This is only a summary. If you want more detail about your coverage and costs, you can get the complete Summary Plan Description at http://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?	$0	The EAP is an employee assistance and counseling program for which no deductible applies.
Are there other deductibles for specific services?	No	You do not have to meet any deductibles for EAP services.
Is there an out–of–pocket limit on my expenses?	No	There are no charges for EAP services obtained from a network EAP provider.
What is not included in the out–of–pocket limit?	There is no out-of-pocket limit.	Not applicable because there are no out-of-pocket expenses.
Is there an overall annual limit on what the plan pays?	Yes	The EAP service provides 6 in-person counseling sessions per problem per year with a network provider. The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services.
Does this plan use a network of providers?	Yes, for a list of network providers call Optum at 800-223-7486	If you use an in-network EAP provider, this plan will pay for 6 in-person counseling sessions with a network provider per problem per year. Services which are not obtained from an in-network provider will not be covered by the plan. 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	The EAP does not cover specialists. If the EAP provider determines that you need treatment from a specialist, the provider will refer you to your medical 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 the applicable Summary Plan Description for additional information about excluded services.

- 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. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on 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.)
- Services obtained from an out-of-network provider who is not authorized by the EAP will not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	none
	Specialist visit	Not covered	Not covered	none
	Other health care provider office visit – Brief Counseling Sessions	$0	Not covered	Limited to 6 in-person counseling sessions/incident. Unlimited phone/web video consultations.
	Preventive care/screening/immunization	Not covered	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	none
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	none
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-888-PEPSI-RX.	Generic drugs	Not covered	Not covered	none
	Preferred brand drugs	Not covered	Not covered	none
	Non-preferred brand drugs	Not covered	Not covered	none
	Specialty drugs	Not covered	Not covered	none
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	none

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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/pdf/sbcuniformglossary.pdf or call 1-866-473-6763 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
surgery	Physician/surgeon fees	Not covered	Not covered	none
If you need immediate medical attention	Emergency room services	Not covered	Not covered	none
	Emergency medical transportation	Not covered	Not covered	none
	Urgent care	Not covered	Not covered	none
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	none
	Physician/surgeon fee	Not covered	Not covered	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	None. See, other health care provider visits on prior page.
	Mental/Behavioral health inpatient services	Not covered	Not covered	none
	Substance use disorder outpatient services	Not covered	Not covered	None. See, other health care provider visits on prior page.
	Substance use disorder inpatient services	Not covered	Not covered	none
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	none
	Delivery and all inpatient services	Not covered	Not covered	none
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	none
	Rehabilitation services	Not covered	Not covered	none
	Habilitation services	Not covered	Not covered	none
	Skilled nursing care	Not covered	Not covered	none
	Durable medical equipment	Not covered	Not covered	none
	Hospice service	Not covered	Not covered	none
If your child needs dental or eye care	Eye exam	Not covered	Not covered	none
	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 applicable Summary Plan Description for other excluded services.) Remember: This Plan is an EAP and it only covers counseling sessions and the items listed below in Other Covered Services. If you need coverage for medical-related benefits, refer to your medical option SBC.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Services and supplies rendered by an out-of-network provider (unless authorized)

Other Covered Services (This isn't a complete list. Check your Summary Plan Description for other covered services and your costs for these services.)

- Other work/life services as set forth in the Summary Plan Description, or by calling Optum at 1-800-223-7486

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 1-866-473-6763. 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.

Further information about your continuation coverage rights can be found in the applicable Summary Plan Description.

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: 1-866-473-6763. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Further information about your appeal rights can be found in the applicable Summary Plan Description.

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 not provide minimum essential coverage. However, this plan is not subject to the minimum essential coverage requirement.

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 not meet the minimum value standard for the benefits it provides. However, this standard is not applicable to this plan.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-387-2770.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-387-2770.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-387-2770.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-387-2770.

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.

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 $0
- Patient pays $7,540 This condition is not covered, so patient pays 100%

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	-
Copays	-
Coinsurance	-
Limits or exclusions	-
Total	$7,540

Note: This Plan is an EAP and does not cover this condition, so the patient pays 100%. If you need medical care, you should enroll in a medical option..

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

- Amount owed to providers: $5,400
- Plan pays $0
- Patient pays $5,400 This condition is not covered, so patient pays 100%

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	-
Copays	-
Coinsurance	-
Limits or exclusions	-
Total	$5,400

Note: This Plan is an EAP and does not cover this condition, so the patient pays 100%. If you need medical care, you should enroll in a medical option..

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- 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 premium you pay. Generally, the lower your premium, 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), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.