The PepsiCo Retiree Health Care and Group Insurance Programs
2015 Standard Program

Summary Plan Description
The PepsiCo Retiree Health Care and Group Insurance Programs

This booklet describes the PepsiCo Retiree Health Care Program (which includes medical and prescription drug benefits) and the PepsiCo Group Insurance Program (which includes life insurance benefits only) (collectively, the "Retiree Programs") available to you and your eligible spouse/domestic partner and dependents. You owe it to yourself to understand how your benefits work; we suggest you read the following pages carefully. If you have any questions about this booklet or certain provisions of your benefit plans, contact The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. The service representatives can answer questions or guide you through specific plan details.

Beginning January 1, 2015, once you turn 65 (or your eligible spouse/domestic partner turns 65) you will no longer be eligible to receive medical and prescription drug coverage from the PepsiCo Retiree Health Care Program. Instead, you will be able to shop for the individual plans that best meet your needs through OneExchange, a private Medicare marketplace. See page 77 for more information about OneExchange. The individual policies offered through OneExchange are not a part of the PepsiCo Retiree Health Care Program.

Este resumen, comunicado en inglés, contiene información de sus derechos y beneficios de acuerdo con los planes de beneficios de PepsiCo. Si usted tiene dificultad entendiendo cualquier parte de este resumen, consulte El Centro de PepsiCo para Ahorro y Retiro de Fidelity al 1-800-632-2014 para recibir asistencia en español.

This booklet provides the Summary Plan Description (SPD) for the PepsiCo Retiree Health Care and Group Insurance Programs plan year beginning as of January 1, 2015. It applies to eligible PepsiCo retirees and their eligible spouses/domestic partners and other eligible dependents from the following divisions and subsidiaries of PepsiCo, Inc.

- PepsiCo, Inc. (Corporate, PCNA and PBI) and Expatriates who retire on or after January 1, 1989.
- Frito-Lay who retire on or after January 1, 1994.
- Frito-Lay (Cleveland Warehouse) who retire on or after July 2, 2013.
- Quaker (Salaried) who retire on or after January 1, 1989.
- Quaker Hourly (Tolleson) who retire on or after January 1, 2003.
- Quaker Hourly (Mountain Top) who retire on or after January 1, 2004.
- Quaker Hourly (Dallas) who retire on or after January 1, 1989.
- Quaker Hourly who retire on or after the date listed below for the following locations:

<table>
<thead>
<tr>
<th>Location</th>
<th>Retirement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeview</td>
<td>1/1/1995</td>
</tr>
<tr>
<td>Cedar Crafts</td>
<td>1/1/1991</td>
</tr>
</tbody>
</table>
Cedar RWDSU 1/1/1991
Danville 1/1/1995
Fullerton 1/1/1989
Indianapolis 1/1/1993
Kissimmee 1/1/1992
Manhattan 1/1/1989
Shiremanstown 1/1/1989
St. Joseph 1/1/1989

- Tropicana (City of Industry) who retire on or after January 2, 1994.
- Tropicana (Salaried) who retire on or after January 2, 1994.
- Tropicana (Mould Makers) who retire on or after December 2, 2002.
- Tropicana (Teamsters 173) who retire on or after January 2, 2004.
- Legacy Pepsi Bottling Group (PBG) who retired on or after January 1, 1993, with the exception of:
  - Legacy PBG Teamsters 125 retirees who retired between January 1, 1993 and May 31, 2001
  - Legacy PBG St. Louis Local 303 retirees who retired between January 1, 1993 and December 31, 1994
  - Legacy PBG St. Louis Local 688 retirees who retired between January 1, 1993 and June 30, 1993
- Legacy PepsiAmericas (PAS) who retired on or after July 1, 1989, with the exception of certain grandfathered Milwaukee and New Milwaukee retirees.

  * For purposes of retiree medical and life insurance, you will be classified as a legacy PBG employee/retiree if you retired from PBG prior to its acquisition by PepsiCo or you were employed by PBG prior to the acquisition by PepsiCo and retired after the acquisition. Special intracompany transfer rules may also apply.

  ** For purposes of retiree medical and life insurance, you will be classified as a legacy PAS employee/retiree if you retired from PAS prior to its acquisition by PepsiCo or you were employed by PAS prior to the acquisition by PepsiCo and retired after the acquisition. Special intracompany transfer rules may also apply.

In addition, certain individuals are eligible for some but not all of the components of the PepsiCo Retiree Health Care Program summarized in this booklet. These individuals belong to the following retiree groups:

- The BlueCare HMO option will be offered only to eligible Tropicana retirees who live in an area where BlueCross BlueShield of Florida has the BlueCare HMO network.

- Quaker salaried retirees who retired prior to April 1, 2003 are not eligible for the life insurance benefits outlined in this booklet. However, they may be entitled to an ancillary death benefit under the PepsiCo Salaried Employees Retirement Plan, which is discussed in that plan’s description.

- Quaker hourly (except Dallas) retirees who retired prior to January 1, 2005 are not eligible for the life insurance benefits outlined in this booklet. However, they may be entitled to an ancillary death benefit under the PepsiCo Hourly Employees Retirement Plan, which is discussed in that plan’s description.

- Quaker hourly (Dallas only) retirees who retired prior to January 1, 2006 are not eligible for the life insurance benefits outlined in this booklet. However, they are entitled to an ancillary death benefit under the PepsiCo Hourly Employees Retirement Plan, which is discussed in that plan’s description.
The life insurance benefits outlined in this booklet are not available to PepsiCo or legacy PBG employees who were under age 40 (regardless of years of pension vesting service) or who had less than 5 years of pension vesting service (other than employees age 60 or older) as of December 31, 2010.

The life insurance benefits outlined in this booklet are not available to legacy PAS retirees, with the exception of certain grandfathered Heartland and Whitman retirees.

Unless otherwise provided in this SPD, references generally to PepsiCo employees/retirees without any other limitations include all employees/retirees regardless of whether you also belong to a special classification of retirees. For example, if you are classified as a Tropicana retiree or a legacy PBG retiree, references in this SPD to a “retiree” or “PepsiCo retiree” apply to your classification (as well as all other classifications).

Retirees and their eligible spouses/domestic partners and dependents who are covered under a different benefit design under the PepsiCo Retiree Health Care Program and/or Group Insurance Program will receive a different SPD; this SPD does not apply to them.

This SPD is intended to provide a summary of the major provisions of the plans in which you may be eligible to participate. Your benefits are described as clearly as possible with minimal use of technical words and phrases appearing in the official plan documents. However, this SPD is not intended to augment rights provided under the terms of the official plan documents.

The plans described in this SPD are intended to be continued; however, PepsiCo, Inc. (the plan’s sponsor) reserves the right at any time, at its discretion, to amend, modify, reduce, discontinue or terminate the plans.

Participation in the plans should not and may not be viewed as a contract or promise of continued benefits.
Contents

The PepsiCo Retiree Health Care and Group Insurance Programs .......................................................... ii
Retiree Health Care Program Highlights for Pre-Age 65 ........................................................................... 1
  Eligibility ................................................................................................................................................ 1
  Enrollment .............................................................................................................................................. 7
When Coverage Begins ............................................................................................................................. 10
Retiree Medical Costs ................................................................................................................................. 12
If You Are Retired and Are Retirement-Eligible ..................................................................................... 15
If You Terminate Employment and Are Not Retirement-Eligible ............................................................ 15
If You Die While Covered Under the PepsiCo Retiree Health Care Program ........................................... 16
When Coverage Ends ............................................................................................................................... 16
Retiree Medical Details .............................................................................................................................. 18
  Coverage Before Medicare Eligibility ................................................................................................. 18
  Coverage If You Become Medicare-Eligible Before Age 65 and Due to Disability or ESRD .................. 20
Pre-Medicare Retiree Medical Provisions ............................................................................................... 25
  Using Network Providers ......................................................................................................................... 25
  How Benefits Are Paid .............................................................................................................................. 28
  Precertification ....................................................................................................................................... 29
Other Specialized Pre-Medicare Medical Services .................................................................................. 31
  Covered Medical Expenses .................................................................................................................... 33
  Expenses Not Covered ............................................................................................................................. 39
Post-Medicare Retiree Medical Provisions for Those Receiving Medicare due to Disability or ESRD ...... 43
  Medicare-Approved Amount .................................................................................................................. 44
  The PepsiCo Plan’s Deductible and Out-of-Pocket Limit .................................................................. 44
  How Medicare Coverage Works With the PepsiCo Plan ................................................................. 44
  How Benefits Are Paid ............................................................................................................................ 45
  Covered Medical Expenses .................................................................................................................... 46
  Expenses Not Covered ............................................................................................................................. 50
Filing Claims ............................................................................................................................................. 53
Mental Health Benefits ............................................................................................................................ 54
  Mental Health and Substance Abuse Treatment .................................................................................... 54
  Exclusions .............................................................................................................................................. 57
  How to File a Claim ................................................................................................................................. 57
Prescription Drug Benefit .......................................................................................................................... 58
  Prescription Drug Highlights ................................................................................................................ 58
  Prescription Drug Coverage .................................................................................................................. 61
Medication and Supplies Not Covered ..................................................................................................... 62
Medications Requiring Coverage Review ............................................................................................... 63
Buying at a Pharmacy ............................................................................................................................... 66
Buying through the Mail Order Service ................................................................................................. 67
BlueCare HMO Option ............................................................................................................................. 69
  BlueCare HMO Medical Highlights .................................................................................................... 69

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Retiree Health Care Program Highlights for Pre-Age 65

The Company’s medical benefits help protect you and your family from the high cost of medical treatment. In most locations, you have access to a network of doctors, hospitals and other health care providers. This section describes the benefits available to eligible retirees and their eligible spouse/domestic partner and eligible dependents before age 65. If you (or your eligible spouse/domestic partner) are age 65 or older this section does not apply to you – go to the section on Retiree Health Care Program Highlights - Coverage After Age 65 on page 77.

When you retire from the Company, you have the opportunity to elect or defer retiree medical coverage. If you choose to enroll yourself and your eligible dependents in the Retiree Health Care Program, each year you’ll elect your coverage just as active employees do. If the medical benefits for the Company’s active employees change, the features of the Retiree Health Care Program generally change too.

* If you are classified as an eligible legacy PAS retiree and you retired before January 1, 2014, your opportunity to defer retiree medical coverage is limited. At retirement, you have the option to defer your initial enrollment if you elect to continue your active medical benefits under COBRA continuation coverage. Once COBRA continuation coverage ends, you must enroll in the Retiree Health Care Program. If you do not enroll in the Retiree Health Care Program at the time your COBRA continuation coverage ends, you will not be able to enroll at a later date.

There are different stages to retiree medical coverage, depending on the age and status of the person receiving benefits:

- **Before Medicare Eligibility:** Until you, your covered spouse/domestic partner, or a covered dependent child become eligible for Medicare, the Retiree Health Care Program works similar to the medical benefits for active employees.

- **If You Become Medicare Eligible Before Age 65:** In certain instances of disability or advanced renal disease, Medicare eligibility may start before age 65. In this case, you will continue to participate in the PepsiCo-sponsored group health plan, but the Retiree Health Care Program will automatically coordinate with Medicare Part A and Part B, regardless of whether you are actually enrolled in Medicare Part A and Part B coverage. This means that once you are eligible for Medicare Part A and Part B the Retiree Health Care Program will pay secondary to Medicare Part A and Part B regardless of whether you are actually enrolled in Medicare Part A and Part B. Therefore, once you become eligible for Medicare Part B you should promptly enroll to avoid having your total benefits reduced. In most instances, enrollment in Medicare Part A is automatic; however, this is not always the case. If this is a concern for you, you should also confirm your enrollment in Part A at the same time you enroll for Part B.

- **After You Become Eligible for Medicare at Age 65:** You will cease to be eligible to receive medical and prescription drug benefits from the PepsiCo Retiree Health Care Program and will instead be eligible to purchase an individual insurance plan via OneExchange. Depending on your age and years of service as of your date of retirement from the Company, you may be eligible for a Retiree Reimbursement Account. See page 77 for more information.

This section contains general information on the Company’s Retiree Health Care Program. If you are a Tropicana retiree, refer to page 68 for information on the BlueCare HMO option.

**Eligibility**

**Retiree**

In order to participate in PepsiCo retiree medical options, you are required to cooperate with the plan administrator and provide the plan administrator with information needed to administer your benefits. This includes providing the plan administrator with the correct names of your eligible spouse/partner and your eligible dependents and their correct Social Security numbers and birthdates. You must also respond to reasonable requests of the plan administrator for additional information. Failure to cooperate with the plan administrator may result in the termination or suspension of your retiree medical benefits.

**Note:** The following eligibility provisions do not apply to legacy PAS employees. If you are a legacy PAS employee, please refer to “Eligibility—For Legacy PAS Employees Only” below for the provisions that apply to you.
As an active employee, when you retire from the Company, you and your eligible spouse/partner/dependents may be eligible for retiree medical coverage if, as of the date you retire from the Company, you are age 65 or older with at least 5 years of pension vesting service or age 55-64 with at least 10 years of pension vesting service. In addition, you must be classified as a full-time active employee at the time you satisfy one of the age and service requirements to be retirement eligible.

1 Age 55 with at least five years of service for Tropicana employees who were actively employed on January 1, 2002, and were at least 40 years of age on January 1, 2002. Employees who qualified for the Special Early Retirement Window offered as a part of the Quaker Oats Transition Severance Program for Tropicana Employees will also be eligible for retiree medical.

2 For legacy PBG employees: Depending on your work location, if you are a non-union hourly employee you may be eligible to elect retiree medical coverage if you retire with 30 years of pension vesting service regardless of age. Further, special rules exist if you are eligible to commence an immediate disability pension.

Special eligibility rules may apply if you are covered by a collective bargaining agreement, a Company severance program or the special transfer rules applicable to transfers among legacy PepsiCo, PBG and PAS.

Under a Company severance program, certain special early retirees and their eligible spouse/partner/dependents may be eligible for retiree medical coverage to the extent eligibility is provided in the official plan documents and summary plan description of the applicable severance program. If you become disabled before you are eligible to retire from the Company, you may still become eligible for retiree medical benefits. To be eligible for retiree medical benefits you must (1) be classified as a full-time active employee of the Company on the date your disability begins and (2) reach age 65 or older with at least 5 years of pension vesting service or reach age 55 through 64 with at least 10 years of pension vesting service by the date your pension vesting service ends under the applicable Company pension plan. Please see the pension plan section of the PepsiCo Benefits Book for information regarding when your pension vesting service ends after becoming disabled. The PepsiCo Benefits Book is located on http://www.pepsicoemployee.com, or you can call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 for a printed copy.

Once you elect a medical option, you must maintain continuous coverage in one of the plan’s medical options. If you decline coverage thereafter (or coverage otherwise terminates for any reason, including for non-payment of premiums), you will lose the right to resume coverage in the future, including at open enrollment.

For more information call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014.

Eligibility—For Legacy PAS Employees Only

As an active non-union employee, when you retire from the Company, you and your eligible spouse/partner/dependents may be eligible to elect retiree medical coverage if, as of the date you retire from the Company, you are age 55 or older with at least ten years of full-time service.

If you are an active employee covered by the Local 344 collective bargaining agreement, and you attain eligibility for early or normal retirement under the applicable company pension plan, you and your eligible spouse/partner/dependents may be eligible to elect retiree medical coverage as of the date you retire from the Company.

If you are designated as a grandfathered employee resulting from the Heartland acquisition, you and your eligible spouse/partner/dependents may be eligible to elect retiree medical coverage as of the date you retire from the Company, provided you are at least 55 when you retire from the Company.

If you become disabled before you are eligible to retire from the Company, you may still be eligible to elect retiree medical coverage. To be eligible to elect retiree medical coverage, you must (1) be in one of the eligibility groups noted above and have at least 10 years of service on the date your disability begins and (2) reach age 55 or older by the date your eligibility for active medical benefits ends under the Company medical plan.

Special eligibility rules may apply if you are covered by a collective bargaining agreement, a Company severance program or the special transfer rules applicable to transfers among legacy PepsiCo, PBG and PAS.

Once you elect a medical option, you must maintain continuous coverage in one of the plan’s medical options. If you decline coverage thereafter (or coverage otherwise terminates for any reason, including for non-payment of premiums), you will lose the right to resume coverage in the future, including at open enrollment.

For more information call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014.

Double Coverage

If both you and your spouse or domestic partner were employed by PepsiCo or a division or subsidiary of PepsiCo and are eligible for the Retiree Health Care Program, each of you may be covered under the plan as either a retiree

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or a spouse/partner but not both. You may pick one plan to cover both of you (as a retiree and spouse/partner), or you may each elect your own plan (as individual retirees). Either of you may cover your eligible children, but they may not be covered by both of you.

**Spouse**

Your spouse is eligible to be covered under the PepsiCo Retiree Health Care Program unless you are divorced. Coverage is available for common-law spouses, provided your marriage was formed in a state that permits (or at a time when the state permitted) common-law marriage. Your common-law marriage must also be recognized as valid under the law of the state where you currently live.

If you marry during the year, it is your responsibility to call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. If you enroll your new spouse within 31 days of the date of your marriage, his/her coverage will be effective on the date of your marriage. Otherwise, you must wait until the next annual open enrollment period (or a qualifying change in status, if earlier) to add your new spouse to your retiree medical coverage.

In the case of a divorce, coverage ends for your spouse on the day the divorce is final. It is your responsibility to report the divorce to The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 within 31 days of the final decree. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded.

**Same-Sex Spouse**

Same sex spouses will be treated as a “spouse” for all plan purposes. A same sex spouse means your legal spouse with whom you have entered into a legal marriage in a state or foreign country that authorizes the legal marriage of two individuals of the same sex. (Civil unions are not considered marriages for this purpose.) For plan purposes, your married status remains regardless of whether you now or in the future reside in a state that does not authorize the marriage of same sex individuals.

**Same-Sex Domestic Partner**

Same-sex domestic partners may be eligible to be covered under the PepsiCo Retiree Health Care Program. To be eligible for domestic partner benefits, you and your domestic partner must meet certain requirements, depending upon the laws of your state of residency:

- If you live in a state that permits same-sex couples to marry, you and your partner will have to get married. In that event, your same-sex spouse will be treated as a “spouse” for all purposes under the plan.

- If you live in a state that permits same-sex couples to enter into civil unions, you and your domestic partner will have enter into such a union. Federal law does not permit civil union couples to be treated as spouses, and therefore for purposes of plan coverage your civil union partner will be treated as a domestic partner.

- If you live in a state that does not permit same-sex couples to marry or enter into civil unions, you and your domestic partner will be required to execute a legally binding domestic partner agreement (see below) that has been notarized or witnessed by a third party. However, if you have previously enrolled your current domestic partner in Tropicana benefits prior to January 1, 2004, you will not be required to execute a domestic partner agreement to continue benefits eligibility.

(Special rules apply to legacy PAS retirees who retired prior to January 1, 2012. See below for additional information.)

In the future, if the right to marriage or a civil union is legally established where you live, you will then be required to marry or enter a civil union in order for your domestic partner and his or her dependent children to remain or become eligible for benefits (regardless of whether your domestic partner was previously enrolled). You will need to enter into the legally available form of commitment before the next open enrollment cycle or within 12 months of the effective date of the change in the law (whichever comes later) in order to continue to qualify for domestic partner coverage. If you and your partner are legally married or enter into a civil union, a domestic partner agreement is not required.

While a domestic partner agreement, civil union or marriage is required for eligibility for benefit coverage for your partner, the Company will not ask you to submit documentation for coverage to become effective. However, as in the case of marriage, the Company reserves the right to audit your and your dependents’ eligibility for the benefits you have elected and to request a copy of your domestic partner agreement (or civil union/marriage license where applicable by law) as proof of your domestic partner’s eligibility.

Elections made during the year must be made within 31 days of the date that you and your domestic partner meet the eligibility requirements, and your elections will be effective as of that date. Otherwise, you must wait until the next
annual open enrollment period (or qualified status change, if earlier) to add your new domestic partner to your retiree medical coverage.

In the case of a termination of your same-sex marriage or civil union or a termination of your domestic partner relationship, coverage ends for your partner on the day the termination is final. It is your responsibility to report the termination of your same-sex marriage or civil union or domestic partner relationship to The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 within 31 days. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded.

Special legacy PAS rules: Prior to January 1, 2012, special domestic partner eligibility rules applied to legacy PAS retirees. If you retired before January 1, 2012, and you enrolled your current domestic partner in retiree medical coverage prior to January 1, 2012, under the special rules, your domestic partner will remain eligible for retiree medical coverage and you will not be required to satisfy the above eligibility requirements. However, the special legacy PAS domestic partner rules no longer apply for retirements on or after January 1, 2012. Any legacy PAS retirees who retire on or after January 1, 2012, and who desire to enroll a domestic partner in retiree medical coverage must satisfy the above domestic partner rules.

Domestic Partner Agreement

At a minimum, a Domestic Partner agreement must acknowledge that you and your partner are:

- In a committed relationship,
- Both legally consenting adults of the same sex,
- Living together,
- Financially interdependent,
- Not married or in a domestic partnership with anyone else, and
- Not related by blood to a degree of closeness that would otherwise prohibit legal marriage.

The Company recommends but does not require that you consult with a lawyer to draft your domestic partner agreement. In general, a domestic partner agreement is a contract between the domestic partners. While contracts are recognized as binding legal documents in all 50 states, each state may have different requirements for a document to be considered a valid contract.

Child

Your children under age 26 are eligible to be covered under the PepsiCo Retiree Health Care Program thru the last day of the month in which they turn age 26, regardless of student status, financial dependency, employment status or marriage status. As described below, eligible children may be covered after reaching age 26 only if they are disabled as determined by the claims administrator. The term “children” includes:

- Your biological and adopted children (and children placed for adoption),
- Your step-children,
- Your or your spouse’s eligible foster children,
- Children for whom you or your spouse are the legal guardian,
- Children of your domestic partner who meet all other eligibility criteria, and
- Children named in an order satisfying the requirements of a Qualified Medical Child Support Order (QMCSO), as determined by the plan administrator.

Grandchildren cannot be covered unless you or your spouse/partner are their legal guardian or have legally adopted them.

Benefits for a newborn child begin at birth, if you enroll the child within 31 days of the date of birth. If you are adopting or taking legal guardianship of a child, the date coverage starts for that child is the date the legal document becomes effective, if you enroll the child within 31 days of the effective date. Talk to your lawyer for more information.
Disabled Child
A physically or mentally disabled child who meets the above eligible child requirements is eligible for coverage even though he or she has reached age 26, if:

- Your child is enrolled for retiree medical coverage and disabled on the date coverage would usually end;
- Your child is dependent on you (or you and your spouse/partner) for financial support;
- Your child has been covered under a PepsiCo medical or retiree medical option since the date the disability began; and
- The claims administrator determines that your child meets the definition of disabled.

If you are a new or existing retiree and you have a physically or mentally disabled child who meets the above requirements but who is not enrolled in PepsiCo retiree medical coverage, your child may be eligible for coverage, provided:

- The disability occurred prior to age 26, and
- You provide proof that the child had continuous major medical coverage or similar coverage as determined by the plan administrator (such as through a prior employer or your spouse’s or domestic partner’s employer) from the date of disability up to the date on which you try to add the child to your coverage.

To avoid delays in your child’s claim processing, provide proof of your child’s disability at least 120 days before the child’s coverage would usually end. If your disabled child is already 26 or older when you are first eligible to enroll, you should submit evidence that you satisfy the above two rules regarding your child’s disability to your claims administrator.

During subsequent enrollment periods you may be required to provide additional information regarding your child’s continuous disability.

Child of a Domestic Partner
Once you have entered into a domestic partner relationship, a dependent child of your domestic partner may be covered under the PepsiCo Retiree Health Care Program. Any dependent child must also meet the above eligibility requirements. Biological and adopted children of your domestic partner, children for whom your domestic partner is the legal guardian, and foster children of your domestic partner may be covered. Eligible children may be covered thru the last day of the month in which the child’s 26th birthday occurs. Coverage may also be extended if the eligible child is mentally or physically disabled and depends on you (or you and your partner) for financial support.

Surviving Spouse/Domestic Partner Coverage
If you die, your eligible surviving spouse/domestic partner and eligible surviving dependent children on the date of your death will continue to be eligible for coverage after your death under PepsiCo’s retiree medical options as long as the required premiums are timely paid, they have valid Social Security numbers on file with the claims administrator and they satisfy any other applicable conditions of the plan. If your surviving spouse or your surviving domestic partner marries, remarries or legally contracts with a new partner, the new spouse/partner and his/her children are not eligible for plan coverage and cannot be added to the plan. In other words, after the PepsiCo retiree’s death, no new spouses/partners or dependent children may be added to Plan coverage.

Surviving Spouses/Domestic Partners of Active Employees
If you are not classified as a Quaker or a legacy PAS employee and you die while an active employee, coverage will be available to your eligible surviving spouse/domestic partner and eligible dependents (determined on the date of your death) if, on the date of your death:

- You are age 55 or over and have 10 or more years of pension vesting service under a qualified PepsiCo retirement plan, or
- You are age 65 or over and have 5 or more years of pension vesting service under a qualified PepsiCo retirement plan.

In addition, you must also be classified as a full-time active employee at the time you satisfy one of the age and service requirements set forth directly above on or before your date of death.

Your surviving eligible dependents may continue medical benefits (if previously covered) under COBRA for 6 months at no cost, after which they will be offered coverage under the retiree medical plan and will be responsible for paying the applicable contributions to continue medical coverage thereafter.
All surviving dependents of employees (regardless of employees’ retirement eligibility status) will be able to continue their dental and vision coverage (if previously covered) through COBRA continuation coverage for 36 months by paying the applicable COBRA premium.

All extended coverage in case of death is subject to the Company’s right to terminate completely or to change in any way the coverage provided to current and former employees and their dependents (for example, by reducing or eliminating benefits or by instituting charges for some or all of the costs).

Surviving Spouses/Domestic Partners of Certain Quaker Active Employees

Surviving spouses/domestic partners and eligible dependents (determined as of the date of death) of certain active Quaker employees are eligible for retiree medical if the Quaker employee who died met one of the following criteria:

- The Quaker employee was at least age 55 with at least 10 years of full-time service,
- The Quaker employee was classified as salaried, had a date of death as an active Quaker employee prior to January 1, 2003, and either was at least age 55 or had 10 or more years of full-time service at death, or
- The Quaker employee was classified as an hourly employee, had a date of death prior to the date listed for his/her work location below and was at least age 55 or had 10 or more years of full-time service at death:

<table>
<thead>
<tr>
<th>Location</th>
<th>Active employee date of death before the following dates</th>
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</thead>
<tbody>
<tr>
<td>Atlanta</td>
<td>1/1/2004</td>
</tr>
<tr>
<td>Bridgeview</td>
<td>1/1/2004</td>
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<tr>
<td>Cedar Crafts</td>
<td>1/1/2005</td>
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<tr>
<td>Cedar RWDSU</td>
<td>1/1/2004</td>
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<tr>
<td>Dallas</td>
<td>1/1/2006</td>
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<td>Danville</td>
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<td>Shiremanstown</td>
<td>1/1/2004</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>1/1/2004</td>
</tr>
</tbody>
</table>

Coverage for surviving spouses/domestic partners of Quaker employees who met the criteria of age 55 or had 10 or more years of full-time service will end when he or she turns age 65, remarries or dies. Coverage for eligible dependents will end when the spouse/partner coverage ends, or when the dependent no longer satisfies the eligibility criteria, if earlier.

Refer to the section of “When Coverage Ends” for specific information about the length of this benefit.

Surviving Spouses/Domestic Partners of Legacy PAS Active Employees

If you are classified as a legacy PAS employee and you die while an active employee, coverage will be available to your eligible surviving spouse/domestic partner and eligible dependents (determined on the date of your death) if, on the date of your death, you satisfied the applicable eligibility requirements for coverage under the Retiree Health Care
Program. Refer to “Eligibility—For Legacy PAS Employees Only” for information about the eligibility requirements for retiree medical coverage.

In addition, you must also be classified as a full-time active employee at the time you satisfy one of the age and service requirements noted in the section “Eligibility—For Legacy PAS Employees Only” on or before your date of death.

Your surviving eligible dependents may continue medical benefits (if previously covered) under COBRA for 6 months at no cost, after which, they will be offered coverage under the retiree medical plan and will be responsible for paying the applicable contributions to continue medical coverage thereafter.

All surviving dependents of employees (regardless of employees’ retirement eligibility status) will be able to continue their dental and vision coverage (if previously covered) through COBRA continuation coverage for 36 months by paying the applicable COBRA premium.

All extended coverage in case of death is subject to the Company’s right to terminate completely or to change in any way the coverage provided to current and former employees and their dependents (for example, by reducing or eliminating benefits or by instituting charges for some or all of the costs).

**Audits of Enrollment Status and Proof of Dependents**

The Company reserves the right to audit at any time any enrollment election or other information you have provided to the Company in connection with your enrollment. This right to audit includes auditing the status of your enrolled spouse/partner and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of your marriage/domestic partnership and for your enrolled dependent children. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be disenrolled from Company benefits, possibly retroactively.

This right to audit also includes any other enrollment issues, including whether the correct premium and Company subsidy apply to you. PepsiCo may revise your premium and Company subsidy to correct a prior incorrect premium or Company subsidy, and this may be done retroactively or prospectively (due to an audit or otherwise).

Providing the Company with false or misleading information regarding your enrollment, a spouse/partner or dependent child, enrolling an individual who does not satisfy the eligibility criteria, or failing to drop an enrolled individual in a timely manner when he/she no longer satisfies the eligibility criteria may constitute fraud or misrepresentation. If the Company determines that fraud or misrepresentation has occurred, the Company may also terminate or suspend your plan coverage, require repayment of an ineligible individual’s prior claims, require payment of the total value of an ineligible individual’s coverage or take other corrective action (retroactively or otherwise).

**Exclusions**

If any individual classified by the Company as not eligible or coming within an ineligible designation is required by the Internal Revenue Service, Department of Labor or other governmental agency, or by any court or other tribunal to be classified as eligible for the PepsiCo Retiree Health Care Program or PepsiCo Group Insurance Program, such individual shall not be eligible to participate unless and until the time he or she is designated by the Company as eligible. Such designation shall only provide for eligibility prospectively from the time it is made, even if the decision or requirement applies retroactively.

**Enrollment**

**Before You Retire**

If you are under age 65 and you meet the retiree medical eligibility requirements, you have the opportunity to review your retiree medical plan options and costs 180 days before your actual retirement date. To do so, you need to contact The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 and request a “modeling kit.” The retiree medical modeling kit includes an enrollment guide and a Personal Fact Sheet that allows you to see your benefit options and their costs.
Once you receive your retiree medical modeling kit, you can make an election based on the options up to 90 days prior to your retirement date. Contact The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 to pre-enroll. Then, when you retire, you will automatically be enrolled in this coverage—assuming you are still eligible for the plan you pre-enrolled in. If, at the time of your actual retirement, your eligibility has changed (e.g., you move to a ZIP code area where that plan is not available), you will receive a new Personal Fact Sheet with your new options and instructions on how to enroll.

Also, note that retiree medical costs usually change annually each January 1, so you may not know the actual cost of your retiree medical coverage until the year you actually retire. (If you are age 65 or older, see page 77)

### Issues to Consider Before You Retire

- Effective as of December 31, 2010, the Company began phasing out the Company contribution that it makes toward retiree medical coverage. See “Retiree Medical Costs” on page 12.

- The cost of retiree medical coverage changes from year to year. With medical inflation expected to continue, you’ll need enough savings to make sure you can afford retiree medical.

- As soon as you and/or your spouse/partner/dependent become eligible for Medicare—after reaching age 65, for disability or for advanced stage renal disease (ESRD)—you must enroll in Medicare Part A and Part B. If you are under age 65 and enroll in Medicare Part D or Medicare Advantage, you will lose your PepsiCo retiree medical and prescription drug benefits and you will not be able to re-enroll for PepsiCo retiree medical and prescription drug coverage in the future.

- If you and/or your spouse/partner/dependent become eligible for Medicare before age 65, Medicare becomes the primary payer of you and/or your spouse/partner/dependent’s medical claims and the PepsiCo Retiree Health Care Program will be the secondary payer regardless of whether you actually enroll in Medicare. That is why you need to take action and enroll in Medicare Part B—it is not done through PepsiCo. Once you are Medicare eligible, PepsiCo assumes that you have enrolled in Medicare Part B regardless of whether you have actually enrolled. You need to ensure that the level of your benefits will not decrease once you and/or your spouse/partner/dependent become eligible for Medicare—call the Social Security Administration at 1-800-772-1213 and enroll in Medicare Part B (outpatient medical coverage). Further, in most instances, enrollment in Medicare Part A is automatic; however, this is not always the case. If this is a concern for you, you should also confirm your enrollment in Part A at the same time you enroll for Part B. If you or your Medicare-eligible spouse/partner/dependent did not enroll in Medicare while you were an active employee, upon your retirement you have limited time to enroll in Medicare. Failure to enroll within the applicable Medicare enrollment period after you or your spouse/partner/dependent become eligible (e.g., age 65 or after receiving 24 months of SSA disability benefits), or after you retire if later, means that you may have to wait until the following year to enroll and may have to pay higher premiums (that will last for your lifetime) once you enroll in Medicare. To determine your applicable Medicare enrollment period or if you have any questions regarding Medicare, you should contact Medicare at (800) 633-4227 or review the Medicare & You Handbook at www.medicare.gov.

- If you plan to retire before age 65, make sure you can afford the cost of pre-Medicare coverage.

- You might be eligible to continue your active medical coverage for up to 18 months under COBRA when you retire. Note that you must be enrolled in PepsiCo medical coverage as an active employee in order to continue coverage under COBRA.

### When You Retire

If you are under age 65 and don’t take advantage of the modeling kit and pre-enroll in retiree medical coverage through Fidelity, when you retire, you will receive a retiree medical enrollment kit. It contains all of the information you need to make an informed decision:

- **A Retiree Benefits Enrollment Guide**, which provides an overview of the coverage and detailed enrollment steps.

- **A Personal Fact Sheet**, which shows the medical options available to you and their costs, as well as your enrollment deadline.

You can enroll online at www.netbenefits.com/pepsico or by calling The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. Note that you must take action by your enrollment deadline. You will need to choose:

- Your medical option (which includes the option of waiving retiree medical coverage initially and enrolling at a later date); and
Your payment option (if you do not waive coverage initially). Requests for payment options cannot be made online. You must call The PepsiCo Savings and Retirement Center at Fidelity.

* If you are classified as an eligible legacy PAS retiree and you retired before January 1, 2014, your opportunity to defer retiree medical coverage is limited. At retirement, you have the option to defer your initial enrollment if you elect to continue your active medical benefits under COBRA continuation coverage. Once COBRA continuation coverage ends, you must enroll in the Retiree Health Care Program. If you do not enroll in the Retiree Health Care Program at the time your COBRA continuation coverage ends, you will not be able to enroll at a later date.

If You Don’t Enroll

If you are under age 65 and do not actively elect coverage for yourself and your family before your enrollment deadline, you will default to “No Coverage.” If you and your dependents waive coverage (or default to “No Coverage”), you will be able to enroll at a later date either during annual enrollment or after a qualified status change. However, you can only defer your medical coverage once.

For legacy PAS retirees: If you are classified as an eligible legacy PAS retiree and you retired before January 1, 2014, your opportunity to defer retiree medical coverage is limited. At retirement, you have the option to defer your initial enrollment if you elect to continue your active medical benefits under COBRA continuation coverage. Once COBRA continuation coverage ends, you must enroll in the Retiree Health Care Program. If you do not enroll in the Retiree Health Care Program at the time your COBRA continuation coverage ends, you will not be able to enroll at a later date.

Enrolling Eligible Dependents

When you enroll in the PepsiCo Retiree Health Care Program through Fidelity, you must choose a coverage category (e.g., retiree only, retiree + spouse, family). Each category has a different cost. You will find your coverage categories and associated costs on your Personal Fact Sheet. If you are under age 65 and enrolling in the PepsiCo Retiree Health Care Program, your eligible spouse/partner or any other eligible dependent(s) generally must be enrolled in the same medical option that you choose. Your spouse/partner and dependent(s) will not be covered under the plan unless you enroll them. If you do not include them in your initial enrollment, you can enroll your eligible dependents within 31 days after a qualified status change or at the next annual enrollment. Please refer to the list of qualified status changes (on page 11)

Benefits for a newborn child begin at birth, if you enroll the child within 31 days of the date of birth.

For legacy PAS retirees who retired before January 1, 2014: If your spouse/partner/dependents are eligible to be enrolled, you must enroll them during your initial enrollment. You cannot add or change a spouse/partner/dependent to your retiree medical coverage once your initial enrollment period has passed.

Coverage After Becoming Eligible for Medicare

Generally an individual becomes eligible for Medicare once they satisfy one of the following criteria:

- **Age 65** – See Retiree Health Care Program Highlights - Coverage After Age 65 on page 77 for information about benefits once you (or your spouse/domestic partner) turn age 65.
- **Receipt of no less than 24 months of Social Security disability benefits regardless of age; or**
- **Diagnosis with end stage renal disease (ESRD, subject to certain exceptions).**

If you become Medicare eligible for reasons of disability or ESRD, you will continue to be covered under the PepsiCo Retiree Health Care Program. Federal law requires PepsiCo to exchange information with Medicare regarding plan participants who may be eligible for Medicare. Once PepsiCo receives information about your and/or your spouse/partner/dependent’s Medicare eligibility for disability or ESRD, you and/or your spouse/partner/dependent will be automatically defaulted to PepsiCo post-Medicare coverage and Medicare must pay your medical claims first. PepsiCo post-Medicare coverage pays secondary to Medicare—regardless of whether you have enrolled in Medicare. Therefore, you are responsible for applying for Medicare, which includes hospital coverage under Medicare Part A and outpatient medical coverage through Medicare Part B. While enrollment in Part A is automatic for most individuals (some minor exceptions apply), enrollment for Part B is not automatic.

- You must contact the Social Security office at 1-800-772-1213 to apply for Medicare Part B. It is not done through PepsiCo.
- If you and/or your spouse/partner/dependents do not enroll in Medicare Part B, the level of your and/or your spouse/partner/dependent’s benefits will be significantly reduced. For example, your PepsiCo post-Medicare...
coverage always pays benefits assuming Medicare paid its portion first. Thus, if you do not timely enroll in Medicare you will not receive any Medicare benefits for those claims.

The above rules apply individually to you and to your spouse/partner/dependent. For example, if you are age 65 and your spouse is age 62, you will no longer receive your medical and prescription drug coverage from the program and may elect an individual policy through OneExchange, and your spouse will keep his/her PepsiCo coverage. Once your spouse turns age 65, he/she will be eligible to purchase an individual policy through OneExchange.

You should also be aware that failure to enroll within the applicable Medicare enrollment period after you or your spouse/partner/dependent become eligible means that you may have to wait until the following year to enroll and may have to pay higher premiums (that will last for your lifetime) once you do enroll in Medicare. To determine your applicable Medicare enrollment period or if you have any questions regarding Medicare, you should contact your local Social Security Office or review the Medicare and You Handbook at www.medicare.gov.

Individuals who are eligible to enroll in Medicare are also eligible to enroll in Medicare’s prescription drug coverage, referred to as Part D. Part D is a voluntary benefit and you may choose to enroll in Part D or not to enroll. You may also be eligible to enroll in a Medicare Advantage plan, referred to as Part C. Generally, a Medicare Advantage plan provides all of your Medicare benefits, including prescription drug benefits. If you are Medicare-eligible and under age 65 and you choose to enroll in Medicare Part C or Part D, your PepsiCo retiree medical and prescription drug coverage will be cancelled for you and your spouse/partner/dependents and you will not be able to re-enroll for PepsiCo retiree medical and prescription drug coverage in the future.

PepsiCo has determined that the total value of prescription drug coverage provided through PepsiCo’s Retiree Health Care Program is on average equal to or better than the Medicare prescription drug coverage. This means that you do not have to pay a higher premium if you later decide to enroll in Part C or Part D. Each October, the Company sends you a Notice of Creditable Prescription Drug Coverage that describes these rules in more detail. If you would like another copy of this notice or have additional questions, please contact a PepsiCo Savings and Retirement Center representative at 1-800-632-2014.

**When Coverage Begins**

The start of your retiree medical coverage generally depends on when you enroll, as follows:

<table>
<thead>
<tr>
<th>If you enroll for retiree medical coverage…</th>
<th>Your coverage becomes effective…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 31 days of your retirement date</td>
<td>The first of the month after your retirement date*</td>
</tr>
<tr>
<td>During the annual enrollment period</td>
<td>As of January 1 of the following calendar year</td>
</tr>
<tr>
<td>Within 31 days of a qualified status change</td>
<td>As of the date of the qualified status change</td>
</tr>
<tr>
<td>For PepsiCo and legacy PBG retirees: Later than 31 days after your retirement date (and not during annual enrollment or within 31 days of a qualified status change)</td>
<td>The first day of the following month that you contact The PepsiCo Savings and Retirement Center to begin your coverage</td>
</tr>
<tr>
<td>For legacy PAS retirees who retired after January 1, 2014: Later than 31 days after your retirement date (and not during annual enrollment or within 31 days of a qualified status change)</td>
<td>The first day of the following month that you contact The PepsiCo Savings and Retirement Center to begin your coverage</td>
</tr>
</tbody>
</table>

* In this case, if you enroll in retiree medical within 31 days of your retirement date, your medical coverage as an active employee will not terminate until the last day of the month in which you retire. This means in that situation there is no gap between your active medical and retiree medical coverages.

Once you are enrolled in the Retiree Health Care Program, your opportunities to change coverage options are limited. You may be able to change your coverage elections if you have a qualified status change or other applicable event, as further explained below. (However, legacy PAS retirees who retired before January 1, 2014, may not change their spouse/partner or dependents after their initial enrollment period. See the section titled “Special rule for Pre-2014 legacy PAS retirees”, below for additional information.) Whenever you have a qualified status change, you must report the change to The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 within 31 days of the event. Otherwise, you must wait until the next annual enrollment period to change your retiree medical coverage (or another applicable qualified status change, if earlier).
Qualified Status Changes

Except as provided below, your benefit elections remain in effect for a full year—January 1 through December 31. However, you may change certain benefit choices during the year if the plan administrator determines that you have experienced one of these qualified status changes:

- Marriage
- Divorce or legally recognized separation
- Commencement or termination of a domestic partner relationship
- Birth, adoption or placement of a child in your home for adoption
- Death of your spouse, domestic partner or dependent child
- Dependent child becomes ineligible (e.g., because they turn age 26)
- Spouse, domestic partner or dependent child’s parent gains or loses medical coverage
- Entitlement or loss of entitlement to Medicare or Medicaid benefits by you or your spouse, domestic partner or dependent
- Issuance of a qualified medical child support order (QMCSO), annulment, or change in legal custody or other judgment, decree, or order resulting from a divorce or legal separation that requires accident or health coverage for your child (you can obtain a copy of the Plan’s procedures for QMCSOs, free of charge, by contacting the plan administrator).

Note: Changes you may make when a qualified status change occurs may vary. Please contact The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 if you have any questions.

You will be eligible to make benefit changes within 31 days of a qualified status change. The changes you make in your medical coverage become effective as of the date of the qualifying event.

Special rules for eligible PepsiCo or legacy PBG retirees:

- If you have never been covered under the retiree medical plan and choose to elect coverage you can do this at any time during the year by calling The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. However, please note that if you have been enrolled in retiree medical coverage and subsequently waived coverage you will not be able to re-enroll, even if you have a qualifying event. This rule does not apply to adding and dropping dependents during appropriate qualifying events.
- Notwithstanding the foregoing, after the retiree’s death the qualified status changes listed above will be restricted so that no new spouses/partners or dependent children can be added to plan coverage who were not eligible spouses/partners or eligible dependent children of the retiree on the date of his/her death.

Special rule for pre-2014 legacy PAS retirees:

- If you retired before January 1, 2014, you must enroll your eligible spouse/partner or dependents during your initial enrollment period. Once your initial enrollment period has passed, you cannot change your spouse/partner or dependent elections and you cannot add a new spouse/partner or dependent.

Please note: The Company may request documentation to verify qualified status changes at any time.

**COBRA Continuation Coverage at Retirement**

At the time of your retirement you will be eligible to elect COBRA continuation coverage for the medical options you were eligible for before retirement. COBRA was established under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA continuation coverage is also available for dental and vision coverage in which you were enrolled as an active employee. If you elect coverage under a retiree medical option, you will be deemed to have voluntarily waived any COBRA continuation coverage for medical. You cannot be enrolled in a retiree medical option and COBRA continuation coverage for a medical option at the same time.

COBRA continuation coverage generally lasts for 18 months. You will receive a COBRA kit soon after you retire. After COBRA continuation coverage ends or terminates early due to your Medicare eligibility after you have elected COBRA, you may elect coverage under the available retiree medical options. See the COBRA Continuation Coverage section for more details, or you can call The HR Service Center at 1-866-HR-FOR-ME.

* If you are classified as an eligible legacy PAS retiree and you retired before January 1, 2014, once your COBRA period ends, you can enroll in the Retiree Health Care Program. If you do not enroll in the Retiree Health Care Program at the time your COBRA coverage ends, you will not be able to enroll at a later date.
**Health Care Reimbursement Account**

If, at the time you retire, you have a Health Care Reimbursement Account (HCRA) for medical expenses, you may submit claims for health care expenses incurred before you retired. You have until June 30 of the following year to submit claims for expenses incurred while you were actively employed. Any funds left in your account after June 30 of the following year will be forfeited. For more information contact The HR Service Center at 1-866-HR-FOR-ME.

Expenses incurred after you retire can be submitted only if you continue to contribute on an after-tax basis to your HCRA through COBRA. This coverage can only be continued through the end of the year in which you retire. Call The HR Service Center at 1-866-HR-FOR-ME for more information.

Eligible medical, prescription drug, dental and vision expenses incurred for yourself, your spouse or your dependent children may be reimbursed from the account. Expenses for your domestic partner and your domestic partner’s dependent children are not eligible for reimbursement from the account, unless they are considered your tax dependents for federal income tax purposes.

**Healthy Advantage Option**

The Healthy Advantage Option is offered to active employees and is not offered to retirees under the plan. If you enrolled in the Healthy Advantage Option and made payroll withholding contributions to a health savings account (HSA) as an active employee, your payroll withholding contributions will terminate with your last paycheck. If you are eligible to defer retiree medical coverage under the plan and enroll in another high deductible health plan (not sponsored by PepsiCo), it may be possible for you to continue your HSA contributions but you must make those contributions directly with your HSA custodian. Your existing HSA balance can be used tax-free to pay for your eligible medical, dental, vision and prescription drug expenses for you and your spouse and tax dependents. You should contact your tax advisor for additional information and to discuss the operation of your HSA after your retirement.

**Retiree Medical Costs**

The following charts explain how the Company contribution toward retiree medical coverage will apply for current and future PepsiCo and legacy Pepsi Bottling Group (PBG) retirees. If you are a legacy PepsiAmericas (PAS) retiree, refer to "For individuals classified as legacy PepsiAmericas (PAS) retirees only" below.

### For individuals classified as legacy PepsiCo retirees only:

<table>
<thead>
<tr>
<th>If you met this description on December 31, 2010 ...</th>
<th>Your pre-65 Retiree Medical Coverage is as follows* ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees</td>
<td>No changes to your Company contribution.</td>
</tr>
<tr>
<td>• Enrolled in PepsiCo retiree medical coverage, or</td>
<td></td>
</tr>
<tr>
<td>• You have retired as retirement-eligible,** and you have deferred enrollment in PepsiCo retiree medical coverage</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>No changes. You will continue to earn the same Company contribution.</td>
</tr>
<tr>
<td>• At least age 60, or</td>
<td></td>
</tr>
<tr>
<td>• At least age 55 with 10 or more years of pension vesting service</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>No changes. You will continue to earn the same Company contribution.</td>
</tr>
<tr>
<td>• At least age 50 with 5 or more years of pension vesting service</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>You retain the Company contribution you earned through 2010, but you will not earn any additional Company contribution after December 31, 2010.</td>
</tr>
<tr>
<td>• Ages 40 to 49 with 5 or more years of pension vesting service</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>You will have access to coverage at group rates, but no Company contribution will be made toward this coverage. You will pay 100% of the applicable group rate.</td>
</tr>
<tr>
<td>• Under age 40 (regardless of years of pension vesting service), or</td>
<td></td>
</tr>
<tr>
<td>• Anyone with less than 5 years of pension vesting service (other than employees age 60 or older)</td>
<td></td>
</tr>
</tbody>
</table>
* Remember, you must meet the retirement eligibility rules set forth in this SPD, in order to be eligible to elect retiree medical coverage. Different rules may apply if you are covered by a collective bargaining agreement, the special transfer rules applicable to transfers among legacy PepsiCo, PBG and PAS, or a Company severance program.

** Retirement-eligible means retiring at a time when you meet the retirement eligibility rules set forth in this SPD.

If you were hired after December 31, 2010 and you later retire and are eligible for retiree medical, you will have access to coverage at group rates, but no Company contribution will be available. You will pay 100% of the applicable group rate. Special rules apply if you are a rehire as discussed later in this section.

For individuals classified as legacy Pepsi Bottling Group (PBG) retirees only:

<table>
<thead>
<tr>
<th>If you met this description on December 31, 2010 ...</th>
<th>Your pre-65 Retiree Medical Coverage is as follows* ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees</td>
<td>No changes to your Company contribution.</td>
</tr>
<tr>
<td>• Enrolled in PBG/PepsiCo retiree medical coverage, or</td>
<td></td>
</tr>
<tr>
<td>• You have retired as retirement-eligible, ** and you have deferred enrollment in PBG/PepsiCo retiree medical coverage</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>No changes. You will continue to earn the same Company contribution.</td>
</tr>
<tr>
<td>• At least age 60, or</td>
<td></td>
</tr>
<tr>
<td>• At least age 55 with 10 or more years of pension vesting service</td>
<td></td>
</tr>
<tr>
<td>• Certain Hourly Employees Only – with 30 years of pension vesting service***</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>No changes. You will continue to earn the same Company contribution.</td>
</tr>
<tr>
<td>• At least age 50 with 5 or more years of pension vesting service</td>
<td></td>
</tr>
<tr>
<td>• Certain Hourly Employees Only – at least age 50 with 5 or more years of pension vesting service but less than 30 years of pension vesting service***</td>
<td></td>
</tr>
<tr>
<td>Active employees</td>
<td>You retain the Company contribution you earned through 2010, but you will not earn any additional Company contribution after December 31, 2010.</td>
</tr>
<tr>
<td>• Ages 40 to 49 with 5 or more years of pension vesting service</td>
<td></td>
</tr>
<tr>
<td>• Hourly Employees Only – ages 40 to 49 with 5 or more years of pension vesting service but less than 30 years of pension vesting service***</td>
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<tr>
<td>Active employees</td>
<td>You will have access to coverage at group rates, but no Company contribution will be made toward this coverage. You will pay 100% of the applicable group rate.</td>
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<tr>
<td>• Under age 40 (regardless of years of pension vesting service)</td>
<td></td>
</tr>
<tr>
<td>• Anyone with less than 5 years of pension vesting service (other than employees age 60 or older)</td>
<td></td>
</tr>
<tr>
<td>• Hourly Employees Only – under age 40 (regardless of pension vesting service) or anyone with less than 5 years of pension vesting service***</td>
<td></td>
</tr>
</tbody>
</table>

* Remember, you must meet the retiree medical eligibility rules set forth in this SPD, in order to be eligible to elect retiree medical coverage. Different rules may apply if you are covered by a collective bargaining agreement, the special transfer rules applicable to transfers among legacy PepsiCo, PBG and PAS, or a Company severance program.

** Retirement-eligible means retiring at a time when you meet the retiree medical eligibility rules.
Applicable only to certain non-union hourly employees based on work location who may retire with 30 years of pension vesting service.

Employees who met the corresponding age and service requirements in this category by December 31, 2006, retain the Company subsidy as it existed on December 31, 2006, for post-Medicare coverage.

If you were hired after December 31, 2010 and you later retire and are eligible for retiree medical, you will have access to coverage at group rates, but no Company contribution will be available. You will pay 100% of the applicable group rate. Special rules apply if you are a rehire as discussed later in this section.

Pre-Medicare Credit (for legacy PBG retirees)
In prior years, the Pre-Medicare Credit allowed you to elect to take a portion of the subsidy that the Company would have applied to your Medicare-eligible coverage and use it for the cost of your current pre-Medicare coverage. In order to receive the Pre-Medicare Credit, you had to elect the Credit during an Annual Enrollment. Once you decided to take the Credit, you could not reverse your decision. Because the Credit is calculated according to how many years away you are from Medicare eligibility, you must continue to take the Credit until you become eligible for Medicare.

New elections for the Pre-Medicare Credit were not allowed after December 31, 2010. If you elected the Credit, the Credit will continue to apply to your pre-Medicare premiums until you become Medicare-eligible (or the Credit would otherwise terminate). Your Credit will be adjusted during the year or in future years if you add or subtract dependents from your retiree coverage. Once you are Medicare-eligible, you will receive the Company subsidy in the form of a contribution to your Retiree Reimbursement Account after you enroll in a Medicare supplement plan through OneExchange.

For individuals classified as legacy PepsiAmericas (PAS) retirees only
If you are classified as a legacy PepsiAmericas retiree, the Company contribution toward retiree medical coverage depends on when you retired. Generally, if you retire after 1989, the Company does not make any contribution toward your retiree medical coverage (both pre-Medicare and post-Medicare coverages). This means that if you meet the eligibility rules in order to be eligible to elect retiree medical coverage, you will have access to coverage at group rates, but you will pay 100% of the applicable total cost of coverage.

All Pre-65 retirees
Your cost for retiree medical coverage will depend on whether you’re entitled to a Company contribution, Medicare eligibility, the total cost of medical care and the plan options in effect at that time. Actual costs will be provided to you when you request a retiree medical enrollment kit from The PepsiCo Savings and Retirement Center at Fidelity.

The amount you pay toward retiree medical coverage is determined by subtracting the amount PepsiCo pays from the total cost of coverage. Since PepsiCo’s contribution is fixed, the amount you pay will change as the cost of medical coverage increases from year to year. The total cost of medical coverage is what it costs to provide this benefit in a given year. Part may be paid by PepsiCo (if you are entitled to a Company contribution) and part (or all) is paid by retirees.

If you are entitled to a Company contribution, your cost for retiree medical coverage may also depend on your employment level and length of service.

Because PepsiCo recognizes that increasing health care costs impact certain income levels more than others, executives who are in Band II or above at the time of retirement and who are entitled to a Company contribution, will pay two times the regular retiree rate, up to the total annual cost of Pre-age 65 coverage.

Retiree medical coverage is neither fixed nor guaranteed. The Company reserves the right to terminate or change in any way the coverage provided to retirees. This may be done at any time, including after retirement has occurred.

Premium Payment Options
You have three options for paying your coverage:

- Have monthly deductions taken from your pension check, if applicable
- Pay by invoice monthly, quarterly or annually (as long as you pay in advance), or
- Have monthly premiums automatically deducted from your bank account using the Automated Bank Withdrawal (ABW) service (US Bank required).
Premiums are generally paid through pension deductions, if applicable. If the premium is greater than your pension payment, you will instead be billed for the total premium due.

If you do not receive a pension or prefer to be billed or have payments automatically withdrawn from your bank account, you must indicate your payment method when you enroll or at any other time by contacting The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. If you elect medical coverage and fail to indicate a premium payment option, your premiums will be deducted from your pension payment, if applicable, or you will be billed. If you fail to make a required premium payment before the end of the “grace period” (60 days or 2 invoices), your medical coverage will be cancelled.

If your medical coverage is cancelled solely as a result of the non-payment of premiums, you may be eligible to have the coverage re-instated, if you contact The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 and you pay all the prior premiums that have not been paid by the date that is 60 days after the coverage is restored. This re-instatement rule may only be used once. If you have already used this re-instatement rule, and your coverage is again terminated for non-payment, the re-instatement rule will not apply and you will lose medical coverage as well as the right to ever reinstate it.

The best way to avoid possible cancellation of your coverage is to sign up for automatic bank withdrawal or have deductions taken from your pension check. You can switch your payment method at any time by contacting The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 or online at www.netbenefits.com/pepsico.

Unlike the contributions you pay for coverage as an employee, which are deducted from your pay on a before-tax basis, contributions for retiree coverage are after-tax payments, even if deducted from your pension benefits.

If You Are Rehired and Are Retirement-Eligible

In general, if you retire from PepsiCo and you are eligible for retiree medical coverage, you can retain your eligibility if you are rehired by the Company in the future under the following conditions:

- If you are enrolled in pre-Medicare retiree medical coverage at the time you are rehired and you are rehired into a position that is eligible for active employee medical coverage, your retiree medical coverage will cease and you will be able to elect any medical option that is available to active employees in your position. You will also be required to pay any applicable premium that applies to the active employee medical option you elect. When you later terminate employment, your active employee medical coverage will terminate, and thereafter you can re-elect your retiree coverage.

- If you are not enrolled in retiree medical coverage at the time you are rehired (e.g., you have deferred your retiree medical enrollment, if deferment is available) and you are rehired into a position that is eligible for active employee medical coverage, you will be able to elect any medical option that is available to active employees in your position. You will also be required to pay any applicable premium that applies to the active employee medical option you elect. When you later terminate employment, your active employee coverage will terminate and you can then elect retiree coverage.

If you have any questions regarding these rules, you should contact The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. Certain special rules may apply to you if you terminated employment as a result of a severance program.

If You Terminate Employment and Are Not Retirement-Eligible

Employees who were actively employed on December 31, 2010, who subsequently terminate employment and who are thereafter rehired within 12 months, will retain the retiree medical eligibility and Company contribution rights they earned prior to termination (as set forth in this SPD). In that situation, upon rehire, your service toward retiree medical eligibility and your Company contribution level will be restored and you will continue to earn benefits from that point. However, time not in service with the Company will not count toward any service or other requirement.

Employees who were actively employed on December 31, 2010, who subsequently terminate employment and are thereafter rehired more than 12 months from their earlier termination, will lose any eligibility service or Company contribution for retiree medical upon termination. In that situation, if you are rehired more than 12 months after a prior termination you will be treated as a new employee for purposes of retiree medical eligibility and any applicable Company contribution.

Special eligibility rules may apply if you are covered by a collective bargaining agreement or a Company severance program.
If You Die While Covered Under the PepsiCo Retiree Health Care Program

If you die while covered under the PepsiCo Retiree Health Care Program, your enrolled spouse/partner and other surviving enrolled dependents may continue coverage by paying the applicable contributions, subject to any other terms and conditions of the plan.

Coverage for your eligible surviving spouse/partner/dependents (determined as of the date of your death) will end as follows:

- Coverage for surviving children will end when eligibility otherwise ends. See "When Coverage Ends" below.
- Coverage will end for your surviving spouse/partner when eligibility otherwise ends.
- Coverage will end when any required premium payments cease or when they are paid later than the grace period.
- Failing to cooperate with the plan or claims administrator with respect to the administration of benefits.
- You engage in misrepresentation or fraud against the plan as provided below.
- The plan or the coverage is discontinued or terminated.

Once survivor coverage ends, it may not be restored. If applicable, COBRA continuation coverage may then be elected. See COBRA continuation coverage for more details. Further, if your surviving spouse or your surviving domestic partner marries, remarries or legally contracts with a new partner, the new spouse/partner and his/her children are not eligible for plan coverage and cannot be added to the plan. In other words, after the retiree’s death, no new spouses/partners or dependent children may be added to Plan coverage, who were not an eligible spouse/partner/ or eligible dependent children of the PepsiCo retiree on the date of his/her death.

All extended coverage in case of death is subject to the Company’s right to terminate completely or to change in any way the coverage provided to retirees and their dependents (for example, by reducing or eliminating benefits or by instituting charges for some or all of the costs).

Participation in this benefit plan should not and may not be viewed as a contract or promise of continued benefits.

When Coverage Ends

Coverage under the PepsiCo Retiree Health Care Program ends for you on the earliest of the following dates. The date when:

- You are no longer enrolled in or eligible for the coverage.
- You do not make the necessary contributions.
- You die.
- You fail to cooperate with the plan or claim administrator with respect to the administration of your benefits.
- You engage in misrepresentation or fraud against the plan as provided below.
- The plan or the coverage is terminated or discontinued.
- You turn age 65 and are not eligible for a Retirement Reimbursement Account (see page 77).

Unless coverage terminates due to your death, your eligible spouse’s/partner’s coverage and eligible dependent’s coverage will automatically terminate when your coverage terminates as listed above. If your coverage terminates due to your death, your eligible spouse’s/partner’s coverage and eligible dependent’s coverage will continue and will terminate as listed in the prior section.
However, your spouse’s/partner’s/dependent’s coverage will terminate earlier than the events listed above if one of the following applies:

- The date you elect to terminate your eligible spouse’s/partner’s/dependent’s coverage.
- The last day in which the eligible spouse/partner or dependent ceases to be eligible for coverage.
- If coverage continues after your death for your surviving spouse/partner and surviving dependent children, this coverage will terminate as listed in the prior section.
- Failure to cooperate with the plan or claim administrator with respect to the administration of benefits.
- Engaging in misrepresentation or fraud against the plan as provided below.
- The plan or the coverage is terminated or discontinued.
- Your spouse/partner turns age 65 and is not eligible for a Company Contribution.

It is the retiree’s or surviving spouse’s/partner’s responsibility to report a change in a spouse’s/partner’s or dependent’s eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. Your coverage and your spouse/partner/dependent’s coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the plan, including filing or participating in filing a false, misleading or fraudulent claim for benefits, or allowing your ID card to be used by an individual who is not enrolled in the plan. Your coverage and your spouse/partner dependent’s coverage may also be terminated or suspended for providing false or misleading information in connection with enrollment, including enrolling an individual who does not satisfy the eligibility criteria or failing to drop an enrolled individual in a timely manner when he/she no longer satisfies the eligibility criteria.
Retiree Medical Details

Coverage Before Medicare Eligibility

If you are not eligible for Medicare, you will have the following choices for retiree medical coverage:

- Basic Medical Option
- Safety Net Option
- BlueCare HMO (for certain eligible Tropicana retirees only. Refer to page 68 for information on this option)
- No coverage (that is, waive PepsiCo coverage, if applicable)

Both the Basic Medical and Safety Net Options provide coverage for a broad range of medical services and supplies and offer the choice of using a network provider. The amount the plan pays for covered care varies between the options and also differs depending on whether you use the network or not.

Except for legacy PAS retirees who retired before January 1, 2014, when you retire, you can choose to waive coverage initially and enroll in an available retiree medical option at a later date. However, you have the opportunity to enroll only once.

If you are classified as an eligible legacy PAS retiree and you retired before January 1, 2014, your opportunity to defer retiree medical coverage is limited. At retirement, you have the option to defer your initial enrollment if you elect to continue your active medical benefits under COBRA continuation coverage. Once COBRA continuation coverage ends, you must enroll in the Retiree Health Care Program. If you do not enroll in the Retiree Health Care Program at the time your COBRA continuation coverage ends, you will not be able to enroll at a later date.

Once you are enrolled in retiree medical coverage under the PepsiCo Retiree Health Care Program, if you then later choose to no longer be covered, you will not be able to re-enroll at a later date. If you are eligible for Medicare as a result of disability or End Stage Renal Disease before age 65, the PepsiCo plan will coordinate benefits with Medicare, as explained in the Post-Medicare Retiree Medical Provisions section. The key features of the Basic Medical and Safety Net Options are summarized below.

### Retiree Health Care Program Options: Pre-Medicare

<table>
<thead>
<tr>
<th></th>
<th>Basic Medical Option</th>
<th>Safety Net Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual deductible</strong>&lt;sup&gt;(1)&lt;/sup&gt; (individual/family)</td>
<td>$750/</td>
<td>$1,250/</td>
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<tr>
<td></td>
<td>$1,500/</td>
<td>$2,500/</td>
</tr>
<tr>
<td><strong>Coinsurance (after deductible)</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>The plan pays a percentage of most medically necessary services, such as office visits and hospitalization, until you reach your out-of-pocket limit; the plan then pays 100%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual out-of-pocket limit</strong>&lt;sup&gt;(1)&lt;/sup&gt; (individual/family)</td>
<td>$2,500/</td>
<td>$5,000/</td>
</tr>
<tr>
<td></td>
<td>$5,000/</td>
<td>$10,000/</td>
</tr>
<tr>
<td><strong>Individual lifetime maximum benefit</strong>&lt;sup&gt;(6)&lt;/sup&gt;</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
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<tr>
<td><strong>Prescription drugs</strong></td>
<td>Mail order: (per 90-day prescription) You pay 25% of the discounted network price.* You pay a</td>
<td></td>
</tr>
</tbody>
</table>
### Retiree Health Care Program Options: Pre-Medicare

<table>
<thead>
<tr>
<th>Basic Medical Option</th>
<th>Safety Net Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Area</strong></td>
<td><strong>Out-of-Area</strong></td>
</tr>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Competitor</td>
<td>Out-of-Network</td>
</tr>
</tbody>
</table>

| **Minimum charge** for a prescription of $10 for generic, $30 for preferred brand-name, and $80 for non-preferred brand-name and elective drugs. The maximum you will pay is $250 per prescription and $1,500 per family per year. However, if by law, treatment protocol or other quantity limitation, your prescribed drug must be dispensed in less than a 90-day mail order prescription, the maximum coinsurance per prescription is as follows—for a 0-30 day mail order prescription the maximum coinsurance charge will be $83.33; for a 31-60 day mail order prescription the maximum coinsurance charge will be $166.67; and for a 61-90 day mail order prescription the maximum coinsurance charge will be $250. |

**Network pharmacy:** You pay 25% of the discounted network price.* You pay a minimum charge for a prescription of $5 for generic, $15 for preferred brand-name drugs, and $40 for non-preferred brand-name and elective drugs. The maximum you will pay is $175 per 30-day supply.

If you have a long-term (maintenance) drug filled at a network pharmacy, you pay 25% of the discounted network price* at the pharmacy for the first three purchases only. Starting with the fourth purchase, you pay 50% of the discounted network price.* The $175 maximum payment will not apply.

**Non-network pharmacy:** You pay 25% of the discounted network price plus 100% of the difference between the retail price and the discounted network price.* The plan minimums and maximums will be the same as if you went to a network pharmacy however, they will not include any amounts you paid for charges above the discounted network price.

Access-only drugs—you’ll pay 100% of the discounted network price.

* If you buy a brand-name when a generic equivalent is available, you’ll pay 25% of the discounted network price of the generic (subject to the minimum copay) plus the cost difference between the generic and brand-name.

See the “Prescription Drug Benefit” section of this SPD for additional details.

### Benefit Coverage:

#### Hospital care

<table>
<thead>
<tr>
<th>Inpatient (requires precertification)</th>
<th>Outpatient</th>
<th>Office visits (7)</th>
<th>Emergency room (“ER”) coverage</th>
<th>Most other medically necessary services</th>
<th>Preventive care</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="1">80%</a></td>
<td><a href="1,3">50%</a></td>
<td><a href="1,3">80%</a></td>
<td><a href="2">80%</a></td>
<td><a href="1,3">50%</a></td>
<td><a href="1">70%</a></td>
</tr>
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<td><a href="1,3">80%</a></td>
<td><a href="1">70%</a></td>
<td>80%(2)</td>
<td>50%(1,3)</td>
<td>70%(1,3)</td>
</tr>
<tr>
<td><a href="1">80%</a></td>
<td><a href="1,3">50%</a></td>
<td><a href="1,3">80%</a></td>
<td><a href="1">70%</a></td>
<td><a href="1,3">50%</a></td>
<td>70%(1,3)</td>
</tr>
<tr>
<td>50%(1,3)</td>
<td><a href="1,3">80%</a></td>
<td><a href="1">70%</a></td>
<td>70%(1)</td>
<td>50%(1,3)</td>
<td>70%(1,3)</td>
</tr>
<tr>
<td><a href="1">80%</a></td>
<td><a href="1,3">50%</a></td>
<td><a href="1,3">80%</a></td>
<td><a href="1">70%</a></td>
<td><a href="1,3">50%</a></td>
<td>70%(1,3)</td>
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<td>50%(1,3)</td>
<td><a href="1,3">80%</a></td>
<td><a href="1">70%</a></td>
<td>70%(1)</td>
<td>50%(1,3)</td>
<td>70%(1,3)</td>
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<tr>
<td><strong>Well baby care</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>(4)</td>
<td></td>
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<td>Not covered</td>
<td><a href="2,3">100%</a></td>
<td><a href="2">100%</a></td>
<td>Not covered</td>
<td>100%(2,3)</td>
</tr>
<tr>
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<td>Not covered</td>
<td><a href="2,3">100%</a></td>
<td><a href="2">100%</a></td>
<td>Not covered</td>
<td>100%(2,3)</td>
</tr>
<tr>
<td><strong>Childhood immunizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(5)</td>
<td></td>
<td></td>
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<td>100%(2,3)</td>
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<tr>
<td><a href="2">100%</a></td>
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<td>Not covered</td>
<td>100%(2,3)</td>
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<tr>
<td><strong>Adult vaccinations</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8)</td>
<td></td>
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<td></td>
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<tr>
<td><a href="2">100%</a></td>
<td>Not covered</td>
<td><a href="2,3">100%</a></td>
<td><a href="2">100%</a></td>
<td>Not covered</td>
<td>100%(2,3)</td>
</tr>
<tr>
<td><a href="2">80%</a></td>
<td>Not covered</td>
<td><a href="2,3">80%</a></td>
<td><a href="2">70%</a></td>
<td>Not covered</td>
<td>70%(2,3)</td>
</tr>
</tbody>
</table>

(1) Access to specialty services

(2) Benefits for dependent children age 17 and under

(3) Beginning in the third full payment period

(4) Well baby care

(5) Childhood immunizations

(6) Adult vaccinations

(7) Access to specialty services

(8) Annual physicals / gynecological exams

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Retiree Health Care Program Options: Pre-Medicare

<table>
<thead>
<tr>
<th>Basic Medical Option</th>
<th>Safety Net Option</th>
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<tbody>
<tr>
<td><strong>In-Area</strong></td>
<td><strong>In-Area</strong></td>
</tr>
<tr>
<td><strong>Out-of-Area</strong></td>
<td><strong>Out-of-Area</strong></td>
</tr>
</tbody>
</table>

- **Flu shots**
  - (including associated lab work)
  - Covered up to $30 per individual per calendar year
  - Covered up to $30 per individual per calendar year

- **Certain cancer screenings**
  - Not covered
  - Not covered

(1) After deductible.
(2) No deductible.
(3) Of reasonable and customary charges.
(4) Up to age 2.
(5) Up to age 18 based on American Medical Association (AMA) Guidelines (see “Covered Medical Expenses” for covered immunizations).
(6) For claims incurred on or after January 1, 2012. Except for legacy PBG retirees, claims incurred prior to January 1, 2012 are subject to a $1,250,000 lifetime maximum; this increase does not apply if you previously met the lifetime maximum on or before December 31, 2011. The lifetime maximum includes all employee and retiree medical and prescription drug claims.
(7) Chiropractic care office visits limited to 26 visits per year per covered individual.
(8) Adult vaccinations will be covered, subject to recommended guidelines, for pneumonia, meningitis, tetanus, hepatitis and shingles.

**Coverage If You Become Medicare-Eligible Before Age 65 and Due to Disability or ESRD**

Generally, you or your spouse/domestic partner or other dependent will remain under the PepsiCo Retiree Health Care Program if you become Medicare-eligible for one of the following reasons:

- After you or a dependent has received no less than 24 months of Social Security disability benefits, regardless of age; or
- After you or a dependent has been diagnosed with end stage renal disease (ESRD), subject to certain exceptions.

When you or your spouse/domestic partner, or other enrolled eligible dependent becomes eligible for Medicare as a result of the above reasons, the PepsiCo retiree medical options available to you will change. You or your Medicare-eligible dependent will be able to choose from the following options:

- Post-Medicare Basic Medical Option (which includes prescription drug coverage)
- Prescription Drug Only Option
- BlueCare HMO (for eligible Tropicana retirees only)
- No coverage (that is, waive PepsiCo coverage)

The Post-Medicare Basic Medical Option provides the same medical and prescription drug coverage as the pre-Medicare Basic Medical Option. However, it coordinates with Medicare—that is, Medicare (the primary payer) pays benefits first, before the Post-Medicare Basic Medical Option (the secondary payer). See the Post-Medicare Retiree Medical Provisions section below for a description of how the plan coordinates with Medicare.

The Prescription Drug Only Option is offered for PepsiCo retirees who prefer to use Medicare Parts A and B for their medical coverage and the Prescription Drug Only Option coverage for prescription drugs. The Prescription Drug Only

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Option is the same prescription drug benefit offered under the Post-Medicare Basic Medical Option, but it has a deductible. It costs less than the Post-Medicare Basic Medical Option as it only covers prescription drugs.

The BlueCare HMO is offered for certain Tropicana retirees who live in those areas of Florida where the BlueCare HMO has a network. See the BlueCare HMO section for more information on this option.

No Coverage: Except for legacy PAS retirees who retired before January 1, 2014, when you retire, you can choose to waive coverage initially and enroll in an available retiree medical option at a later date. You have the opportunity to enroll only once, however.

If you are classified as an eligible legacy PAS retiree and you retired before January 1, 2014, your opportunity to defer retiree medical coverage is limited. At retirement, you have the option to defer your initial enrollment if you elect to continue your active medical benefits under COBRA continuation coverage. Once COBRA continuation coverage ends, you must enroll in the Retiree Health Care Program. If you do not enroll in the PepsiCo Retiree Health Care Program at the time your COBRA continuation coverage ends, you will not be able to enroll at a later date.

Once you are enrolled in the PepsiCo Retiree Health Care Program's retiree medical coverage, if you thereafter choose to no longer be covered, you will not be able to re-enroll at a later date.

If you or your spouse/partner become eligible for Medicare because of disability or ESRD, you may actively choose a post-Medicare option for the Medicare-eligible individual by contacting The PepsiCo Savings and Retirement Center at Fidelity. If you do not actively choose a post-Medicare option, you will automatically be enrolled in the Post-Medicare Basic Medical Option (with prescription drug coverage)
The key features of the Post-Medicare Basic Medical Option and Prescription Drug Only Option are summarized below.

| PepsiCo Retiree Health Care Program Options: Medicare Eligible before Age 65 |
|---|---|---|
| | Post-Medicare Basic Medical Option | Prescription Drug Only Option |
| Annual deductible (individual/family)\(^{(1)}\) | $750/$1,500 | $150/$300 \(^{(1)}\) |
| Deductible does not apply to prescription drug coverage | | |
| Coinsurance (after deductible) | 80% | See “Prescription Drugs” below. |
| The plan pays a percentage of most medically necessary services, such as office visits and hospitalization, until you reach your annual out-of-pocket maximum; the plan then pays 100%. | | |
| Annual out-of-pocket limit (individual/family) - excludes deductible | $2,500/$5,000 | See “Prescription Drugs” below. |
| Individual lifetime maximum benefit\(^{(6)}\) | $1,500,000 | |
| Prescription drugs | **Mail order:** (per 90-day prescription) You pay 25% of the discounted network price.* You pay a minimum charge for a prescription of $10 for generic, $30 for preferred brand-name, and $80 for non-preferred brand-name and elective drugs. The maximum you will pay is $250 per prescription and $1,500 per family per year. However, if by law, treatment protocol or other quantity limitation, your prescribed drug must be dispensed in less than a 90-day mail order prescription, the maximum coinsurance per prescription is as follows – for a 0-30 day mail order prescription the maximum coinsurance charge will be $83.33; for a 31-60 day mail order prescription the maximum coinsurance charge will be $166.67; and for a 61-90 day mail order prescription the maximum coinsurance charge will be $250. |
| **Network pharmacy:** You pay 25% of the discounted network price.* You pay a minimum charge for a prescription of $5 for generic, $15 for preferred brand-name drugs and $40 for non-preferred brand-name and elective drugs. The maximum you will pay is $175 per 30-day supply. |
| If you have a long-term (maintenance) drug filled at a network pharmacy, you pay 25% of the discounted network price* at the pharmacy for the first three purchases only. Starting with the fourth purchase, you pay 50% of the discounted network price*. The $175 maximum will not apply. |
| **Non-network pharmacy:** You pay 25% of the discounted network price plus 100% of the difference between the retail price and the discounted network price.* The plan minimums and maximums will be the same as if you went to a network pharmacy, however they will not include any amounts you paid for charges above the discounted network price. |
| Access-only drugs—you’ll pay 100% of the discounted network price |
| * If you buy a brand-name when a generic equivalent is available, you’ll pay 25% of the discounted network price of the generic (subject to the minimum copay) plus the cost difference between the generic and brand-name. |
| See the “Prescription Drug Benefit” section of this SPD for additional details. |
**PepsiCo Retiree Health Care Program Options: Medicare Eligible before Age 65**

<table>
<thead>
<tr>
<th>Benefit Coverage</th>
<th>Post-Medicare Basic Medical Option</th>
<th>Prescription Drug Only Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Inpatient</td>
<td>80%&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>▶ Outpatient</td>
<td>80%&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>Office visits&lt;sup&gt;(7)&lt;/sup&gt;</td>
<td>80%&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency room (&quot;ER&quot;) coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ If ER visit is deemed a true emergency</td>
<td>80%&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>▶ If ER visit is deemed not a true emergency</td>
<td>50%&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>Most other medically necessary services</td>
<td>80%&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Well baby care&lt;sup&gt;(4)&lt;/sup&gt;</td>
<td>100%&lt;sup&gt;(3)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>▶ Childhood immunizations&lt;sup&gt;(5)&lt;/sup&gt;</td>
<td>100%&lt;sup&gt;(3)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>▶ Annual physicals / gynecological exams (including associated lab work)</td>
<td>80%&lt;sup&gt;(3)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>▶ Shingles vaccinations</td>
<td>100%&lt;sup&gt;(4)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>▶ Certain cancer screenings</td>
<td>100%&lt;sup&gt;(4)&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(1) A deductible of $150 per individual or $300 per family must be satisfied before benefits are paid under the Prescription Drug Only Option. There is no deductible for prescription drug coverage under the Basic Medical Option.

(2) After deductible.

(3) No deductible.

(4) Up to age 2.

(5) Up to age 18 based on American Medical Association (AMA) Guidelines (see “Covered Medical Expenses” for covered immunizations).

(6) For claims incurred on or after January 1, 2012. Except for legacy PBG retirees, claims incurred prior to January 1, 2012 are subject to a $1,250,000 lifetime maximum; this increase does not apply if you previously met the lifetime maximum on or before December 31, 2011. **The lifetime maximum includes all employee and retiree medical and prescription drug claims.**

(7) Chiropractic care office visits limited to 26 visits per year per covered individual.

You are responsible for enrolling in Medicare, which includes hospital coverage under Medicare Part A and outpatient medical coverage under Medicare Part B. When a covered person becomes eligible for Medicare (e.g., after receiving 24 months of SSA disability benefits), the plan will always pay claims as if the covered person has enrolled in Medicare Part A and B, whether or not he or she is actually enrolled. Further, the Company’s retiree medical coverage is secondary to any other coverage you or your spouse/partner/dependent have through other employers.

- **Medicare Part A Enrollment:** Unless you have delayed your enrollment, typically, enrollment in Medicare Part A is automatic once you begin receiving Social Security. There is no cost for this coverage.

- **Medicare Part B Enrollment:** Enrollment in Medicare Part B is not always automatic. This coverage requires a monthly premium, which can be deducted from your monthly Social Security check. To enroll, contact the Social Security Administration at 1-800-772-1213.

Individuals who are eligible to enroll in Medicare Part B are also eligible to enroll in Medicare’s prescription drug coverage, referred to as Part D. Part D is a voluntary benefit and you may choose to enroll in Part D or not to enroll. You may also have the option of enrolling in Medicare Part C, referred to as Medicare Advantage. If you do not enroll in Medicare Advantage or Part D, your PepsiCo retiree medical and prescription drug coverage will continue for as long as you remain eligible and pay the required premiums. However, if you choose to enroll in a Medicare Advantage Plan or Part D, your PepsiCo retiree medical and prescription drug coverage will be permanently
cancelled for you and your spouse/partner/dependents and you will not be able to re-enroll for PepsiCo retiree medical and prescription drug coverage in the future.

PepsiCo has determined that the total value of prescription drug coverage provided through the PepsiCo Retiree Health Care Program is on average equal to or better than the Medicare prescription drug coverage. This means that you would not have to pay a higher premium if you later decide to enroll in Medicare prescription drug coverage.
Pre-Medicare Retiree Medical Provisions

This section focuses on the Basic Medical and Safety Net Options available to retirees and their eligible dependents who are not yet eligible for Medicare. The Basic Medical and Safety Net Options cover the same services and supplies. The Basic Medical Option pays more for covered services than the Safety Net Option and, therefore, costs more when you enroll.

If you live in a network area, the Basic Medical and Safety Net Options offer you a choice of providers when you need care. You choose whether or not to use the network of doctors and hospitals. When you use a network provider, your costs are lower and more services are covered.

The Basic Medical and Safety Net Options include three types of coverage:

- **In-Network**: Coverage you receive when you live in a location where a network is available and you go to a network provider.
- **Out-of-Network**: Coverage you receive when you live in a location where a network is available and you choose not to go to a network provider. Some treatment such as routine care and annual physicals are not covered when you use out–of–network providers.
- **Out-of-Area**: Coverage you receive when you live in an area where no network is available.

**Using Network Providers**

**The Networks**

Most retirees have access to networks set up and managed by Anthem Blue Cross and Blue Shield or UnitedHealthcare.

If you live in an area where more than one network is available, you must choose a network when you enroll for medical coverage. You will use the network you choose for the entire year unless you have an applicable qualified status change (see the Qualified Status Changes section for more information). Your dependents must also use the network you choose.

Anthem Blue Cross and Blue Shield and UnitedHealthcare offer networks of providers where you can receive a higher level of benefits if you choose to see a network provider. Anthem Blue Cross and Blue Shield offers a network of providers through the BlueCross BlueShield Association’s BlueCard Preferred Provider Organization (PPO) Program. Retirees in the following states have access to the following alternate BlueCross BlueShield networks with better discounts:

- NetworkBlue PPO network (Florida);
- Blue Open Access POS network (Georgia);
- Horizon Managed Care Network (New Jersey); and
- Blue Preferred POS network (Wisconsin).

UnitedHealthcare offers a network of providers through their Choice Plus network.

Sometimes providers decide to leave the networks they are part of. While the Company recognizes the disruption this causes employees, the Company is not able to reverse these decisions.

**Transition of Care Benefits**

Transition of care benefits allow you and your eligible family members the ability to obtain in-network benefits from out-of-network providers in circumstances when you or your family members have been receiving care for pregnancy or a serious illness from a doctor who is suddenly no longer available in the network. The purpose of this benefit is to enable you or your family members to transition to a new provider if you need ongoing care. Your medical plan carrier, Anthem Blue Cross and Blue Shield or UnitedHealthcare, must approve all transition of care benefits.

These benefits will be available when your provider leaves the network mid–year and you or your family members are in the middle of treatment for a pregnancy or serious illness.

To receive transition of care benefits, call your medical plan carrier, either Anthem Blue Cross and Blue Shield at 1-877-224-0030 or UnitedHealthcare at 1-800-638-7785.
All transition of care benefits are at the discretion of your medical plan carrier. These benefits will be approved for discrete periods of time based on the severity of the illness or the length of pregnancy. If approved, all transition of care benefits will be provided subject to Reasonable and Customary (R&C) limits.

**Out-of-Area Coverage**

Most covered individuals live in an area with access to network providers. If you are covered under either the Basic Medical or Safety Net Option and you live in an area where no network is currently available, you will receive out-of-area benefits.

**Finding Network Providers**

To locate doctors and hospitals near your home:

- Call your claims administrator and request a personalized provider directory or search for providers using your claims administrator's website. Contact information is provided below.
  
  **Anthem Blue Cross and Blue Shield**
  Via Phone: 1-877-224-0030
  Via the Internet: [www.anthem.com](http://www.anthem.com)
  
  **UnitedHealthcare**
  Via Phone: 1-800-638-7785
  Via the Internet: [www.myuhc.com](http://www.myuhc.com)

- Call your doctor
  
  o If you are enrolled in Anthem Blue Cross and Blue Shield, you will need to ask if the doctor participates in the BlueCross BlueShield PPO BlueCard network. If you are enrolled in Anthem Blue Cross and Blue Shield and live in Florida, Georgia, New Jersey or Wisconsin, you will need to ask if the doctor participates in the NetworkBlue network (Florida), Blue Open Access POS network (Georgia), Horizon Managed Care Network (New Jersey) or Blue Preferred POS network (Wisconsin).
  
  o If you are enrolled in UnitedHealthcare, you will need to ask if the doctor participates in the United Choice Plus network.

**When a Network Provider Is Not Available (Q-Care)**

If you live in an area where there are no network providers available that can provide a medically necessary service you require, you may be able to receive in-network reimbursement levels from an out-of-network provider (based on R&C charges) through a benefit provision known as Q-Care (United Healthcare refers to this provision as Network Gap.).

All out-of-network care is subject to R&C limits even if benefits are paid at the in-network level. Q-Care will need to be re-approved for all new claims even if the type of service being rendered is the same as a prior Q-Care case.

**Outpatient Providers**

All outpatient Q-Care must be requested by the member and approved by your medical plan carrier (UnitedHealthcare or Anthem Blue Cross and Blue Shield) prior to the services being delivered.

To become approved for Q-Care, the member must call the medical plan carrier’s member services and request an in-network provider.

- If member services is unable to find in-network providers that are within a 30-mile radius of the member’s home ZIP code, they will approve an in-network level of benefits to be paid for an out-of-network provider based on R&C charges.
- If member services identifies in-network providers that are within a 30-mile radius of the member’s home ZIP code, the member must use identified providers or have claims paid out-of-network, unless:
  
  o Providers are unable to perform the services needed
  
  o The retiree obtains letters from three different in-network providers (not within the same practice) stating that they are unable to perform services requested
  
  o The retiree submits letters to the medical plan carrier and receives Q-care approval prior to services being rendered
Inpatient Providers

All inpatient Q-Care must be requested by you and approved by your medical plan carrier (Anthem Blue Cross and Blue Shield or UnitedHealthcare) before care is received from an out-of-network facility.

ID Cards

Whenever you need care, you must use your identification card to identify yourself as a plan participant. If you do not have your ID card with you when you receive care, you may be required to submit payment to the doctor at the time of service. You will then need to send in a claim form for reimbursement. If you need additional ID cards, call your medical plan carrier—Anthem Blue Cross and Blue Shield or UnitedHealthcare. Providing your ID card to someone who is not enrolled in the plan may constitute fraud against the plan, and your plan coverage may be terminated or suspended. You may also be required to repay claims that were paid as a result of the improper use of your ID card. ID cards are also available for printing through your carrier’s website.

When You Visit the Doctor’s Office

When you visit a network doctor, show your ID card.

If you are enrolled in the Basic Medical or Safety Net Option and are seeing a network doctor, you usually do not need to pay anything at the time you receive care. The doctor will submit the bill to your medical plan carrier. You will then be billed for charges not paid by the Basic Medical or Safety Net Option. However, your doctor may request any remaining deductible and coinsurance at the time of services. The doctor will submit the bill to your medical plan carrier. The fee for service is generally lower with a network doctor.

If you visit a doctor who is not in the network, your costs will be higher. It’s still a good idea to show your ID card so the receptionist can check your eligibility and coverage. In some cases, the out-of-network provider will file a claim for you. In other cases, you will have to file a claim for reimbursement. Keep in mind that when you go to an out-of-network provider you will be reimbursed 50% of reasonable and customary (R&C) charges and will have to pay the doctor 100% of the amount above R&C charges. In some cases, you may have to pre-pay the full amount at the time of services.

When You Need Laboratory Services

To ensure the highest level of benefit, ask your doctor to send lab tests to an in-network provider. If you are an Anthem member, your lab provider must also be in-network within the specific state of where the services were rendered (i.e., blood drawn, specimen collected).

You are responsible for ensuring that an in-network provider is used. If lab tests and screenings are sent to an out-of-network provider, benefits will be paid at the out-of-network level, and you will be responsible for any amounts above the R&C rate.

When You Must Be Hospitalized or Need to See a Specialist

If your doctor is in the network, ask to be referred to specialists or hospitals in the network so you’ll receive higher benefit levels.

If you visit a doctor who is not in the network, your costs will be higher.

Remember that you must call your medical plan carrier before any hospital, skilled nursing, and convalescent or rehabilitation facility inpatient admission to precertify your stay. If you don’t, you’ll be penalized. (See the Precertification pages of this section.)

To precertify/authorize inpatient mental health or substance abuse treatment, you must call your medical plan carrier using the contact information on page 54. See the Mental Health Benefits section for more information.

A referral from a network doctor is not a guarantee that the specialist belongs to the same network. If the specialist is NOT a network provider, benefits will be paid at the out-of-network level.
If you are not certain whether a provider is in the network, it’s always best to call your medical plan carrier. When you call to make your appointment, make sure the doctor’s staff or facility knows you’re a network member. If the provider is not in the network, you will receive out-of-network coverage.

**Centers of Excellence**

In certain geographies, retirees and family members enrolled in the Basic Medical or Safety Net Option have access to specialized treatment facilities across the country. Centers of Excellence (for Anthem, these are known as Blue Distinction Centers) are available for complex cancers, congenital heart disease, bariatric resource services and organ and bone marrow/stem cell transplants. Centers of Excellence infertility treatment centers are available through UnitedHealthcare only.

Centers of Excellence can provide the following advantages:

- Higher success rates
- In-network benefits
- Expert counseling from nurse consultants who can provide information about treatment options, symptoms and side effects
- Guidance in choosing a physician and treatment center that best meets your needs
- Travel and lodging benefits in certain situations and subject to limits (contact your medical plan carrier for details)

To use these services, contact your medical plan carrier, either Anthem Blue Cross and Blue Shield at 1-877-224-0030 or UnitedHealthcare at 1-800-638-7785.

**Emergency**

In an emergency, get the care you need immediately. If you experience a sudden and unexpected change in your physical or mental condition that is severe enough to require immediate care, go to the nearest hospital (whether or not the hospital is in the network). Refer to the summary table in the Retiree Medical Plan Details section to find out what level of reimbursement you will receive based on whether or not your visit to the emergency room is deemed a true emergency or not.

If you are not sure you need emergency care, call your doctor or call the Nurse Line provided through your carrier (Anthem Blue Cross and Blue Shield at 1-877-224-0030 or UnitedHealthcare at 1-800-638-7785).

If you are admitted to the hospital and stay overnight, you must call your medical plan carrier within 48 hours of the admission to ensure that no penalty will apply to your stay. Your doctor or a family member may call on your behalf. It is not necessary to call your medical plan carrier if you visit the emergency room and are discharged the same day.

**When You Are Away from Home**

If you are traveling within the U.S. and need care, you should call your medical plan carrier. You’ll be referred to a network doctor if one is available. If one is not available, you will receive the in–network level of benefits based on reasonable and customary charges. If a network doctor is available but you do not go to him or her, you will receive the out-of-network level of benefits. If you are out of the country, you will be reimbursed at the in-network level of benefit.

**If Your Covered Child Is Away at School or Lives Elsewhere**

If your covered child needs care while at school or you have a covered child who lives apart from you and needs care, you should call your medical plan carrier for a referral to a network doctor. If a network doctor is not available, your covered child will receive the in-network level of benefits based on reasonable and customary charges. If a network doctor is available but your covered child does not use him or her, your covered child will receive the out-of-network level of benefits. If your covered child is attending school out of the country, you will be reimbursed at the in-network level of benefits.

**How Benefits Are Paid**

Here’s how benefits are paid under the Pre-Medicare Basic Medical and Safety Net Options:
Basic Medical Option

You pay an in-network and/or out-of-network deductible each year. Once your deductible is met, the option pays a percent of covered expenses (80 percent of negotiated fees in-network and 50 percent of reasonable and customary charges out-of-network). If you reach your annual out-of-pocket limit, the option will pay 100 percent of covered medical expenses for the rest of the calendar year, unless you exceed your lifetime maximum.

Please note: If you receive care from a provider who is not in the network, reasonable and customary limits apply in determining covered expenses, even if you have met your out-of-pocket limit for the year.

In-Network and Out-of-Network Deductible

The deductible amounts are different for in-network and out-of-network expenses. In-network charges do not apply towards the out-of-network deductible. Covered out-of-network expenses do count toward the in-network deductible.

For example, if you choose the Basic Medical Option and have incurred $850 in covered medical expenses using in-network providers or hospitals, then you have satisfied your individual in-network deductible of $750. The in-network deductible is then satisfied for all future in-network services for that calendar year. However, if you utilize medical services with out-of-network providers, you will still have to meet the $1,250 out-of-network deductible.

If you incur $850 in covered medical expenses using out-of-network providers, you will have satisfied your in-network deductible since out-of-network charges will apply toward the in-network deductible. You will still have to meet an additional $400 for the $1,250 out-of-network deductible.

Out-of-Area Coverage

You pay a deductible each year. After you satisfy your deductible for the year, the Basic Medical Option pays 80 percent of the reasonable and customary charges for covered expenses until you reach the annual out-of-pocket limit. If you reach the annual out-of-pocket limit, the Basic Medical Option pays 100 percent of the reasonable and customary charges for covered expenses for the rest of the calendar year, unless you exceed your lifetime maximum.

Safety Net Option

You pay an in-network and/or out-of-network deductible each year. Once your deductible is met, the option pays a percent of covered expenses (70 percent of negotiated fees in-network and 50 percent of reasonable and customary charges out-of-network). If you reach your annual out-of-pocket limit, the option will pay 100 percent of covered expenses for the rest of the calendar year, unless you exceed your lifetime maximum.

Please note: If you receive care from a provider who is not in the network, reasonable and customary limits apply in determining your covered expenses, even if you have met your out-of-pocket limit for the year.

In-Network and Out-of-Network Deductible


For example, if you choose the Safety Net Option and have incurred $1,500 in covered medical expenses using in-network providers or hospitals, then you have satisfied your individual in-network deductible of $1,250. The in-network deductible is then satisfied for all future in-network services for that calendar year. If you receive medical services from out-of-network providers, then you will still have satisfied your individual $1,250 out-of-network deductible.

Out-of-Area Coverage

You pay a deductible each year. After you satisfy your deductible for the year, the Safety Net Option pays 70 percent of the reasonable and customary charges for covered expenses until you reach the annual out-of-pocket limit. If you reach the annual out-of-pocket limit, the Safety Net Option pays 100 percent of the reasonable and customary charges for covered expenses for the rest of the calendar year, unless you exceed your lifetime maximum.

Precertification

The plan only covers treatment that is medically necessary. The plan requires that certain procedures and treatments be certified by a third party before being rendered to ensure medical necessity. In some emergency situations,
certification can occur following the treatment. Further, precertification is not required for certain minimum hospital stays following the birth of a child.

**General Medical Services**

The following are general medical services requiring precertification:

- Non-emergency hospital admissions
- Skilled nursing admissions
- In-home private duty nursing care
- Convalescent admissions
- Rehabilitation facility admissions
- Home health care
- Home Infusion Therapy
- Temporomandibular joint disorders (TMJ) treatment (surgical)
- Durable medical equipment (DME) and orthotics after $1000 (purchase or rental)
- Hospice (inpatient and outpatient)
- Organ and tissue transplant (inpatient and outpatient)
- Bone marrow and stem cell transplant (inpatient and outpatient)
- Air ambulance
- Partial hospitalization for mental health/substance abuse
- Intensive outpatient therapy (non-residential individual, group and family therapy) for mental health/substance abuse

You must follow certain precertification procedures to avoid strict financial penalties. **It is your responsibility to make sure either you or your doctor calls:**

- At least one week before any non-emergency hospital, skilled nursing, convalescent or rehabilitation facility admission to precertify the admission.
- Within 48 hours after you are admitted to the hospital in the case of an emergency. A family member or doctor may call for you. You only have to call if you are admitted to the hospital, not if you visit the emergency room and are released the same day.
- If your doctor wants to extend your hospital stay. It is up to you or your family to make sure that either your doctor or the hospital calls your medical plan carrier to precertify the extension.

**Mental Health & Substance Abuse Admission Precertification**

Inpatient care must be precertified by your medical plan carrier. If you don't precertify inpatient care, no benefits will be paid. For outpatient care, precertification is required for services such as intensive outpatient therapy (non-residential individual, group and family therapy) and partial hospitalization to confirm medical necessity. Check with your medical plan carrier to determine if precertification is required for any other services. All outpatient and inpatient care must be medically necessary to be considered an eligible expense.

To precertify/authorize mental health or substance abuse admissions, call your medical plan carrier at:

- Anthem Blue Cross and Blue Shield: 1-877-224-0030
- BlueCross BlueShield of Florida: 1-800-664-5295
- UnitedHealthcare: 1-800-638-7785

If you participate in the BlueCare HMO option, your primary care physician can assist you with obtaining authorization for mental health or substance abuse care.
How to Precertify

Call your medical plan carrier at the number above to start the precertification process. Precertification requests are subject to the claims and appeals process described in the Administrative Information section.

When you call your medical plan carrier, be prepared to provide the following information:

- Retiree’s name, Social Security number, address and phone number
- Patient’s name
- Name, address and phone number of the attending physician
- Name and address of the hospital or diagnostic center
- Scheduled admission date or test date
- Reason for the admission or test

Your medical plan carrier may contact your physician to confirm the need for hospitalization or testing. Next, your medical plan carrier will contact you to let you know whether your hospital stay or test has been certified and, if so, for how long.

During your stay, your medical plan carrier may follow up with your doctor, and if necessary, extend your certified stay. If it is determined that an extended stay isn’t medically necessary, the extra days won’t be covered.

To start the precertification process, call Anthem Blue Cross and Blue Shield at 1-877-224-0030 or UnitedHealthcare at 1-800-638-7785.

Penalties if You Don’t Call

Except for maternity admissions that do not exceed the automatically precertified level and inpatient mental health or substance abuse care, whenever you don’t call to precertify:

- The first $500 of covered costs including those above any automatically precertified level will not be recognized as covered expenses in calculating benefits.

In addition, no benefits will be paid if:

- Certification is requested and denied, and you are admitted to the hospital or tested anyway.
- Certification is not requested and your hospitalization or test is not considered medically necessary.

These unpaid expenses will be your responsibility and will not count toward your deductible or annual out-of-pocket maximum.

These penalties vary for inpatient mental health or substance abuse care. See the Mental Health Benefits section for more information.

Please note that an independent consultation may be required to determine medical necessity.

Other Specialized Pre-Medicare Medical Services

Care Management Program

Whether you are facing a planned surgery, navigating at-home recovery after a recent hospitalization or dealing with a serious health condition, the Care Management Program is designed to ensure you have the support you need from a team of qualified professionals.

Provided through our medical plan carriers, Anthem BCBS and UnitedHealthcare, Health ACE registered nurses have real-time access to information on your benefits and claims, so they can provide effective support, guidance and education.

The Care Management programs are available to retirees, spouses/partners and dependent children who:

- Are enrolled in the Basic Medical or Safety Net Option and who are not Medicare-eligible
- Have an ongoing health condition, sudden health event or serious illness
- Have a high health risk and can most benefit from the support of these programs.
You can call 1-877-224-0030 if you participate in Anthem BCBS or 1-800-638-7785 if you participate in UnitedHealthcare to speak with a Health ACE nurse.

**What’s In It for You**

Here’s what you can expect when you participate in the Care Management Program.

- Personal attention from trained, registered nurses who are dedicated to you and your family—someone who will listen to you and help you navigate the health care system to get the best possible health outcome by:
  - Answering questions about your diagnosis and treatment plan
  - Making sure all of your care providers are working together on a clear and focused treatment plan
  - Helping you maintain quality and continuity of care as you progress from one caregiver to another or from hospital care to home care
  - Keeping you in control of your care and focused on getting well
  - Providing extra support in working with your doctor to help you get the most out of your treatment (while your Health ACE nurse will help you work with your doctor, it does not replace your doctor)
- Support from a multidisciplinary team of health professionals (e.g., pharmacist, social worker)
- Expertise to help put you in control of your health and improve the odds against complications
- Guidance on setting and achieving realistic health goals.

**How the Program Works**

1. **Getting Started.**

You can call a Health ACE nurse if you think you would benefit from working with a nurse. The nurse will discuss your situation and can offer support and advice that may be beneficial to you and your family. Your Health ACE nurse is not seeking to replace an existing doctor, but instead to provide extra support on a one-on-one basis.

Contact numbers are: 1-877-224-0030 if you participate in Anthem BCBS or 1-800-638-7785 if you participate in UnitedHealthcare.

2. **Work with a Health ACE nurse.**

The medical system can be complex. Your nurse will work with you over the phone to navigate your way through it. Specifically, a Health ACE nurse can:

- Review you doctor’s treatment plan and assess your progress in managing your health
- Help you set personal goals—for example, get prescription drug refills on time; get specified tests; review results with your doctor, etc.
- Educate you on the facts about your condition and the steps to better health
- Help you find other needed resources, like support groups, therapies and medical equipment
- Provide referrals to other appropriate programs to address your health risks.

**Nurse Line**

Call the Nurse Line provided through your carrier (Anthem Blue Cross and Blue Shield at 1-877-224-0030 or UnitedHealthcare at 1-800-638-7785) with your health questions.
Nurse Line provides expert advice to help you:

- Understand your medical symptoms and choose the most appropriate source of care. For example, should you go to the emergency room? Schedule an appointment with your doctor? Or self-treat at home?
- Get answers and information regarding basic medical questions, including health education materials on many health topics.
- Make informed decisions regarding medical procedures and treatments.

Simply call your medical plan carrier and follow the prompts to reach the Nurse Line. Nurses are available 24 hours a day, seven days a week.

**Covered Medical Expenses**

The Pre-Medicare Basic Medical and Safety Net Options cover a portion of most medically necessary services and supplies, both inside and outside of a hospital. Medical necessity or medically necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence. The medical plan carrier (or other applicable claims administrator) makes the determination as to whether a service is medically necessary. Keep in mind that the fact that a physician or other provider has “performed or prescribed a procedure or treatment” does not always mean that it is medically necessary. Also, the fact that it may be the only available treatment for a particular injury or sickness is not a guarantee of benefits (e.g., the treatment could be considered experimental). In some circumstances, Anthem Blue Cross and Blue Shield or UnitedHealthcare will determine that the recommended care is not medically necessary and coverage may be denied.

If you are unsure if a service is medically necessary, have your physician submit a pre-treatment estimate that clearly describes the services to be rendered and includes the appropriate procedure codes.

To establish that a service is medically necessary, UnitedHealthcare or Anthem Blue Cross and Blue Shield may require a review of medical records and/or a medical evaluation from time to time.

If care is deemed medically necessary, it does not mean that the care will be covered as an in-network benefit. In most circumstances, in-network benefits will be paid only if treatment is provided by a network provider.

See the Expenses Not Covered pages of this section for a listing of some expenses that are not covered.

How much the retiree medical options pay depends on the option you choose and, for pre-Medicare coverage, whether or not you use a network provider.

- Eligible network provider charges are based on negotiated arrangements between the provider and the medical plan carrier.
- Eligible non-network provider charges are based on reasonable and customary limits.
- The percentage the plan pays is higher when you use a network provider.

**Preventive Care**

The following preventive care is covered *only when you use a network doctor or when out-of-area coverage applies*, with the exception of flu shots.

**Exams Up to Age Two**

- Unlimited well-care up to age 2 for your covered dependents, covered at 100% with no deductible.

**Exams/Screenings after Age Two**

- One physical and one gynecological exam for you and your covered dependents each year, subject to the 80 percent coinsurance of covered expenses for in-network and out-of-area services under the Basic Medical Option, and subject to 70 percent coinsurance of covered expenses for in-network and out-of-area services under the Safety Net Option. Deductibles do not apply to these exams. Routine lab work associated with an annual physical is also covered before the deductible, subject to the applicable coinsurance. This includes:
  - Osteoporosis screening (bone density)
> o Barium enema screening
> o Hemoglobinopathy screening, including sickle cell and other blood problems
> o Fecal blood test
> o Complete blood count (CBC)
> o Metabolic panel
> o Thyroid study
> o Chlamydia screening
> o Rubella serology (German measles)
> o Cholesterol/lipid panel
> o Rapid plasma reagin/venereal disease research lab (RPR/VDRL)
> o Chest X-ray
> o Hepatitis B test
> o HIV testing
> o Urinary analysis (UA)
> o Venipuncture
> o Lead test
> o Heart test (EKG)
> o Purified protein derivative (PPD)
> o Prostate cancer screening (PSA)
> o Digital rectal exam
> o Mammogram
> o Immunizations (age limits apply)
> o Flu shots. Note that flu shots are covered if you use an out-of-network provider up to $30 per individual, per calendar year.

Screenings: Mammograms, pap smears, prostate, and colon screenings are covered at 100 percent (when provided during an office visit) with no deductible under either the Basic Medical or Safety Net Options. (Routine colonoscopies are only covered for those over 50 years old or with a history of colon disease.) Any associated services and consultations in conjunction with these tests other than the yearly physical will be subject to deductible and coinsurance.

**Immunizations**

All childhood immunizations recommended by the American Medical Association for members 17 and under are covered at 100 percent with no deductibles under either the Basic Medical or Safety Net Options.

Adult immunizations for pneumonia, meningitis, tetanus, hepatitis and shingles are covered at 100 percent with no deductibles (subject to recommended guidelines) under either the Basic Medical or Safety Net Options.

These immunizations must be received in-network to be covered.

Preventive exams other than the annual exams described above are not covered.

**Ambulance Services**

For a true emergency as determined by your health plan, ambulance services will be covered at the in-network level. This will be based on negotiated charges for in-network providers and based on reasonable and customary charges for out-of-network providers. You will be responsible for charges above reasonable and customary for out-of-network providers, which will not count towards the out-of-pocket maximum.
Hospital Services and Supplies

The Basic Medical and Safety Net Options pay a percentage of the standard rate for semi-private room and board in a recognized hospital or approved rehabilitative facility. (If you stay in a private room because no semi-private rooms are available or because your doctor establishes that isolation is medically necessary, the Basic Medical and Safety Net Options pay a percentage of private room and board expenses.)

While in a network hospital, if you receive services from a non-network emergency room physician, anesthesiologist, radiologist, or pathologist, you will be reimbursed at the in-network level based on reasonable and customary charges. You will be responsible for charges above reasonable and customary, which will not count towards the out-of-pocket maximum.

Covered hospital expenses include:

- Services of a surgeon
- Preoperative and postoperative care
- Administration of anesthesia
- Ambulance service to the first hospital where you receive treatment and transfers when medically necessary
- X-rays, laboratory and pathology services
- Blood and blood transfusions
- Cosmetic surgery to repair bodily injury, if performed within 18 months of a non occupational accident
- Cosmetic surgery to repair a congenital defect where the surgery will lead to increased bodily function
- Inpatient prescription drugs
- Other inpatient services and supplies billed by the hospital

Outpatient Services and Supplies

The Basic Medical and Safety Net Options also pay a portion of the cost of many other medically necessary services and supplies that you receive outside a hospital, including:

- Care or treatment by a legally qualified physician (special limits apply for outpatient psychiatric and substance abuse treatment, and for chiropractic care)
- Services of registered, graduate nurses in a clinic or doctor's office, nurse midwives, osteopaths or podiatrists
- Second surgical opinions
- Outpatient hospital and surgical treatment for an illness or injury
- Prenatal care
- Diagnostic X-rays and laboratory tests (including pre-admission testing)
- Oxygen
- Purchase or rental (depending on which is most cost effective) of durable medical and surgical equipment
- Artificial limbs and eyes

If you receive outpatient services from a network provider and that provider refers you or sends your blood work or X-rays to a non-network lab or radiologist, you will be reimbursed at the out-of-network level. It is your responsibility to check if the lab or radiologist is in-network.

Prescription drugs are covered separately (see Prescription Drug Benefit Details).

Mastectomy Treatments

The Women’s Health and Cancer Rights Act requires group health plans that cover medically necessary mastectomies to cover:

- Breast reconstruction (for the breast that required the mastectomy)
- Reconstruction of the other breast (to produce a symmetrical appearance)
Prostheses

Treatment of physical complications at all stages of the mastectomy, including lymphedemas

Expenses related to the above are subject to the usual deductibles and coinsurance associated with your plan. This coverage will be determined in consultation with the attending physician and patient.

Infertility Treatments

The plan will cover certain types of infertility treatments. Only treatments for IVF, GIFT, ZIFT, IVC and artificial insemination for eligible retiree-participants and their eligible dependents are covered. Charges for the reversal of sterilization procedures, charges for or related to the pregnancy of a surrogate mother and charges for or relating to donor activities are not covered, even for eligible retiree-participants and their dependents. There is a separate $10,000 individual lifetime maximum on covered infertility benefits, which includes infertility medications. These infertility expenses are included in your $1,500,000 lifetime maximum.

Centers of Excellence infertility treatment centers are available through UnitedHealthcare only. UnitedHealthcare members eligible for Centers of Excellence for infertility treatments should call UnitedHealthcare at 1-800-638-7785 to use these services.

Newborn Child

The Basic Medical and Safety Net Options pay eligible benefits for a newborn child—starting at delivery. You must enroll the child within 31 days of the date of birth by calling The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014.

This includes benefits for the baby's nursery care in the hospital and other covered medical expenses, regardless of whether the services are provided by a network or non-network doctor and regardless of whether the pregnancy was covered.

Grandchildren are not covered unless you are their legal guardian or have adopted them.

Hearing Benefits

Hearing benefits are covered under both the Basic Medical and Safety Net Options. If you are enrolled in the Basic Medical or Safety Net Option, have out-of-area coverage, or see a non-network provider under either medical option, your hearing treatment, (excluding hearing aids) is subject to the in- or out-of-network deductible and coinsurance.

Routine hearing exams are covered at 100 percent with no deductible, limited to one per calendar year. Routine hearing exams must be received in-network to be covered.

Hearing aids: Hearing aids are not subject to deductibles or coinsurance. Hearing aid batteries are not a covered expense.

Chiropractic Services

The plan covers chiropractic care performed by a licensed chiropractor for up to 26 visits per calendar year, as detailed below:

- Diagnostic and treatment only for a misalignment or dislocation of the spine (including any strained muscle or related ligament).
- If you are enrolled in the Basic Medical or Safety Net Option, your chiropractic treatment is subject to the applicable deductible and coinsurance.
- Claims may be reviewed for medical necessity.

Acupuncture

The plan covers acupuncture treatments performed by a licensed physician or licensed acupuncturist for the treatment of pain, illness or injury. Acupuncture is not covered for acne, drug or alcohol dependency, obesity or eating disorders.

- If you are enrolled in the Basic Medical or Safety Net Option, your acupuncture treatment is subject to the applicable deductible and coinsurance.
**Physical, Speech, Vision and Occupational Therapy**

Physical, speech, vision and occupational therapy are covered when the therapy is expected to result in the improvement of a body function, including the restoration of the level of an existing speech function, which has been lost or impaired due to an injury, illness or congenital defect. This includes developmental disorders.

A treatment recommendation from your doctor does not mean that the treatment will be covered under the plan. In some circumstances, the physicians at your medical plan carrier will determine that the recommended care is not medically necessary and coverage may be denied. Coverage is limited to 100 visits annually for all therapies combined (in- and out-of-network).

**Educational Counseling**

- The plan covers educational counseling only for nutritional education for diabetes or morbid obesity. If your claims administrator is Anthem Blue Cross and Blue Shield, educational counseling is also covered for those who are overweight or obese. To be covered, the counseling must be approved by your medical plan carrier. Diabetic education is capped at four visits.

**Dental Work and Oral Surgery**

The Basic Medical and Safety Net Options cover certain dental work performed by a licensed dentist if prompt repair of natural teeth or body tissues is required due to an accident. General anesthesia related to dental work is only covered if approved by your medical plan carrier. Benefits are paid only if the repair is performed within one year of the accident.

The surgical procedure to treat temporomandibular joint (TMJ) is covered under the medical plan if approved by your medical plan carrier. This does not include office visits or diagnostic testing associated with TMJ. Non-surgical treatments for TMJ are not covered under the medical plan.

**Hospital Alternatives**

The Basic Medical and Safety Net Options may provide coverage for care at home or in facilities that are not hospitals.

<table>
<thead>
<tr>
<th>CONSIDER HOSPITAL ALTERNATIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you do not need to be in a hospital, receiving medical care in another setting is often less costly, more comfortable, more efficient and just as safe. These alternatives include:</td>
</tr>
<tr>
<td>HOME HEALTH CARE, to help you recuperate in your own home from an illness or injury</td>
</tr>
<tr>
<td>CONVALESCENT, REHABILITATIVE OR SKILLED NURSING FACILITY CARE, if you are well enough to be discharged from the hospital, but not healthy enough to go home</td>
</tr>
<tr>
<td>HOSPICE CARE, for terminally ill patients and their families.</td>
</tr>
</tbody>
</table>

Precertification is necessary for inpatient admissions such as convalescent, rehabilitation, hospice or skilled nursing facilities. Call your medical plan carrier to make sure the alternative care will be covered.

**Home Health Care**

Through the use of an authorized home health care agency, you may be able to shorten your hospital stay and speed your recovery in your own home. The Basic Medical and Safety Net Options cover a percentage of expenses billed by an authorized home health care agency for covered services and supplies, which must be prescribed by your physician.

If you need home health care, call your medical plan carrier. A nurse may be able to arrange for care at preferred rates.

Home health care includes:

- Part-time or intermittent nursing care by a registered nurse (RN), or a licensed practical nurse (LPN) if an RN is not available or necessary;
Part-time or intermittent home health aide services that consist primarily of patient care;

- Physical, occupational or speech therapy provided by the home health care agency;

- Medical supplies; and

- Laboratory services provided by or on behalf of a hospital, to the extent they would have been covered if you had been hospitalized.

Coverage for drugs or medications prescribed by your doctor is provided under the Prescription Drug Benefit section.

The plan covers a maximum of 200 home health care visits per calendar year. Precertification is necessary along with the following requirements:

- The home health care program is established and approved by the attending physician, begins within seven days after hospitalization and is determined to be medically necessary by your medical plan carrier;

- Care is provided for a condition related to the condition for which the patient was hospitalized; and

- The attending physician certifies that, in the absence of home health care, hospitalization would be required.

Each visit by a nurse or therapist counts as one home health care visit. If your claims administrator is UnitedHealthcare, every four hours of home health aide services counts as one home health care visit.

Expenses for the following services are not covered:

- Services of a person who resides in your home or is a member of your (or your spouse’s or domestic partner’s) family;

- Custodial care;

- Transportation services; and

- Any period in which the covered individual is not under the continuing care of a physician.

Please see the Care Management section for more information.

Convalescent, Rehabilitative, or Skilled Nursing Facility Care

If you or an eligible dependent are recovering from an illness or injury, benefits for extended care facility charges are payable for certain services and supplies.

Care at an extended care facility is covered if precertified by your medical plan carrier and if the claims administrator/case manager determines that:

- A physician recommends confinement in a convalescent or skilled nursing facility approved by the claims administrator;

- The patient is under a physician’s continuing care; and

- The initial hospital stay begins while the patient is enrolled in one of the medical options.

The maximum number of covered days during any one convalescent period is 120. A new convalescent period will not begin until you have been free of confinement for 90 days—in either a hospital, convalescent facility or other institution providing nursing care.

Covered expenses include the following:

- Room and board, including charges for general nursing care;

- Use of special treatment rooms, X–rays, laboratory examinations, most therapy and other medical services customarily provided to patients; and

- Drugs, biologicals, solutions, dressings, and casts.

Expenses that are not covered include:

- Custodial care;

- Treatment of disorders such as drug addiction, chronic brain syndrome, alcoholism, mental retardation or senility except as covered under the Mental Health benefit;

- Medical supplies not listed above; and
Private duty or special nursing services provided by the convalescent facility.

Hospice Care

Hospice care refers to the medical, psychological, and nursing care provided to terminally ill patients generally with a life expectancy of less than six months. It allows someone to leave an acute care hospital for a more comfortable and dignified setting.

The following expenses are covered if precertified by your medical plan carrier and when they are determined to be part of an approved hospice care program by the claims administrator or case manager:

- Semiprivate room and board
- Services and supplies furnished for pain control and other acute and chronic symptom management
- Part-time or intermittent nursing care by an RN or LPN for up to eight hours in any one day
- Medical social services under the direction of a physician
- Psychological and dietary counseling
- Consultation or case management services by a physician
- Physical and occupational therapy
- Part-time or intermittent home health aide services for up to eight hours in any one day, and
- Medical supplies, drugs and medicines prescribed by a physician. (Prescriptions filled on an outpatient basis are covered under the Prescription Drug Benefit.)

Hospice care may be provided either at home or through an accredited hospice care agency.

Charges that are **not covered** include:

- Bereavement counseling
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling, and
- Homemaker or caretaker services, such as sitter or companion services, transportation, house cleaning and respite care.

Expenses Not Covered

The Basic Medical and Safety Net Options, and the Mental Health Benefit, cover only treatments, services or supplies that are determined by your claims administrator to be medically necessary, effective and recommended by the attending physician. Medical, mental health and substance abuse expenses that are not covered include:

- Expenses that are above what is reasonable and customary or that you or your enrolled dependents are not required to pay
- Services and supplies not related to the treatment of an illness, injury or pregnancy such as well–baby care (unless provided by a network physician) or birth control devices
- Routine well-baby care and yearly physical exams, unless given by a network physician (if you are in a pre-Medicare Plan; subject to plan limits)
- Routine vision exams
- Drugs and medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury (also see the Prescription Drug Benefit Details section for more information.)
- Dental work and oral surgery, except when the result of an accident
- Custodial care
- Radial keratotomy, LASIK
- Transportation, except for emergencies to the first hospital where treatment is received and for transfers when medically necessary
- Care not provided under the supervision of a physician (or other qualified provider) operating within the scope of his or her license
- Nursing or other services performed by a person who ordinarily resides in the patient's home or is a member of your family or your spouse's/partner's family
- Services or supplies provided before coverage is in effect or after termination of coverage
- Expenses that would not have been incurred if no coverage existed
- Services or supplies available due to service in the armed forces of any government and any expenses incurred while serving in the armed forces of any government
- Any expenses related to an occupational injury
- Any services or supplies available under a governmental plan (except a plan established by a government for its own civilian employees and their dependents)
- Expenses that are payable by Medicare Part A or B whether you have enrolled in Medicare Part A and Part B or not
- Expenses for drawing and storage of your own blood if surgery does not definitely necessitate blood transfusion
- Physical, speech, vision and occupational therapies that are expected to result in the improvement of a body function, including the restoration of the level of an existing speech function are not covered if the loss was not due to an illness or injury or congenital defect or developmental disorder
- Treatment for an injury resulting from the covered person's commission or attempted commission of a violent crime
- Charges for the consultation of a sterilization procedure and the reversal of sterilization procedures
- Charges for or related to the fertility treatment or pregnancy of a surrogate mother
- Charges for or related to egg or sperm donors
- Charges for organ donors or the retrieval of organs unless they are performed at a United Resource Network facility and are covered under a global rate. The donor services must be performed at the same facility as the transplant
- Autopsies
- Charges for or related to smoking cessation
- Charges for or related to the treatment of weight control or diet. However, obesity treatment and surgery is covered if the case is considered medically necessary by your medical claims administrator and is being medically managed
- Expenses related to missed appointments or storage of your health care information or data
- Expenses incurred after you have reached your lifetime maximum
- Services or supplies which are considered to be experimental, investigational or unproven in terms of generally accepted medical standards, as determined by your medical plan carrier
- Chiropractic care office visits in excess of the 26-visit limit per calendar year
- Mental and psychoneurotic disorders not listed in the International Statistical Classification of Diseases, Injuries and Causes of Death, or services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental Health Services as treatment for a primary diagnosis of sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders, gambling disorders and other disorders with a known physical basis
- Bioenergetic therapy, carbon dioxide therapy, expressive therapies, primal therapy, transcendental meditation
- Ecological or environmental medicine, diagnosis or treatment
- Wilderness programs
- Herbal medicine, holistic or homeopathic care, including drugs
- Services, supplies, treatments or drugs that have not been scientifically proven to be treatment options or not certified by the U.S. Food and Drug Administration (FDA)
- Any item or supply that is not a prescription drug approved by the FDA (this exclusion does not apply to insulin or related supplies)
- Treatment for any of the following diagnoses: mental retardation (except the initial diagnosis), chronic organic brain syndrome or learning disabilities
- Testing and evaluation for the purpose of maintaining employment
- Court ordered care or testing, or required as a condition of parole or probation
- Educational evaluation/remediation therapy and school consultations
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Services for marital, pre-marital or pastoral counseling
- Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction
- Substance Use Disorder Services for the treatment of nicotine or caffeine use
- Administrative psychiatric services when these are the only services rendered
- Erhard Seminar Training (EST) or similar motivational services
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the claims administrator
- Private duty nursing services while confined in a facility
- Testing for aptitude, ability, intelligence or interest
- Intensive behavioral therapies such as applied behavioral analysis for autism spectrum disorders
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Routine use of psychological testing without specific authorization
- For participants in the BlueCare HMO option, mental health services in a residential treatment facility, and
- Claims for which you fail to submit completed claim information within the claim filing period.
WHAT ARE EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES?

Experimental, investigational or unproven services include medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies; supplies, treatments, procedures, drug therapies or devices that are determined by the claims administrator to not have been approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use. For example, a drug that is the subject of an ongoing Phase III clinical trial would be considered experimental, as would a drug that has been approved for use against breast cancer but is being used to cure influenza. Additionally, any health care technologies, treatments, procedures or other processes that are not subject to FDA approval are considered experimental if they are determined by the claims administrator to be not sufficiently prevalent in the medical field or not sufficiently reviewed in the peer-review literature.
Post-Medicare Retiree Medical Provisions for Those Receiving Medicare due to Disability or ESRD

Note that these provisions apply only to retirees or eligible dependents who are Medicare-eligible as the result of a disability or ESRD only. See page 77 for information about Post-Medicare coverage at age 65.

When you, your spouse/domestic partner or other enrolled eligible dependent becomes eligible for Medicare as the result of a disability or ESRD, medical coverage under the PepsiCo Retiree Health Care Program changes.

The provisions in this section apply to you or your spouse/domestic partner or other dependent if you or they become eligible for Medicare:

- After you or a dependent has received no less than 24 months of Social Security disability benefits, regardless of age; or
- After you or a dependent has been diagnosed with end stage renal disease (ESRD), subject to certain exceptions.

This section focuses on the Basic Medical Option for pre-age 65 Medicare-eligible retirees and their dependents. It covers the same medical care and prescription drugs as it does prior to Medicare eligibility; the difference is in how plan benefits are determined and in the annual out-of-pocket maximum. The PepsiCo plan is no longer the primary payer. Instead, Medicare becomes the primary payer and the PepsiCo plan becomes the secondary payer. This means that Medicare pays benefits first, before the Basic Medical Option. It's still a good idea to show your PepsiCo retiree medical ID card, as well as your Medicare card, so the provider’s office staff will know you have secondary coverage.

If you do not actively choose a plan and were enrolled in a pre-Medicare retiree medical option, you will automatically be enrolled in the Post-Medicare Basic Medical Option.

If you are Medicare eligible and are enrolled in a post-Medicare medical option and if your covered dependent is not Medicare eligible and enrolled in a pre-Medicare medical option (or vice versa), you will keep the same claims administrator that you had for your pre-Medicare medical option when you become enrolled in a post-Medicare medical option.

When you become eligible for Medicare, it is not necessary to seek in-network providers. You should instead make sure your doctor accepts Medicare. The PepsiCo Post-Medicare Basic Medical Option will generally pay benefits based on Medicare’s approved amount for covered services.

If you or your covered dependents are eligible for Medicare, PepsiCo will process your claims as if you were enrolled in Medicare Parts A and B, even if you’re not. If you or your covered dependents are eligible for Medicare but have not enrolled, your level of reimbursement from the PepsiCo plan will be significantly reduced.

You are responsible for applying for Medicare, which includes hospital coverage under Medicare Part A and outpatient medical coverage through Medicare Part B. When a covered person becomes eligible for Medicare, the plan will always pay claims as if the covered person has Medicare Parts A and B, whether or not you are actually enrolled.

- Medicare Part A Enrollment: Typically, enrollment in Medicare Part A is automatic once you begin receiving Social Security. There is no cost for this coverage.
- Medicare Part B Enrollment: Enrollment in Medicare Part B is not always automatic. This coverage requires a monthly premium, which can be deducted from your monthly Social Security check. To enroll, contact the Social Security Administration at 1-800-772-1213.

If you enroll in a Medicare Part C plan (Medicare Advantage) or Medicare Part D, you may not participate in the PepsiCo Retiree Health Care Program. You and your covered spouse/partner/dependents will be automatically and permanently dropped from all of PepsiCo's retiree medical and prescription drug coverage. You can never reenter the PepsiCo Retiree Health Care Program, even at a future open enrollment period.

For information on prescription drug coverage under the Post-Medicare Basic Medical Option and the Prescription Drug Only Option, see Prescription Drug Benefit Details.
**Medicare Basics**

Medicare is the federal government’s health insurance program that provides coverage after age 65 or during disability. Medicare has two basic parts: hospital insurance (Part A) and medical insurance (Part B).

Contact the Social Security Administration at 1-800-772-1213:

- To enroll in Social Security and Medicare
- To determine if/when you are eligible for Medicare, or
- To obtain information on programs which may assist you with the payment of your Medicare Part B monthly premium.

For additional information on the benefits provided by Medicare, please visit Medicare’s web site at [www.Medicare.gov](http://www.Medicare.gov) or call 1-800-633-4227 (1-800-Medicar(e)).

**Medicare-Approved Amount**

Medicare pays only a specified portion of the approved (allowed) amounts for the expenses it covers. The Medicare-approved amount for providers’ services covered by Medicare Part B is based on a national fee schedule. The schedule assigns a dollar value to each service based on work, practice costs, and malpractice insurance costs. Each time you go to a doctor for a service covered by Medicare, the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount.

Providers who take assignment on a Medicare claim agree to accept the Medicare-approved amount as payment in full. They are paid directly by the Medicare carrier. You pay the Medicare deductible and the remaining 20 percent of the approved charge. Providers who do not accept assignment on a Medicare claim are still limited by Medicare to the amount they can charge for covered services. The most these doctors can charge for services covered by Medicare is 115 percent of the fee schedule amount.

For eligible charges not covered under Medicare, PepsiCo benefits are paid based on reasonable and customary charges (R&C).

**The PepsiCo Plan’s Deductible and Out-of-Pocket Limit**

The annual deductible is the amount of money you have to pay each year before the plan begins to pay benefits. Any amounts that you pay toward the Medicare deductible will apply to the plan’s deductible. Under Medicare Coordination, if Medicare pays the same or more than the plan pays, then the plan will not pay anything even if you have met your deductible.

The annual out-of-pocket limit is the maximum amount that you have to pay for eligible expenses in a year. After you satisfy your individual out-of-pocket limit of $2,500 in a calendar year for covered expenses, the plan will generally pay 100 percent of covered expenses for the rest of the year, subject to the lifetime maximum limit. In calculating the plan’s out-of-pocket limit, the following amounts do not count towards the limit:

- The PepsiCo deductible;
- Medicare Part B premiums; or
- Prescription drug coinsurance and deductibles.

In a given year, eligible expenses applied to the out-of-pocket limit in a pre-Medicare option are counted toward the out-of-pocket limit in the post-Medicare-eligible option and vice versa.

Medicare has its own deductibles and out-of-pocket limits, which are subject to change. You should check with Medicare via the Social Security Administration for details on the current year’s deductibles and out-of-pocket limits.

**How Medicare Coverage Works With the PepsiCo Plan**

The plan benefits will coordinate with Medicare. For purposes of calculating the benefits payable by the plan, the non-duplication approach applies. The intent of the non-duplication approach is to limit the plan’s liability to only the amount (if any) that its benefits exceed the amount paid by Medicare.

When you go to a provider who accepts Medicare, he or she will accept a fee for that service that has been approved by Medicare. This fee is the total the provider will charge for that service. Depending on whether the charge is
hospital-based (Part A of Medicare) or office-based (Part B of Medicare), Medicare will pay different amounts of that agreed-upon fee.

In the event Medicare pays the same or more than the plan would have paid, the plan pays nothing.

Remember, the plan’s benefits are processed as if you were enrolled in Medicare Part A and Part B (even if you are not). It is your responsibility to ensure your Medicare Part A and B coverage is in place as soon as you are eligible.

How Benefits Are Paid

Generally, when you submit a claim for covered services under the Post-Medicare Basic Medical Option:

1. The plan determines the amount it would have paid in the absence of Medicare.
2. The amount the plan would have paid in the absence of Medicare is compared with the amount that Medicare pays.
   - If the amount that the plan would have paid is less than or equal to the amount that Medicare pays, then the plan pays $0.
   - If the amount that the plan would have paid is greater than the amount that Medicare pays, then the plan pays the difference, if any, according to the terms of the plan.
3. If the provider does not accept Medicare assignment, the participant pays the amount (if any) that remains after the Medicare and plan benefits are coordinated.
4. The amount that the participant pays for covered services is applied toward any annual deductible and out-of-pocket limits required under the plan.

Following are two examples of how Medicare coordination is administered by the plan’s claims administrators.

**Example 1:** First Claim After the Medicare Part B and PepsiCo Plan Deductible Have Been Satisfied

<table>
<thead>
<tr>
<th>Payer</th>
<th>What Medicare Part B Pays</th>
<th>What the Basic Medical Option Would Pay in the Absence of Medicare</th>
<th>What the Basic Medical Option Pays After Medicare Coordination</th>
<th>What the Plan Participant Pays After Medicare Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim for covered services</td>
<td>$ 85</td>
<td>$ 85</td>
<td>$ 85</td>
<td>$ 85</td>
</tr>
<tr>
<td>Payment</td>
<td>$ 85</td>
<td>$ 85 × 80% (percentage Medicare covers)</td>
<td>$ 0</td>
<td>$ 85 − $ 68 (the amount that Medicare pays) − $ 0 (the amount that the PepsiCo plan pays)</td>
</tr>
<tr>
<td></td>
<td>$ 68</td>
<td>$ 68 × 80% (percentage the PepsiCo plan covers)</td>
<td></td>
<td>$ 17</td>
</tr>
</tbody>
</table>

End Result: The $17 that you pay following Medicare coordination is applied toward the PepsiCo plan’s individual $2,500 out-of-pocket limit.

Remember, the plan’s benefits are processed as if you were enrolled in Medicare Parts A and B (even if you are not), so you should enroll in Medicare Part B as soon as you are eligible.

**Example 2:** First Claim for Covered Part B Services After the Basic Medical Option’s Out of Pocket Maximum Has Been Satisfied

<table>
<thead>
<tr>
<th>Payer</th>
<th>What Medicare Part B Pays</th>
<th>What the Basic Medical Option Would Pay in the Absence of Medicare</th>
<th>What the Basic Medical Option Pays After Medicare Coordination</th>
<th>What the Plan Participant Pays After Medicare Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim for covered services</td>
<td>$ X</td>
<td>$ X</td>
<td>$ X</td>
<td>$ X</td>
</tr>
<tr>
<td>Payment</td>
<td>$ X × 80% (percentage Medicare covers)</td>
<td>$ X × 80% (percentage the PepsiCo plan covers)</td>
<td>$ 0</td>
<td>$ X − $ 0 (the amount that Medicare pays) − $ 0 (the amount that the PepsiCo plan pays)</td>
</tr>
</tbody>
</table>

End Result: The $0 that you pay following Medicare coordination is applied toward the PepsiCo plan’s individual $0 out-of-pocket limit.
## Covered Medical Expenses

The Post-Medicare Basic Medical Option coordinates with Medicare to cover a portion of most medically necessary services and supplies, both inside and outside of a hospital.

See the Expenses Not Covered pages of this section for a listing of some expenses that are not covered.

### Ambulance Services

For a true emergency as determined by your health plan, ambulance services will be covered subject to the deductible and coinsurance.

### Hospital Services and Supplies

The Post-Medicare Basic Medical Option coordinates with Medicare to pay a portion of the standard rate for semi-private room and board in a recognized hospital or approved rehabilitative facility.

Covered hospital expenses include:

- Services of a surgeon
- Preoperative and postoperative care
- Administration of anesthesia
- Ambulance service to the first hospital where you receive treatment and transfers when medically necessary
- X-rays, laboratory, and pathology services
- Blood and blood transfusions
- Cosmetic surgery to repair bodily injury, if performed within 18 months of a non–occupational accident
- Cosmetic surgery to repair a congenital defect where the surgery will lead to increased bodily function
- Inpatient prescription drugs
- Other inpatient services and supplies billed by the hospital.

### Outpatient Services and Supplies

The Post-Medicare Basic Medical Option coordinates with Medicare to pay a portion of the cost of many other medically necessary services and supplies that you receive outside a hospital, including:

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<table>
<thead>
<tr>
<th>Payer</th>
<th>What Medicare Part B Pays</th>
<th>What the Basic Medical Option Would Pay in the Absence of Medicare</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Claim for covered services</td>
<td>$ 125</td>
<td>$ 125</td>
<td>$ 125</td>
<td>$ 125</td>
</tr>
<tr>
<td>Payment</td>
<td>$ 125 × 80% (percentage Medicare covers)</td>
<td>$ 125 × 100% (percentage the PepsiCo plan covers)</td>
<td>$ 25 Because the amount that Medicare pays is less than the amount the PepsiCo plan would pay in the absence of Medicare, the PepsiCo plan pays a portion of the difference: $125 − $100 = $25</td>
<td>$ 125 − 100 (the amount that Medicare pays) − 25 (the amount that the PepsiCo plan pays)</td>
</tr>
</tbody>
</table>

**End Result**

After Medicare coordination, you pay $0 for the covered services.
• Care or treatment by a legally qualified physician (special limits apply for outpatient psychiatric and substance abuse treatment and for chiropractic care)
• Services of registered, graduate nurses in a clinic or doctor’s office, nurse midwives, osteopaths, or podiatrists
• Second surgical opinions
• Outpatient hospital and surgical treatment for an illness or injury
• Prenatal care
• Diagnostic X-rays and laboratory tests (including pre-admission testing)
• Oxygen
• Purchase or rental (depending on which is most cost effective) of durable medical and surgical equipment
• Artificial limbs and eyes.

Prescription drugs are covered separately (see Prescription Drug Benefit Details).

**Mastectomy Treatments**

The Women’s Health and Cancer Rights Act requires group health plans that cover medically necessary mastectomies to cover:

• Breast reconstruction (for the breast that required the mastectomy)
• Reconstruction of the other breast (to produce a symmetrical appearance)
• Prostheses
• Treatment of physical complications at all stages of the mastectomy, including lymphedemas

Expenses related to the above are subject to the usual deductibles and coinsurance associated with the plan. This coverage will be determined in consultation with the attending physician and patient.

**Hearing Benefits**

Medical hearing treatments (excluding hearing aids) are covered subject to the deductible and coinsurance. Routine hearing exam is covered at 100 percent with no deductible, limited to one per calendar year.

Hearing aids: Hearing aids are not subject to deductibles or coinsurance. Hearing aid batteries are not a covered expense.

**Chiropractic Services**

The plan covers chiropractic care performed by a licensed chiropractor for up to 26 visits per calendar year, as detailed below.

• Diagnostic and treatment only for a misalignment or dislocation of the spine (including any strained muscle or related ligament).

• Chiropractic treatment is subject to the applicable deductible and coinsurance.
• Claims may be reviewed for medical necessity.

**Acupuncture**

The plan covers acupuncture treatments performed by a licensed physician or licensed acupuncturist for the treatment of pain, illness or injury, subject to the applicable deductible and coinsurance. Acupuncture is not covered for acne, drug or alcohol dependency, obesity or eating disorders.
Physical, Speech, Vision and Occupational Therapy

Physical, speech, vision and occupational therapy are coordinated with Medicare when the therapy is expected to result in the improvement of a body function, including the restoration of the level of an existing speech function, which has been lost or impaired due to an injury, illness, or congenital defect. This includes developmental disorders. Coverage is limited to 100 visits annually for all therapies combined.

A treatment recommendation from your doctor does not mean that the treatment will be covered under the plan. In some circumstances, the physicians at your medical plan carrier will determine that the recommended care is not medically necessary and coverage may be denied.

Educational Counseling

Educational counseling will only cover nutritional education for diabetes or morbid obesity that has been approved by your medical plan carrier. If your claims administrator is Anthem Blue Cross and Blue Shield, educational counseling is also covered for those who are overweight or obese, if approved by your medical carrier. Diabetic education is capped at four visits.

Dental Work and Oral Surgery

The Post-Medicare Basic Medical Option covers certain dental work performed by a licensed dentist if prompt repair of natural teeth or body tissues is required due to an accident. General anesthesia related to dental work is only covered if approved by Medicare. Benefits are paid only if the repair is performed within one year of the accident.

The surgical procedure to treat temporomandibular joint (TMJ) is covered under the medical plan if approved by Medicare. This does not include office visits or diagnostic testing associated with TMJ. Non-surgical treatments for TMJ are not covered under the plan.

Hospital Alternatives

If you do not need to be in a hospital, receiving medical care in another setting is often less costly, more comfortable, more efficient, and just as safe. The Post-Medicare Basic Medical Option coordinates with Medicare and may provide coverage for care at home or in facilities that are not hospitals. These alternatives include:

- HOME HEALTH CARE, to help you recuperate in your own home from an illness or injury
- CONVALESCENT, REHABILITATIVE OR SKILLED NURSING FACILITY CARE, if you are well enough to be discharged from the hospital, but not healthy enough to go home
- HOSPICE CARE, for terminally ill patients and their families.

Home Health Care

Through the use of an authorized home health care agency, you may be able to shorten your hospital stay and speed your recovery in your own home. The Post-Medicare Basic Medical Option coordinates with Medicare to cover a percentage of expenses billed by an authorized home health care agency for covered services and supplies, which must be prescribed by your physician.

Home health care services may include:

- Part-time or intermittent nursing care by a registered nurse (RN), or a licensed practical nurse (LPN) if an RN is not available or necessary;
- Part-time or intermittent home health aide services that consist primarily of patient care;
- Physical, occupational or speech therapy provided by the home health care agency;
- Medical supplies; and
- Laboratory services provided by or on behalf of a hospital, to the extent they would have been covered if you had been hospitalized.

Coverage for drugs or medications prescribed by your doctor is provided under the Prescription Drug Benefit.

The plan covers a maximum of 200 home health care visits per calendar year. Precertification is necessary along with the following requirements:

- The home health care program is established and approved by the attending physician, begins within seven days after hospitalization and is determined to be medically necessary by Medicare;
- Care is provided for a condition related to the condition for which the patient was hospitalized; and
- The attending physician certifies that, in the absence of home health care, hospitalization would be required.

Each visit by a nurse or therapist counts as one home health care visit. If your claims administrator is UnitedHealthcare, every four hours of home health aide services counts as one home health care visit.

Expenses for the following services are not covered:
- Services of a person who resides in your home or is a member of your (or your spouse’s or domestic partner’s) family;
- Custodial care;
- Transportation services; and
- Any period in which the covered individual is not under the continuing care of a physician.

**Convalescent, Rehabilitative, or Skilled Nursing Facility Care**

If you or an eligible dependent are recovering from an illness or injury, benefits for extended care facility charges are payable for certain services and supplies.

Care at an extended care facility is coordinated with Medicare if:
- A physician recommends confinement in a convalescent or skilled nursing facility approved by Medicare;
- The patient is under a physician’s continuing care; and
- The initial hospital stay begins while the patient is enrolled in the Post-Medicare Basic Medical Option.

The maximum number of covered days during any one convalescent period is 120. A new convalescent period will not begin until you have been free of confinement for 90 days—in either a hospital, convalescent facility or other institution providing nursing care.

Covered expenses may include the following:
- Room and board, including charges for general nursing care;
- Use of special treatment rooms, X-rays, laboratory examinations, most therapy and other medical services customarily provided to patients; and
- Drugs, biologicals, solutions, dressings, and casts.

Expenses that are not covered include:
- Custodial care;
- Treatment of disorders such as drug addiction, chronic brain syndrome, alcoholism, mental retardation or senility except as covered under the Mental Health benefit;
- Medical supplies not listed above; and
- Private duty or special nursing services provided by the convalescent facility.

**Hospice Care**

Hospice care refers to the medical, psychological, and nursing care provided to terminally ill patients generally with a life expectancy of less than six months. It allows someone to leave an acute care hospital for a more comfortable and dignified setting.

The following expenses may be coordinated with Medicare:
- Semiprivate room and board
- Services and supplies furnished for pain control and other acute and chronic symptom management
- Part-time or intermittent nursing care by an RN or LPN for up to eight hours in any one day
- Medical social services under the direction of a physician
- Psychological and dietary counseling
Consultation or case management services by a physician
- Physical and occupational therapy
- Part-time or intermittent home health aide services for up to eight hours in any one day, and
- Medical supplies, drugs and medicines prescribed by a physician. (Prescriptions filled on an outpatient basis are covered under the Prescription Drug Benefit.)

Hospice care may be provided either at home or through an accredited hospice care agency.

Charges that are not covered include:
- Bereavement counseling
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling, and
- Homemaker or caretaker services, such as sitter or companion services, transportation, house cleaning, and respite care.

Newborns’ and Mothers’ Health Protection Act

Group health plans generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Expenses Not Covered

The Post-Medicare Basic Medical Option, including the Mental Health Benefit, covers only treatments, services or supplies that are determined by the claims administrator or Medicare to be medically necessary, effective, and recommended by the attending physician. Medical, mental health and substance abuse expenses that are not covered by the Post-Medicare Basic Medical Option include:

- Expenses that are above Medicare’s allowable charge, or above what is reasonable and customary for services not covered by Medicare, or that you or your enrolled dependents are not required to pay
- Services and supplies not related to the treatment of an illness, injury or pregnancy
- Routine vision exams
- Drugs and medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury (also see the Prescription Drug Benefit Details section for more information.)
- Dental work and oral surgery, except when the result of a non-occupational accident
- Custodial care
- Radial keratotomy, LASIK
- Transportation, except for emergencies to the first hospital where treatment is received and for transfers when medically necessary
- Care not provided under the supervision of a physician (or other qualified provider) operating within the scope of his or her license
- Nursing or other services performed by a person who ordinarily resides in the patient’s home or is a member of your family or your spouse’s/partner’s family
- Services or supplies provided before coverage is in effect or after termination of coverage
- Expenses that would not have been incurred if no coverage existed
- Services or supplies available due to service in the armed forces of any government and any expenses incurred while serving in the armed forces of any government
• Any expenses related to an occupational injury
• Any services or supplies available under a governmental plan (except a plan established by a government for its own civilian employees and their dependents)
• Expenses that are payable by Medicare Part A or B whether or not you have enrolled in Medicare Part A and Part B
• Expenses for drawing and storage of your own blood if surgery does not definitely necessitate blood transfusion
• Physical, speech, vision and occupational therapies that are expected to result in the improvement of a body function, including the restoration of the level of an existing speech function are not covered if the loss was not due to an illness or injury or congenital defect or developmental disorder
• Treatment for an injury resulting from the covered person’s commission or attempted commission of a violent crime
• Charges for consultation regarding a sterilization procedure and the reversal of sterilization procedures
• Charges for or related to the fertility treatment or pregnancy of a surrogate mother
• Charges for or related to egg or sperm donors
• Charges for organ donors or the retrieval of organs, unless they are performed at a United Resource Network facility and are covered under a global rate. The donor services must be performed at the same facility as the transplant
• Autopsies
• Charges for or related to smoking cessation
• Charges for or related to the treatment of weight control and diet. However, obesity treatment and surgery is covered if the case is considered medically necessary by the claims administrator and is being medically managed
• Expenses related to missed appointments or storage of your health care information or data
• Expenses incurred after you have reached your lifetime maximum
• Services or supplies which are considered to be experimental, investigational or unproven in terms of generally accepted medical standards, as determined by Medicare or your claims administrator
• Chiropractic care office visits in excess of the 26-visit limit per calendar year
• Mental and psychoneurotic disorders not listed in the International Statistical Classification of Diseases, Injuries and Causes of Death, or services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
• Mental Health Services as treatment for a primary diagnosis of sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders, gambling disorders and other disorders with a known physical basis
• Bioenergetic therapy, carbon dioxide therapy, expressive therapies, primal therapy, transcendental meditation
• Ecological or environmental medicine, diagnosis or treatment
• Wilderness programs
• Herbal medicine, holistic or homeopathic care, including drugs
• Services, supplies, treatments or drugs that have not been scientifically proven to be a treatment option or not certified by the U.S. Food and Drug Administration (FDA)
• Any item or supply that is not a prescription drug approved by the FDA (this exclusion does not apply to insulin or related supplies)
• Treatment for any of the following diagnoses: mental retardation (except the initial diagnosis), chronic organic brain syndrome or learning disabilities
• Testing and evaluation for the purpose of maintaining employment
• Court ordered care or testing, or required as a condition of parole or probation
- Educational evaluation/remediation therapy and school consultations
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Services for marital, pre-marital or pastoral counseling
- Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Methadone treatment as maintenance, L.A.A.M. (1-Acetyl-Methadone), Cyclazocine, or their equivalents for drug addiction
- Substance Use Disorder Services for the treatment of nicotine or caffeine use
- Administrative psychiatric services when these are the only services rendered
- Erhard Seminar Training (EST) or similar motivational services
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the claims administrator
- Private duty nursing services while confined in a facility
- Testing for aptitude, ability, intelligence or interest
- Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Routine use of psychological testing without specific authorization
- For participants in the BlueCare HMO option, mental health services in a residential treatment facility, and
- Claims for which you fail to submit completed claim information within the claim filing period.

WHAT ARE EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES?

Experimental, investigational or unproven services include medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies; supplies, treatments, procedures, drug therapies or devices that are determined by the claims administrator to not have been approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use. For example, a drug that is the subject of an ongoing Phase III clinical trial would be considered experimental, as would a drug that has been approved for use against breast cancer but is being used to cure influenza. Additionally, any health care technologies, treatments, procedures or other processes that are not subject to FDA approval are considered experimental if they are determined by the claims administrator to be not sufficiently prevalent in the medical field or not sufficiently reviewed in the peer-review literature.
Filing Claims

How to File Your Claim

Medical Claims (Pre-Medicare Eligible)

When you go to a network provider, the doctor or hospital will usually file the claim for you. If you go to a network provider you will not need a claim form. If you go to an out-of-network provider you will need to submit a claim to your medical plan carrier—Anthem Blue Cross and Blue Shield or UnitedHealthcare. Forms are available through the medical plan carrier. Prescription drug claim forms (only needed for prescriptions filled at non-network pharmacies) should be sent to Express Scripts. Prescription drug claim forms are available through Express Scripts.

Medical Claims (pre-age 65 Medicare-Eligible)

You will need to file a claim for all covered medical services to your plan—Anthem Blue Cross and Blue Shield or UnitedHealthcare.

Benefits under the plan will be coordinated with Medicare. You are responsible for reimbursing your provider for any unpaid balance that remains following Medicare coordination.

WHERE TO SEND YOUR MEDICAL CLAIMS

If Anthem Blue Cross and Blue Shield is your medical plan carrier:
Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

If UnitedHealthcare is your medical plan carrier:
UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Tips for Filing Claims

- Keep records of each person’s expenses as they occur
- Make a copy of the claim form and bills before mailing them
- Check that you have the correct medical claim form
- Mail your medical claims to the carrier printed on your ID card and your prescription claims to Express Scripts. There is a separate claim form for prescription drugs
- Review your explanation of benefits statement to make sure you’ve received the correct benefits.

The deadline for filing a medical, mental health or substance abuse claim is two years from the date you received the service or the supply was provided. The deadline for filing a prescription drug claim is one year from the date you had the prescription filled.

Please see the Administrative Information Section for more information regarding filing claims and appeals.

NOTE: If you are age 65 and older and Medicare-eligible and, enrolled in a Medicare supplement or advantage plan through OneExchange, contact your insurance carrier or OneExchange benefit advisor for details regarding filing claims.
Mental Health Benefits

The plan’s mental health benefits cover reasonable and customary medical expenses for mental health and substance abuse treatment. Treatment may be provided through a network provider. Your medical plan carrier - BlueCross BlueShield of Florida (BCBSF), Anthem Blue Cross and Blue Shield or UnitedHealthcare – will manage your mental health and substance abuse benefits. The plan uses networks established and managed by these claims administrators. NOTE: This section does not apply to you if you are age 65 and older and Medicare-eligible; check with your OneExchange benefit advisor.

You will use your medical plan carrier’s network to confirm your provider is in-network or to look for new in-network providers. If you have questions about mental health or substance abuse services or treatments, you should contact your medical plan carrier.

Mental Health and Substance Abuse Treatment

Mental health and substance abuse coverage is offered to eligible retirees. Treatment may be provided through your claims administrator’s contracted facilities and individual providers. The plan covers a portion of expenses for mental health and substance abuse treatment as described in this section.

Coverage is only available to retirees or the spouse/partner/dependents of retirees who participate in the Basic Medical, Safety Net or BlueCare HMO Options. Mental health benefit coverage is not available if you are enrolled in the Prescription Drug Only Option. You and your enrolled spouse/partner/dependents begin to participate in the mental health benefit at the same time that you begin to participate in the Basic Medical, Safety Net or BlueCare HMO Options. Coverage under the mental health benefit terminates at the same time that your coverage under the applicable medical option terminates. See the Retiree Health Care Program Highlights section to determine when your coverage under the medical option begins and terminates.

Expenses for mental health benefits do not count toward your medical deductible or your medical out-of-pocket maximum. Expenses related to mental health benefits count toward your medical lifetime maximum.

Services or treatments that are excluded from medical coverage are also excluded as a mental health or substance abuse service or treatment. See the Pre-Medicare Retiree Medical Provisions or the BlueCare HMO Option sections for expenses that are not covered by the mental health benefit.

Outpatient Care for Mental Health and Substance Abuse

In-network and out-of-network benefits are available at different reimbursement levels, with different restrictions, regardless of whether you are enrolled in the Basic Medical or Safety Net options. Note: Out-of-network benefits are not available under the BlueCare HMO option.

In-Network

Under the Basic Medical Option: The first 5 sessions are covered at 100 percent with no deductible. Sessions 6-52 will be covered at 80 percent with no deductible. (You are responsible for the remaining 20 percent.)

Under the Safety Net Option: The first 5 sessions are covered at 100 percent with no deductible. Sessions 6-52 will be covered at 70 percent with no deductible. (You are responsible for the remaining 30 percent.)

Out-of-Network

If you are enrolled in the Basic Medical or Safety Net Option, when you go to a non-network provider, there is an annual benefit limit of 30 private sessions. Eligible claims are covered at 50% of reasonable and customary charges (you are responsible for the remaining 50 percent). There is no out-of-pocket maximum. Note: Out-of-network benefits are not available under the BlueCare HMO option.
**Number of Sessions**

The annual maximum number of sessions is 52, of which only 30 can be out-of-network. You may increase the total number of sessions by exchanging some or all of your individual sessions for group sessions. You may exchange any private session for two group sessions. The number of visits covered is based on medical necessity. Further, in general, the plan and medical plan carriers reserve the right to review medical necessity at any time, and your annual number of outpatient sessions can be limited if your outpatient sessions are found to be no longer medically necessary. Prescription drugs are covered separately. (See the Prescription Drug Benefit Details section for more information.) Note: Out-of-network benefits are not available under the BlueCare HMO option.

**Inpatient Care for Mental Health and Substance Abuse**

If you are enrolled in the Basic Medical or BlueCare HMO Option, benefits are paid at 80 percent with no deductible. Covered out-of-area expenses are paid at 80 percent of reasonable and customary charges with no deductible.

If you are enrolled in the Safety Net Option, benefits are paid at 70 percent with no deductible. Covered out-of-area expenses are paid at 70 percent of reasonable and customary charges with no deductible.

Under all options there is an annual benefit limit of 30 inpatient days per person and a lifetime maximum of 75 inpatient days per person. The annual 30-day maximum may be increased if authorized by your medical plan carrier (but not beyond the 75-day lifetime maximum). The number of admissions and days covered is based on medical necessity. Just remember, you must call your medical plan carrier for precertification before entering a facility.

At the time you precertify treatment, you will be referred to an appropriate inpatient network provider.

**Emergency Care**

In an emergency, you, your doctor or a family member must call your claims administrator to certify your inpatient stay within 48 hours of admission. If you certify after the 48-hour notification period, benefits will be paid at 50 percent from the time you certify until the time you leave the hospital. (In that case, you will receive no benefits for the period of time between your hospital admission and the time of certification.)

If you are enrolled in the BlueCare HMO Option, you must notify your primary care physician within 24 hours of admission as well as BlueCross BlueShield of Florida within 48 hours of admission, to certify your inpatient stay.

There is an alternative to traditional inpatient care called intermediate care. Intermediate care includes short-term treatment in the following types of programs: licensed residential treatment centers, day treatment, partial hospitalization and intensive structured outpatient services. If it is medically appropriate and necessary for you to use intermediate care and you precertify with your medical plan carrier, the plan will cover 100 percent of eligible expenses. You may also be eligible to have days covered in excess of the usual inpatient limits. Call your medical plan carrier for details. Note, if you are enrolled in the BlueCare HMO Option, services received in a residential treatment facility are not covered.

To be a covered expense, mental health or substance abuse treatments must be provided by a licensed behavioral health clinician practicing within the scope of his or her license.
### Coverage Amounts

#### Mental Health And Substance Abuse

<table>
<thead>
<tr>
<th>Basic Medical Option / BlueCare HMO Option</th>
<th>Safety Net Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong>[^1]</td>
<td></td>
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<tr>
<td><strong>Option pays:</strong></td>
<td></td>
</tr>
<tr>
<td>In–network:</td>
<td></td>
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<tr>
<td>1-5 sessions: covered at 100%, no deductible</td>
<td></td>
</tr>
<tr>
<td>6-52 sessions: covered at 80%, no deductible</td>
<td></td>
</tr>
<tr>
<td>Out–of–network:</td>
<td></td>
</tr>
<tr>
<td>1-30 sessions: covered at 50%, no deductible, subject to Reasonable and Customary charges (See the Retiree Medical Benefit Definitions section for a definition of Reasonable and Customary)</td>
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<td>Note: Out-of-network benefits are not available under the BlueCare HMO option</td>
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<td>Note: Out-of-network benefits are not available under the BlueCare HMO option</td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient[^2,3]**

**Option pays:**

In–network: Must get approval from your medical plan carrier; covered 80%, no deductible, with precertification up to 30 days per year per person[^4]

Out–of–network: Covered 50%, no deductible, with precertification, subject to Reasonable and Customary charges, up to 30 days per year per person[^4]

Note: Limits are combined for in and out-of-network care.

Note: Out-of-network benefits are not available under the BlueCare HMO option

In–network: Must get approval from your medical plan carrier; covered 70%, no deductible, with precertification up to 30 days per year per person[^4]

Out–of–network: Covered 50%, no deductible, with precertification, subject to Reasonable and Customary charges, up to 30 days per year per person[^4]

Note: Limits are combined for in and out-of-network care.

[^1]: The annual maximum for out-of-network outpatient treatment is 30 private sessions. For in–network outpatient treatment, the annual maximum is 52 private sessions. The annual maximum number of sessions covered is 52. You may exchange any private session for two group sessions. Note: Out-of-network benefits are not available under the BlueCare HMO option. Annual session maximums are subject to medical necessity.

[^2]: Inpatient care must be authorized through your medical plan carrier. To obtain an in–network provider for outpatient care, your medical plan carrier should be contacted.

[^3]: The total lifetime benefit for inpatient mental health and substance abuse treatment is 75 days per covered individual. The number of admissions and days covered is based on medical necessity.

[^4]: These benefits may be extended up to the 75-day lifetime maximum if determined by your medical plan carrier to be medically necessary.

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### Transition of Care Benefits

Transition of care benefits provide you and your eligible family members the ability to obtain in-network benefits from out-of-network providers based on reasonable and customary charges in circumstances when you or your family member have been receiving care for a serious illness from a doctor who is suddenly no longer available in the network. The purpose of this benefit is to enable you or your family member to transition to a new provider if you need ongoing care.

If you or your eligible family member are in an ongoing course of treatment with a mental health provider who is not in your medical plan carrier’s network, call your medical plan carrier to determine whether you or your family member qualifies for transition of care benefits.

All transition of care benefits are at the discretion of your medical plan carrier. These benefits will be approved for discrete periods of time, based on the severity of the illness.
Exclusions

Services or treatments that are excluded from medical coverage are also excluded as a mental health or substance abuse service or treatment. See the Pre-Medicare Retiree Medical Provisions or the BlueCare HMO sections for expenses that are not covered as a mental health benefit.

How to File a Claim

In-network and out-of-network claims are administered by your medical plan carrier.

In-Network

If you receive treatment from a network provider arranged by your medical plan carrier, the claim will be submitted by the treating provider to your medical plan carrier. You will not be required to submit a claim form.

Out-of-Network

If you receive treatment from an out-of-network provider you will have to pay for the treatment directly to the provider and submit a claim form for reimbursement. Claim forms are available through your medical plan carrier.

If you have questions about your claim, call your medical plan carrier.

The deadline for filing a mental health or substance abuse claim is two years from the date you received the service or the supply was provided. If your medical plan carrier is BlueCross BlueShield of Florida, your claim must be submitted within 6 months from the date the service was received.

Please see the Administrative Information Section for more information regarding filing claims and appeals.

WHERE TO SEND YOUR CLAIMS:

If Anthem Blue Cross and Blue Shield is your medical plan carrier:
Anthem Blue Cross and Blue Shield
P. O. Box 105187
Atlanta, GA  30348-5187

If UnitedHealthcare is your medical plan carrier:
UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

If BlueCross BlueShield of Florida is your medical plan carrier:
BlueCare HMO
BlueCross BlueShield of Florida
P.O. Box 45277
Jacksonville, FL 32231
Prescription Drug Benefit

When you elect the Basic Medical Option, the Safety Net Option or the BlueCare HMO Option, you are automatically enrolled in the Prescription Drug Benefit. The Prescription Drug Benefit is administered by Express Scripts, which offers services to you through its two subsidiaries: Express Scripts retail pharmacies, and Express Scripts Mail Order Service. Note: If you are enrolled through OneExchange, this section does not apply to you. Check with your OneExchange benefit advisor for more details.

The Prescription Drug Benefit described in this section is intended to be continued; however, PepsiCo, Inc. (the plan's sponsor) reserves the right at any time, at its discretion, to amend, modify, reduce, discontinue or terminate the plan.

Participation in this benefit plan should not and may not be viewed as a contract or promise of continued benefits.

Prescription Drug Highlights

The Prescription Drug Benefit is easy to use and offers you three ways to purchase prescription drugs:

- At a network pharmacy
- At a non-network pharmacy
- Through the Express Scripts mail order service

If you have any questions, call Express Scripts Member Services at:
1-888-PEPSI-Rx
1-888-737-7479

CUSTOMER SERVICE HOURS
24 hours a day, 7 days a week (except Thanksgiving and Christmas)

or visit the web site at http://www.Express-Scripts.com

Important Information

The Prescription Drug Benefit is administered by Express Scripts. The benefit covers prescriptions filled on an outpatient (through a doctor's office) basis only. Prescription drugs dispensed in a hospital or other inpatient setting are covered in the same way as other medical expenses under the retiree medical options. Express Scripts reserves the right at any time to exclude any particular drug or drug class, to place limits on the quantity of any particular drug or drug class that may be purchased and to limit the pharmacies at which a particular drug or drug class may be purchased.

This benefit is only available to retirees and the spouse/partner/dependents of retirees who are enrolled in the Basic Medical, Safety Net, BlueCare HMO or Prescription Drug Only Options. You and your enrolled spouse/partner/dependents begin to participate in the Prescription Drug Benefit at the same time that you begin to participate in the above listed medical options. Coverage under the Prescription Drug Benefit terminates at the same time that your coverage under the applicable medical option terminates. See the Retiree Health Care Program Highlights section to determine when your coverage under the medical option begins and terminates.

If You Are Enrolled in the Basic, Safety Net or BlueCare HMO Option

There is no deductible for prescription drugs purchased through Express Scripts. Expenses for prescription drugs purchased through Express Scripts do not count toward your medical deductible or out-of-pocket maximum. Expenses related to prescription drugs count towards your lifetime maximum.
If You Are Enrolled in the Prescription Drug Only Option

If you are covered under the Prescription Drug Only Option, there is a $150 deductible for each covered individual and a $300 deductible for each covered family. (Network, non-network and mail-order expenses are applied towards the deductible, but surcharges and extra costs do not apply.) Expenses related to prescription drugs count towards your lifetime maximum.

The PepsiCo Retiree Health Care Program and Medicare

Medicare began offering prescription drug coverage (Medicare Part D) to Medicare eligible individuals in 2006. You can call the Social Security Administration at 1-800-772-1213 or visit www.ssa.gov for more information.

Please note PepsiCo has determined that the total value of prescription drug coverage through the PepsiCo Retiree Health Care Program is, on average for all plan participants, equal to or better than the value of the Medicare prescription drug coverage. Thus, PepsiCo’s prescription drug coverage is considered Creditable Coverage. Because PepsiCo’s prescription drug coverage meets this criterion, you can retain your PepsiCo coverage and not pay a penalty of higher premiums should you opt to enroll in Medicare’s prescription drug coverage in the future. When you reach Medicare eligibility at age 65, your OneExchange benefit advisor can provide you with more information to make a decision about enrolling in Medicare Part D.

Network Pharmacies

Except as provided below, when you have your prescription filled at an Express Scripts network pharmacy, you pay 25 percent of the discounted network price at the pharmacy. There is a $175 per prescription maximum for a 30-day supply, as well as a $5/$15/$40/$40 per prescription minimum for generics, preferred brand-name drugs, non-preferred brand-name drugs and elective drugs respectively. You do not have to file a claim form.

Note: Any extra surcharges and costs (including the brand name drug surcharge and the long-term medication retail surcharge) are not limited by the co-pay maximums.

Elective drugs include erectile dysfunction drugs (e.g., Viagra), anorexiants (e.g., Meridia), antifungals (e.g., Lamisil), oral contraceptives, contraceptive patches, vaginal rings/diaphragms/Depo-Provera and infertility drugs.

If you have a long-term (maintenance) drug filled at an Express Scripts network pharmacy, you pay 25 percent of the discounted network price at the pharmacy for the first three purchases only. Starting with the fourth purchase, you will pay 50 percent of the discounted network price with no maximum. A long-term (maintenance) drug is any drug that is intended to be prescribed for more than a three-month period, such as a drug to treat high blood pressure or high cholesterol. If you have any questions as to whether a certain drug is a long-term (maintenance) drug and is subject to this special rule, you should contact Express Scripts. The most effective way to fill long-term medications is through the mail order service.

You pay 100 percent of the discounted rate for Access-only drugs. Access-only drugs include non-sedating antihistamines (NSAs), cosmetic drugs (e.g., Alera) and hair-growth drugs (e.g., Rogaine). They will be available at the discounted network price but you’ll pay 100 percent. These drugs are being provided as “access-only” because alternate medications are now widely available over the counter (e.g., NSAs) or they serve no medical purpose (e.g., cosmetic and hair-growth drugs).

If you go to a pharmacy that is not in the Express Scripts network, you’ll pay the full retail price for your prescription drugs. After you send your claim form to Express Scripts you’ll only be reimbursed 75 percent of the discounted network price. There is a $175 per prescription maximum for a 30-day supply, as well as a $5/$15/$40/$40 per prescription minimum for generics, preferred brand-name drugs, non-preferred brand-name drugs and elective drugs respectively.

Note: If you are enrolled in the Prescription Drug Only Option, there is an annual deductible of $150 per covered individual and a $300 annual deductible per covered family that must be satisfied before the plan pays benefits. (Network, non-network and mail order expenses are applied towards the deductible, but surcharges and extra costs do not apply).
Mail Order Service

When you order long-term prescriptions through Express Scripts, you pay 25 percent of the discounted price for up to a 90-day supply of medication. There is a $10/$30/$80/$80 minimum for generics, preferred brand-name drugs, non-preferred brand-name drugs and elective drugs respectively. Further, there is a $250 per prescription coinsurance maximum and a $1,500 family annual out-of-pocket maximum for drugs purchased through the mail order service. However, the annual maximum does not apply to prescription drugs classified as access-only drugs, and your cost for access-only drugs is excluded from determining whether the annual maximum is satisfied. Further, any extra surcharges or costs (including the brand name drug surcharge) do not accumulate toward the annual maximum.

If by law, treatment protocol or other quantity limitation, your prescribed drug must be dispensed in less than a 90-day mail order prescription, the maximum coinsurance per prescription is as follows: for a 0-30 day mail order prescription, the maximum coinsurance charge will be $83.33; for a 31-60 day mail order prescription, the maximum coinsurance charge will be $166.67; and for a 61-90 day mail order prescription, the maximum coinsurance charge will be $250.

Elective drugs include erectile dysfunction drugs (e.g., Viagra), anorexiants (e.g., Meridia), antifungals (e.g., Lamisil), oral contraceptives, contraceptive patches, vaginal rings/diaphragms/Depo-Provera and infertility drugs.

You pay 100 percent of the discounted rate for Access-only drugs. Access-only drugs include non-sedating antihistamines (NSAs), cosmetic drugs (e.g., Alera) and hair-growth drugs (e.g., Rogaine). They will be available at the discounted network price but you’ll pay 100 percent. These drugs are being provided as “access-only” because alternate medications are now widely available over the counter (e.g., NSAs) or they serve no medical purpose (e.g., cosmetic and hair-growth drugs).

Note: If you are enrolled in the Prescription Drug Only Option, an annual deductible of $150 per covered individual and $300 per covered family must be satisfied before the plan pays benefits. (Network, non-network and mail order expenses are applied towards the deductible, but surcharges and extra costs do not apply).

Generic Drug Incentive

PepsiCo offers coverage for both generic and brand-name drugs so that you can choose the one that best meets your needs. However, if you decide to buy a brand-name drug when a generic equivalent is available, you’ll pay 25 percent of the cost of the discounted network generic (subject to the minimum generic copay) plus the cost difference between the generic and the brand-name. Further, your total cost will not be limited by the maximum co-pay or the mail order out-of-pocket maximum.

Mail Order Incentive for Long-Term Medications

PepsiCo offers the mail order service to help manage the costs of long-term prescription drugs, such as those used to treat high blood pressure or high cholesterol. The most effective way to fill long-term medications is through the mail order service. To encourage you to move these prescriptions to mail order, PepsiCo’s prescription drug program includes a special provision that requires you to pay more at retail—sometimes referred to as the retail refill allowance. Specifically, if you choose to buy long-term medications at a network pharmacy rather than through the Express Scripts Mail Order Service, you will pay 25 percent of the discounted network price for the first three purchases. Starting with the fourth purchase, you will pay 50 percent of the discounted network price with no maximum. If you switch your prescription to mail order, you’ll pay the normal coinsurance. However, the retail refill allowance does not apply to prescription drugs classified as access-only drugs. Further, the long-term medication surcharge will not be limited by any co-pay maximum.
Prescription Drug Coverage

The prescription drug benefit is the same under the Basic Medical, Safety Net, and BlueCare HMO Options. If you are enrolled in the Prescription Drug Only Option, there is an annual deductible of $150 per covered individual and a $300 annual deductible per covered family that must be satisfied before the plan pays benefits. The amount you pay is based on whether you use a network or non-network retail pharmacy or mail order. Filling prescription drugs through the Express Scripts mail order service is a “win/win” situation: PepsiCo pays less, and the savings are passed on to you.

<table>
<thead>
<tr>
<th>For This Type of Drug</th>
<th>If You Fill a Prescription Through a Network Pharmacy (up to a 30-day supply)*</th>
<th>If You Fill a Prescription Through Express Scripts Mail Order Service (up to a 90-day supply)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>You pay 25% with a $5 minimum/$175 maximum</td>
<td>You pay 25% with a $10 minimum/$250 maximum</td>
</tr>
<tr>
<td>Preferred</td>
<td>You pay 25% with a $15 minimum/$175 maximum</td>
<td>You pay 25% with a $30 minimum/$250 maximum</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>You pay 25% with a $40 minimum/$175 maximum</td>
<td>You pay 25% with a $80 minimum/$250 maximum</td>
</tr>
<tr>
<td>Elective</td>
<td>You pay 25% with a $40 minimum/$175 maximum</td>
<td>You pay 25% with a $80 minimum/$250 maximum</td>
</tr>
<tr>
<td>Access Only</td>
<td>You pay 100% of discounted rate</td>
<td>You pay 100% of discounted rate</td>
</tr>
</tbody>
</table>

* If you fill a prescription at a non-network pharmacy, you will pay the full difference between the discounted network price and the retail price, plus the regular coinsurance payments in the chart above.

** There is a $1,500 family annual out-of-pocket maximum for drugs purchased through mail order. The annual maximum does not apply to prescription drugs classified as access-only drugs, and your cost for access-only drugs is excluded from determining whether the annual maximum is satisfied. Any extra surcharges (such as the brand name drug surcharge) do not accumulate toward the annual maximum.

Types of Drugs

**FDA approved Generic drugs** must meet the same standard for safety, purity, strength and quality as brand-name drugs.

**Preferred drugs** are on a list, or formulary, of commonly prescribed brand name medications. You will pay less when you use preferred drugs. For a complete list of preferred brand-name drugs, contact Express Scripts. The plan administrator determines the preferred drug list, which is subject to change.

**Non-Preferred drugs** are brand name drugs not found on the preferred brand name drug list.

**Elective drugs** include erectile dysfunction drugs (e.g., Viagra), anorexiants (e.g., Meridia), antifungals (e.g., Lamisil), oral contraceptives, contraceptive patches, vaginal rings/diaphragms/Depo-Provera and infertility drugs.

**Access-only drugs** include non-sedating antihistamines (NSAs), cosmetic drugs (e.g., Alera) and hair-growth drugs (e.g., Rogaine). They will be available at the discounted network price but you’ll pay 100 percent. These drugs are being provided as “access-only” because alternate medications are now widely available over the counter (e.g., NSAs) or they serve no medical purpose (e.g., cosmetic and hair-growth drugs).

Important Notes:

- If you buy a brand-name drug when a generic equivalent is available, you’ll pay 25% of the discounted network price of the generic (subject to the minimum generic co-pay) plus the cost difference between the generic and the brand-name. Further, your cost will not be limited by any co-pay maximum.
- If you buy long-term drugs at a network pharmacy, you’ll pay 50% of the discounted network price, starting with the fourth purchase. The $175 maximum payment will not apply.
- Maximum payments for certain high-cost specialty drugs purchased via mail order for less than a 61-day supply will be adjusted to ensure mail order is the most cost effective way to buy these drugs.
Express Scripts Formulary

Express Scripts Preferred Prescriptions Formulary will help you better manage your prescription drugs for quality and cost. A formulary is a list of **generic** drugs or **preferred** brand-name drugs that have been selected for their clinical effectiveness and reasonable costs. Drugs that are not included in the formulary are **non-preferred** brand-name drugs.

<table>
<thead>
<tr>
<th>Prescription Drug Type</th>
<th>What It Is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>A drug that is the chemical equivalent to a brand-name drug</td>
</tr>
<tr>
<td></td>
<td>Typically lowest-cost alternative</td>
</tr>
<tr>
<td>Preferred Brand-Name</td>
<td>A brand-name drug listed on Express Scripts’ formulary list</td>
</tr>
<tr>
<td></td>
<td>Clinically effective</td>
</tr>
<tr>
<td></td>
<td>Often lower cost than other brand-name drugs</td>
</tr>
<tr>
<td>Non-Preferred Brand-Name</td>
<td>A brand-name drug that is not on the formulary list</td>
</tr>
<tr>
<td>Elective</td>
<td>Elective drugs include erectile dysfunction drugs (e.g., Viagra), anorexiants (e.g., Meridia), antifungals (e.g., Lamisil), oral contraceptives, contraceptive patches, vaginal rings/diaphragms/Depo-Provera and infertility drugs</td>
</tr>
<tr>
<td>Access-Only</td>
<td>Access-only drugs include non-sedating antihistamines (NSAs), cosmetic drugs (e.g., Alera) and hair-growth drugs (e.g., Rogaine). These drugs are being provided as “access-only” because alternate medications are now widely available over the counter (e.g., NSAs) or they serve no medical purpose (e.g., cosmetic and hair-growth drugs).</td>
</tr>
</tbody>
</table>

As new drugs become available and uses for existing drugs change, Express Scripts reviews the formulary for quality and cost. The Express Scripts formulary is always subject to change at any time.

**Medication and Supplies Not Covered**

Items not covered by the Prescription Drug Benefit include:

- Medicine that can be purchased over-the-counter, with the exception of chlorpheniramine and niacin
- Prescription non-sedating antihistamines (NSAs), such as Clarinex or Allegra
- Contraceptive implants/injections, contraceptive devices, such as IUDs or diaphragms, or contraceptive jellies, creams or foams
- Prenatal vitamins
- Illegal drugs and medicines that may not be prescribed within the scope of the doctor’s license
- Drugs for cosmetic purposes (if medically necessary Retin-A will be covered for non-cosmetic conditions with prior authorization through the mail order service)
- Nutritional and diet supplements
- Over-the-counter drugs used for smoking cessation
- Support hose
- Ostomy bags and supplies
- Immunization agents
- Biological and blood or blood plasma products
- Prescriptions for more than a 30-day supply at retail pharmacies at any one time, a 90-day supply from mail-order at any one time and any other quantity limitation applied by Express Scripts for a particular drug or drug class
Certain “controlled” substances (called Schedule II drugs) in excess of a 30-day supply (by law, Schedule II drugs are subject to dispensing limits)

Prescriptions that can be reimbursed under any Workers’ Compensation law or government program

Refill orders submitted too early (i.e., before 30 percent or less of the previous supply is remaining)

Prescriptions ordered later than one year from the date the doctor wrote the prescription (or earlier if required by applicable law)

Prescriptions ordered for a quantity greater than the doctor prescribed

Therapeutic devices, appliances and supplies (except for disposable hypodermic syringes and needles for the administration of insulin)

Prescription drugs which are experimental and/or investigational (as defined above)

Prescription drugs which are not medically necessary (as defined above)

Prescriptions which must be shipped outside the U.S. or to Puerto Rico are not covered under the mail order program

Prescriptions purchased before coverage is in effect or after termination of coverage

Prescriptions for or related to the treatment of obesity, with the exception of prescriptions for or related to the treatment of morbid obesity provided the case is considered medically necessary

Prescriptions that are determined to be fraudulent, duplicative or that exceed dispensing protocols

New prescription drugs become available every year—and uses for existing prescription drugs often change. Express Scripts will periodically review new and existing drugs to determine whether they will be covered or continue to be covered. The Express Scripts mail order service may exclude coverage for any drug that cannot be dispensed in accordance with Express Scripts’ customary dispensing protocols. To find out if the drug your doctor has prescribed for your condition is covered, call Express Scripts at 1-888-PEPSI-Rx (1-888-737-7479) or log on to www.ExpressScripts.com and select “Price a medication” from the left hand menu.

**Medications Requiring Coverage Review**

Certain drugs (both at retail and through mail order service) must be reviewed and approved by Express Scripts before they are covered under the Prescription Drug Benefit. This coverage review process utilizes rules based on what the FDA has approved in terms of prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective for the particular medication.

In most cases, if the medication prescribed for you requires review, your participating retail pharmacist or Express Scripts mail order service will initiate the review process on your behalf. Your physician will be contacted to review the prescription and determine whether the drug can be covered by the benefit. You will be notified when the process has been completed. At any point you can choose to pay the full cost of the drug prescribed and avoid the review. However, in such event you will not be reimbursed for paying the full cost. To find out if the drug your doctor has prescribed for your condition requires a coverage review, log on to www.Express-Scripts.com, select “Price a medication” from the left hand menu and after searching for your medication, select “coverage notes” on the results page.

**Prior Authorization**

Prior Authorization requires a clinical coverage review for all or some claims presented for specific drugs to determine if the member qualifies for coverage based upon the plan’s pre-defined criteria that supports the intent of the prescription benefit. These criteria may include evaluation of treatment diagnosis and other recommended prescribing guidelines for that drug.
For example, Tazorac is prescribed for acne. Prior authorization will prevent the use of this drug for cosmetic purposes/wrinkles.

Drugs subject to prior authorization include. This list is subject to change:

- Anorexiants
- Amphetamines/CNS Stimulants
- Growth hormones
- Anti-narcoleptics (e.g., Provigil)
- Botox/Myobloc/Dysport
- Erythroid stimulants (e.g., Epogen, Procrit, Aranesp)
- Forteo
- Psoriasis agents (e.g., Amevive, Stelara)
- Certain Diabetic agents (e.g., Symlin, Byetta, Victoza)
- Tazorac
- Xolair
- Retin-A*
- Antiemetic agents (e.g., Anzemet, Zofran, Kytril, Emend)
- Cancer agents (e.g., Nexavar, Gleevec, Temodar, Sutent, Tarceva, Avastin)
- Respiratory Syncytial Virus (RSV) agents (e.g., Synagis, Respigam)
- Pulmonary Arterial Hypertension agents (e.g. Revatio, Tracleer, Ventavis, Flolan, Remodulin, Letaris)
- Infertility Drugs
- Anabolic Steroids/Androgens
- Interferons (e.g., Intron A, Actimmune)
- Immunomodulatory Agents (Thalomid, Revlimid)
- Myeloid Stimulants (e.g., Neupogen)
- Platelet Proliferating Agents
- Thromboietin Receptor Agonist
- Pulmozyme
- Multiple Sclerosis Agents
- Immune Globulins
- Solodyn
- Antiviral agents (e.g., Incivek, Victrelis)
- Other Specialty drugs (e.g. Zavesca, Cerezyme, Interleukins, Xenazine, Ophthalmic agents, Apokyn, Soliris, Berinert, Cinryze, Kalibitor, Benlysta, Ferriprox, Chenodal, Acthar Gel, Kuvan, Kalydeco, Xgeva, Korlym)

* Retin-A (or its generic equivalents) does not require prior authorization up to age 36. Prior authorization required for ages 37 and over. Retin-A (or its generic equivalents) are available at mail order only. If you purchase the Retin A (or its equivalents) at a retail pharmacy you will be charged the full cost of the drug.

When your prior authorization expires, you will be required to submit additional documentation to continue coverage under the program.
Step Therapy

Step therapy requires that a lower-cost first line treatment be tried before higher-cost second line treatments. For example, Singulair is prescribed for asthma and allergies. Step therapy requires you try a nasal steroid and/or antihistamines before taking Singulair for allergies. (Note: Use in asthma is not affected.) Another example is the Proton Pump Inhibitor (PPI) class to treat ulcers and reflux. With the PPIs, you are required to try generic omeprazole or brand Nexium prior to any other brand PPIs.

Drugs subject to step therapy include. This list is subject to change.

- Narcotic Pain drugs (e.g., Actiq/Fentora)
- Byetta
- Lyrica
- Elidel/Protopic
- Leukotriene inhibitors (e.g., Singulair, Accolate)
- Rheumatoid arthritis agents (e.g., Enbrel, Humira, Kineret, Orencia, Remicade)
- Proton Pump Inhibitors (e.g., Prevacid, Protonix)
- Sleep Agents—Hypnotics
- Depression Drugs—Selective Serotonin Reuptake Inhibitors (SSRI)
- Osteoporosis Drugs—Bisphosphonates
- Respiratory Agents—Intranasal Steroids
- Migraine therapy agents (e.g., Triptans)
- COX II Inhibitors (Celebrex)
- Angiotensin II Receptor Blockers, ARBs (e.g., Diovan, Atacand, Benicar)
- Atypical Antipsychotic agents (e.g. Abilify, Invega, Saphris)
- Certain Gout agents (e.g., Uloric, Krystexxa)
- Certain Brand Cholesterol agents (e.g., Crestor, Vytorin)
- Cystic Fibrosis agents (e.g. Cayston, Tobi)
- Certain Insulin products
- Topical Estrogen products
- Glaucoma products

Quantity Duration

All drugs under the Prescription Drug Benefit are limited to an established days’ supply for a single purchase, such as a 30-day supply for a retail pharmacy. However, certain “as needed” drugs, such as hypnotics and pain-killers are limited to a specific amount, based on typical use or clinical guidelines. One example is Lunesta, which is prescribed for insomnia. Quantity duration limits apply for this drug because it is intended for short term, intermittent use.

Drugs subject to additional quantity duration limits include. This list is subject to change.

- Hypnotics (e.g., Lunesta, Ambien CR)
- Migraine agents (e.g., Imitrex, Maxalt)
- Prescription smoking cessation drugs (e.g., Chantix, Zyban)
- Anti-virals (e.g., Famvir, Valtrex)
- Certain Antibiotics and Anti-fungals
- Erectile Dysfunction Drugs (e.g., Viagra, Cialis)
Pain Management Drugs

Pulmonary Arterial Hypertension

Rheumatoid Arthritis Agents

Antiemetics

Cystic Fibrosis Drugs

Cancer agents (e.g., Nexavar, Gleevec, Temodar, Sutent, Tarceva, Avastin)

Respiratory Syncytial Virus (RSV) agents (e.g., Synagis, Respigam)

Multiple Sclerosis Agents

Myeloid Stimulants (e.g., Neupogen)

Certain Gout agents (e.g., Uloric, Krystexxa)

Samsca

Respiratory Syncytial Virus (RSV) agents (e.g., Synagis, Respigam)

Other Specialty drugs (e.g. Zavesca, Cerezyme, Interleukins, Xenazine, Ophthalmic agents, Apokyn, Soliris, Berinert, Cinryze, Kalibitor, Benlysta, Ferriprox, Chenodal, Acthar Gel, Kuvan, Kalidexco, Xgeva, Korlym)

Buying at a Pharmacy

Express Scripts Network Pharmacies

You can call Express Scripts at 1-888-PEPSI-Rx (1-888-737-7479), or visit their website at www.Express-Scripts.com for the name of a pharmacy close to you.

At an Express Scripts network pharmacy you may purchase up to a 30-day supply of prescription drugs at a discounted network price. Occasionally pharmacies offer special prices on drugs. You'll get the lower of the network price or the special sale price.

Be sure to bring your Express Scripts ID card with you when you pick up your prescription to ensure that you receive the full benefit. If you need additional prescription drug ID cards, call Express Scripts at 1-888-PEPSI-Rx (1-888-737-7479) or if you are traveling and require medication, call to find the location of the nearest participating pharmacy. Providing your ID card to someone not enrolled in the plan may constitute fraud, and your medical and prescription drug coverage may be terminated or suspended and you may be required to repay ineligible claims.

Non-Network Pharmacies

If you go to a pharmacy that is not in the Express Scripts network, you'll pay the full retail price for your prescription drugs. After you send your claim form to Express Scripts, you will be reimbursed for 75 percent of the Express Scripts discounted network price, even though you paid the full retail price for your prescription. See the Prescription Drug Coverage section above for additional details on how drugs are covered and applicable coinsurance.

Filing Claims

To receive reimbursement for prescriptions filled at non-network pharmacies, fill out a claim form, attach your receipt from the pharmacy and send it to Express Scripts. The claim form asks you to fill in certain numbers from your prescription. If these numbers are not on your receipt, call your pharmacist for the information. You will have one year from the date that you fill the prescription to file your claim for reimbursement.

Claim forms are available by calling Express Scripts at 1-888-PEPSI-Rx (1-888-737-7479).

Mail your out-of-network claim form to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

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### Information to Include on Prescription Drug Claim Forms
(For prescriptions filled at non-network pharmacies)

<table>
<thead>
<tr>
<th>You complete the form with:</th>
<th>The attached bill should include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Retiree's name</td>
<td>▶ Patient's full name (if other than retiree)</td>
</tr>
<tr>
<td>▶ Express Scripts ID# (found on your Rx card)</td>
<td>▶ Date of purchase</td>
</tr>
<tr>
<td>▶ Date of birth, sex and relationship to member</td>
<td>▶ Prescription number (Rx#)</td>
</tr>
<tr>
<td>▶ Current address</td>
<td>▶ Prescription number (NDC#)</td>
</tr>
<tr>
<td>▶ Pharmacy name, address, phone number</td>
<td>▶ Days supply and metric quantity (dosage)</td>
</tr>
<tr>
<td></td>
<td>▶ Quantity and cost of each prescription or medical item</td>
</tr>
<tr>
<td></td>
<td>▶ Name and address of pharmacy</td>
</tr>
<tr>
<td></td>
<td>▶ Pharmacy number (NABP#).</td>
</tr>
</tbody>
</table>

### Buying through the Mail Order Service

When you purchase your prescription through the Express Scripts mail order service, you pay a discounted price (subject to the minimum and maximum copays) for up to a 90-day supply of medication. The amount you pay for a 90-day supply of medication through the mail order service depends on the type of drug you purchase. See the “Prescription Drug Coverage” section above for applicable coinsurance levels. Also, remember a $1,500 family out-of-pocket annual maximum applies for generic, preferred, non-preferred and elective drugs purchased through the mail order service. However, the annual maximum does not apply to prescription drugs classified as access-only drugs, and your cost for access-only drugs is excluded from determining whether the annual maximum is satisfied.

In addition, if you are covered under the Prescription Drug Only Option, there is a $150 deductible for each covered individual or a $300 deductible for each covered family. (Network, non-network and mail-order expenses are applied towards the deductible, but surcharges and extra costs do not apply.)

### New Prescriptions

The mail order service offers you two ways to fill a NEW long-term “maintenance” drug (i.e., one that is intended to be prescribed for more than three months) prescription:

- You can mail your 90-day prescription to:
  
  Express Scripts Mail Order Service  
  P.O. Box 6500  
  Cincinnati, OH 45273-8152  

  You can call Express Scripts to request a pre-addressed mail order envelope.

- Your doctor can fax your new prescription directly to Express Scripts. Your doctor can call 1-888-EASY Rx1 (1-888-327-9791) for instructions.

Prescriptions for “controlled” substances may not be faxed, and your doctor will receive instructions in these situations.

To pay for your prescription:

- Charge it to your credit card;
- Send a check to Express Scripts Mail Order Service; or
- Receive an invoice, and then make payment by check or credit card. (Note: This payment option may be limited to a specific account balance. Call Express Scripts Member Services at 1-888-PEPSI-Rx (1-888-737-7479) for more details.)

Your prescription will usually be delivered within 7-10 days after Express Scripts receives your order and will include instructions for refills and information about the drug.
If your doctor prescribed a new long-term medication, you may ask for a 30-day prescription for retail as well as a 90-day mail order prescription. This way you will be sure to have enough medication while your new mail order drug is filled.

**Refills**

Once your prescription is on file at Express Scripts, you may order a refill by:

- **The Internet:** Log on to www.Express-Scripts.com and follow the instructions
- **Phone:** Call Express Scripts Member Services at 1-888-PEPSI-Rx (1-888-737-7479) and use the automated refill system
- **Mail:** Send the refill slip or order prescription to Express Scripts.

Pay for your refilled prescriptions using the same options as described for new prescriptions. In order to get a refill, 70 percent of the original prescription must be already used. When your prescription expires or when your refill runs out, you must get a new prescription and submit it to Express Scripts.

All rights in the product names of the third-party products mentioned in this document, whether or not appearing in italics or with a trademark symbol, are the property of their respective owners.
BlueCare HMO Option

The BlueCare HMO Option is available to Tropicana retirees who live in those areas of Florida where the BlueCare HMO has a network. Call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 for more information. Note that Retirees who are enrolled in this Option must transition to coverage through OneExchange when they reach Medicare eligibility at age 65. If you become eligible for Medicare for reasons of disability before age 65, you will remain eligible for the BlueCare HMO Option.

The medical benefit described in this section is intended to be continued; however, PepsiCo, Inc. (the plan's sponsor) reserves the right at any time, at its discretion, to amend, modify, reduce, discontinue or terminate the plan.

Participation in this benefit should not and may not be viewed as a contract or promise of continued benefits.

BlueCare HMO Medical Highlights

The BlueCare HMO is administered by BlueCross BlueShield of Florida (BCBSF) and is an association of doctors, hospitals and other Florida health care providers. If you choose medical coverage through the BlueCare HMO, medical care must be approved and provided by a participating provider of BCBSF to be reimbursable through the plan. Generally, when you join an HMO, there are no deductibles or coinsurance. However, there can be copays for services including doctor visits, emergency room treatment and hospital treatment. If you elect to participate in the BlueCare HMO, you agree to participate according to all the terms and provisions of the BlueCare HMO. If you enroll in the BlueCare HMO, further information regarding the terms and provisions of this option will be provided to you.

In addition, if you elect the BlueCare HMO, you are eligible for the Prescription Drug Benefit (administered by Express Scripts) and the Mental Health Benefit (as administered by BlueCross BlueShield of Florida). For more information regarding prescription drugs, see the Prescription Drug Benefit section. For more information regarding mental health or substance abuse treatment, see the Mental Health Benefit section.

Coverage under the BlueCare HMO option terminates at the same time that your coverage under the Retiree Health Care Program terminates. See the Retiree Health Care Program Highlights section to determine when your coverage begins and terminates.

BlueCare HMO Definitions

Primary Care Physician

Your primary care physician ("PCP") is the physician you choose to have primary responsibility for your or your eligible dependents' health. The PCP may provide the treatment or service or refer you to another provider.

You must choose a PCP for yourself and each of your eligible dependents. The BlueCare HMO offers physicians who have a variety of approaches to primary care, including family practice, general practice, internal medicine or pediatrics. A listing of all PCPs is available at www.bcbsfl.com or may be obtained by calling the BlueCare Customer Service Department at 1-800-664-5295.

It is important that you develop a working relationship with your PCP. If this is a new doctor, you might want to schedule a physical exam to meet your new PCP and discuss your (or your dependents') medical needs.

You may request a change to a different PCP by calling the BlueCare Customer Service Department. Generally, your change will be effective the first day of the following month.

HMO Copays for Medical Treatment & Services

A copay is your share of the cost for medical treatment or services. The copay is generally due to the BlueCare HMO provider at the time of service.

HMO Penalty

All care must be received from participating providers in the HMO network. HMO members are allowed to go to participating providers without a referral. However, if the member goes to a PCP physician other than their assigned PCP physician, they would be charged the specialist copay.

HMO Grievance Procedure

The BlueCare HMO has established administrative grievance and binding arbitration procedures to provide a full and fair review of grievances and to assist you in resolving grievances. This procedure is intended to provide prompt
consideration of your grievances at the appropriate decision making levels at the HMO. Call the BlueCare Customer Service Department at 1-800-664-5295 for complete information on these procedures.

**BlueCare HMO Copays for Medical Treatment & Services**

**The Pre-Medicare BlueCare HMO Option**

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<thead>
<tr>
<th>BlueCare HMO Copays</th>
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<tbody>
<tr>
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<td><strong>Emergency care</strong></td>
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<td>Surgery performed on an outpatient basis</td>
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<tr>
<td><strong>BlueCare hospitalization (when precertified by your PCP)</strong></td>
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<tr>
<td>Room &amp; board (semi-private room)</td>
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<tr>
<td>Diagnostic testing</td>
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<tr>
<td>Delivery of a baby</td>
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<tr>
<td>Out-of-pocket maximum</td>
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*For claims incurred on or after January 1, 2012. Claims incurred prior to January 1, 2012 are subject to a $1,250,000 lifetime maximum; this increase does not apply if you previously met the lifetime maximum or if you will meet the lifetime maximum as of December 31, 2011. The lifetime maximum includes all employee and retiree medical and prescription drug claims.
Medicare BlueCare HMO Option

If you are under age 65 and Medicare eligible for reasons of disability and choose to receive medical coverage through the BlueCare HMO option, you will be required to enroll in Medicare Part B.

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</tr>
<tr>
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BlueCare HMO Features

Annual Well-Woman Exams: You or your dependents may choose to schedule annual pap smears with your PCP or with a BlueCare Ob/Gyn specialist. A referral is not required. However, precertification is still required for hospitalization.

Chiropractic: You do not need a referral from your PCP to use a BlueCare Network provider in this specialty. Visit limits apply. Check with BlueCare Customer Service for details.

Emergency Room: You must notify your PCP within 24 hours or BlueCare within 48 hours of an admission.

Infertility Treatments: Applicable copay each visit up to the annual $1,500 individual out-of-pocket maximum per person; lifetime maximum payment of $20,000 per person.

Lifetime Maximum: There is a $1,500,000 lifetime maximum amount on payments for covered medical services including infertility services. This is also true if you shift between the Basic Medical and Safety Net Options and BlueCare HMO, as your lifetime maximum will carry over if you shift between these plans.

Expenses for prescription drugs and mental health benefits count toward your lifetime maximum. Prescription drug benefits are not administered by BCBSF and are described in a separate section in this booklet.

BlueCare HMO Covered Medical Expenses

There are basic guidelines for medical treatment that must be met before coverage is extended through the BlueCare HMO. For information about specific treatment or services, consult your PCP or call the Customer Service Department at 1-800-664-5295 before you incur the expense.

All treatment must be medically necessary. These guidelines are generally used to determine if a treatment is medically necessary:

- It is prescribed by a physician and is consistent with the symptoms, diagnosis and treatment of your condition;
- It is necessary and appropriate and in accordance with accepted medical standards;
- It is not primarily for the convenience of you or your family, the physician or other provider; and
- It is not considered experimental and/or investigational in terms of generally accepted medical standards.

The BlueCare HMO within its sole discretion makes the determination of whether a treatment is medically necessary.

If the basic guidelines are met, the following treatments are generally covered by the BlueCare HMO option. This list is not complete and some benefits may be subject to limitations and restrictions.

Physician Services

Covered services must be performed by a physician, specialist, surgeon or other health care professional who is not related to you. The BlueCare HMO also covers the following diagnostic tests and treatments when prescribed by a physician:

- Physical examinations and well child care
- Immunizations, injections and allergy shots
- Treatment for illness and injuries
- Surgery
- Laboratory procedures
- X-ray, sonogram and other related procedures
- Prenatal care and delivery of babies
- Disease screenings including pap smears, mammography, and PSA (prostate-specific antigen test)
- Physical, speech or occupational therapy (under certain circumstances)
- In-office procedures
- Supplies and durable medical equipment
- Care for chronic diseases
Hospital Services (Inpatient or Outpatient and If Precertified)

- Semi-private room
- Intensive care or other covered specialty
- Surgery
- Emergency care (if certified)
- Delivery of babies*
- Drugs and supplies
- Anesthesia and oxygen
- Blood transfusion, including the cost of using your own blood
- Nursery care for newborn dependents

* BlueCare HMO, in accordance with federal law, does 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 normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (96 hours as applicable). Nor is it required that a provider obtain authorization from the administrator(s) for prescribing a length of stay not in excess of the above periods.

Other Services

- Emergency ambulance service
- Repairs to the jaw and/or natural teeth damaged as the result of an accident, but only if repairs are made during the first 62 days after the accident
- Artificial limbs or other prosthetic devices
- Sterilization procedures

Home Health Care

Home health care is an alternative to long-term hospital care if you are not critically ill, but still need some treatments that normally would be provided in a hospital setting. Home health care covered services must begin within 7 days of your hospital stay and include visits from a registered nurse, health care professional or home health aide. Your doctor must precertify that home health care is a replacement for hospital confinement and submit a home health care plan.

In the BlueCare HMO, all care must be requested by your PCP and approved by the HMO. Home health care generally includes the following benefits:

- Administration of IVs, injections, wound care or other treatments you normally would have received in the hospital
- Laboratory tests
- Physical, speech or occupational therapy

The BlueCare HMO does not cover the cost of services provided by someone who lives in your home and/or provides custodial care such as meals, personal grooming or transportation.

Skilled Nursing

Skilled nursing is an alternative to long-term hospital care if you are not critically ill, but you have not recovered sufficiently to go home with home health care. Your doctor must precertify that your condition requires professional and practical nursing care and submit a treatment plan. You must have been hospitalized at least 3 days out of the prior 14 days from when you requested the skilled nursing service and the treatment needed in the skilled nursing facility must be due to the same condition requiring your hospital stay. The lifetime maximum number of days in the skilled nursing facility per injury or illness is 120 days. Custodial care or confinement in a rest home or home for the aged is not covered. In the BlueCare HMO, all care must be requested by your PCP and approved by the HMO.
**Hospice Care**

Hospice care is a program designed to meet the special needs of terminally ill patients and their families. You are terminally ill if your doctor determines that there is no reasonable prospect of cure and your life expectancy is less than six months.

In the BlueCare HMO, all hospice care must be requested by your PCP and approved by the HMO and generally includes:

- Inpatient or home health care
- Drugs, medicines and supplies
- Counseling and other supportive services for you and your family

The BlueCare HMO does not cover the cost of services provided by someone who lives in your home and/or provides custodial care such as meals or personal grooming or transportation.

**Organ Transplants**

Transplantation must be precertified by the BCBSF medical director based on the facts and circumstances of each case. If determined to be medically appropriate, services, treatments and supplies necessary to the transplant of human organs including heart, lungs, liver, kidney, bone marrow or other body tissue, generally are covered.

In the case of a kidney transplant, the surgery costs for an organ donor for you or your eligible dependents are covered. However, the options do not offer coverage if you or your eligible dependents donate any human organs, including kidneys to a person not covered under the BlueCare HMO.

**Reconstructive Surgery Following a Mastectomy**

The BlueCare HMO provides coverage, following a mastectomy, for reconstruction of the affected breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedemas. This coverage is subject to the generally applicable copays or limitations that apply under the various coverage options described in this SPD.

**BlueCare HMO Services Not Covered**

The treatments and services below generally are not covered under the BlueCare HMO:

- Medical care that is or has been paid for by another group medical plan, liability plan, Workers’ Compensation plan, Medicare, a military service, the Veterans Administration or any federal or state medical plan
- Any services, treatments or supplies which are not covered medical services
- Any service, treatment or procedure that is required to be requested by a PCP and approved by the HMO and is not timely precertified or approved. Examples include precertifications for hospitalization, home health care, skilled nursing, hospice care, mental health and substance abuse, weekend hospitalization and organ transplant.
- Any treatment, supplies or service provided by an individual who lives in your home, is a member of your immediate family, is related to you or is a dependent
- Services or supplies for your personal comfort, convenience or enhancement of your appearance. Examples are telephone or television charges during a hospital stay, homemaker services, or cosmetic surgery. Weight loss or personal exercise programs are not covered unless ordered by your doctor and approved by your medical option as treatment for a specific disease
- Treatment resulting from your participation in an illegal occupation, felony, riot or rebellion, or war
- Outpatient prescription drugs
- Eyeglasses, radial keratotomy, laser radial keratotomy, eye exercises and training
- Hearing aids
- Certain elective procedures related to the reproductive system such as reversal of voluntary sterilization or treatment for sex reassignment
- Private duty nursing by a registered nurse or licensed practical nurse
Foot care unrelated to the diagnosis or treatment of a medical condition, such as a pedicure and orthopedic shoes

Travel expenses

Air conditioners, humidifiers and purifiers

Gastric bypasses

Custodial care

Autopsy or other post-mortem examination

Any treatment or services received before coverage becomes effective and after coverage terminates

Any services, treatment, procedure or supply which is determined to be not medically necessary or is not prescribed by a doctor

Injuries occurring while chewing

Dental care, unless treatment is needed to repair damage to natural (not artificial) teeth, jaws or mouth caused by an accident and is performed within 62 days of the accidental injury

Fraudulent charges

Services or supplies available due to service in the armed forces of any government and any expenses incurred while serving in the armed forces of any government

Treatment for an injury resulting from the covered person's commission or attempted commission of a violent crime

Charges for or related to the fertility treatment or pregnancy of a surrogate mother, or charges for or related to egg or sperm donors

Services or supplies which are considered to be experimental, investigational or unproven in terms of generally accepted medical standards, as determined by BlueCare HMO

Expenses related to missed appointments or storage of your health care information or data

Expenses incurred after you have reached your lifetime maximum

Services that are rendered in connection with a condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association

Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation

Services that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation

Services for marriage counseling, when not rendered in connection with a condition classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association

Services for pre-marital counseling

Services for court ordered care or testing, or required as a condition of parole or probation

Services for testing for aptitude, ability, intelligence or interest

Services for testing and evaluation for the purpose of maintaining employment

Cognitive remediation

Inpatient confinements that are primarily intended as a change of environment, and

Mental health services received in a residential treatment facility.
BlueCare HMO—Administrative Provisions

Reimbursing the Plan: The BlueCare HMO has the right of reimbursement, and you must reimburse BlueCare HMO for recoveries you may receive from third parties. The provisions in the Reimbursing the Plan section in the Administrative Information section apply to the BlueCare HMO. Please see this section for a description of these provisions.

Right of Subrogation: The BlueCare HMO has the right of subrogation. The provisions in the Right of Subrogation section in the Administrative Information section apply to the BlueCare HMO. Please see this section for a description of these provisions.

Double Coverage: The BlueCare HMO will coordinate coverage with other health care coverage you may have. The provisions of the Coordination of Benefits section in the Administrative Information section apply to the BlueCare HMO. Please see this section for a description of these provisions.

Recovery of Excess Payments: Whenever payments have been made in excess of the amount necessary to satisfy the provisions of the BlueCare HMO, the plan has the right to recover these excess payments from any individual or other entity or organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered. Whenever payments have been made based on inaccurate or fraudulent information provided by you or your spouse/partner/dependent, the plan will exercise all available legal rights to recover the overpayment, including its right to withhold payment on future benefits until the overpayment is recovered.

HIPAA Certificate of Creditable Coverage: You and your covered spouse/partner/dependents will receive a HIPAA certificate of creditable coverage for the time that you are enrolled in the BlueCare HMO. Please see the HIPAA Certificate of Creditable Coverage section of the Retiree Health Care Program Highlights section for details on when you will receive a certificate and on how you may request a certificate.
Retiree Health Care Program Highlights - Coverage After Age 65

Beginning January 1, 2015, if you meet the eligibility requirements described above under “Retiree Health Care Program Highlights – Eligibility”, once you (or your spouse/partner) turn age 65, you will no longer be eligible to receive medical (including mental health and substance abuse benefits) or prescription drug coverage from the PepsiCo Retiree Health Care Program. Instead, after age 65, you (and your spouse/partner) will be eligible to purchase an individual policy through OneExchange, a private Medicare marketplace selected by PepsiCo. Please note, individual Medicare supplemental, Medicare Advantage or Medicare Part D, dental or vision plans or policies purchased through OneExchange are not part of the PepsiCo Retiree Health Care Program and PepsiCo does not have any responsibility for those plans or policies. To obtain information concerning the operation, procedures, eligibility, coverage, terms and conditions of any individual Medicare supplemental, Medicare Advantage or Medicare Part D, dental or vision plans or policies, you must contact the insurance carrier of those individual plans or policies.

What is a Private Medicare Marketplace?

A private Medicare marketplace, or exchange, enables you to shop for different kinds of health plans—medical, prescription drug, dental and vision—from a variety of insurance carriers. Plans in this type of private exchange are generally more affordably priced than standard group medical plans. That’s due to the competition among insurance carriers within the exchange, as well as the access insurance carriers have to the volume of people who come to the exchange.

How OneExchange Can Help You

You will set up a personal phone appointment and complete a personal profile either online at Medicare.OneExchange.com/PepsiCo or by calling 1-855-241-5717 (TTY:711), Monday through Friday, 8 am to 9 pm Eastern Time.

During your phone appointment, you will talk with an experienced benefit advisor who will provide:

- Unbiased education about the types of individual plans available to you, how each pays benefits and what each plan will cost.
- Advice and decision-making support, based on your current coverage and future needs, for coverage alternatives beyond Medicare Parts A and B.
- Help with enrolling in coverage.
- Ongoing support after enrollment, including help with coverage, claims and network questions.

You will also have access to decision-making tools and other resources online, through the OneExchange website, any time at www.medicare.oneexchange.com/pepsico.

You will be contacted by OneExchange before you turn 65 with more information and tools to help you understand your options and get enrolled. If you are near your 65th birthday and have not yet heard from OneExchange, call them at 1-855-241-5717, Monday through Friday, 8 am to 9 pm Eastern Time.

The Retiree Reimbursement Account (RRA)

If you are eligible, PepsiCo will fund an RRA for you and your eligible spouse/partner who is age 65 and older. The RRA is opened in your name, and PepsiCo makes contributions into that account for both you and your eligible spouse/partner. You can use the RRA balance toward premiums for the medical, dental and vision plans you elect through OneExchange, as well as for Medicare Part B premiums. You may also use the RRA to reimburse yourself for certain eligible out-of-pocket health care expenses too (such as hearing aids and prescription drug costs).

Your eligibility for and the amount of your RRA contribution will depend on the legacy company you retired from as well as when you retired. You will receive information about your RRA eligibility from OneExchange. Note that you must continue your enrollment through OneExchange each year in order to receive that year’s RRA contribution. If you are eligible for a RRA, you will also receive a separate Summary Plan Description for the RRA.
Retiree Life Insurance Details

Except as provided below, if you are eligible for a retiree medical subsidy under the Company’s Retiree Health Care Program, when you retire, a portion of the basic Company-provided life insurance coverage you received while an active employee will continue, with benefits paid to your beneficiary when you die. The Company currently provides this insurance at no cost to you.

Please note: All questions regarding your retiree life insurance eligibility, amount, beneficiaries or claims should be directed to The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014.

Eligibility

If you satisfy the eligibility requirements for retiree medical as set forth under “Eligibility” in the “Retiree Health Care Program Highlights” section and if you are eligible for a retiree medical subsidy under the Company’s Retiree Health Care Program, you are covered from your first day of retirement by basic Company-provided life insurance. (For example, for legacy PepsiCo employees, if you were actively employed as of December 31, 2010 and retire on or after age 65 with at least 5 years of pension vesting service under a qualified PepsiCo retirement plan or between ages 55 and 64 with at least 10 years of pension vesting service under a qualified PepsiCo retirement plan, you will be eligible for retiree life insurance as described in this section.) In addition, the following special rules, terms and conditions apply for purposes of this retiree life insurance section:

- If you are not eligible for a retiree medical subsidy when you leave the Company, then your Company-provided life insurance terminates on the day you leave the Company. You should review the Life Insurance section of the Health and Insurance Benefits Book on http://benefitplandetails.pepsico.com for further information and any continuation or conversion rights.
- Company-provided retiree life insurance is not available to legacy PepsiCo or legacy PBG employees who were under age 40 (regardless of years of pension vesting service) or who had less than 5 years of pension vesting service (other than employees age 60 or older) as of December 31, 2010.
- Tropicana salaried employees who retired prior to January 1, 2002 and at retirement were over 40 years old with at least 5 years of service are eligible for retiree life insurance from their first day of retirement.
- Certain special early retirees may be eligible for retiree life insurance coverage to the extent eligibility is provided in the official plan documents and summary plan description of the special early retirement window.
- Quaker salaried retirees who retired prior to April 1, 2003 are not eligible for retiree life insurance coverage under this program. You are eligible for an ancillary death benefit under the PepsiCo Salaried Employees Retirement Plan equal to the greater of $5,000 or a lump sum amount equal to 12 times the Single Life Annuity amount effective on your benefit commencement date. In order to receive this benefit, you had to complete 10 or more Years of Pension Vesting Service when you retired; and your date of death must be more than 31 days after your benefit commencement date.
- Quaker hourly (except Indianapolis and Dallas) retirees who retired prior to January 1, 2005 are not eligible for retiree life insurance coverage under this program. You are eligible for an ancillary death benefit under the PepsiCo Hourly Employees Retirement Plan. Upon your death, your beneficiary will be entitled to receive the greater of $5,000 or a lump sum amount equal to 12 times the Single Life Annuity amount effective on your benefit commencement date. In order to receive this benefit, you had to complete 10 or more Years of Pension Vesting Service when you retired and your date of death must be more than 31 days after your benefit commencement date.
- Quaker hourly (Indianapolis only) retirees who retired prior to January 1, 2005 are not eligible for retiree life insurance coverage under this program. You are eligible for an ancillary death benefit under the PepsiCo Hourly Employees Retirement Plan. If you die more than 31 days after retirement, a lump-sum death benefit equal to $2,000, will be paid to your named beneficiary. If you did not name a beneficiary, or your named beneficiary is deceased, the benefit will be paid to a surviving relative or to your estate.
- Quaker hourly (Dallas only) retirees who retired prior to January 1, 2006 are not eligible for retiree life insurance coverage under this program. You are eligible for an ancillary death benefit under the PepsiCo Hourly Employees Retirement Plan. If you die more than 31 days after retirement, a lump-sum death benefit equal to $2,000, will be paid to your named beneficiary. If you did not name a beneficiary, or your named beneficiary is deceased, the benefit will be paid to a surviving relative or to your estate.
- Employees who are entitled to a deferred vested pension benefit or who leave the Company before they qualify for early or normal retirement are not eligible for retiree life insurance coverage.
Legacy PAS retirees are not eligible for Company-provided retiree life insurance coverage, with the exception of certain grandfathered Heartland and Whitman retirees.

Disabled retirees are treated like any other retiree for purposes of retiree life insurance.

Under federal tax law, you must pay taxes on the IRS-declared value of any Company-provided life insurance coverage over $50,000. This is called imputed income.

**Amount of Coverage**

*For Eligible legacy PepsiCo and legacy PBG Retirees*

If you are eligible for a retiree medical subsidy under the Retiree Health Care Program, your Company-provided life insurance will continue after retirement and is calculated as a percentage of your amount of insurance in force immediately before your retirement. The amount is established based on the age you retire and then decreases each year until it reaches a minimum of $5,000, as shown below.

For example, if you were age 60 at retirement, your retiree life insurance will begin at 50 percent of your Company-provided active coverage, and each year thereafter will decrease by 10 percent until you reach age 65, as shown in the following chart:

<table>
<thead>
<tr>
<th>Age of Retiree</th>
<th>As an eligible retiree, your basic life insurance coverage amount as an active employee is reduced to the following percentage (subject to a minimum coverage amount of $5,000):</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>100%</td>
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<tr>
<td>56</td>
<td>90%</td>
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<td>57</td>
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<td>62</td>
<td>30%</td>
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<tr>
<td>63</td>
<td>20%</td>
</tr>
<tr>
<td>64</td>
<td>10%</td>
</tr>
<tr>
<td>65 or older</td>
<td>$5,000 unreduced</td>
</tr>
</tbody>
</table>

All insurance amounts are rounded up to the nearest $1,000. In addition, if you are eligible for retiree life insurance under a special early retirement window, the amount of your retiree life insurance benefit will be provided to you in the official plan documents and summary plan description of the special early retirement window.

When you retire at or after age 65, your insurance will be reduced to $5,000 on your retirement date.

Additional life insurance and dependent, spouse/partner or child life insurance are not available after retirement. You may, however, convert this coverage to an individual policy upon retirement, as described in “Conversion to a Private Policy.”

*For Eligible legacy PAS Retirees*

Company-provided retiree life insurance is not offered to legacy PAS retirees, except as noted below.

- If you are classified as an eligible grandfathered Whitman retiree, please call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 to confirm the amount of Company-provided life insurance coverage you will receive when you retire.
If you are classified as an eligible grandfathered Heartland retiree, your Company-provided life insurance will continue after retirement and is calculated as a percentage of your annual salary immediately before your retirement. The amount is established based on the age you retire and then decreases each year until it reaches a minimum of $5,000, as shown below.

<table>
<thead>
<tr>
<th>Age of Retiree</th>
<th>Your Company-provided life insurance coverage amount as an active employee is reduced to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>100%</td>
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<tr>
<td>56</td>
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</tr>
<tr>
<td>65 or older</td>
<td>$5,000 unreduced</td>
</tr>
</tbody>
</table>

All life insurance amounts are rounded up to the nearest $1,000.

When you retire at or after age 65, your insurance will be reduced to $5,000 on your retirement date. Additional life insurance and dependent, spouse/partner or child life insurance are not available after retirement.

**Conversion to an Individual Policy**

When you retire you can convert the reduced amount of your basic life insurance coverage into an individual policy without a medical examination. You may also convert dependent group term life insurance for your covered children/domestic partner’s children to an individual policy. You must submit an application and pay the first premium within 31 days of the date your group insurance coverage ends. The converted policy becomes effective at the end of the 31-day period during which conversion is possible. In addition, if the policy between the Company and the insurance carrier ends, a conversion privilege may be available to an individual who has been covered under the contract for at least five years. The maximum amount of coverage that may be converted is subject to state regulations. If you have questions about these options, you can contact Securian Life at 1-877-254-9110.

**Benefit for Terminal Illness**

If you become terminally ill, you may elect to have up to 100 percent of your retiree life insurance coverage amount paid to you before you die (subject to a $5,000 minimum and state-regulated maximums). This is known as an accelerated benefit.

In all cases, medical evidence and insurance company approval are required.

**Beneficiaries**

You may change or add beneficiaries at any time by completing the beneficiary form available online, or request a beneficiary form by calling The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. To use the online form, go to [www.netbenefits.com/pepsico](http://www.netbenefits.com/pepsico), click **Your Profile** then click the **Beneficiaries** link in the **About You** section. You will receive an instant online confirmation. The form is available online or you can call The PepsiCo Savings and Retirement Center at Fidelity to request the form. If you use the online form, you can track the status of your beneficiary submission until it is received by The PepsiCo Savings and Retirement Center at Fidelity and determined to be complete and correct.
Applying for Benefits

A beneficiary should contact the Survivor Services Unit at The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 as soon as possible after an insured’s death to request the necessary forms. The Survivor Services Unit will send a letter to the beneficiary(ies) which outlines the procedures for applying for benefits as well as where the requested documentation should be sent.

In order to claim benefits, the survivor/beneficiary must complete a claimant’s affidavit and send it to Securian Life at:

Securian Life Insurance Company
P.O. Box 64114
Saint Paul, MN 55164-0114

How Benefits Are Paid

Benefits may be paid in a lump sum or by any other payment option offered by Securian Life. A lump–sum payment will be made if your beneficiary does not specify a method of payment. If you have not named a beneficiary, your benefits will be paid to the first survivor among:

► Your legal spouse or domestic partner, in full;
► Your natural and adopted children, in equal shares;
► Your parents, in equal shares;
   or
► Your brothers and sisters, in equal shares.

If you do not have any living beneficiaries or immediate relatives, your benefits will be paid to your estate. You can call The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014 for assistance.

When Coverage Ends

Your life insurance coverage will end if the plan ends or if your coverage is otherwise terminated or discontinued. If you die within 31 days of the date your life insurance coverage ends, your beneficiary will be paid the amount in effect before coverage ended.

Retiree life insurance coverage is neither fixed nor guaranteed. The Company reserves the right to terminate or change in any way the coverage provided to retirees. This may be done at any time, including after retirement has occurred.

For information about the administration of your retiree life insurance benefit, please see “Administrative Information.”

Healthy Money: Free Financial Education

PepsiCo retirees have access to free personal financial education through the Company’s Healthy Money program. Call and speak to a PricewaterhouseCoopers (“PwC”) professional financial counselor and create a financial plan for your retirement. PwC counselors are familiar with PepsiCo benefit plans, and can help with all your financial questions. PwC does not sell financial products, so you’ll receive independent, confidential guidance. Call 1-866-737-7498, Monday-Friday, 9:00 a.m. – 8:00 p.m. Eastern time for help with tax withholding decisions, when to start Social Security, budgeting in retirement, when and how to withdraw from your 401(k), and more.
Definitions

The following definitions are used in this SPD. Many definitions are specific to the Basic Medical, Safety Net Medical, Post-Medicare Basic Medical and Prescription Drug Only Options. However, other definitions are used throughout the SPD. If you participate in BlueCare HMO, please refer to the BlueCare HMO section of this SPD. If you participate in a Medicare supplement or Medicare advantage plan through OneExchange, please contact your benefit advisor for information.

Annual Deductible

The annual deductible is the amount of money you pay each year before the plan begins to pay benefits for medical expenses. Once the annual deductible is met, if applicable, the plan pays a share of the cost of most covered medical expenses—and you pay the rest. The in-network expenses will not count towards the out-of-network deductible. Any out-of-network expenses will count towards the in-network deductible. The individual deductible is applied separately toward the covered expenses of each family member. Under Medicare there is no difference between in- and out-of-network benefits.

Family Deductible

The family deductible amount is twice the individual deductible. Once the family deductible is met, all covered members will be considered to have met their individual deductibles for the year. However, no one person can contribute more than the equivalent of one individual deductible toward the family deductible.

Common Accident

If two or more family members are injured in the same accident, you only have to meet one individual deductible for all injured family members combined. If expenses from the same accident continue into the next year, you will again only have to pay one individual deductible for any expenses in the second year related to the accident.

Out-of-Pocket Limit

The out-of-pocket limit is the maximum amount that you and your family have to pay for covered expenses in a year. The out-of-pocket limit protects you against having to pay extraordinary medical bills for covered expenses in a given year unless you or a family member exceeds your lifetime maximum. The annual deductible, expenses not covered by the plan, and any charges above reasonable and customary limits are not counted towards the out-of-pocket limit.

The medical options each have an individual and family out-of-pocket maximum. If you elect family coverage, and the expenses paid in coinsurance for one family member reach the individual out-of-pocket maximum, the plan will pay 100 percent of that family member’s additional eligible expenses for the rest of the year. If eligible expenses paid in coinsurance for all family members combined reach the family maximum, the plan will pay 100 percent of any additional eligible medical expenses for all covered family members for the rest of the year.

In-network expenses will not count towards the out-of-network limit. Out–of–network expenses will count towards the in-network limit. Expenses incurred when you don’t use a network provider are subject to reasonable and customary limits.

Lifetime Maximum Benefits

The lifetime maximum is the most the plan will pay for an individual during his/her lifetime. Effective for claims incurred after December 31, 2011, the maximum lifetime benefit for the PepsiCo Retiree Health Care Program is
$1,500,000. Prior limits apply to previous claims and to individuals who satisfied a prior lifetime maximum. The lifetime maximum includes all employee and retiree medical and prescription drug claims.

The individual lifetime maximum is calculated by totaling these expenses:

- Claims paid by the Pre-Medicare Basic Medical Option, the Pre-Medicare Safety Net Option, the Post-Medicare Basic Medical Option and the BlueCare HMO Option (both pre-Medicare and post-Medicare).
- Claims paid for prescription drugs, including claims under the Prescription Drug Only Option.
- Claims paid for mental health and substance abuse expenses.
- Claims paid under the PepsiCo Employee Health Care Program or any other PepsiCo medical/mental health/prescription drug option in which you or your spouse/partner/dependent were enrolled prior to your retirement.
- If applicable, claims paid under any employee or retiree medical/mental health and prescription drug options or plans that were predecessors to a PepsiCo employee or retiree medical/mental health or prescription drug plan (e.g., claims paid under a previous employer’s medical plan prior to the previous employer becoming part of the PepsiCo organization).

As provided in this booklet, a special individual lifetime maximum applies to infertility treatments and to inpatient mental health and substance abuse claims for each covered person. Expenses for infertility treatments and inpatient mental health and substance abuse claims are included in the lifetime maximum as well.

**Legacy PepsiCo, PBG or PAS**

Throughout this SPD, the terms PepsiCo, legacy PepsiCo, legacy PBG and legacy PAS are used. These definitions are explained as follows:

- Legacy PBG: You will be classified as a legacy PBG employee/retiree if (1) you retired from Pepsi Bottling Group (PBG) prior to the acquisition by PepsiCo or (2) you were employed by PBG prior to the acquisition by PepsiCo and retired after the acquisition.
- Legacy PAS: You will be classified as a legacy PAS employee/retiree if (1) you retired from PepsiAmericas (PAS) prior to the acquisition by PepsiCo or (2) you were employed by PAS prior to the acquisition by PepsiCo and retired after the acquisition.
- Legacy PepsiCo: You will be classified as a legacy PepsiCo employee/retiree if (1) you retired from PepsiCo (or any subsidiary or division) prior to the acquisition by PepsiCo of PBG and PAS or (2) you were employed by PepsiCo (or any subsidiary or division) prior to the acquisition by PepsiCo of PBG and PAS and retired after the acquisition.

If this SPD uses the term “PepsiCo employee / retiree” without the term “legacy” or just uses the term “employee/retiree” without any qualifying designation, such as PBG or Quaker, then such phrase refers to all employees/retirees.

Special intracompany transfer rules may also apply.

**Reasonable and Customary**

Reasonable and customary charges (sometimes called the Maximum Allowable Amount) are charges that are within the normal range of fees charged by doctors in your geographic area for similar services, taking into account any unusual circumstances. They are used when there is no negotiated discounted rate available. Reimbursement for expenses incurred when you don’t use a network provider is based on the reasonable and customary charge for the treatment or service you receive. Reasonable and customary limits do not apply to network charges because network providers have agreed to already reduced fees for their services. You pay a share of these pre-negotiated fees. If you do not use a network provider, the Plan pays 50 percent of the reasonable and customary fees after the deductible. You pay the difference. If you are receiving out-of-area coverage, the Plan pays 80 percent or 70 percent of reasonable and customary fees after the deductible, depending on your Retiree Medical Option. You pay the difference.
Reasonable and customary charges are determined by taking into account:

- The normal range of fees charged by doctors in your geographic area for similar services;
- Doctors’ usual fee for the service you receive or for similar services; and
- Any other circumstances determined to be reasonable and appropriate by the claims administrator.

If your provider charges more than reasonable and customary fees as determined by your claims administrator, you will be responsible for paying the additional amount. These additional amounts will not count toward your deductible or your out-of-pocket limit. You may want to discuss charges that are above reasonable and customary with your doctor or hospital to be certain that the bill is correct and complete. Reasonable and customary charges do not apply if you are on Medicare.

**Examples:**

**Out-of-Network**

You are in the Pre-Medicare Basic Medical Option and receive care from an out-of-network provider for a broken leg. The doctor charges $100 for the office visit. The reasonable and customary charge for that office visit is $80.

You will usually pay the doctor at the time of service: $100
You will be reimbursed 50% of $80 = $40

**Your responsibility will be $100 – $40 = $60**

**In-Network**

You are in the Pre-Medicare Basic Medical Option and receive care from an in-network provider for a broken leg. The doctor charges $100. The negotiated rate for that office visit is $80.

You will usually pay the doctor at the time of service: $0
The doctor will be paid by the carrier 80% of the negotiated fee = $64
You will be billed by the provider and pay $16

**Your responsibility will be $80 – $64 = $16**

Reasonable and customary charges are based on the three factors discussed before the examples and may not be the same between medical plan carriers.

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<table>
<thead>
<tr>
<th>Do These Expenses Count Toward Your Out-of-Pocket Limit?</th>
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</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td><strong>Your expenses for:</strong></td>
</tr>
<tr>
<td>- Most medically necessary services</td>
</tr>
<tr>
<td>- Home health, hospice and convalescent care</td>
</tr>
<tr>
<td>- Hospital stays that have been precertified by your medical claims administrator</td>
</tr>
<tr>
<td>- Inpatient and outpatient surgery</td>
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</table>
Administrative Information

This section contains information on the administration and funding for your retiree medical and life insurance plans, as well as your rights as a plan participant. While you may not need this information for day-to-day participation in your benefit plans, you should read through this section. It is important for you to understand your rights, the procedures you need to follow and the appropriate contacts you may need in certain situations. If you are enrolled in an individual Medicare supplement plan or Medicare advantage plan through OneExchange, your plan will have different administrative information that will be provided to you when you enroll.

Employer Information

Name, Address and Identification Number

PepsiCo, Inc. sponsors the plans described in this booklet, with the exception of any individual plan offered through OneExchange. The employer identification number assigned to PepsiCo, Inc. by the IRS is #13-1584302.

PepsiCo, Inc.
700 Anderson Hill Road
Purchase, NY 10577
914-253-3300

Plan Administrator

The PepsiCo Administration Committee is the plan administrator of the plans which are governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The plan administrator is responsible for the operation and administration of each benefit plan, except as specifically designated in any insurance contract or policy used to provide benefits under the plan or as may be delegated to certain third-party administrators. The plan administrator has the discretionary authority to construe and interpret the provisions of the PepsiCo benefit plans and make factual determinations regarding all aspects of the plans and their benefits, including the power and discretion to determine the rights or eligibility of employees, retirees and any other persons, and the amounts of their benefits under the plans, and to remedy ambiguities, inconsistencies, or omissions, and such determinations shall be binding on all parties.

The plan administrator may designate other organizations or persons to carry out specific fiduciary responsibilities in administering the PepsiCo benefit plans including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the plan, including the processing and payment of claims under each plan and the related recordkeeping;
- The responsibility to prepare, report, file, and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under each plan; and
- The responsibility to act as claims administrator and to review claims and claim denials under the plan to the extent an insurer or administrator is not empowered with such responsibility.

The plan administrator will administer the PepsiCo benefit plans on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated. The plan administrator may be contacted by phone, in writing, or in person through the Company’s Benefits Department at:

PepsiCo, Inc.
Attn: Plan Administrator
Benefits Department
Mail drop: 2/2-221
700 Anderson Hill Road
Purchase, NY 10577
914-253-3300

Agent for Service of Legal Process

Process can be served on the PepsiCo Administration Committee by directing service to:

Chairperson, PepsiCo Administration Committee
Benefits Department
Union Agreements

Retirees who were represented for collective bargaining purposes while actively employed by PepsiCo, Inc. are eligible to participate in the plans described in this booklet, only to the extent that the language of the applicable collective bargaining agreement and the plan document specifically provide for such participation.

Plan Funding

The benefit plans are funded in different ways, depending upon the type of plan, as described below. In all cases, PepsiCo, Inc. makes the decisions about how the plans are designed, including eligibility and participation.

Contributions to the benefit plans are made by PepsiCo, Inc. and participants. For both insured and uninsured programs, participant contributions are based on the total price of providing coverage as determined by PepsiCo, Inc., reduced to reflect employer contributions. Administrative expenses are included in the price of coverage.

Company-Funded Benefits

The cost of benefits under the retiree medical (including the RRA), mental health and substance abuse, and prescription drug benefits are paid out of the general assets of the Company, and are not pre-funded or insured. The benefits are administered through contracts with third parties. The name and address of each claims administrator can be found in the Other Administrative Facts section of this book. In each benefit, the claims administrator has the discretionary authority to determine all benefits in accordance with the official plan documents and applicable contracts. The administrative services provided by the claims administrator include claims processing and payment.

Third-Party Insured Benefits

Life insurance benefits are fully insured by a third party. The name and address of the insurer can be found in the Other Administrative Facts section. The administrative services provided by the insurer include claims processing and payment. The master contract for coverage specifies the time when and the circumstances under which the insurer is to pay for benefits. For example, the insurer would not have to pay claims after the contract is terminated. The insurer has the discretionary authority to determine and guarantees all benefits according to the terms of the official plan documents and applicable contracts. All Company and retiree contributions (if any) are paid directly to the insurer, which is responsible for paying all benefits.

Cooperation with the Plan and Claims Administrators

In order to participate in PepsiCo retiree medical and life insurance programs, you and your enrolled spouse/partner/dependents are required to cooperate with the plan and claims administrators and provide the plan and claims administrators with information that is needed to administer your benefits. This includes providing the plan and claims administrators with your and your spouse/partner/dependent’s correct Social Security numbers, correct legal names and correct birthdates. You must also respond to reasonable requests of the plan and claims administrators for additional information, and assist the plan and claims administrators in correcting any claims paid in error or for the wrong amount. Failure to cooperate with the plan and claims administrators may result in the termination or suspension of your and your spouse/partner/dependent’s retiree medical coverage.

Filing a Health & Welfare Benefit Claim

Usually, health and welfare benefits are paid by following the plan’s medical carrier’s procedures described in this booklet. However, occasionally benefits are denied for various reasons including plan eligibility and/or services that are not covered by the plan. If you disagree with the benefits being denied and wish to have an additional review, you
may file a formal claim for benefits with the claims administrator. If your formal claim is denied, you have the right to appeal the decision.

The plan administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the plans, to decide all questions of eligibility for benefits, and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by the court, arbitrator or any other tribunal, it shall be reviewed under the arbitrary and capricious standard (e.g., the abuse of discretion standard). Benefits will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. The plan administrator has periodically exercised its authority to delegate discretionary authority in contracts, letters, and various plan documents to various claims administrators, and insurers listed in the Other Administrative Facts section and to their predecessors and successors.

The health and welfare plans distinguish between internal claims and appeals, and external appeals. Internal Claims – which differ for benefits and eligibility - are handled internally by the plan, its medical carriers and other third party administrators. With external appeals, the decision is made by an independent review organization (IRO) rather than the plan and its medical carriers. External appeals are only available for certain medical benefit claims. This section discusses procedures for filing:

Internal Claims and Appeals for Health and Welfare Benefits;
External Appeals for Medical Benefits; and

Internal Claims and Appeals for Health and Welfare Eligibility.

Note that these procedures do not apply to you if you are age 65 or older and enrolled in a Medicare supplement plan through OneExchange. Check with your benefit advisor for more information about filing claims.

Internal Claims and Appeals for Health and Welfare Benefits

If your health and welfare benefits are denied and you want to make an internal claim for benefits, you must file a written claim:

- If the claim relates to medical benefits, you must file your claim with the applicable claims administrator. The address is shown in the Other Administrative Facts section or on the claim form (if any) prescribed by the claims administrator. For certain benefits, your service provider may file a claim for you (e.g., your network medical provider may file a claim for benefits on your behalf). However, it is always your responsibility to make certain a formal claim for benefits has been filed with the appropriate party. For purposes of these procedures, in the case of insured programs, “claims administrator” means the insurer or its delegates, except for claims involving eligibility for coverage, in which case “claims administrator” means the plan administrator or its delegates. In the case of programs that are not insured, “claims administrator” means the plan administrator or its delegates. See the Plan Funding pages of this section to determine if a program is insured.

- If the claim relates to eligibility, enrollment or other non-benefit issue, you should file your claim with the plan administrator:
  
  PepsiCo, Inc.
  Attn: Retiree Health Care and Group Insurance Program Plan Administrator
  Benefits Department
  Mail drop: 2/2-221
  700 Anderson Hill Road
  Purchase, NY 10577
  914-253-3300

Internal Benefit Claims for Precertification

For participants not eligible for Medicare, certain claims for benefits under the PepsiCo Retiree Health Care Program must be precertified. You must call your medical claims administrator to request precertification for services or treatments at:

- Anthem Blue Cross and Blue Shield: 1-877-224-0030
- BlueCross BlueShield of Florida: 1-800-664-5295
- UnitedHealthcare: 1-800-638-7785

For participants who are Medicare eligible, since Medicare is the primary payer once you are Medicare eligible, your benefit approval is provided by Medicare.
BlueCare HMO Option—For all participants, your primary care physician guides you through this process. If you have an emergency hospitalization, you or a family member, must inform your primary care physician within 48 hours for coverage to be effective.

Prescription Drug Benefit—Prior authorization is required for certain prescription drugs. Call Express Scripts at 1-888-737-7479 for more information.

**Internal Benefit Claim Denial**

If your internal claim for benefits is denied in whole or in part, you will receive a written notification of the denial. This claim denial notice will include: specific reasons why the claim was denied, including:

- Specific references to applicable provisions of the official plan documents or other relevant records or papers on which the denial is based, and information regarding where you may review them; and
- An explanation of how to appeal for reconsideration of the claims administrator’s decision, including your right to submit written comments and have them considered, your right to review, upon request and free of charge, relevant documents and other information, and your right to file suit under the Employee Retirement Income Security Act of 1974 (“ERISA”) with respect to any adverse determination after appeal of your claim; and a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary.

For denied life insurance benefits, you will receive this denial notice within 90 days of the date the claim is received (or 180 days if special circumstances arise and you are notified in writing that an extension period is required).

Special rules apply to any claims arising under the PepsiCo Retiree Health Care Program, as follows:

If your internal claim is under the PepsiCo Retiree Health Care Program (medical, prescription drug or mental health and substance abuse benefits), you will receive notice from the claims administrator about your claim according to the type of claim you have filed.

- **Urgent Care Claims:** You will receive notice, in writing or by telephone, facsimile, or other electronic method, as soon as possible, taking into account the severity of the patient’s medical condition, but not later than 72 hours after the receipt of the claim by the claims administrator. Urgent care claims are claims for benefits where medical care is necessary to avoid serious jeopardy to your life or health, or to regain maximum function. The treating physician will determine whether the urgent care procedures apply and will inform the claims administrator.

- **Pre-Service Claims:** You will receive written notice within 15 days for a non-urgent claim for medical benefits where precertification is required before care is provided; unless an extension of time is required to review your claim, in which case you will be notified in writing of the need for an extension of up to 15 additional days.

- **Post-Service Claims:** You will receive written notice within 30 days for a non-urgent claim for medical benefits where precertification was not required and care has already been provided; unless an extension of time is required to review your claim, in which case you will be notified in writing of the need for an extension of up to 15 additional days.

- **Concurrent Claims:** If your request to extend a course of treatment is an Urgent Care Claim, you will receive written notice within 24 hours provided the request is received at least 24 hours prior to the end of the approved treatment. If a request to extend approved treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be processed according to the above time frame for an Urgent Care Claim. If the ongoing course of treatment is not an Urgent Care Claim, a request to extend the treatment will be considered a new claim and processed according to the Pre-Service Claim or Post-Service Claim procedures, whichever is applicable. You will be notified of any reduction or termination of the course of treatment sufficiently in advance so as to permit a full appeal before the termination or reduction takes effect. However, in any event, if a course of treatment was previously approved, coverage for that course of treatment will continue pending outcome of an internal appeal.

The claims administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide your claim. If an extension is required because there is insufficient information to review your claim, you will receive a notice explaining the unresolved issues that prevent a decision on the claim and a listing of the additional information needed to resolve those issues. You will be given 45 days (48 hours in the case of an urgent care claim) from the receipt of that notice to provide the additional information to the claims administrator. During the time that a request for information from you is outstanding, the running of the time period in which the claims administrator must decide your claim is suspended.
Appealing a Denied Internal Claim for Health and Welfare Benefits

The carriers administering benefits under the PepsiCo Retiree Health Care Program are the claim fiduciaries. Appeals for denied internal claims for benefits should be sent directly to your claims administrator’s attention. Contact information for your claims administrator can be found in the Other Administrative Facts section of this SPD.

If your claim has been denied in whole or in part, you may appeal the denial:

- Submit a written request for review to the claims administrator. See the Other Administrative Facts section for a listing of the claims administrators.
  - Your written request for review of a life insurance benefit denial must be sent within 60 days of the date that you received the claim denial.
  - Your written request for review of a claim denial under the PepsiCo Retiree Health Care Program (medical, mental health and substance abuse and prescription drug) must be sent within 180 days of the date you received the claim denial.
- If you do not appeal on time, you will lose your right to appeal the determination and you will also lose your right to file suit in court, as you will have failed to exhaust your administrative appeal rights, which is generally a prerequisite to bringing suit.

Your right to appeal a denied internal benefits claim includes the opportunity for you or your authorized representative to:

- State the reasons why you feel your claim should not have been denied;
- Submit written comments, documents, additional facts, and other information supporting your claim;
- Ask additional questions;
- Request to receive reasonable access (free of charge) to copies of all documents, records, and other information relevant to your claim; and
- Ask for a review that takes into account all comments, documents, records, and other information you have timely submitted, whether or not it was submitted or considered in the initial determination of your claim.

In addition, if your internal benefits appeal relates to medical benefits, the applicable plan will:

- Continue medical coverage for a course of treatment pending the outcome of an internal appeal, if such course of treatment was previously approved;
- Provide to you, in advance of an internal appeal determination, any new or additional evidence or rationale relied upon or considered in making the determination, and give you an opportunity to respond prior to making the internal appeal determination.

If your internal benefits appeal is denied in whole or in part, you will receive written notification of the decision as described below. Such written notification will contain the following information: the specific reasons for the partial or complete denial of your claim; reference to the specific plan provisions on which the benefit determination was based; a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and a statement of your right to bring an action under ERISA Section 502(a) as amended.

In addition, if your internal claim is for health care benefits you also have the right to receive a copy of any internal rule, guideline, protocol or other similar criterion relied upon in the claim determination, if any, or a statement of your right to receive a copy of such internal rule, guideline, protocol, or other similar criterion, upon request and free of charge. If your internal appeal was denied based on a medical necessity or experimental treatment or similar exclusion, you have the right to receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement of your right to receive such explanation upon request.

For life insurance benefits, you will receive the written decision on appeal within 60 days of the date the appeal was received (or 120 days if special circumstances arise and you are notified in writing within the initial 60-day period of the need for an extension).

If your internal benefits appeal arises under the PepsiCo Retiree Health Care Program (medical, prescription drug or mental health and substance abuse benefits), you must submit your appeal in writing to the claims administrator within 180 days of your receipt of the initial denial of your claim. You will then receive notification of the claims administrator’s decision on appeal according to the type of claim you have filed.
Urgent Care Claims: You will receive notice, in writing or by telephone, facsimile or other electronic method, within 72 hours of a claim for benefits where medical care is necessary to avoid serious jeopardy to your life or health, or to regain maximum function (or as determined by your treating physician).

Pre-Service Claims: You will receive written notice within 30 days for a non-urgent claim for medical benefits where precertification is required before care is provided.

Post-Service Claims: You will receive written notice within 60 days for a non-urgent claim for medical benefits where precertification was not required and care has already been provided.

Concurrent Care Claims: You will receive written notice within the time frame for an Urgent Care Claim, Pre-Service Claim or Post-Service Claim, whichever is applicable. However, you will be notified of the determination on appeal before a reduction or termination of a course of treatment takes effect. If your claim is for medical benefits, the plan will continue medical coverage for a course of treatment pending the outcome of an internal appeal, if such course of treatment was previously approved.

United Healthcare has two levels of internal appeals. You must complete both levels of appeal before you can apply for external review. For appeals with United Healthcare you must file an internal appeal within 180 days of your initial claim denial. If your first level of appeal is denied, United Healthcare will inform you of the deadline for filing for your second level of appeal. This deadline will be listed on your Explanation of Benefits (EOB) you receive from your first level of appeal denial.

For the PepsiCo Retiree Health Care Program, the individual who decides your internal benefits appeal will not be the same individual who decided your initial internal benefits claim denial and will not be that individual’s subordinate. The claims administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The identity of a medical expert consulted in connection with your appeal will be provided.

The claims administrator’s or his or her delegate’s decision on appeal will be final and binding on all affected parties. Neither the Company nor the plan administrator will review any claims for which claims administration has been delegated to a carrier or other third-party administrator.

External Appeals for Medical Benefit Claims

The external appeal procedures apply only to adverse medical benefit determinations (i.e., denied medical benefit claims or appeals) that involve a medical judgment (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).

External appeal procedures do not apply to any other adverse determination (other than medical judgments as set forth above), including denied eligibility claims and appeals and denied life insurance claims and appeals.

Filing an External Appeal Request

If your internal claim for medical benefits is denied and you have properly filed an internal appeal of that benefit claim which is also denied, an additional external appeal procedure may apply. To file a request for an additional external appeal, you must:

- File the request with your medical carrier or prescription drug administrator (e.g., United Healthcare, Anthem Blue Cross and Blue Shield, Express Scripts or BlueCare HMO of Florida). (Note: BlueCare HMO of Florida may have different external appeal rules than discussed in this section.)

- The request must be filed within four months after the date you received your denied internal appeal (of for United Healthcare, your last denied internal appeal). If there is no corresponding date four months after the date you received your denied internal appeal, then the request must be filed by the first day of the fifth month following the receipt of the denied internal appeal. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Procedures after an External Appeal Request is Filed. Within five business days following the date your request for an external appeal is received, the carrier or other applicable party will complete a preliminary review of the request to determine whether:
You are or were covered under a PepsiCo retiree medical option at the time the item or service was requested or, in the case of a retrospective review, were covered under a PepsiCo retiree medical option at the time the health care item or service was provided;

The external appeal relates to a medical judgment or rescission of coverage;

The denied appeal does not relate to your failure to meet the requirements for eligibility under the terms of the PepsiCo Retiree Health Care Program;

You have exhausted the internal appeal process (except for expedited appeals below); and

You have provided all the information and forms required to process an external appeal.

Within one business day after completing the above preliminary review, your medical carrier or other applicable party will issue a notification in writing. If the request is complete but not eligible for external appeal, such notification must include the reasons for its ineligibility. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and you will have the later of the remaining time within the four-month filing period or 48 hours following the receipt of the notification to complete your appeal request.

If Your Request for External Appeal is Approved:

Your medical carrier or other applicable party will assign it to an independent review organization (IRO) to conduct the external appeal. To ensure independence, your medical carrier or other applicable party will randomly assign the appeal request to one of at least three IROs with whom the medical carrier or other applicable party has contracted for such external appeals.

The assigned IRO will timely notify you in writing of your eligibility and acceptance for external appeal. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date you receive the notice additional information that the IRO must consider when conducting the external appeal.

The IRO is not required to, but may accept and consider additional information submitted after 10 business days. Any additional information the IRO receives from you will be shared with the medical carrier and the PepsiCo Retiree Health Care Program. Upon receiving this information, the medical carrier or other applicable party may reconsider its prior appeal decision and reverse the prior denial of the internal appeal.

The IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached by your medical carrier or other applicable party during the internal claim and appeal process.

The IRO must complete its review within 45 days after the IRO receives the request from you for an external appeal.

The IRO will deliver a notice of the final external review decision to you and your medical carrier or other applicable party. If the medical carrier and plan receive notice of a final external appeal decision reversing the internal appeal denial, they will provide the applicable coverage or payment of the claim.

If the medical carrier reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly and the external appeal will be terminated.

**Expedited External Appeal Requests.** You may also make an expedited external appeal request to your medical carrier at the time you receive:

- A denied urgent care internal claim if you have also filed at the same time an internal appeal;
- A denied urgent care internal appeal; or
- A denied internal appeal which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility.
Upon receiving the request for expedited external review, your medical carrier must determine whether the request meets the reviewability requirements set forth above. If those requirements are satisfied, the medical carrier will immediately send a notice to you. Upon a determination that a request is eligible for expedited external appeal, the IRO will follow the procedures discussed above with respect to standard external appeals, provided that certain procedures will be expedited as follows:

- The medical carrier or other applicable party must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and
- The IRO will provide notice of the external appeal decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review.

Claims Exhaustion. If your internal claim and appeal is denied, and an external appeal is available, you must complete the external appeal process prior to filing suit against the applicable plan. The claim exhaustion and the limitation on claims provisions are discussed in more detail below.

Foreign Language Assistance

If you reside in a county where 10% or more of the population is literate in a non-English language,* the PepsiCo Retiree Health Care Program will provide the following language assistance:

- Oral language services in the applicable non-English language for benefit questions, claims, appeals and external review;
- Upon request, an explanation of benefits (EOB) or other adverse benefit determination in the applicable non-English language; and
- Provide in English versions of EOBs and other adverse benefit determinations a statement in any applicable non-English language indicating how to access the language services.

The above foreign language assistance applies to your medical carrier and The PepsiCo Savings and Retirement Center at Fidelity. If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact your medical carrier (or The PepsiCo Savings and Retirement Center at Fidelity, if applicable) using the phone number on the back of your ID card.

*As determined by the United States Department of Labor. In general, for the foreign language assistance rule to apply, your county must be listed in United States Census Bureau data as a county where 10% of more of the population is literate in a non-English language.

Internal Claims and Appeals for Health and Welfare Eligibility

If you would like to make a formal claim for eligibility or enrollment under the PepsiCo Retiree Health Care Program, you must file your claim in writing with the plan administrator. The plan administrator’s address and additional information are located above. If you file an eligibility or enrollment claim under the PepsiCo Retiree Health Care Program, you will be notified of the plan administrator's determination within 60 days of the plan administrator receiving the claim. If additional information is needed to process the claim, the plan administrator will notify you prior to the end of the 60-day period. You will then have 45 days to provide the requested information, and during the time that a request for information is outstanding, the applicable claim and time period are suspended.

If, for reasons beyond the control of the plan administrator, an extension of time is required to process the claim, the plan administrator shall send you a notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the 60-day period. However, in no event shall the extension exceed a period of an additional 30 days from the end of the initial 60-day period.

If your eligibility claim is denied (in whole or in part) and you wish to appeal, you must appeal by sending your written appeal to the plan administrator within 180 days of your claim denial. The plan administrator’s address and additional information are located above. You will be notified of the determination on appeal within 60 days after the plan administrator receives the request for review of a denied eligibility claim.

Exhaustion of Administrative Remedies

Before filing any claim or action in court or in another tribunal with respect to any ERISA benefit plan, which includes the PepsiCo Retiree Health Care Program and the PepsiCo Group Insurance Program, you must first fully exhaust all of your actual or potential rights under the claims procedures provided above by filing an initial claim and then seeking a timely appeal of any denial, including any external appeal that may be available (referred to generally as the exhaustion requirement).
Upon review by any court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible. In any action or consideration of a claim in court or in another tribunal following exhaustion of the plan’s claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the plan administrator in the claims procedure process.

This exhaustion requirement applies: (1) regardless of whether other claims, disputes, issues, actions or other matters (including those that a court might consider at the same time) are of greater significance or relevance; (2) to any rights the plan administrator may choose to provide in connection with novel claims or in particular situations; (3) regardless of whether the rights are actual or potential; and (4) even if the plan administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a claim (in which case the plan administrator, upon notice of the claim, shall either promptly establish such claims procedures or shall apply or act by analogy to the claims procedures that otherwise apply to claims for benefits).

The plan administrator may make special arrangements to consider a claim on a class basis or to address unusual conflicts concerns, and such minimum arrangements in these respects shall be made as are necessary to maximize the extent to which exhaustion is required.

For purposes of this exhaustion requirement, a “claim” is any dispute, issue, action, matter or other claim that involves any one or more of the following:

- The interpretation of the plan;
- The interpretation of any term or condition of the plan;
- The interpretation of the plan (or any of its terms or conditions) in light of applicable law;
- Whether the plan or any term or condition under the Plan has been validly adopted or put into effect;
- The administration of the plan;
- Whether the plan, in whole or in part, has violated any terms, conditions or requirements of ERISA or other applicable law or regulation, regardless of whether such terms, conditions or requirements are, in whole or in part, incorporated into the terms, conditions or requirements of the plan;
- A request for plan benefits or an attempt to recover plan benefits;
- An assertion that any entity or individual has breached any fiduciary duty; or
- Any dispute, issue, action, matter or other claim that (i) is deemed similar to any of the above items by the plan administrator, or (ii) relates to the plan in any way.

Failure to follow this exhaustion requirement means that any claim, action or suit filed in court will generally be dismissed.

**Limitations on Court Actions**

Any claim or action that is filed in a court or other tribunal against or with respect to the PepsiCo Retiree Health Care Program and/or the plan administrator must be brought within the timeframes noted below.

For any claim or action relating to health benefit services or supplies furnished on or after March 1, 2013, any claim or action must be brought in court within eighteen months of the later of:

- The date you are notified that your internal appeal* is denied (in whole or in part), or
- If applicable, the date you are notified that your external appeal* is denied (in whole or in part).

For any claim or action relating to health benefit services or supplies furnished before March 1, 2013, the claim or action must be brought in court within three years of the date the services were rendered or the supply was furnished.

* Internal and external appeals are discussed above.
For all other claims or actions (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim. Any claim or action brought after the above timeframes will be void.

Any claim or action that is filed in a court or other tribunal against or with respect to the PepsiCo Group Insurance Program and/or the plan administrator must be brought within the following timeframes:

- For benefits that accrue prior to March 1, 2013, the claim or action for benefits must be brought within three years of the date your benefits accrued under the Plan, and
- For benefits that accrue on or after March 1, 2013, the claim or action for benefits must be brought within two years of the date your benefits accrued under the Plan.

Any claim or action brought after the above timeframes will be void.

**Exclusive Venue**

Any claim, action or other lawsuit relating to the PepsiCo Retiree Health Care Program (including claims for eligibility, benefits or other matters) and any claim, action or other lawsuit relating to the PepsiCo Group Insurance Program (other than a claim against an insurer for benefits) must only be brought or filed in the United States District Court for the Southern District of New York.

**Authorized Representative**

You may appoint an authorized representative to act on your behalf for purposes of the plans. If you need to make an appointment of an authorized representative for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims, you must follow the procedures of the applicable claims administrator for such claim or appeal. If the claims administrator has no procedures, then the procedures listed below will apply.

If you need to make an appointment of an authorized representative for any other purpose (or in situations where a Claims Administrator has no procedures), the appointment of an authorized representative must:

- Be in writing and dated;
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative;
- Be signed by you and notarized by a notary public;
- Satisfy any other legal requirement applicable to appointments under state or federal law; AND
- Be approved by the plan administrator (or its delegate) in writing.

A plan will also recognize a court order appointing a person as your authorized representative. The plan administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys. Please contact the plan administrator with any questions or to qualify someone as your authorized representative.

**Qualified Medical Child Support Orders**

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree, or order (including a settlement agreement or administrative notice), issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process under state law which has the force and effect of law in that state, and meets the requirements of ERISA.

If the PepsiCo Retiree Health Care Program receives a judgment, decree, or order (including a QMCSO) requiring the plan to provide health coverage to your child or foster child who is your dependent, the plan will automatically change your benefit elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date specified in the order or, if none is specified, the date of the order. You may decrease your coverage for that child, if the court order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. You also may make other corresponding changes to your benefit elections under the plan, to the extent permitted by the Internal Revenue Code and the plan.
You may obtain a copy of PepsiCo’s procedures governing QMCSO determinations, free of charge, by contacting the plan administrator. Orders that need to be qualified should also be sent to the plan administrator. An order will not apply to the plan as discussed above unless and until the order is determined to be a QMCSO by the plan administrator.

HIPAA Privacy Notice

The HIPAA privacy rules protect your health information that is created or received by the PepsiCo Retiree Health Care Program. The retiree health plan is required to publish a HIPAA Privacy Notice that explains the HIPAA privacy rules. You were previously provided with a HIPAA Privacy Notice. The HIPAA Privacy Notice may be viewed on the web at www.netbenefits.com/pepsico. If you would like another copy of the HIPAA Privacy Notice, please contact The PepsiCo Savings and Retirement Center at 1-800-632-2014.

Information about Taxes

The plans described in this book provide benefits to eligible retirees in accordance with federal law and governing documents. Participant contributions to the health programs are intended to be made on an after-tax basis. Participant contributions on behalf of domestic partners and their dependent children (where permitted) will also be made on an after-tax basis. It is intended that the value of health and welfare plan coverage generally be non-taxable for federal income tax purposes to the extent permitted by law. The value of health and welfare plan coverage for domestic partners and their dependent children will generally be taxable unless the domestic partner and dependent children qualify as the retiree’s tax dependent. In this regard, participant contributions shall first be applied to pay for the value of coverage for domestic partners and their dependent children, any remaining participant contributions shall be applied to the participant’s coverage.

The Company does not guarantee the tax consequences of plan participation, and no one at the Company is authorized to give you tax advice. You are urged to consult with a tax advisor if you have any questions or concerns about your individual situation.

Assignment

Your rights and benefits under a medical option cannot be assigned, sold or transferred to any person, including your health care provider. At its option, your medical plan carrier may make payments directly to a health care provider, but a direct payment to a health care provider will not constitute an assignment of health benefits or rights under the plan. Any purported assignments of benefits or rights under the plan will be void and will not apply to the plan.

In addition, you may authorize your medical plan carrier, on behalf of PepsiCo, to make payments directly to participating network providers for covered services. These are assignments of payments, and not assignments of benefits. To the extent that a health care provider’s assignment of payment includes an assignment of benefits, any assignment of benefits will be void and will not apply to the plan.

Anthem BCBS and UnitedHealthcare may also make payments directly to you. Except where otherwise indicated, in the case of services provided by an out-of-network provider, Anthem BCBS will make payments directly to you, while UnitedHealthcare will make payments to the designated provider. Payments, as well as notice regarding the receipt and/or adjudication of claims, may also be made to an alternate recipient or that person’s custodial parent or authorized representative. If Anthem BCBS or UnitedHealthcare makes a payment, this will fulfill the plan’s obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as allowed by a Qualified Medical Child Support Order.

In addition to the above, any assignment of payments to a health care provider or any direct payments from a carrier to a health care provider will not be an assignment of benefits.

Payment of Claims

Once a claim is filed with your claims administrator, the claim will be processed and then to the extent payable, it will be paid based on the applicable rules and conditions that are established by your claims administrator. This means that claim payments will only be sent to the health care provider (who provided the services or supplies) or to you, as the enrolled employee, in the discretion of the claims administrator. For purposes of the medical options, this language is in addition to the assignment language above.
Reimbursing the Plan

If you or one of your dependents suffers a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your medical expenses. For this purpose, a “party” means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you or your dependents due to you or your dependent’s accident, injury or illness, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner’s/renter’s insurance, personal umbrella coverage, workers’ compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC). For purposes of any applicable coordination of benefits rules, a third party shall pay primary and the plan shall pay secondary. Any amounts paid or received from or on behalf of a third party are referred to as third party proceeds.

For example, if you are injured in a car accident, the person who caused the accident (and the person’s insurer) are the “third parties” and may be responsible for paying for your injury–related expenses. You and your dependent will be required to provide the plan or its agents information concerning any claim or lawsuit you or your dependents may have against a third party for an injury caused by that party. You or your dependent must also provide the plan or its agents any documents or information relevant to the protection of the plan’s rights of reimbursement. You may be asked to sign a repayment agreement as a condition for receiving benefits under the plan. If the agreement is not signed or you fail to cooperate with the claims administrator, you will lose your benefits related to the accident/injury/illness.

If you do not cooperate, the claims administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date. The plan is not required to enter into a reimbursement agreement. Entering into a reimbursement agreement and the terms and conditions thereof are within the sole discretion of the claims administrator (or plan administrator). Rather, in order to recover any third party proceeds, the plan may, in its sole discretion, reduce and/or offset the payment of current and future plan benefits (in whole or in part) relating to you and/or any dependent by the amount of the third party proceeds and may initiate actions to collect prior plan benefits that were paid. The plan may reduce and/or offset plan benefits from and after a designated date, even if plan benefits were not reduced and/or not offset prior to a designated date.

If you decide to sue the person who caused the accident/injury/illness, you must inform the Company. The plan may initiate legal action against you or your dependent (or anyone else holding the third party proceeds, such as a legal representative or trust) to collect the third party proceeds and may take any other actions (even if not set forth in this section) to protect the plan’s right of reimbursement.

If you receive any type of payment, reimbursement or legal recovery from the third party or an insurer (referred to as third party proceeds), you are obligated to reimburse the plan for:

- any benefits or expenses that the plan paid (and will pay in the future) for the accident/injury/illness;
- Any projected benefits or expenses the plan will pay in the future with respect to the accident/injury/illness; plus

any related legal and collection costs the plan incurred. Your obligation to reimburse the plan exists for any legal recovery that relates to an accident, injury or illness for which the plan paid benefits (including any amounts used to pay your legal fees), even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical expenses. The plan’s reimbursement shall not be reduced by any legal or attorney costs or fees you may incur in obtaining the third party proceeds, unless and only to the extent such reduction is allowed by a signed reimbursement agreement.

In addition, the right of full and unreduced reimbursement shall also apply even if the rights of the plan are separated and treated as not resolved in the judgment, settlement, verdict or insurance proceeds (but in this case the plan’s rights shall be assigned to you to the extent reimbursement is actually received out of the recovery). The plan’s right to receive any payment, reimbursement, or recovery discussed in this section supersedes and has priority over you and your dependent’s right to receive any payment, reimbursement and recovery and supersedes any applicable state laws that otherwise may directly or indirectly conflict with the provisions of this section.
In order to recover any reimbursement, payment, overpayment or excess payment to which the plan has a right of reimbursement as provided above, you and your dependents, as a condition of receiving benefits under the Plan, grant to the Plan the following rights:

- A first priority equitable lien against the third party proceeds (i.e., any settlement, verdict, insurance proceeds or other amounts) received by you or your dependents from or on behalf of any third party that may be responsible for an illness, injury or condition for which the Plan incurred expenses or paid benefits. The amount of the lien is equal to the amount of prior and future benefits to be paid by the plan.
- The right to impose a constructive trust on the third party proceeds (i.e., any settlement, verdict, insurance or other amounts) awarded, transferred or paid by or on behalf of a third party to you or your dependents and any other person or entity holding the proceeds, including a legal representative or trust.
- The right to bring any legal action or proceeding to enforce the above rights in any court of competent jurisdiction as the Plan may elect, and upon receiving benefits under the plan you and your dependents hereby submit to each jurisdiction regardless of your current or future residence.

**Right of Subrogation**

When another party is legally responsible or agrees to compensate you or your dependent for an accident, illness or injury for which the plan has paid benefits, the plan has the same rights ("right of subrogation") that you and your dependent have against the party. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you or your dependents due to you or your dependent’s injury, illness or condition, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner’s/renter’s insurance, personal umbrella coverage, workers’ compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC).

The plan’s rights of subrogation shall supersede any applicable state laws that otherwise may directly or indirect conflict with the plan’s right or subrogation.

In addition, the plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated. If you or your dependent enters into litigation or settlement with another party, the plan’s right of subrogation will still apply.

You and your dependent will need to provide the plan or its agents with any relevant information, assistance and documents that help the plan obtain its subrogation rights. Also, you could be required to sign and deliver to the plan or its agents documents to secure the plan’s subrogation rights, and you and your dependent will be required to obtain the consent of the plan or its agents before releasing any party from liability for payment. If you fail to cooperate with the claims administrator, you will lose your benefits related to the accident/injury/illness. If you do not cooperate, the claims administrator may terminate your injury-related benefits from and after a certain date, even if your injury-related benefits were approved before that date.

**Coordination of Benefits**

Coordination of benefits provisions apply to the medical and prescription drug plans only and are described in this section.

If you or a member of your family is covered by another benefit plan, there may be some duplication of benefit coverage between the PepsiCo Retiree Health Care Program, and the other benefit plan. For this purpose, “benefit plan” includes any group or individual health insurance plan or policy, any employer’s medical plan, any Medicare plan, the medical care component of any long-term care plan or policy, any group or individual automobile insurance policy or contract (including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, and no-fault automobile insurance coverage), the medical care component of a personal umbrella or first-party insurance policy, the medical care component of homeowner/renter insurance policy and any workers’ compensation or similar coverage. However, a benefit plan does not include any policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy.

Typically, the claims administrator periodically requests information regarding your coverage under another benefit plan. However, even if the claims administrator does not request this information, you are required to notify the claims administrator if you or an enrolled dependent are covered by another benefit plan listed above (or there is a change in that information.) For example, if your enrolled spouse enrolls in a benefit plan through your spouse’s employer, you are required to notify the claims administrator of this information, and any future change in that information. If you fail...
to provide information (or fail to provide any future change in that information) with respect to any other benefit plan coverage on a timely basis, your or your dependent’s PepsiCo Plan coverage may be suspended or terminated. Further if you provide false, inaccurate, or misleading information with respect to any other benefit plan coverage or potential coverage, your or your dependent’s PepsiCo plan coverage may be suspended or terminated. These rules apply regardless of whether the information is provided in connection with a claim or potential claim for benefits, enrollment in the plan or otherwise.

When you or your spouse/partner/dependent(s) are eligible for benefits under another benefit plan, the eligible expenses under the medical and prescription drug plans will be determined. One of the plans involved will pay benefits first—the primary plan—and the other plan(s) will pay benefits next—the secondary plan(s). The total benefits paid from both plans cannot be greater than the benefits under the richer plan. The following are the regular coordination of benefit rules. Special rules are discussed below with respect to special coordination situations.

The PepsiCo Retiree Health Care Program will be the primary plan on claims:

- For you, if you are not covered as an employee by another benefit plan;
- For your spouse or domestic partner, if your spouse or domestic partner is not covered as an employee or retiree by another benefit plan; and
- For your dependent children as follows: The birthdays of the parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent’s birthday in the calendar year will be considered primary coverage. (For example, if your spouse’s birthday is in January and your birthday is in May, your spouse’s benefit plan is the primary plan for your children.) If both parents have the same birthday, then the benefit plan coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other or are domestic partners.

When a child is claimed as a dependent by parents who are separated or divorced, the primary plan is the health plan of the parent who has court-ordered financial responsibility for the dependent child’s health care expenses. Otherwise, the PepsiCo plans will be secondary. When a child’s parents are separated or divorced and there is no court decree, then benefits will be determined in the following order:

- The health plan of the parent with custody of the child;
- The health plan of the spouse or the parent with custody of the child;
- The health plan of the parent not having custody of the child.

Further, when the preceding rules do not resolve which plan is primary, the plan covering the individual the longest is primary. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and the other plan’s coverage is automatically considered primary.

If You Are a Pre-Medicare Retiree

If you are a pre-Medicare retiree, your PepsiCo coverage is primary, unless you are covered as an employee by another health plan. Your spouse’s health plan or domestic partner’s health plan (through his or her employer) is considered secondary for you. The primary plan pays benefits first, up to that plan’s limits. The secondary plan will not pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the richer plan.

If You or Your Spouse/Partner Are Under Age 65 and Medicare-Eligible

You normally become eligible for Medicare when you turn age 65. However, you may become eligible for Medicare prior to age 65 as a result of disability or End Stage Renal Disease (“ESRD”). If you become eligible for Medicare as a result of disability or ESRD and you are younger than age 65, the PepsiCo plan will pay primary for 30 months from the date you became eligible for Medicare due to ESRD, and Medicare will be secondary. After the 30-month period, Medicare will become primary and the PepsiCo plan will be secondary. However, when you turn age 65 you will be eligible to enroll in coverage through OneExchange, and Coordination of Benefits will no longer apply.

If You or Your Spouse/Partner Are Age 65 or Older and Medicare-Eligible

Once you turn age 65, you will no longer receive medical coverage under the PepsiCo Retiree Health Care Program so the Coordination of Benefits rules will no longer apply.
Special Coordination Rules

Even if the PepsiCo Retiree Health Care Program is your normal primary or secondary health plan, in all events any workers’ compensation coverage, the medical or other compensation component of a personal umbrella insurance policy or contract, the medical or other compensation component of any homeowner’s/renter’s insurance policy or contract, and any group or individual automobile insurance policy or contract (including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, and no-fault automobile insurance coverage) will be the primary plan for accidents and injuries that are covered by, reimbursable by or for which compensation is otherwise payable by the applicable policy or contract. The PepsiCo Retiree Health Care Program will then pay secondary. In addition, for retirees and spouses/partners/dependents covered by no-fault automobile insurance all medical and prescription drug expenses related to an automobile accident should be submitted to the automobile carrier first. The PepsiCo Retiree Health Care Program will pay covered expenses only according to the coordination of benefit rules discussed above.

How Coordination Works

When the PepsiCo Retiree Health Care Program is primary, the plan pays benefits as if it was the only plan. After the plan pays its benefits, or denies a claim, you may file a claim for any unpaid amounts with the secondary plan.

Here is how the PepsiCo Retiree Health Care Program coordinates benefits when it pays secondary to any benefit plan, health plan, policy or contract (e.g., automobile insurance):

- The PepsiCo plan determines the benefit that would be paid if it was the only plan. This includes applying the appropriate benefit levels and all other benefit limitations.
- The amount of benefit paid by the primary plan, policy or contract (e.g., automobile insurance) is subtracted from any benefit that would be paid by the PepsiCo plan. This means that when the PepsiCo plan is secondary, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan, policy or contract.

Facility of Payment

When benefit payments that would have been made under a PepsiCo plan have been made under another plan, the PepsiCo plan has the right to pay the other plan the amount that satisfies the intent of the provision. Any payment made will be considered payment of benefits under the PepsiCo plan and, to the extent of such payments, the PepsiCo plan’s obligation to pay benefits will be satisfied.

Right of Recovery

All PepsiCo plans have the right to recover any payment made in excess of the maximum amount payable under the terms of the plan. A PepsiCo plan may recover from one or more of the following entities in an effort to make the plan whole:

- Any persons it paid or for whom payment was made
- Any insurer and any other organization
- Any entity that was thereby enriched.

The PepsiCo plans also have the right to offset future benefits/payments against any overpayment or other payment that the plan has made in excess of the maximum amount payable under the terms of the plan.

Release of Information

Certain facts are needed to apply the rules of this provision. The claims administrator has the right to decide which facts are needed. The claims administrator may get the needed facts from or give them to any other organization or person. The claims administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the claims administrator will determine the information necessary to operate this provision.

Other Administrative Facts

The chart below shows (i) the formal name of each plan; (ii) the insurer, and/or claims administrator; (iii) the plan number; and (iv) the last day of the plan year. In various places throughout this SPD, we sometimes refer to a “plan.” Any reference to a plan in this SPD, shall mean the PepsiCo Retiree Health Care Program, the PepsiCo Group Insurance Program, or both as the context requires. Any reference to a claim(s) administrator is a reference to the applicable claims administrator related to the applicable benefit as set forth below.
<table>
<thead>
<tr>
<th>Type of Plan</th>
<th>Type of Benefit(s)</th>
<th>Insurer or Claims Administrator</th>
<th>Plan Name</th>
<th>Plan Number</th>
<th>End of Plan Year</th>
</tr>
</thead>
</table>
| Health Plan | ▶ Basic Medical, Safety Net and BlueCare HMO Options | UnitedHealthcare  
P.O. Box 740800  
Atlanta, GA 30374-0800  
Or  
Anthem Blue Cross and Blue Shield  
P.O. Box 105187  
Atlanta, GA 30348-5187  
Or  
BlueCare HMO  
BlueCross BlueShield of Florida  
P.O. Box 45277  
Jacksonville, FL 32231 | PepsiCo Retiree Health Care Program | 726 | Dec. 31 |
|             | ▶ Prescription Drug Benefits | Express Scripts.  
P.O. Box 14711  
Lexington, KY 40512 | | | |
| Welfare Plan | Basic Life Insurance | Securian Life  
400 Robert Street North  
Saint Paul, MN 55101 | ▶ PepsiCo Group Insurance Program  
▶ Policy Number is 34362 | 600 | Dec. 31 |

**COBRA Continuation Coverage**

**Your Rights under COBRA Continuation Coverage**

The health care program gives you and your spouse/partner/dependents the option to extend your health care coverage in certain instances when coverage under the program would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Domestic partners and their eligible dependent children are not eligible for COBRA coverage unless they qualify as the retiree's tax dependent. In place of COBRA, the Company offers domestic partners and their eligible dependent children continuation coverage, which generally provides for similar coverage as under COBRA. This coverage (referred to throughout this SPD as "continuation coverage") will generally be administered in the same manner as COBRA coverage unless specifically noted otherwise. Domestic partner continuation coverage is not COBRA coverage and is not required by law. The Company reserves the right to amend, modify, reduce, discontinue or terminate continuation coverage at any time.

**You may have other options available to you when you lose health coverage.** Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family thought the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax-credit through the Marketplace. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov) or by calling 1-800-318-2596.
COBRA Continuation Coverage Participation

If one of the circumstances listed in the COBRA Continuation Coverage Period Chart causes you or a spouse/partner/dependent to lose health coverage, you may continue retiree medical, mental health and prescription drug coverage - if you pay the entire cost of coverage, plus 2% to cover administrative expenses.

COBRA continuation coverage is available for a maximum of 36 months, depending on the circumstances outlined in the COBRA Continuation Coverage Period Chart. The maximum continuation period if multiple circumstances should occur is a total of 36 months.

It is the responsibility of you or your spouse, domestic partner, dependent child or dependent child of your domestic partner (each a "covered dependent") who would lose coverage to contact The PepsiCo Savings and Retirement Center at Fidelity (1-800-632-2014) within 60 days of the event to request an application to continue participation due to a qualifying event such as divorce, legal separation, termination of domestic partnership, or your child or your domestic partner's child losing eligibility for coverage. If you do not contact Fidelity within the 60-day time period, your COBRA continuation coverage rights will be lost.

The Company is responsible for notifying the plan administrator of certain qualifying events that result in your loss of coverage such as retirement, Medicare eligibility or death.

You or your covered dependents must pay the full group rate for continued coverage, plus 2% for administrative expenses.

If COBRA continuation coverage is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, coverage and cost will be modified as the Company makes regular changes to its benefit plans, and you will be given the opportunity to make a new election during annual enrollment or when you have a qualifying status change. Any newly eligible dependents you may have may be enrolled under the same rules that apply to retirees.

You or your covered dependents have 60 days from the COBRA continuation coverage election notice date to elect participation under COBRA continuation coverage. Once you make your election, you will have 45 days to pay the initial premium payment. COBRA continuation coverage will be effective the day after the qualifying event.
The COBRA Continuation Coverage Period Chart

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Maximum Continuation Period for Each Qualified Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree / Employee</td>
</tr>
<tr>
<td>Employee Retires*</td>
<td>18 months*</td>
</tr>
<tr>
<td>Retiree-participant dies</td>
<td>N/A</td>
</tr>
<tr>
<td>Retiree-participant and spouse become legally separated or divorced, or domestic partnership ends</td>
<td>N/A</td>
</tr>
<tr>
<td>Child no longer qualifies as a dependent</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* This applies to your active employee health coverage in effect when you retire. If you do not elect retiree medical at your retirement date, you may continue your active employee medical, dental and vision coverage and health care reimbursement account coverage through COBRA. Alternatively, if you elect retiree medical at your retirement, you will automatically waive COBRA continuation coverage for active employee medical, but you may continue your active employee dental and vision coverage and health care reimbursement account coverage through COBRA.

** Spouse/partner and dependent coverage does not terminate as a result of the death of the retiree-participant.

In some cases, filing a proceeding in bankruptcy under Title II of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to PepsiCo, Inc., and that bankruptcy results in the loss of coverage of any retiree covered under the plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree-participant's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of coverage under the plan. For more information, please contact the plan administrator.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate before the end of the indicated time period if:

- After electing COBRA continuation coverage, you or your covered dependent becomes covered under another group health care plan (provided the plan does not have pre-existing condition exclusions affecting the covered individuals)
- You or certain of your covered dependents become entitled to Medicare after electing COBRA continuation coverage
- The first required premium is not paid within 45 days, or any subsequent premium is not paid within 30 days of the due date
- If all health plans for retirees are terminated by PepsiCo.

Contacting PepsiCo

If you have any questions about COBRA continuation coverage or the application of the law, please contact the COBRA Administrator at The PepsiCo Savings and Retirement Center at Fidelity at 1-800-632-2014. For more information about your rights under COBRA you may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Address and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.
Keep Us Informed of Address Changes

In order to protect your and your family’s rights, you should keep The PepsiCo Savings and Retirement Center at Fidelity informed of any changes in your and your family members’ addresses. You should also keep a copy for your records of any notices you send to The PepsiCo Savings and Retirement Center at Fidelity.

Plan Termination and Amendment

PepsiCo, Inc., reserves the right to discontinue or terminate any plan or program, to modify the plans or programs to provide different cost–sharing between the Company and participants, or to reduce, amend, or modify the plans or programs in any respect. This may be done at any time and without prior notice. For example, PepsiCo reserves the right to amend or terminate covered expenses, benefit copays, and lifetime maximums, and reserves the right to amend the plan to require or increase participant contributions. PepsiCo also reserves the right to amend the plan to implement any cost control measures that it may deem advisable. Any such amendment, modification or termination shall be made by the Company or by any one with authority or who has been delegated the authority to amend, modify or terminate the plan.

Benefits for claims occurring after the effective date of a plan modification, amendment or termination are payable in accordance with the revised plan documents.

All statements in this book and all representations by the Company or its personnel are subject to this right of termination and amendment. This right applies without limitation, even after an individual’s circumstances have changed by retirement, death, disability or otherwise.

Plan benefits do not become vested.

In the event of the dissolution, merger, consolidation or reorganization of PepsiCo, the plan will terminate unless the plan is continued by a successor to PepsiCo.

Your Rights under ERISA

The following statement is required by federal law and regulation. As a participant in the benefit plans described in this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans 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 plans, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The plan administrator may make a reasonable charge for the copies.

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Receive a summary of the plans’ annual financial reports. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Pension Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. This statement is provided free of charge.

**Continue Group Health Plan Coverage**

You may be entitled to continue health care coverage for yourself, your spouse/partner, or your dependents if there is a loss of coverage under the PepsiCo Retiree Health Care Program as a result of a qualifying event. You or your spouse/partner/dependents may have to pay for such coverage. Review this summary plan description and the documents governing the PepsiCo Retiree Health Care Program on the rules governing your COBRA continuation coverage rights.

For more information, refer to COBRA Continuation Coverage.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are 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 solely in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a plan 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 the plan documents or the latest annual report from the plan and do not receive them within 30 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court.

If it should happen that a plan fiduciary misuses plan money, or if you are 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 are 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 the court finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about a 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 area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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.

**Note:** Any individual Medicare supplemental, Medicare Advantage or Medicare Part D, dental or vision plans or policies purchased through OneExchange are not ERISA benefits and are not part of the PepsiCo Retiree Health Care Program. Only the RRA is part of the program. To obtain information concerning the operation, procedures, eligibility, coverage, terms and conditions of any individual Medicare supplemental, Medicare Advantage or Medicare Part D, dental or vision plans or policies, you must contact the insurance carrier of those individual plans or policies.