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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network Individual: **$250** /Family: **$500** Out-of-network: **Not applicable**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: Individual **$3,200** /Family: **$6,400**; Out-of-network: **Not applicable**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

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

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit; deductible does not apply.	Not covered	———— None ————
	Specialist visit	$35 copay / visit; deductible does not apply	Not covered	———— None ————
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	———— None ————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	———— None ————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://www.express-scripts.com/sonypics**.	Generic drugs	$10 copay/prescription (retail); $20 copay/prescription (mail order)	Not covered	Maintenance prescriptions: Must be filled at a CVS pharmacy or through mail order; mail order cost share applies, covers 90-day supply. All other prescriptions: Covers up to 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Please see "Important Questions" regarding the plan's out-of-pocket limit.
	Preferred brand drugs	30% coinsurance (retail - minimum $25/prescription; maximum $75/prescription); (mail order - minimum $55/prescription; maximum $125/prescription)	Not covered	
	Non-preferred brand drugs	40% coinsurance (retail - minimum $40/prescription; maximum $100/prescription); (mail order - minimum $70/prescription;	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		maximum $150/prescription)		
	Specialty drugs	Specialty Drugs follow the respective tier's cost sharing	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	———————— None ————————
	Physician/surgeon fees	10% coinsurance	Not covered	———————— None ————————
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Non-emergency use not covered.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-emergency use not covered.
	Urgent care	$35 copay/visit; deductible does not apply	Not covered	Non-urgent use not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	———————— None ————————
	Physician/surgeon fees	10% coinsurance	Not covered	———————— None ————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay / visit; other outpatient services: 10% coinsurance, deductible does not apply.	Not covered	———————— None ————————
	Inpatient services	10% coinsurance	Not covered	———————— None ————————
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	———————— None ————————
	Childbirth/delivery facility services	10% coinsurance	Not covered	———————— None ————————
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Coverage is limited to 120 visits per calendar year.
	Rehabilitation services	$35 copay/visit; deductible does not apply	Not covered	Limited to 60 visits/calendar year for Physical, Occupational & Speech Therapy combined. No

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				coverage for therapeutic services offered in an educational setting.
	Habilitation services	10% coinsurance, deductible does not apply.	Not covered	No coverage for therapeutic services offered in an educational setting.
	Skilled nursing care	10% coinsurance	Not covered	Coverage is limited to 120 days per calendar year.
	Durable medical equipment	10% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	Not covered	———————— None ————————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You may have other vision coverage not described here.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency services outside of the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture: 30 visits per calendar year
- Bariatric surgery
- Chiropractic care: 30 visits per calendar year
- Hearing aids: 1 hearing aid per ear annually, no dollar maximum
- Private duty nursing
- Fertility treatment: Fertility counseling and assisted reproductive technology treatments up to 4 SMART cycles administered through Progyny. Call 833-404-2011 to register.

For more information about limitations and exceptions, see the plan or policy document at **www.aetna.com** or call **1-888-385-1053** to request a copy

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

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

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

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-385-1053.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-385-1053.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-385-1053.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-385-1053.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist *copay*	$35
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,520**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist *copay*	$35
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,670**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist *copay*	$35
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

The plan would be responsible for the other costs of these EXAMPLE covered services.