This is only a summary. If you want more detail about your coverage and costs, you can get the complete summary plan description on the Total Rewards website via the link on www.mypepsico.com or by calling 1-866-473-6763. Remember, your eligibility and benefits will only be determined in accordance with and subject to the applicable summary plan description.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network - $1,300 Individual/$2,600 Family; Out of Network - $2,000 Individual/$4,000 Family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your summary plan description to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In Network - $4,500 Individual/$9,000 Family; Out of Network - $8,000 Individual/$16,000 Family. Includes deductible.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, charges above R&C limits, expenses this plan doesn't cover and penalties for precertification.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.Anthem.com or call 1-877-224-0030.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your summary plan description for additional information about **excluded services**.

Questions: Call 1-877-224-0030 or visit us at www.Anthem.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-877-224-0030 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service, after you meet the deductible. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 and you have met your deductible, your **coinsurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**. Network providers charge negotiated fees, which are normally below or equal to the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost In Network	Your Cost Out of Network	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Other practitioner office visit	20% coinsurance after deductible	50% coinsurance after deductible	Chiropractic limited to 20 visits/year.
	Preventive care/screening/ immunization	100% covered	Not covered	Limited to federal preventive care guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	20% of discounted cost after deductible	20% of retail cost after deductible	Retail (up to 30 days supply); Mail order up to (90 days supply). - Your retail cost increases to 100% of the discounted cost for all maintenance medication after the original prescription and one refill at retail. Mail order remains the same.
	Preferred brand drugs	20% of discounted cost after deductible	20% of retail cost after deductible	
	Non-preferred brand drugs	20% of discounted cost after deductible	20% of retail cost after deductible	

Common Medical Event	Services You May Need	Your Cost In Network	Your Cost Out of Network	Limitations & Exceptions
1-888-PEPSI-RX or www.express-scripts.com/pepsico.	Elective drugs	20% of discounted cost after deductible	20% of retail cost after deductible	- If you buy a brand-name drug, when a generic is available, the plan will pay based on the generic level and you will pay the difference. - Mandatory quantity limits and step therapy limits apply. - Surcharges and extra costs do not count towards your deductible or out of pocket maximum. - Access-only drugs do not count towards your deductible or out of pocket maximum. - Preventive care drugs (determined based on IRS rules) are not subject to the annual deductible.
	Access only drugs	100% of discounted cost after deductible	100% of retail cost after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible; 50% coinsurance after deductible if not a true emergency	20% coinsurance after deductible; 50% coinsurance after deductible if not a true emergency	——————none——————
	Emergency medical transportation	20% coinsurance after deductible; 50% coinsurance after deductible if not a true emergency	20% coinsurance after deductible; 50% coinsurance after deductible if not a true emergency	——————none——————

Common Medical Event	Services You May Need	Your Cost In Network	Your Cost Out of Network	Limitations & Exceptions
	Urgent care	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required.
	Physician/surgeon fee	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required.
	Substance use disorder outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Substance use disorder inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required outside of federal minimum stays.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 200 visits/year. Preauthorization required.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Physical, occupational, speech and vision therapy limited to 100 visits/year for all therapies combined in and out-of-network.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Physical, occupational, speech and vision therapy limited to 100 visits/year for all therapies combined in and out-of-network.

Common Medical Event	Services You May Need	Your Cost In Network	Your Cost Out of Network	Limitations & Exceptions
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 120 visits/episode, combined in and out-of-network. Preauthorization required.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for purchase or rental over $1,000.
	Hospice service	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required.
If your child needs dental or eye care	Eye exam	Covered	Not covered	Covered as part of preventive care. Not a complete eye exam.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your summary plan description for other excluded services.)

- Cosmetic surgery
- Long-term care
- Non-emergency dental care
- Over the counter drugs or supplies
- Routine dental care
- Routine eye care
- Routine foot care
- Services and supplies above the allowed amount or above UCR
- Services and supplies not pre-authorized (if required)
- Services and supplies paid by another plan under the plan's coordination of benefits rules
- Services and supplies that are experimental / investigational
- Services and supplies that are not medically necessary

Other Covered Services (This isn't a complete list. Check your summary plan description for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (subject to limits)
- Chiropractic care (up to 20 visits)
- Hearing aids (limitations apply)
- Infertility treatment ($10,000 lifetime limit)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-224-0030. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-224-0030.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-473-6763.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-473-6763.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-473-6763.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-473-6763.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.
These examples assume family coverage, so the family deductible must be met before the plan pays any benefits.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,850
- **Patient pays** $3,690

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,600
Copays	$0
Coinsurance	$940
Limits or exclusions	$150
Total	**$3,690**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-888-383-7971.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,190
- **Patient pays** $3,210

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,600
Copays	$0
Coinsurance	$530
Limits or exclusions	$80
Total	**$3,210**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-888-383-7971. .

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- The examples are based on the family coverage tier. The amount you pay may be different for other coverage tiers.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **medical pay check contribution** you pay. Generally, the lower your **medical pay check contribution**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs) that help you pay out-of-pocket expenses.