April 2019

Important Notice Regarding Changes to PepsiCo Health and Insurance Benefit Programs

Summary of Material Modifications

This Notice is a summary of material modifications ("SMM") to the PepsiCo Employee Health Care Program (plan number 725) and the PepsiCo Disability Plan (plan number 630) (referred to singularly and collectively, as applicable, as the "plan"). This SMM amends the summary plan description ("SPD") for each plan, also known as the Health & Insurance Benefit Plan Details, as well as your 2019 Annual Enrollment materials and any other documentation that the plan administrator determines applies to you. This SMM describes only material changes to the plan and SPD. This SMM should be read together with your SPD. You should keep this SMM together with your SPD and other plan documentation. If you need an additional copy of an SPD, you may obtain a copy online at www.mypepsico.com or you may call the HR Service Center at 1-866-473-6763.

All changes are effective January 1, 2019, unless otherwise noted. Please read this Notice carefully as not all of the changes described may apply to you.

Este folleto contiene un resumen en Inglés de sus derechos y beneficios bajo los planes de beneficios de la Compañía. Si usted tiene dificultad entendiendo cualquier parte de este folleto, consulte El Centro de atencion HR Service Center al **1-866-473-6763** para recibir ayuda con beneficios de seguro y seguro de salud.

Benefit Basics

The following language replaces the existing language in the "Domestic Partner and Domestic Partner Child Coverage" section.

Coverage of an Eligible Domestic Partner

Same-sex and opposite-sex domestic partners are eligible for medical, dental, vision, optional life and accident insurance coverage, if you and your domestic partner (a) are parties to a civil union that is valid in the jurisdiction in which it was entered into; or (b) meet all of the following requirements–

- Neither you nor your domestic partner is married to, or in a domestic partnership with, another person;
- Your domestic partner is at least 18 years of age;
- You and your domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in the state(s) or country(ies) in which you legally reside;
- You and your domestic partner share a committed, exclusive relationship;
- You and your domestic partner share a residence; and
- You and your domestic partner are financially interdependent.

In addition, you must have provided such documentation as the Plan Administrator may require as verification of the above.

Coverage of an Eligible Domestic Partner's Child

Once you have entered into a domestic partner relationship, a dependent child of your eligible domestic partner is also eligible for medical, dental, vision, dependent life and accident insurance coverage. A biological or adopted child of your domestic partner, child for whom your domestic partner is the legal guardian, or foster child of your domestic partner may be covered up to age 26, provided the child also meets the plan's child eligibility requirements. See the Child Coverage section of the SPD for the requirements to be an eligible child.

Taxation of Coverage for Eligible Domestic Partner or Eligible Domestic Partner's Child

The income tax treatment of your domestic partner's and his/her dependent children's coverage will be based on whether you have completed a valid Certification of Domestic Partner Tax Dependent Status (for United States citizens and residents only). Certifications can be obtained by contacting the HR Service Center. To the extent that you have completed and returned a valid certification to the HR Service Center, you can pay for coverage for your domestic partner and his/her dependent children on a pre-tax basis and you will not be imputed additional income. In this situation, reimbursements from your HCRA and DCRA are also available for your domestic partner's and his/her dependent children's eligible expenses. You must notify the HR Service Center, if/when the requirements noted on the certification are no longer correct.

If you have not completed and returned a valid certification, the income tax treatment of your domestic partner's coverage is different from that of other dependents, as follows:

- Your premiums for domestic partner coverage will be paid on an after-tax basis. This is accomplished by deducting employee contributions for your domestic partner's coverage on a pre-tax basis and then imputing this amount back to your W-2 wages. The result is the same as if the contributions were deducted from your pay on an after-tax basis.
- The Company's share of the cost of medical coverage for your partner is taxable to you as imputed income. (Imputed income is an amount that is reported on your W-2 to reflect the value of taxable non-cash benefits you receive from the Company.)
- Reimbursements from your HCRA and DCRA are not available for your domestic partner's (and his/her dependent children's) expenses.

The income tax treatment of your domestic partner's dependent children will also be the same as your domestic partner noted above.

The rules set forth above apply to United States citizens and residents. If you reside outside the United States, special rules may exist regarding the tax treatment of your domestic partner's (and his/her dependent children's) benefits in the country in which you live. Please contact your local Human Resources representative for additional information.

Qualified Status Changes
The following new qualified status changes are added to the list of qualified status changes in the "Qualified Status Changes" section.

- Formation and termination of an eligible domestic partnership.
- Your eligible domestic partner gaining a new dependent child.
- Your eligible domestic partner or eligible domestic partner's child gains or loses medical coverage.
- Your eligible domestic partner's child becomes ineligible for coverage.

Medical Options

This portion of the SMM applies to the Core Plus, Healthy Advantage, Blue Advantage Iowa, BlueCare HMO of Florida, Northeast Hourly PPO, Medford Core, and the Cigna Global Health Benefits Medical Options (collectively, the "Medical Options").

Limited Authorization of Payments and Health Care Provider Agreements

The following language replaces the existing language in the "Limited Authorization of Payments and Health Care Provider Agreements" section.

To the extent allowed by the claims administrator, you may authorize your claims administrator to make payments directly to a health care provider for covered services. Further, even without such authorization, a claims administrator may make direct payments to a health care provider for covered services according to the claims administrator's rules and procedures at the applicable time. Authorization of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though a claims administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a plan participant or plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

In addition, sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider but that do not include the plan administrator or the Company) are not binding on and will have no legal effect whatsoever on any terms, conditions or requirements of the plan or any claims administrator. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed for anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

No Assignment of Rights and Benefits
The following language replaces the existing language in the "No Assignment of Rights and Benefits" section.

Your rights and benefits under a medical option are personal to you and your enrolled family members and they cannot be assigned, sold or transferred (in whole or in part) to any person, including your health care provider. For this purpose, your plan rights and benefits include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal and any other plan rights and benefits, whether actual or potential. Any purported assignments of rights and/or benefits under the plan will be void and will not apply to the plan. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative. See the Authorized Representative provisions in the Administrative Information section for more information.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed to anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Reimbursement Accounts: Health Reimbursement Account (HRA)

The HRA described in the SPD is no longer available to accept contributions, effective January 1, 2019. For eligible employees with an existing HRA, reimbursement of eligible expenses must be requested by December 15, 2019; any unused amounts remaining in an HRA after such date will be forfeited.

Short Term Disability (STD)

Rehabilitation Programs
The following language replaces similar language in the "Rehabilitation Program" section.

If your recovery has progressed far enough that you're physically able to do some work, but not yet ready to resume your job on a full-time basis, the Company may provide you with a transition period through a rehabilitation program. The program's goal is to gradually increase your work hours until you are ready to go back to your regular job full-time. If you are a candidate for this program, you may be able to return to active work a few hours a day before the end of your certified disability absence. The PLCC will work with your doctor, nurse practitioner or physician's assistant and your supervisor to design a program that meets your abilities and job requirements.

A rehabilitation program may consist of active work –

- On a modified and/or transitional duty basis,
- On a part-time basis, or
- With or without accommodation.

Active work performed during a rehabilitation program may be paid at a different rate or level of pay received by you prior to your disability period. Your STD payments will be reduced only by 50 percent of your rehabilitation income, not on a dollar-for-dollar basis. See the Returning to Work section of the SPD for additional information.

Reduction in Benefits
The following language replaces similar language in the "Reduction in Benefits" section only with respect to the one provision set forth below. All other provisions remain the same.

Your STD benefits will be reduced for –

- Retirement or similar benefits from a Company-sponsored retirement plan, including whether the benefits are paid in whole or in part in a lump sum or annuity and including benefits paid to you or paid on your behalf (such as benefits that are rolled over to an individual retirement account, another qualified retirement plan or similar arrangement).

Long Term Disability (LTD)

Appropriate Care and Treatment
The following language replaces similar language in the "Appropriate Care and Treatment" section.

To receive LTD benefits, you must visit with a doctor as often as is required to effectively manage and treat your disabling condition. A doctor means an individual who: (a) is licensed and practicing within the scope of his or her license; and (b) is a medical doctor (M.D.), a doctor of osteopathy (D.O.), podiatrist or has a doctoral degree in psychology (Ph.D. or Psy.D.) whose primary practice is treating patients and who coordinates with a medical doctor or doctor of osteopathy if prescribing medications is part of appropriate treatment, a nurse practitioner (NP) or physician's assistant (PA), subject to any additional rules or limitations determined by the claims administrator. A doctor does not include your spouse, any individual related to you through marriage or blood or any individual living in your household.

Reduction in Benefits
The following language replaces similar language in the "Reduction in Benefits" section only with respect to the one provision set forth below. All other provisions remain the same.

Your LTD benefits will be reduced for –

- Retirement or similar benefits from a Company-sponsored retirement plan, including whether the benefits are paid in whole or in part in a lump sum or annuity and including benefits paid to you or paid on your behalf (such as benefits that are rolled over to an individual retirement account, another qualified retirement plan or similar arrangement).

This SMM must be read together with the SPD and your 2019 Annual Enrollment materials. This SMM describes only material changes and provides only material clarifications to the SPD and your 2019 Annual Enrollment materials regarding the rules applicable to and the benefits provided by the applicable plan. Except to the extent a provision in the SPD is revised in this SMM, the SPD applies. Terms and phrases not defined in this SMM have the meanings given to them in the SPD. References in this SMM to "you" or "your" refer to the applicable person covered under the applicable plan, including the employee, spouse, dependent children and their authorized representatives. If you have any questions regarding this SMM, please contact the HR Service Center.

This SMM, the SPD, and the www.mypepsico.com website are intended to provide a summary of some of the provisions of the plan, but are not intended to expand rights provided under the terms of the official Plan documents. Nothing in this SMM makes you eligible for a plan, or eligible for a specific level or amount of benefits, unless the official documents provide for such eligibility or benefits. Your eligibility and benefits are determined in accordance with and subject to the official plan documents. You may request a copy of the official plan documents by contacting the HR Service Center. No benefits will be paid or provided unless and until the plan administrator, or its delegate, determines, in its sole discretion, that you are entitled to such benefits. While PepsiCo, Inc. (the plan sponsor) currently intends to continue the plan, PepsiCo reserves the right to amend, modify or terminate the plan at any time. Nothing in this SMM should be construed as a promise or guarantee of future benefits or of any level or amount of benefits, or as a promise or guarantee of employment or future employment for any duration.

If you have questions about these changes, please call the HR Service Center toll-free at 1-866-473-6763.

Reminders About PepsiCo Commuter Benefit Program

This Section of the Notice is not an update to the Health & Insurance Benefit Plan Details. It provides some reminders about the PepsiCo Commuter Benefit Program, a program that can save you money on work-related commuting expenses. The program allows you to set aside money from your pay for eligible transit and parking costs for commuting to and from work. Federal tax law limits the monthly amount you can set aside on a pre-tax basis ($265 in 2019, subject to adjustment each year); if you elect a larger amount, the excess will be set aside on an after-tax basis.

Details of the Commuter Benefit Program can be found at www.mypepsico.com (by selecting the "Reimbursement Accounts" tab on the *myHR* webpage). When participating in the program, please keep in mind the following, as required by federal tax law:

- Participation in the Commuter Benefit Program terminates when your active employment terminates (your "Termination Date"). If you are eligible for a severance program, your Termination Date for purposes of the Commuter Benefit Program is your "effective date" defined in your severance program SPD.
- New elections under the Commuter Benefit Program cannot be made after your Termination Date, and any elections in effect on your Termination Date will be cancelled.
- Pre-tax amounts set aside under the Commuter Benefit Program cannot be refunded at any time—even if your employment terminates with unused funds remaining in your account. For example, this means that if you become eligible for a severance program, any unused pre-tax funds in your account will be forfeited on your severance program effective date.

January 2018

Important Notice Regarding Changes to PepsiCo Health and Insurance Benefit Programs

Summary of Material Modifications

This Notice is a summary of material modifications ("SMM") to the PepsiCo Employee Health Care Program, Plan Number 725, the PepsiCo Disability Plan, Plan Number 630, the PepsiCo Group Insurance Program, Plan Number 600, and any other health and welfare Plan noted herein (referred to singularly and collectively, as applicable, as the "plan"). This SMM amends the plan's Summary Plan Descriptions ("SPD"), otherwise referred to as the Health and Insurance Benefits Book, your 2018 Annual Enrollment materials (including the What's New in 2018 brochure), and any other plan documentation that the Plan Administrator determines is applicable to you. This Notice describes only material changes in the plan and the SPD. You should keep this SMM together with your SPD and other plan documentation. If you need an additional copy of an SPD, you may obtain a copy online at www.mypepsico.com or you may call the HR Service Center at 1-866-473-6763.

All changes are effective January 1, 2018, unless otherwise noted. Please read this Notice carefully as not all of the changes described below will apply to you.

Este folleto contiene un resumen en Inglés de sus derechos y beneficios bajo los Planes de beneficios de la Compañía. Si usted tiene dificultad entendiendo cualquier parte de este folleto, consulte El Centro de atencion HR Service Center al **1-866-473-6763** para recibir ayuda con beneficios de seguro y seguro de salud.

Medical Options

Except as set forth below, the provisions in this section apply to the Core Plus, Healthy Advantage, Blue Advantage Iowa, BlueCare HMO of Florida, Northeast Hourly PPO, Medford Core, and the Cigna Global Health Benefits Medical Options (collectively, the "Medical Options").

Healthy Living Programs and Healthy Living Rewards

The following language replaces the existing language in the health living program and rewards sections –

As discussed in the 2018 Annual Enrollment materials, the Company is enhancing the Healthy Living Program. As part of these enhancements, the program will include a flexible points-based approach for earning Healthy Living rewards. The enhanced program also includes interactive apps from Jiff, our new digital wellness partner. This new resource will help you choose activities that are right for you to lead a healthier life. As you choose to participate in these activities you will earn points that you can redeem for gift cards, contributions to your health savings account and more. More information is available on the myHealthHub.pepsico.com site and the Winter 2018 edition of *Insight.*

As you review the activities and earn your points, if you are pregnant, disabled or have been advised by a physician that it is medically inadvisable for you to engage in one or more points-

based activities, you may qualify for an opportunity to earn certain activity points by different means. Call Jiff at 844-707-3701 and a representative will work with you to find alternatives.

The data and personal information you share with any of the plan's healthy living program partners is protected by HIPAA and other Federal privacy laws. Based on those laws, your data and information collected as part of the healthy living programs may be shared with the plan and its applicable third party administrators and vendors for purposes of plan administration and other allowable purposes. Data and personal information collected as part of the healthy living programs are subject to the plan's Notice of Privacy Practices and the ADA Notice regarding Wellness Programs. You can obtain a copy of the Notice online at www.mypepsico.com or you may call the HR Service Center at 1-866-473-6763.

Reimbursing the Plan
The following is added at the end of the Reimbursing the Plan section –

Third party proceeds which are held directly or indirectly by you or a dependent are intangible assets of the plan, and are held by you or a dependent in a constructive trust for the benefit of the plan. Any participant or dependent who directly or indirectly holds or exercises any control over third party proceeds is an ERISA fiduciary with respect to the third party proceeds and must hold the third party proceeds for the exclusive benefit of the plan. A legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of third party proceeds and not with respect to his or her legal representation of you and/or a dependent.

The plan's right of reimbursement shall apply without regard to any equitable defenses that a third party, participant and/or dependent asserts or may be entitled to assert, including any defense of unjust enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of reimbursement. Neither the make whole doctrine nor the common fund doctrine apply to the plan.

Prescription Drugs

Co-Pay Assistance Programs
If you are a participant in the Core Plus, Healthy Advantage, and BlueCare HMO of Florida medical options you may be eligible for Co-Pay Assistance Programs ("Co-Pay Assist Program"). Co-Pay Assist Programs are third-party programs that may help you pay for certain high cost medications. These medications are normally specialty medications issued through Accredo, Express Scripts' specialty pharmacy. If applicable, Co-Pay Assist Programs pay all or a substantial portion of your cost for a prescribed medication. Individuals should contact Express Scripts at 888-737-7479 with questions regarding whether a Co-Pay Assist Program applies to a specific prescribed medication.

The amount paid by a Co-Pay Assist Program is not an amount that is paid by you and you are not required to repay that amount. For this reason, such amounts are not credited to your deductible or out of pocket maximum. However, the actual amount that you do pay for the medication (if any) after the Co-Pay Assist Program payment has been applied to your cost, is credited to your deductible and out of maximum, because like any other co-pay, this amount is actually paid by you.

Please note that the 2018 Healthy Advantage plan design changes introducing per prescription maximums are intended to reduce the impact of high cost medications on your out of pocket cost. The per prescription cost maximums, per IRS guidelines, can only apply after you have met your deductible.

Short Term Disability (STD) and Long Term Disability (LTD)

STD and LTD Benefit Amounts

The following additional language is added at the end of the STD and LTD Benefit Amount sections –

In all cases once your eligible pay or eligible weekly pay (as applicable) is determined for purposes of calculating your STD or LTD benefits, the amount of eligible pay or eligible weekly pay (as applicable) will remain the same and will not change for your entire period of your disability.

In addition, your STD or LTD benefit percentage is determined as of your last active day at work for purposes of calculating your STD or LTD benefits, and once it is determined, the benefit percentage will remain the same and will not change for the entire period of your disability.

Reduction in Benefits

The following language replaces similar language in the reduction in benefits section only with respect to the two provisions set forth below –

Your STD and LTD benefits will be reduced for –

- Income (other than rehabilitation income for STD or other than 50% of rehabilitation income for LTD) received from any employer if such income is considered to be wages or income in lieu of wages, and income from any occupation for pay or profit, including self-employment; and
- Retirement or similar benefits from a Company-sponsored retirement plan, including whether the benefits are paid in whole or in part in a lump sum or annuity and including whether you actually receive the benefits or the benefits are transferred to an individual retirement account or similar arrangement.

Right of Reimbursement

The following is added at the end of both the STD and LTD Right of Reimbursement sections –

Third party proceeds which are held directly or indirectly by you are intangible assets of the plan, and are held by you in a constructive trust for the benefit of the plan. Any participant who directly or indirectly holds or exercises any control over third party proceeds is an ERISA fiduciary with respect to the third party proceeds and must hold the third party proceeds for the exclusive benefit of the plan. A legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of third party proceeds and not with respect to his or her legal representation of you.

The plan's right of reimbursement shall apply without regard to any equitable defenses that a third party, participant and/or dependent asserts or may be entitled to assert, including any defense of unjust enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of reimbursement. Neither the make whole doctrine nor the common fund doctrine apply to the plan.

Long Term Disability (LTD)

What is Not Covered

At the end of this section the following additional language is added –

A participant shall not be eligible for LTD benefits for a disability, unless the participant filed a claim for short term disability benefits for the same disability under the PepsiCo short term disability program and he/she was approved for such short term disability benefits. The prior sentence applies regardless of whether the participant actually received short term disability benefits for such disability under the PepsiCo short term disability program.

Maximum Benefits for Certain Conditions
The following language replaces the existing language in the LTD Benefit section –

Benefits for a total disability are limited to 24 months (including the period you received STD benefits) if the total disability is caused by or contributed to by:

- A mental or nervous condition
- Substance abuse, chronic alcoholism or the use of narcotics, barbiturates, hallucinogenic substances or other controlled substances
- Attention deficit disorder (ADD)
- Chronic fatigue syndrome
- Epstein Barr Virus
- Infectious mononucleosis
- Fibromyalgia

If the above conditions apply, your LTD benefits and your eligibility to participate in the LTD program will end 24 months after the first date your disability began.

Administrative Information

Internal Benefit Claim Denials for the PepsiCo Disability Plan
The following additional information applies to internal benefit claim denials for the PepsiCo Disability Plan –

If you reside in a county where 10 percent or more of the population is literate in a non-English language, the claims administrator will provide foreign language assistance for benefit questions, claims, and appeals. If you have questions about foreign language assistance, please see the statements on your internal benefit claim denial from the claims administrator.

Effective April 1, 2018, adverse benefit determinations will be revised to include a more complete discussion of the denial, the standards used in the denial and the calendar date by which the adverse benefit determination must be appealed (see below).

Appealing a Denied Internal Claim under the PepsiCo Disability Plan
The following language replaces the existing language under this Section for purposes of the PepsiCo Disability Plan –

If your internal benefits appeal arises under the PepsiCo Disability Plan, you must submit your appeal in writing to the claims administrator within 180 days of your receipt of the initial denial of your claim. For purposes of counting the 180-day appeal date, you are considered to have received the initial claim denial letter –

- Five calendar days after the date set forth on the claim denial letter, if the letter is mailed; and
- The date set forth on the claim denial letter, if the letter is sent to you electronically.

If you receive the claim denial letter after the applicable date set forth above, you may submit information of receiving it at a later date and the claims administrator will consider your information as part of your appeal. In addition, the claims administrator will consider matters beyond your reasonable control in determining whether you have filed a timely appeal, including presidentially-declared disasters, your or your authorized representative's hospitalization and other acts that disrupt mail service.

To be considered a valid appeal, your written appeal must be complete and received within the 180-day timeframe by the claims administrator at the proper mailing address (or electronic address or fax number, if applicable) for filing appeals.

In processing your appeal, the claims administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator in connection with the claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which the appeal decision is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. The claims administrator will allow you 21 calendar days to respond to the new or additional evidence. If you respond to the new or additional evidence, the claims administrator must consider your response prior to issuing any appeal denial notice.

In issuing any appeal denial notice, the claims administrator will include in the denial notice a discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) –

- The views presented by the claimant to the claims administrator of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with a claimant's appeal denial, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the claims administrator made by the Social Security Administration.

The claims administrator will provide you with its decision on your appeal within 45 days of the date that your appeal was received. This decision period may be extended by an additional 45 days if additional information is required to review your appeal, provided that you are notified in writing of the need for the extension before the end of the initial 45-day period.

If you are receiving state disability or state voluntary plan benefits, these appeal procedures do not apply. For state disability benefits, you should contact the state or applicable agency that pays your benefits regarding its appeal procedures. For state voluntary plan benefits, you should contact the disability administrator listed in Other Administrative Facts.

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 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.

This SMM must be read together with the SPD and your 2018 Annual Enrollment materials. This SMM describes only the material changes and provides only the material clarifications to the SPD and your 2018 Annual Enrollment materials regarding the rules applicable to and the benefits provided by the applicable plan. Unless a plan provision is revised in this SMM, the SPD and your 2018 Annual Enrollment materials otherwise apply. Terms and phrases not defined in this SMM have the meanings given to them in the SPD. References in this SMM to "you" or "your" refer to the applicable person covered under the applicable plan, including the employee, spouse, dependent children and their authorized representatives. If you have any questions regarding this SMM, please contact the HR Service Center.

This SMM, the SPD and the www.mypepsico.com website are intended to provide a summary of some of the provisions of the plan. However, this SMM, the SPD and the website are not intended to augment rights provided under the terms of the official plan documents. Nothing in this SMM makes you eligible for a plan unless the official plan documents provide for such eligibility or contributions. Your eligibility and benefits will be determined in accordance with and subject to the official plan documents. No benefits will be paid or provided unless and until the Plan Administrator, or its delegate, determines, in its sole discretion, that you are entitled to such benefits. While the Company currently intends to continue the plan, the Company reserves the right to amend, modify or terminate the plan at any time. Nothing in this SMM should be construed as a promise or guarantee of future benefits or of any level or amount of benefits, or as a promise or guarantee of employment or future employment for any duration.