repair, relining of appliances for Night Guard/Occlusal Guard Services is limited to once every 6 months. The adjustments of appliances for Night Guard/Occlusal Guard Services is limited to once every 12 months.

- Limitation on Periodontal Maintenance. Periodontal prophylaxes 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 dentures and bridgework (including crowns and inlays forming the abutments) when such expenses are for replacement of teeth which were extracted while the covered individual was not covered under this plan; and 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 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 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 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 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, unless you request when filing a proof of claim that the payment be made directly to the dentist providing the services. All **benefits** not paid to the **provider** will be 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 his or her 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 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 203 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 Web site 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 219).

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 (applies to first service—exam or materials—received)	$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, and lined trifocal lenses, and occupational lenses

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 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;
- UV-protected 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 Web site 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 falls 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 years. The maximum includes the cost for supplementary testing.

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 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 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.

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 the exam 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, 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 Web site 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 385018
Birmingham, AL 35238-0518

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 206).

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 Cigna.

- **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, to a maximum of $1,000,000 rounded up to the next higher $1,000.

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 up to the next higher $1,000, up to a maximum 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:

- If you elect Supplemental Life Insurance Coverage of greater than $500,000
- If you elected Supplemental Life Insurance when you first became eligible and later want to increase your Supplemental Life Insurance coverage by more than one times your annual salary
- During open enrollment, if you increase your coverage more than one times your base salary or $500,000
- You have a qualified status change, e.g., marriage, divorce, birth of a child and you elect to increase your coverage by more than one times your base salary or $500,000

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 your coverage amount for both Basic and Supplemental Life Insurance coverage and your employee contribution for supplemental coverage will be based on your salary on September 1st of that year. Your coverage will increase accordingly effective January 1st of the following year, subject to the coverage maximums described above. The coverage amounts 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.

If You Become Totally Disabled

Basic Life Insurance: If you cease to be actively at work due to total disability and you are receiving disability payments from an SPE disability plan, your Basic Life Insurance will be continued by SPE for up to 6 months from your date of disability. If you do not return to active employment when your Basic 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).

Supplemental Life Insurance: If you remain totally disabled for more than six (6) months, you may be eligible to apply for Waiver of Premium for the Supplemental Life Insurance amount in force just prior to your disability. To qualify for Waiver of Premium, you must meet the following criteria:

- Your total disability must start after you have been covered for Supplemental Life benefits for at least six (6) months, and
- Your total disability began before age 60.

If you would like to apply for Waiver of Premium, you must request a Waiver of Premium application from Cigna at the six-month mark out on disability. The application should be completed and submitted to Cigna within nine (9) months of continuous disability. If Cigna approves your application for Waiver of Premium, your Supplemental Life Insurance will continue at no cost to you until the earlier of:

- The date you are no longer totally disabled; or,
- The date you do not give Cigna proof of total disability when required

While you are on Waiver of Premium, Cigna will periodically (not more than once per year) ask you to submit proof that you continue to be totally disabled. Cigna may require you to have a physical exam by doctors of their choice and at their expense. Also, while on Waiver of Premium, you may experience an increase to imputed income as described in a subsequent section.

If you do not return to active employment when your 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 a portion of your coverage amount paid to you one time while you are living. If approved by the Cigna, Accelerated Benefits proceeds can be up to 80% of the amount of life insurance in force on the date the Claims Administrator receives proof of your terminal illness, up to a maximum of $500,000. 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 6 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 Cigna.

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://benefits.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;
- 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 Cigna; and
- A signed or certified copy of the written assignment has been received and registered by Cigna.

SPE or Cigna 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 pad 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, while sane or insane, 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. Cigna 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 31-day period from the date coverage ends, or if later, 15 days from the date the conversion notice is given if the notice was given 15 days prior to the date coverage was terminated. In no event will the conversion period extend beyond 90 days from the date coverage was terminated. If you die during this 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 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 Cigna 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 80, 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 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%

*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.

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:

- Suicide and intentionally self-inflected injury;
- Active participation in a riot;
- Participation in a felony;
- Drug addiction;
- Travel or flight in any vehicle or device for aerial navigation including boarding or alighting from it while:
  - It is being used for test or experimental purposes;
  - You are operating, learning to operate, or serving as a member of the crew;
  - It is being operated by or for or under the direction of any military authority.

  This exclusion does not apply to:
  - Transport type aircraft operated by the Military Airlift Command of the United States; or
  - Similar air transport service of any other country;
- Travel or flight in any aircraft or device for aerial navigation, including boarding or alighting form it, owned or leased by or on behalf of SPE;
- Disease of the body or diagnostic, medical or surgical treatment or mental disorder s set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders; or
- War, declared or undeclared, or any act of war.

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) to age 26.

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.

Coverage Rules

Evidence of Insurability
Spouse/domestic partner life insurance will always be subject to Evident of Insurability (EOI). Child dependent life insurance is guaranteed issue and not subject to EOI.

Accelerated Death Benefits
If you have elected Spouse Dependent Life Insurance and your spouse becomes terminally ill while covered, you may apply to have a portion of the coverage amount paid to you while your spouse is living.

If approved by Cigna, Accelerated Benefits proceeds can be up to 80% of the amount of life insurance in force on the date the Claims Administrator receives proof of terminal illness. 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 6 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 Cigna.

Suicide Exclusion
Dependent Life Insurance benefits will not be paid if a covered dependent commits suicide, while sane or insane, within two (2) years after the effective date of dependent life coverage and/or the effective date of any increase in the amount of your dependent life coverage. If this exclusion applies, you or your contingent beneficiary will be reimbursed an amount equal to any contributions paid for the excluded coverage, without interest, if there are no other surviving eligible dependents.

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 Cigna. 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. Cigna 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 31-day period from the date coverage ends, or if later, 15 days from the date the conversion notice is given if the notice was given 15 days prior to the date coverage was terminated. In no event will the conversion period extend beyond 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 Cigna 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.

Applications must be submitted to Cigna within 31 days after the coverage ends.

Business Travel Accident Insurance

How the Plan Works

SPE automatically provides Business Travel Accident Insurance equal to two times your insured earnings, subject to a minimum of $100,000 and a maximum of $2,000,000, in the event you should die in an accident while traveling on company business. That means you have 24-hour 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.

In addition, the plan 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 one year of the accident:

Loss	Percentage of the 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 the sight in one eye	100%
One foot and the sight in one eye	100%
One hand or one foot	50%
Thumb and index finger on the same hand	25%

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.

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. This coverage is limited to a 250-mile radius of your original business destination and cannot exceed three days of travel.

Additional coverage includes:

- Seatbelt coverage equal to an additional 10% of the benefit to a maximum of $50,000, payable if a 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;
- Air bag benefit equal to an additional 10% of the benefit to a maximum of $50,000, 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;
- Coma benefit equal to 1% of the benefit monthly up to 11 months, payable in the event you lapse into a coma as a result of an accident that occurred while you were on a business trip;

- Psychological benefit equal to an additional 5% of the benefit to a maximum of $50,000, payable if there is a need for psychological counseling due to injury from a covered accident;
- Rehabilitation benefit equal to an additional 5% to a maximum of $50,000, payable in the event there is a need for a rehabilitation program due to an injury from a covered accident;
- AIG Assist with unlimited insured benefits of $100,000 for repatriation and $100,000 for medical evacuation in the event of a medical emergency whole on company business 100 or more miles from home;
- Everyday commutation coverage to and from work;
- Bomb scare or explosion while on the premises of SPE;
- Losses incurred due to a criminal act of violence either on or off the premises of SPE;
- Hijacking.

The maximum aggregate benefit is $10,000,000 per accident.

The coverage does not apply while commuting between home and place of work, during personal deviations, or while on company premises.

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 personal deviation.

Note: If you travel to another city, and expect to work there for more than 60 days, this is considered a change of your permanent assignment.

Exclusions

The following exclusions apply:

- Suicide, or any attempt at suicide while sane or self-destruction, or any attempt at self-destruction while insane;
- Disease of any kind;
- Bacterial infections, except pyogenic infection that occurs through an accidental cut or wound;
- Hernia of any kind;
- Injury sustained while riding as a passenger in any aircraft except as provided in the policy;
- Declared or undeclared war or any act thereof, except as provided by the policy;
- Service in the military, naval or air service of any country;
- Being under the influence of drugs or intoxicants, unless taken under the advice of a physician;
- Committing or attempting to commit a felony.

Offset Provision

The accidental death and dismemberment (AD&D) benefits under this plan will be offset by any benefits paid under a local corporate travel accident policy sponsored by SPE.

Filing Life and AD&D Insurance 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.

CIGNA 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.

CIGNA 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 days after the accident, unless extenuating circumstances warrant an extension of up to a year.

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 Claims

Once you or your beneficiary files a claim, the Claims Administrator, CIGNA, 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 206).

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, New Jersey and New York);
- 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 Liberty Mutual, provides a monthly benefit if you become totally disabled due to injury or illness and remain disabled for more than 180 days.

If you qualify for LTD coverage after 180 days of short-term disability, the LTD Plan will provide you with 60% of your insured 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 basic 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 basic monthly earnings.

Certain reductions, delays, 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. Basic monthly earnings does not include bonuses, commissions, overtime pay and 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 as soon as administratively possible, 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. By paying for supplemental coverage on an after-tax basis, all benefits are income tax free. Consult your tax advisor for tax advice for your specific situation.

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:

- Social Security Disability Benefits.
- Any Workers' Compensation occupational disease, unemployment compensation law, or similar federal or state law.
- Any statutory disability or retirement plan or law sponsored by any local, state, or federal government as it pertains to Sony. (This does not include any Sony-sponsored retirement plan.)
- Any work loss provisions in mandatory "no-fault" auto insurance.
- Any sick pay or leave pay provided by Sony.
- Benefits payable from another franchise, group insurance, or similar plan.
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment arbitration, or otherwise from a third party.
- Any wage or salary for work performed. (Special rules apply for an approved rehabilitation program.)

Eligibility for Benefits

If you have LTD coverage when you become disabled and expect to be unable to work for 180 days or longer, you will be eligible to begin receiving a benefit under the plan. Liberty Mutual 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. Liberty Mutual determines if you qualify for benefits.

Note:

Liberty Mutual, 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 plan defines disability as:

- For the first twenty-four months: You must be unable to perform each of the material duties of your regular occupation due to injury or sickness; and you are unable to earn more than 80% of your indexed basic monthly earnings.

- After twenty-four months: You must be unable to perform each of the material duties of any gainful employment that you are reasonably qualified for through training, education, or experience; and you are unable to earn more than 80% of your indexed basic monthly earnings.

When Benefits End

Benefits continue until the earliest of the date you:

- Are no longer disabled.
- Earn more than 80% of your indexed basic monthly earnings.
- Refuse to participate in rehabilitation efforts as required by the insurance company.
- Are no longer receiving appropriate care.
- Reach your normal retirement age under Social Security, as shown below (or if later, the date you reach the end of your maximum benefit period as shown below).
- Die.

Normal retirement age under Social Security is determined as follows:

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 to 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

Your maximum benefit period depends on your age when your disability begins:

62 or younger	When you reach age 65 or if later, when you receive 42 monthly LTD benefit payments
63	When you receive 36 monthly LTD benefit payments
64	When you receive 30 monthly LTD benefit payments
65	When you receive 24 monthly LTD benefit payments
66	When you receive 21 monthly LTD benefit payments

67	When you receive 18 monthly LTD benefit payments
68	When you receive 15 monthly LTD benefit payments
69 or older	When you receive 12 monthly LTD benefit payments

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 months or more after you return to work, or if it's due to a different cause, regardless of how much time has passed, it's considered a separate disability. In these cases, LTD benefits begin again after you satisfy a new 180 day waiting period.

Disabilities Due to Alcoholism, Drug Abuse, or Mental Disorder

If your disability is caused by, or contributed to by, any one of the following conditions, your benefits will be paid on a limited basis and will be limited to a one time lifetime benefit of twenty-four months:

- Alcoholism;
- Anxiety disorder;
- Delusional disorder;
- Depressive disorder;
- Drug addiction or abuse;
- Eating disorder;
- Mental illness; or
- Somatoform disorder (psychosomatic illness).

If, before reaching the lifetime maximum benefit, you're confined in a hospital for more than fourteen consecutive days, that period of confinement will not count against the lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

If You Die While Receiving LTD Benefits

If you die after six months 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.

Eligible survivors are your spouse/domestic partner and your unmarried dependent children under age 21. If do not you have eligible survivors, then proceeds will be paid to your estate.

If you die while disabled, a single, lump-sum LTD benefit will be paid to your eligible survivors. The amount will be determined as follows:

- If you're disabled and receiving LTD benefits for twelve months or less (or die after approval for LTD benefits but before receiving your first monthly benefit), the single payment benefit amount will be three times your monthly LTD benefit, without reduction for other disability benefits you were eligible to receive in the month before you die.

- If you're disabled and receiving LTD benefits for more than twelve months, the single payment benefit amount will be six times your monthly LTD benefit, without reduction for other disability income benefits you were eligible to receive in the month before you die.

Partial Disability

Partial disability means you, are a result of Injury or Sickness you are able to:

1. Perform one or more, but not all, of the material and substantial duties of your own occupation or any occupation on a active employment or part time basis

2. Perform all of the material and substantial duties of your own occupation or any occupation on a part time basis.

3. Earn between 20% and 80% of your basic monthly earning.

For the first 24 Months, the work incentive benefit will be an amount equal to your Basic Monthly Earnings multiplied by the benefit percentage shown in the Schedule of Benefits, under the Heading titled, "Amounts of Insurance", without any reductions from earnings. The work incentive benefit will only be reduced, if the Monthly Benefit payable plus any earnings exceed 100% of your Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus your earnings does not exceed 100% of your Basic Monthly Earnings.

Thereafter, the Monthly Benefit will be calculated as follows: 1. Your Basic Monthly Earnings minus your earnings received while you are Partially Disabled. This figure represents the amount of lost earnings. 2. Multiply the amount of lost earnings by 75%; and then 3. deduct Other Income Benefits (shown in the Other Income Benefits and Other Income Earnings provision of this plan) from this amount. The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits.

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. Liberty 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 Liberty. Such assistance will be offered only if Liberty determines that assistance would be beneficial.

What If Your Claim Is Denied?

Liberty'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 Liberty's notice of denial. You have the right to:

1. Submit to Liberty, 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 t 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.

Liberty 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 Liberty 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 Liberty 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. Liberty'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 Liberty 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, while sane or insane;

3. active Participation in a Riot;

4. the committing of or attempting to commit a felony;

5. cosmetic surgery unless such surgery is in connection with an Injury or Sickness sustained while you are covered under this plan.

Pre-Existing Condition limitations:

This plan will not cover any Disability or Partial Disability:

1. which is caused or substantially contributed to by, or results from a Pre-Existing Condition or medical or surgical treatment of a Pre-Existing Condition; and

2. which begins in the first 12 months immediately after your effective date of coverage.

"Pre-Existing Condition" means a physical or mental condition whether diagnosed or undiagnosed, resulting from an Injury or Sickness for which you received Physician’s advice or Treatment within three months prior to your effective date of coverage.

Flexible Spending Accounts and Health Savings Account Overview

How Flexible Spending Accounts (FSA) Work

The FSA benefit includes both the Health Care Spending Account and Dependent Care 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.
- 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 Spending Account and Dependent Care 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 Aetna/Payflex 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 Aetna/Payflex site from www.KENKOatSPE.com Web site.

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 puts money into your account. For 2019, SPE will contribute up to $500 (for employee only coverage) and $1,000 (for family coverage) to your account. This amount may change in future years. SPE's full contribution to your account will be deposited as soon as administratively possibly in January. Employee hired and actively enrolled after March 31will receive a pro-rated amount deposited as soon as administratively possible. . You must be actively employed and enrolled in the Sony Consumer Choice Plan have opened your HSA at the time of SPE's quarterly contribution in order to receive the funds in your account.

SPE's contributions are included in the maximum annual HSA contribution limit.

After you enroll, you can use the Aetna/Payflex 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 link to the Aetna/Payflex site at www.aetna.com or www.payflex.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 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 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 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 $2,700 to your Health Care Spending Account in 2019. There is no minimum annual contribution.

Plan carefully and be conservative with your estimates. You can use the Spending Account Estimator available on this site at the time you make your enrollment decision. 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 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: you will need a doctor's prescription in order to receive reimbursement from the Health Care Spending Account for over-the-counter (OTC) medications such as allergy medicines, ibuprofen, cough syrup, etc.

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
- Ambulance services
- Birth control pills
- Car controls for the handicapped
- Chiropractor
- Contact lenses (excluding insurance)
- Crutches (purchase or rental)
- Dental treatment
- Doctor's fees
- Eyeglasses, lenses, frames, and exams
- 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
- Hearing aids
- Infertility treatments
- 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
- Lifetime care—advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient
- Medical services
- Medical care provided in a nursing or retirement home (custodial care is not covered)
- Nursing services
- Oxygen or oxygen equipment
- 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
- Health or fitness club dues
- 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)
- Over-the-counter (OTC) drugs (allergy medicines, antacids, cold medicine, pain relievers) without a doctor's prescription, and vitamins
- 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

For More Information

For more information on the Health Care Spending Account, contact Aetna/Payflex at 1-888-678-8242.

Dependent Care Spending Account

How the Account Works

The Dependent Care 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 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 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. He or she 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 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 2018, you earned $120,000 or more) according to Internal Revenue Service (IRS) participation rules, your contribution amount may be subject to a lower limit (for 2018, 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 Aetna/Payflex 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 Spending Account, you should also take the federal dependent care tax credit into consideration.

The Dependent Care 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 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 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 hour institutional care (for example, a nursing home). **Note:** Some expenses may be reimbursable under the Health Care Spending Account.
- Care provided by someone whom you claim as a dependent on your income tax return or by your child if he or she is 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 Aetna/Payflex Web site for more information. Go to “Return to the Main Window” at the top of the page and choose the Aetna/Payflex 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.

Aetna/Payflex Card

The Aetna/Payflex card, which is available through Aetna/Payflex, 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 Aetna/Payflex 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 $3,450(employee only) and $6,900 (family) to your HSA account in 2018. 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	$2,950	$500	$3,450
Family	$5,900	$1,000	$6,900

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.

For More Information

For more information on the Health Care Spending Account, contact Aetna/Payflex at 1-888-678-8242.

Filing Claims for FSA Reimbursement

Health Care 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 Aetna/Payflex Web site 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 Aetna/Payflex Service Center.

Complete the form and mail, fax or scan it to the Aetna/Payflex 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.

If you contribute $1 or more to your account, you'll automatically receive a Aetna/Payflex debit card to use for eligible health care account transactions. See page 131 and go to the Aetna/Payflex Web site for more details.

Once you're reimbursed for the total amount of your annual contribution for the year, no more reimbursements are made.

Dependent Care Spending Account Claims

When you have eligible dependent care expenses to submit, you can file your claim on the Aetna/Payflex Web site. You can also request a claim form by calling 1-888-678-8242.

Complete the form and send it to the Aetna/Payflex 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 Aetna/Payflex claim, the Claims Administrator will follow the benefit review process for the Health Care or Dependent Care 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 206).

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 Aetna/Payflex Web site 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 Aetna/Payflex 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 Aetna/Payflex Web site for more information.

Legal Plan Overview

Hyatt Legal Plans, Inc. has been selected to provide legal benefits 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 Plan that are not answered in this summary or on the Hyatt Legal Plans Web site at **www.legalplans.com**, please call Hyatt Legal Plans directly at 1-800-821-6400.

Enrolling in the Plan

For the 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 Plan enrollment decision until the next open enrollment period.)

Initial Enrollment for a Newly Eligible Employee
You have 30 days to enroll in the Plan from the date your enrollment information is sent to you to enroll in the 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 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 30 days, you're assigned no coverage automatically for the 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 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 Plan and you do not currently have coverage.

If you do not make an election during the open enrollment period, your 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 Plan, you and your eligible family members can use the Plan for covered services. 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

When Coverage Ends
Your eligibility and family members' eligibility to receive legal services under the 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 ends on December 31 of the current year.

If you are no longer eligible to participate in the Plan or your employment with Sony ends, the 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 Plan. No new matters will be covered after you become ineligible.

Coverage is portable for thirty (30 months). To continue coverage on your own, you must contact Hyatt Legal Plans' Client Service Center at **800-821-6400** within 30 days of your employment termination date and request to continue coverage. (While the term for portability is currently a set period of 30 months, this term is subject to change by Hyatt for new enrollees without notice.)

You would be required to pay Hyatt the full premium upfront. For example, based on Sony's current monthly rate of $16.70 (2018), you would pay $501.00 (30 months × $16.70). The covered services and Hyatt's coverage of you, your eligible spouse or domestic partner and any eligible dependents would remain the same as current coverage for those 30 months.

How to Get Legal Services

Use the Hyatt Legal Plans Web Site
MetLaw® was established to provide personal legal services for eligible company employees, their spouses, or domestic partners and dependent children. To use MetLaw®, visit the Hyatt Legal Plans Web site at **www.legalplans.com**. Once there, click on the "Members Log in" icon at the top of the page. You will be taken to a secure page that will require you to enter your membership number.

After you enter your membership number you will jump to a page that is specific for member services. On this page you can choose the following options:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number
- Life Guide

- Self-Help Documents/Forms

Call the Client Service Center

You may also use MetLaw® by calling the Hyatt Legal Plans Client Service Center at 1-800-821-6400 Monday – Friday, 8:00 a.m. to 7:00 p.m., Eastern Time. Be prepared to give your membership number. If you are a spouse or an eligible dependent child of a Sony employee, you will need the Social Security number of the employee through whom you are eligible. 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, which 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 the Legal Plan.

You then call the Plan attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select your own attorney. Also, where there are no participating law firms, you will be asked to select your own attorney. In both of these circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a case number, and retained an attorney; also, the attorney must begin work on the covered legal matter while you are covered by the Plan.

What Services Are Covered

MetLaw® entitles you and your eligible family members (your spouse or domestic partner and dependent children as defined for the Benefits Plan to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions, which must be met. Please take time for yourself and your family to read the description of covered services carefully.

Important Note: Throughout this section, "you" refers to the Sony employee, the employee's spouse or domestic partner and eligible dependent children unless otherwise indicated.

Advice and Consultation

Office Consultation

This service provides the opportunity to discuss with a Plan attorney any personal legal problems that are not specifically excluded. The Plan attorney will explain your rights, point out your options, and recommend a course of action. The Plan attorney will identify any further coverage available to you under the Plan, and will undertake representation if you so request.

If representation is covered by the Plan, you will not be charged for the Plan attorney's services. If representation is recommended, but is not covered by the Plan, the Plan attorney will provide a written fee statement in advance. You may choose whether to retain the Plan attorney at your own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year that you or an eligible family member may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Plan attorney in order to seek advice that would allow you to undertake your own representation.

Telephone Advice

This service provides the opportunity to discuss with a Plan attorney any personal legal problems that are not specifically excluded. The Plan attorney will explain your rights, point out your options, and recommend a course of action. The Plan attorney will identify any further coverage available under the Plan, and will undertake representation if you so request. If representation is covered by the Plan, you will not be charged for the Plan attorney's services.

If representation is recommended, but is not covered by the Plan, the Plan attorney will provide a written fee statement in advance. You may choose whether to retain the Plan attorney at your own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year that you or an eligible family member may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Plan attorney in order to seek advice that would allow you to undertake your own representation.

Consumer Protection

Consumer Protection Matters

This service covers you 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.

Small Claims Assistance

This service covers counseling you on prosecuting a small claims action; helping you prepare documents; advising you on evidence, documentation, and witnesses; and preparing you 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 benefit provides you 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, foreclosure, repossession, or garnishment, up to and including trial if necessary.

It does ***not include*** vacating a judgment; 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 Sony, MetLife, or their respective parents, subsidiaries, and affiliates.

Identity Theft Defense
This service provides you 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 you with online help and information about identity theft and prevention.

It does ***not include*** counter claims, cross claims, bankruptcy, any action arising out of divorce or post-decree matters, or any matter where the creditor is affiliated with Sony, MetLife, or their respective parents, subsidiaries, and affiliates.

Personal Bankruptcy or Wage Earner Plan
This service covers the Sony employee and his/her spouse or domestic partner 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 Sony, even if you or your 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 your tax return; negotiating with the agency; advising you 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 you 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 you 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 you in the defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent.

Document Preparation

Affidavits
This service covers preparation of any affidavit in which you are the person making the statement.

Deeds
This service covers the preparation of any deed for which you are either the grantor or grantee.

Demand Letters
This service covers the preparation of letters that demand money, property, or some other property interest that you have, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.

Mortgages
This service covers the preparation of any mortgage or deed of trust for which you are the mortgagor. This service does not include documents pertaining to business, commercial, or rental property.

Notes
This service covers the preparation of any promissory note for which you are the payer or payee.

Document Review
This service covers the review of your personal legal documents, such as letters, leases, or purchase agreements.

Family Law

Name Change
This service covers you for all necessary pleadings and court hearings for a legal name change.

Premarital Agreement
This service covers the preparation of an agreement by the Sony Employee and his/her fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce, or death of a spouse. Representation is provided only to the Sony employee. The fiancé(e)/partner must have separate counsel or must waive representation.

Protection From Domestic Violence
This service covers the Sony employee, not his/her spouse or domestic partner or dependents, as the victim of domestic violence. It provides the Sony employee 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.

Uncontested Adoption
This service covers all legal services and court work in a state or federal court for an uncontested adoption for the Sony employee and his/her spouse or domestic partner. If an adoption becomes contested, the Sony employee or his/her spouse or domestic partner must pay all additional legal fees.

Uncontested Guardianship or Conservatorship
This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Sony employee or his/her spouse or domestic partner is appointed 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. If the proceeding becomes contested, the Sony employee or his/her spouse or domestic partner must pay all additional legal fees.

This service **does not** include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

Immigration Assistance
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents, and helping you prepare for hearings.

Personal Injury (25% Network Maximum)
Subject to applicable law and court rules, Plan attorneys will handle personal injury matters (where you are the plaintiff) at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all costs.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)
This service covers negotiations and litigation arising from boundary or title disputes involving your primary residence, where coverage is not available under your homeowner or title insurance policies.

Eviction and Tenant Problems (Primary Residence—Tenant Only)
This service covers you 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.

Security Deposit Assistance (Primary Residence—Tenant Only)
This service covers counseling you as a tenant in recovering a security deposit from your primary residential landlord for your primary residence; 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 you in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation, and witnesses; and preparing you for the small claims 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.

Home Equity Loans (Primary Residence)
This service covers the review or preparation of a home equity loan on your primary residence.

Property Tax Assessment (Primary Residence)
This service covers you for review and advice on a property tax assessment on your primary 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 Home (Primary Residence)
This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation, and taxation), which are involved in refinancing of or in obtaining a home equity loan on your primary residence. 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 second home, vacation property, rental property, or property held for business or investment.

Sale or Purchase of Home (Primary Residence)
This service covers the review or preparation, by an attorney representing you, 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 your primary residence or of a vacant property to be used for building a primary 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 second home, vacation property, rental property, property held for business or investment, or leases with an option to buy.

Zoning Applications
This service provides you with the services of a lawyer to help get a zoning change or variance for your primary residence. Services include reviewing the law, reviewing the surveys, advising you, 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 the Sony employee and his/her dependent child in any juvenile court matter, provided there is no conflict of interest between the Sony employee and the dependent child. In that event, this service provides an attorney for the Sony employee only, including services for parental responsibility.

Traffic Ticket Defense (Excluding DUI)
This service covers representing you in defense of any traffic ticket (except driving under the influence of drugs or alcohol or vehicular homicide), including court hearings, negotiation with the prosecutor, and trial.

Restoration of Driving Privileges
This service covers you with representation in proceedings to restore your driving license.

Wills and Estate Planning

Living Trusts
This service covers the preparation of a living trust for you. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills
This service covers the preparation of a living will for you.

Powers of Attorney
This service covers the preparation of any power of attorney when you are 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 your responsibility to pay this reduced fee and all costs.

Wills and Codicils
This service covers the preparation of a will for you. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It ***does not*** include tax planning.

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, Sony, 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 Plan is provided for and administered through a contract with Hyatt Legal Plans, Inc. Hyatt Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to Hyatt Legal Plans, Inc.

Plan Confidentiality, Ethics, and Independent Judgment

Your use of the 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 Plan; it will have access only to limited statistical information needed for orderly administration of the Plan.

No one will interfere with your Plan attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the Plan, is responsible for all services provided by their attorneys.

You should understand that the 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 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 Hyatt 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 Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this 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 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, Hyatt 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 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

Hyatt verifies eligibility using information provided by Sony. When you call for services, you will be advised if you are ineligible and Hyatt 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 209 for the Appeals section.

Denials of Coverage

If you are denied coverage by Hyatt Legal Plans or by any Plan attorney, you may appeal by sending a letter to:

Hyatt Legal Plans, Inc.
Director of Administration
Eaton Center

1111 Superior Avenue

Cleveland, Ohio 44114-2507

The Director will issue Hyatt 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 Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt 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 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 Hyatt Legal Plans. As the Plan Administrator's delegate, Hyatt Legal Plans has the authority to review and decide on all claims and appeals for benefits under the Plan.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (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.

Funding Information and Source of Contributions

Costs for participation in the 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.

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.

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 year		
Individual Coinsurance Limit	$0 per calendar year	$0 per calendar year	$0 per calendar year
(Include deductibles, coinsurance, copays and Prescription copays for in-network only. Does not include precertification penalties. Includes Outpatient Prescription Drugs when outside the US)			
Family Coinsurance Limit	$0 per calendar year	$0 per calendar year	$3,000 per calendar year
(Include deductibles, coinsurance, copays and Prescription copays for in-network only. Does not include precertification penalties. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Member Payment Percentages			
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

Allergy Testing and Treatment	No charge	No charge after $10 copay	20% after deductible
Allergy Serum and Injection	No charge	No charge	20% after deductible
PPO			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Mental Health Services			
Mental Health Inpatient Coverage	No charge	No charge	20% after deductible
Unlimited days per calendar year			
Mental Health Outpatient Coverage	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	No charge	No charge	20% after deductible
Unlimited visits per calendar year			
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	No charge	$10 copay per one month supply (includes Mail Order Drugs)	20% after deductible
Brand Name Drugs *(365 day maximum supply)*	No charge	$20 copay per one month supply (includes Mail Order Drugs)	20% after deductible
Other Services			
Global Emergency Assistance Program *($500,000 calendar year 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	No charge
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	No charge	No charge
Adults age 22+ & -65: 1 exam/24 months Adults age 65+: 1 exam/12 months (includes immunizations)			
Routine Gynecological Exams	No charge	No charge	No charge
Includes 1 exam and pap smear per calendar year			
Mammograms *(Unlimited visits per calendar year)*	No charge	No charge	No charge
Prostate Specific Antigen (PSA)	No charge	No charge	No charge
Includes 1 PSA per calendar year for males 40+			
Digital Rectal Exam (DRE)	No charge	No charge	No charge
Includes 1 DRE per calendar year for males 40+			
Cancer Screening	No charge	No charge	No charge
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 10 years			
Routine Hearing Exam	20%	No charge	40%
Includes one routine exam every 24 months.			
Hearing Aids	20%	20%	40% after deductible
1 hearing aid per ear to $1,000 maximum per ear every 3 years for child to age 24			
Vision Care			
Routine Eye Exam	20%	No charge	40%
(Covered under medical) Includes one routine exam every 24 months			
Vision Care Supplies	No Charge up to $100 maximum	No Charge up to $100 maximum	No Charge up to $100 maximum
Scheduled maximums apply every 24 months			

PPO			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Other Services			
Travel Immunizations	No charge	No charge	No charge
TMJ *($1,000 lifetime maximum)*	No charge	No charge	20% after deductible
Hair Prosthesis *($500 calendar year maximum)*	No charge	No charge	No charge
Bereavement Counseling	No charge	No charge	20% after deductible
Nutritional Evaluations *(3 visits per calendar year)*	No charge	No charge	20% after deductible
Skilled Nursing Facility *(120 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 combined, includes Private Duty Nursing)*	No charge	No charge	20% after deductible
Spinal Disorder Treatment *(20 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 Occupational, Physical and Speech Therapies; 60 combined maximum 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
Durable Medical Equipment *(Unlimited calendar year maximum)*	No charge	No charge	20% after deductible
Bariatric Surgery *($10,000 per lifetime)*	No charge	No charge	20% after deductible
Base Infertility Services	No charge	No charge	20% after deductible
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			

Autism *Member cost sharing is based on the type of service performed and the place of service where it is rendered*	Autism covered same as any other expense.		
Payment for Non-Preferred Providers*	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
PPO Dental			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$05 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 Coverage for Adults and Dependents up to age 20	50%	50%	50%
Please refer to the Dental Plan Caveats below for additional benefit coverages for Types A, B and C			
Services and Programs			
Informed Health Line (24-hour nurse line) **International Disease Management** **International Maternity Management Program** **Wellness Checkpoint** **Weight Watchers® Program** **On-Line Global Health and Travel Information through HTH Worldwide (http//www.aetnainternational.com)**			
Medical Plan Caveats			

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. Precertification penalties 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.

Copayments and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor

Benefit maximums per Calendar year are calculated between 01/01and 12/31 of the year.

Pre-Existing Conditions:

- *Option: Option 5 - (No Restriction)*
- *On Effective Date: Pre-existing condition limitation is waived on the effective date.*
- *After Effective Date: Pre-existing condition limitation is waived after the effective date.*
- *Pre-Existing Conditions is waived for dependents under age 19.*

**** Payment for Non-Preferred Providers** We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.*

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

Your out-of-network doctor sets the rate to charge you. It may be higher --sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles

Dental Plan Caveats

PPO Dental

Type A
Includes Prophylaxis, Bitewing and full mouth series X-rays, Space Maintainers, Oral Exams, Fluoride applications, Sealants, and Periapical X-rays.

Type B
Includes Fillings, Simple Extractions and Oral Surgery.

Type C
Includes Crown Lengthening, Crown Buildup, Inlays/onlays, Bridgework, Osseous surgery, Soft tissue grafts, Partial and full bony impactions, General anesthesia and intravenous sedation, Dentures (benefit includes all relines, rebases and adjustments within 6 months of installation), Molar root canal therapy, Prosthetic repairs, and Occlusal Guards (for bruxism only).

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 lib, 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 15 days or less during the elimination period. No benefit is payable for or during the elimination period.

Your Elimination Period is 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 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 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 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, an eligible employee is eligible to receive a severance payment in an amount equal to the number of months of the employee's base earnings as set forth in the schedule below:

Organization Level	Number of Months of Base Earnings
1- 3	1 month of base earnings
4	2 months of base earnings
5	4 months of base earnings
6-10	6 months of base earnings

An employee's Organization Level is determined at the sole discretion of SPE.

Additionally, an eligible employee terminated due to a job elimination or a lay-off, whose Organization Level is 1, 2 or 3, and who has completed more than five years of continuous service, in addition to receiving one month of base earnings is also eligible to receive two weeks of base earnings for each completed year of continuous service after the first five years up to a maximum severance payment under the Severance Policy of 26 weeks times the employee's base salary.

An eligible employee terminated due to a job elimination or a lay-off, whose Organization Level is 4, 5 or 6, and who has completed more than five years of continuous service, in addition to receiving the above designated months of base earnings is also eligible to receive two weeks of base earnings for each completed year of continuous service after the first five years up to a maximum severance payment under the Severance Policy of 52 weeks times the employee's base salary.

An eligible employee terminated due to a job elimination or a lay-off, whose Organization Level is 7, 8, 9 or 10 and who has completed more than twelve months of continuous service, in addition to receiving the above designated months of base earnings is eligible to receive an additional 6 months of base earnings as severance pay.

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 continuous service under the Severance Policy. Completion of six 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, but will not be considered a full year for eligibility purposes.

In addition to the above severance payment, eligible employees who timely elect to continue their (and, if applicable, their eligible family members') coverage in SPE's medical (including prescription drug), vision, and/or dental plans, as they may be modified from time to time, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), will be covered at SPE's expense for an equivalent number of months as the employee's severance entitlement set forth above (the "COBRA Benefit").* Eligible employees terminated due to a job elimination or layoff, whose Organization Level is 1, 2, 3 or 4, are eligible for a COBRA Benefit of 3 months or an equivalent number of months as the employee's severance entitlement set forth above, whichever is greater. The COBRA Benefit applies only to the premiums associated with the eligible employee's (and, if applicable, his/her family members') continued coverage and not to any deductibles, co-payments, co-insurance or other out-of-pocket costs and commences on the first day of the full month following the employee's separation from service with SPE. 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 45 days of the employee's termination date and returned to SPE for the employee to be eligible for severance pay and COBRA Benefit.

Severance payments are paid in a lump sum less applicable deductions and withholdings. The complete terms and conditions of the Severance Policy are set forth in the Sony Pictures Entertainment Severance Benefits Policy document. In the event of any inconsistency between this summary and the Severance Policy document the terms of the Severance Policy document shall govern.

SPE has the right to change or terminate the Severance Policy at any time. The Severance Policy shall be effective as of April 1, 2017 and shall not apply to any termination, layoff or job elimination prior to April 1, 2017.

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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 Spending Account ("DCSA") 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 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 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 **Infertility benefits** is Aetna Life Insurance Company.

All categories of medical claims are administered by the Claims Administrator listed below. See "Health and Insurance Plan Claims Review Procedures" on page 146 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

ComPsych
PO Box 8379
Chicago, IL 60680-8379
1-855-327-7669

Employee Life and AD&D Insurance Plans

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
1-800-732-1603
FLX-980248

Business Travel Accident

CIGNA (Life Insurance Company of North America)
1600 West Carson Street, Suite 300
Pittsburgh, PA 15219
1-800-238-2165

Long Term Disability Plan

Liberty Mutual
PO Box 7209
London, KY 40742-7209
1-800-320-7585
Mylibertyconnection.com

Flexible Spending Accounts (including Health Savings accounts)

Aetna/Payflex
151 Farmington Avenue
Hartford, CT 06156
1-888-678-8242
www.aetna.com
ASA #810072

* Note: Aetna/Payflex also administers the Health Savings Account; however, this is not an ERISA plan and is not subject to the Claims and Appeals procedure or the ERISA rights described below. If you have questions about the Health Savings Account, please contact Aetna/Payflex directly.

Legal Plan

Hyatt Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 441141-
800-821-6400
www.legalplans.com

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 **Infertility 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 the plan	N/A

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 respond to the plan's request, or until the 45-day deadline was expired, whichever is earlier	**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)

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 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 hours after receiving your appeal.
- For pre-service health claims, within fifteen days after receiving your appeal.
- For post-service health claims, within thirty 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 211.

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 211. 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 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 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 123 calendar

days filing period or within the 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 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 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 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 emergencycare, 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 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 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 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 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 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 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 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve months (eighteen 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. 20210

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 September 21, 2013. You can view or print the revised notice from the Plan Information section on www.KENKOatSPE.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 48 hours following a vaginal delivery, or less than 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 48-hour (or 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 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 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.

Premium Assistance

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 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 A. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp x	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901- 4999
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshe alth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid / Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health- care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HI PP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.ht m Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**

Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost- health-care/program-administration/premium-payment- program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid

Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, 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
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565