Medical Plans

Diageo NA offers you a variety of medical coverage options to choose from, including three Preferred Provider Organization (PPO) options with a choice of networks (UnitedHealthcare Choice Plus or Aetna Choice Plans) and Health Maintenance Organizations (HMOs) offered by UnitedHealthcare, Aetna and Kaiser Permanente. All of the plans are designed to meet your and your family's health care needs by providing coverage for a wide range of services. They can help you manage your medical expenses, and protect you from the potentially high cost of medical care.

This section describes the UnitedHealthcare and Aetna Plans in detail and provides a general overview of the Kaiser HMOs. For more information about Kaiser coverage, see "HMOs" on page 58 or contact Kaiser directly.

For More Information

For details about eligibility for benefits, when you can change your coverage, and how you pay for coverage, see *Participating in the Benefits Plans*. For information about your legal rights under ERISA, general information on claims review and appeal procedures, and other important administrative details, see *Administration*.

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Preferred Provider Organization (PPO) Plans

Diageo offers three design options for our national Preferred Provider Organization (PPO) Plans. The UnitedHealthcare (UHC) Choice Plus and Aetna Choice Plans offer the coverage options from which to choose:

- Option 80
- Option 90
- Option 100

The three options provide coverage for the same medical services, but differ by your cost per paycheck and how benefits are paid.

These plans offer you two options when you need medical care. You may use an in-network provider and benefit from negotiated reduced costs, or you may use an out-of-network provider of your choosing but pay a higher cost for care.

If you enroll in any of the above options, you must also elect prescription drug coverage. Your choices are:

- The Select Option
- The Enhanced Option

How the Preferred Provider Organization (PPO) Plans Work

All of the Preferred Provider Organization (PPO) Plans offer you a choice about how to receive health care. Each time you need medical care, you decide which health care provider to see. You can receive care from an in-network provider or out-of-network provider. If you go out-of-network for care, although you have benefits, you typically pay more out of your own pocket.

In-Network Benefits

When you go to an in-network provider for the network you elected, there are no claim forms to complete. You just pay your office visit copay or coinsurance. There is a deductible you must meet for most Preferred Provider Organization (PPO) options, so you will receive a bill for the additional amount you owe. You may see any network provider without a referral, and you are not required to designate a primary care physician (PCP). To find a network provider, log on **to www.myuhc.com** or **www.aetna.com** for your respective plan or call the customer service numbers (see Contact Information)

When you receive care in-network, you pay less for medical services and have no paperwork. Using an in-network provider means:

- Lower, or no deductibles
- Lower, or no coinsurance rates
- Lower, or no out-of-pocket amounts

- A copay each time you receive care (For exceptions, see “Comparing the Preferred Provider Organization (PPO) Plans” on page 44.)
- No claim forms to file, because the provider files all claims on your behalf
- No lifetime maximum amount of medical plan benefits that you can receive

Generally, in-network providers must:

- Have graduated from an accredited school of medicine
- Be board-certified or have met the criteria for board certification
- Have unrestricted malpractice insurance
- Have full hospital privileges
- Have an unrestricted state license
- Have sufficient support staff and office equipment

Once doctors are accepted into the network, they are regularly monitored to ensure that they continue to meet the plan’s standards for care.

UnitedHealthcare

UnitedHealthcare’s provider network includes 470,000 primary care physicians and specialists, and more than 4,500 hospitals. You can use Find-a-Doctor, United’s online provider directory, to find network providers near you. Just visit **www.myuhc.com/groups/diageobenefits**, look under “Links and Tools” for “Find a Doctor,” and fill in the requested information. For Plans 100-80, search the **Plan 100, Plan 90, or Plan 80** network; for the UHC HMO, search the **HMO** network. Although you can use any provider you wish in the PPO Plans, you will receive a higher level of benefits when you us an in-network provider. You must use an in-network provider in the HMO Plans to receive your covered benefits.

The UnitedHealthcare provider directory lets you search for doctors, hospitals, facilities and other providers, as well as providers of medical equipment and supplies. You can search for a specific doctor, all doctors in a given area, specialists, doctors recognized by the National Committee for Quality Assurance (NCQA), and more. You can also refine your search by “gender and language preferences. Provider details include office hours, education and credentials, and hospital affiliations.

Aetna

Aetna maintains one of the nation’s largest networks of doctors, hospitals, pharmacies and other health care providers. They contract with more than 462,000 primary care doctors and specialists, and over 4,700 hospitals. This means you can find a variety of network providers near you. In fact, many of the providers you now use most likely belong to Aetna’s network.

You can determine if your doctor participates or find a new doctor by going to the Aetna DocFind® website.

Using DocFind® to Locate a Provider

For Plans 100-80, you will need to search the Choice POS II network. For the HMO, you will need to search the Open Access Aetna Select network. Although you can use any provider you wish in the PPO Plans, you will receive a higher level of benefits when you use an in-network provider. You must use an in-network provider in the HMO Plans to receive your covered benefits.

To learn more about Aetna, go to **www.aetna.com**.

Out-of-Network Benefits

When you go out-of-network for your medical care, you have the freedom to choose any doctor, hospital, or other provider, but you pay more for this flexibility. You may choose to go out-of-network at any time to see a doctor or specialist without a referral, or receive care at any hospital. When you receive care out-of-network, the Preferred Provider Organization (PPO) Plans will pay a percentage of reasonable and customary (R&C) charges after you meet your annual deductible. You will need to file a claim form to determine coverage and to receive benefits.

Using an out-of-network provider means:

- Freedom to choose any medical provider
- Higher annual deductibles
- Higher coinsurance rates
- Higher out-of-pocket amounts
- You must call your plan for preauthorization of benefits for certain medical services, or coverage will be reduced to 50%. See “Comparing the Preferred Provider Organization (PPO) Plans” on page 44
- You must file a claim form each time you or a family member receives care

If you go out-of-network, you will need to notify your plan:

- UnitedHealthcare Choice Plus Plan members call **1-888-697-9063**
- Aetna Choice Plan members call **1-800-562-2955**

Reasonable and Customary (R&C) Charges

Reasonable and customary (R&C) charges are established based on what providers with similar professional backgrounds, education, and experience charge for a specific service within a given area. Providers not participating in the network will bill their full charge. The plans cover costs up to R&C limits, and you are responsible for paying any portion of the bill over the limits. Charges above R&C amounts will not apply toward your deductible, coinsurance, or annual out-of-pocket maximum.

Annual Deductibles

You must meet an annual deductible before the plan pays benefits. Once you satisfy the annual deductible requirement, the plan reimburses a percentage of covered expenses. An individual deductible applies separately to you and to each one of your family members. A new deductible applies each calendar year.

The Preferred Provider Organization (PPO) Plans also offer a family deductible, which is the total amount you and your covered family members have to pay in deductibles each year, regardless of your family's size. The family deductible amount is three times the individual deductible amount for any of the PPO plan options. The maximum amount of any individual family member's medical expenses that can count toward meeting the family deductible can't exceed the individual deductible for your plan. All of your covered dependent's expenses count towards meeting the family deductible, even if a family member has not met their own individual deductible.

Deductible

The deductible is the amount you pay each year for eligible medical expenses before the plan begins to pay benefits.

The specific deductible amounts for the Preferred Provider Organization (PPO) Plans are shown in the "Comparing the Preferred Provider Organization (PPO) Plans" section on page 44.

Expenses Above Deductible (Coinsurance)

After you meet your deductible, each time you receive in-network medical services, including office visits, inpatient hospitalization and outpatient surgery, you and the Company each pay for a percentage of the cost. The exact percentages vary depending on what Preferred Provider Organization (PPO) option you elect. You pay a higher coinsurance amount for care received from out-of-network providers.

Coinsurance

The coinsurance is the percentage of benefits you and the Company pay for eligible medical expenses.

The coinsurance amounts for the PPO Plans are shown in the "Comparing the Preferred Provider Organization (PPO) Plans" section on page 44.

Out-of-Pocket Maximum

To protect you from unpredictable large medical bills, the Preferred Provider Plans have an annual out-of-pocket maximum. If you reach your out-of-pocket maximum in a given year, the plan will generally pay 100% of covered R&C charges for the rest of the year. See "Comparing the Preferred Provider Organization (PPO) Plans" on page 44.

Out-of-pocket maximum

This is the most you will pay in covered R&C medical expenses during the year, including any applicable deductibles.

The out-of-pocket maximum does not include office visit, hospital, surgical and mental health copays for care and charges that you pay above R&C limits.

ID Card

You will receive an ID card within a few weeks of enrolling in a Preferred Provider Plan. The ID card provides information that you will need when making appointments, including your name, your ID number, and any other covered dependents. If you have any questions about your coverage, call your Plan directly:

UnitedHealthcare members at 1-888-697-9063 or Aetna members at 1-800-562-2955

If you require medical care before you receive your ID card, tell your doctor that you are a Diageo NA employee and whether you are covered by UHC or Aetna. The group numbers for the respective administrators are:

For UHC members, use Group #144737. Your doctor can contact UHC at 1-888-697-9063.You may also get a temporary card by logging on to **www.myuhc.com.**

Aetna members, use Group #818957**.** Your doctor can contact Aetna at 1-800-562-2955.You may also get a temporary card by logging on to **www.aetna.com**

If you do not receive your ID card within a few weeks of enrolling, call your plan to inquire.

If You Have a Flexible Spending Account

If you enroll in a Flexible Spending Account (FSA), you will also receive an FSA debit card. Present the debit card whenever you have an eligible expense, and the proper amount will automatically be deducted from your FSA funds.

If you sign up for a Health Care Account, which is a type of FSA, you may not submit expenses for FSA reimbursement that are paid for by your medical plan. You may only submit the amount of your eligible out-of-pocket expenses.

Medco Health Solutions Prescription Drug Coverage

If you enroll in any of the Preferred Provider Organization (PPO) Plans, you must also select prescription drug coverage. Your choices are:

- The Select Option
- The Enhanced Option

Both the Select and Enhanced Options provide coverage for prescription drugs purchased through a retail pharmacy or using the home delivery service. The difference between the two options is the cost per paycheck and copay amounts.

If you do not receive your ID card within a few weeks of enrolling, call your plan to inquire.

Your pharmacist can contact Medco at 1-800-922-1557 or call customer service at 1-800-711-0917.

Care Coordination—Medical Plan Management

For PPO Assistance

If you have any questions about your medical coverage, call your plan:

UHC at 1-888-697-9063

OR

Aetna at 1-800-562-2955

The Preferred Provider Plans use a process called Care Coordination to ensure that both the patient and the doctor are aware of all of the benefits that are available through the plans so that both parties can make an educated decision regarding treatment options.

If you are enrolled in one of the PPO Plans and use an out-of-network provider, there are times when you will need to place a notification call to the plan before receiving certain types of medical care. If you receive certain care without making the notification call, benefits will be reduced to 50%.

If you use in-network providers, your doctor will automatically make the notification call for you so that you are assured maximum coverage.

Services Requiring a Notification Call

The following services or treatments require a Notification Call:

- Accidental dental services
- Birthing center
- Cardiac rehabilitation therapy
- Chiropractic care
- Durable medical equipment (DME) and prosthetic appliances for items with a purchase or cumulative rental (generally those that cost more than $1,000)
- Home health care
- Hospice care
- Inpatient and outpatient surgery
- Inpatient hospital admissions
- Maternity care, if the stay exceeds 48 hours for a vaginal delivery, or 96 hours for a cesarean section
- Pulmonary rehabilitation therapy
- Reconstructive procedures
- Skilled nursing facility and inpatient rehabilitation facility services
- Transplants
- Treatment for mental health and substance abuse

Durable Medical Equipment (DME)

Equipment that is related to the care of a medical condition, such as a wheelchair or hospital bed.

Hospice care

Home care or inpatient care for a patient with a terminal illness.

Out-of-Network Health Care Coordination Process

Before surgery, hospitalization, or any other medical service above, contact your plan (UHC members at 1-888-697-9063 or Aetna members at 1-800-562-2955) and follow the phone prompts. A Care Coordinator will verify your Diageo NA coverage and ask you for the following information:

- Patient's name
- Doctor's name and phone number
- Recommended treatment
- Reason for the treatment
- Name of the hospital (if applicable)
- Date of the proposed treatment

The Care Coordinator will also:

- Contact your doctor for any additional information.
- Advise you, your doctor, and the hospital (if applicable) of the benefits your plan provides for the proposed treatment program, as well as any other coverage the plan offers that may be useful in treating the condition.
- Let you and your doctor know if a particular service is not covered by the plan. Written confirmation will be mailed to you, your doctor, and the hospital (if applicable).
- Work with your doctor to obtain any necessary medical equipment, rehabilitation services, home health care, or other medical services to help you or your family member recuperate

If a Medical Service Is Not Covered

The Care Coordinator will advise both you and your doctor if the plan does not cover a particular type of treatment or condition, and may recommend alternate forms of care covered by the plan. At that time, you and your doctor may forward any additional information to help the Care Coordinator evaluate the plan's coverage.

If you are dissatisfied with the outcome of the Care Coordination process, you and your doctor may appeal the decision, in writing, to your plan. (Refer to the *Participation* section.)

The final choice in treatment options is always made by the doctor and the patient.

Benefits Covered by the Preferred Provider Organizations (PPOs)

The PPOs cover a wide variety of health care services. The following chart lists a number of covered services, and compares how each PPO option pays benefits.

Following the chart is a more detailed description of some of the benefits covered by the PPOs.

Comparing the Preferred Provider Organization (PPO) Plans

Benefits and Services	Option 80		Option 90		Option 100	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible	$1,000 per person/ $3,000 per family	$2,000 per person/ $6,000 per family	$250 per person/$750 per family	$500 per person/ $1,500 per family	None	$350 per person/ $1,050 per family
Plan coinsurance	80% after deductible (unless otherwise noted)	60% of R&C after deductible	90% after deductible (unless otherwise noted)	70% of R&C after deductible	100%	80% of R&C after deductible
Maximum annual out-of-pocket expenses *(includes deductible)*	$5,000 per person/ $10,000 per family	$10,000 per person/ $20,000 per family	$1,000 per person/ $2,000 per family	$5,000 per person/ $10,000 per family	Does not apply	$3,500 per person/ $7,000 per family
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Doctor's Services						
Primary Care Physician *(office visit)*	100% after $25 copay per visit	60% of R&C after deductible	100% after $20 copay per visit	70% of R&C after deductible	100% after $15 copay per visit	80% of R&C after deductible
Routine annual physical exam *(ages six and older)*	100%	60% of R&C after deductible	100%	70% of R&C after deductible	100%	80% of R&C after deductible
Routine physical exam *(child to age six)*	100%	60% of R&C after deductible	100%	70% of R&C after deductible	100%	80% of R&C after deductible

Benefits and Services	Option 80		Option 90		Option 100	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OB/GYN annual exam *(one exam per year, two Pap smears, and related tests)*	100%	60% of R&C after deductible	100%	70% of R&C after deductible	100%	80% of R&C after deductible
Chiropractic care* *(30-visit limit for in-network and out-of-network)*	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Acupuncturist	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Allergist *(includes injections)*	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Naturopath	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Hospital Services						
Pre-admission testing	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Doctor hospital visit	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Hospital room & board* *(semi-private rate)*	80% after $deductible	60% of R&C after deductible	90% after $250 copay per admission	70% of R&C after $500 copay per admission	100% after $100 copay per admission	80% of R&C after $200 copay per admission
Hospital ancillary services	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Inpatient surgery* *(includes surgeon's fees, assistant surgeon's fees, and anesthesia)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible

Benefits and Services	Option 80		Option 90		Option 100	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient surgery* *(includes facility, surgeon's fees, assistant surgeon's fees and anesthesia)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Obesity surgery* *(Must meet obesity guidelines. Contact your medical plan for information.)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Hospital emergency room *(true emergency only—call your plan within 48 hours)*	100% after $100 copay (copay waived if admitted)	100% of R&C after $100 copay (copay waived if admitted)	100% after $100 copay (copay waived if admitted)	100% of R&C after $100 copay (copay waived if admitted)	100% after $75 copay (copay waived if admitted)	100% of R&C after $75 copay (copay waived if admitted)
Ambulance	100% for true emergency					
	80% for non-emergency	60% for non-emergency	90% for non-emergency	70% for non-emergency	100% for non-emergency	80% for non-emergency
Testing and Treatment						
Hearing exams and tests *(one preventive exam per year)*	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Hearing aids *(one device and fitting per year, per lifetime)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Lab tests and X-rays	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Radiation and chemotherapy treatment	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Mammograms	100%	60% of R&C after deductible	100%	70% of R&C after deductible	100%	80% of R&C after deductible
	Ages 35-39: one baseline exam; Age 40+: one exam per year. No age restriction if family history of breast cancer. If there is a medical diagnosis, it is subject to the deductible and coinsurance.					
Temporo-Mandibular Joint Syndrome (TMJ) *(surgical and non-surgical correction)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
	$10,000 combined lifetime benefit for in-network and out-of-network care					

Benefits and Services	Option 80		Option 90		Option 100	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Reproductive and Maternity Services						
Family Planning	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Assisted Reproductive Therapy (ART) (artificial insemination, invitrofertilization, GIFT, ZIFT)	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
	$20,000 individual lifetime benefit including physician's services, diagnostic tests, facility charges, and fertility medication dispensed or injected by the doctor and included on his/her bill.					
Infertility specialist *(subject to ART maximum, see above)*	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
Infertility treatment of underlying condition	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Maternity care	100% after $40 copay for first visit	60% of R&C after deductible	100% after $30 copay for first visit	70% of R&C after deductible	100% after $25 copay for first visit	80% of R&C after deductible
Nurse midwife	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Birthing center*	80% after $250 copay per admission	60% of R&C after $500 copay per admission	90% after $250 copay per admission	70% of R&C after $500 copay per admission	100% after $100 copay per admission	80% of R&C after $200 copay per admission
Newborn hospital and doctor hospital visits and circumcision	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
	If the newborn is admitted after birth, a separate hospital copay will apply.					
Sterilization *(male and female)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Abortion *(elective and therapeutic)*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible

Benefits and Services	Option 80		Option 90		Option 100	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health Care and Substance Abuse Treatment						
Inpatient mental or nervous disorder treatment and alcohol or substance abuse treatment* ***(semi-private rate)***	Mental Health Care: $250 copay per admission Substance Abuse Treatment: 80% after $250 copay per admission	Mental Health Care: 60% of R&C after $500 copay per admission Substance Abuse Treatment: 60% of R&C after deductible	Mental Health Care: 90% after $250 copay per admission Substance Abuse Treatment: 90% after $250 copay per admission	Mental Health Care: 70% of R&C after $500 copay per admission Substance Abuse Treatment: 70% of R&C after deductible	Mental Health Care: 100% after $100 copay per admission Substance Abuse Treatment: 100% after $250 copay per admission	Mental Health Care: 80% of R&C after $200 copay per admission Substance Abuse Treatment: 80% of R&C after deductible
Outpatient mental or nervous disorder treatment and alcohol or substance abuse treatment*	100% after $40 specialist copay per individual therapy visit; $10 copay for group therapy	60% of R&C after deductible	100% after $30 specialist copay per individual therapy visit; $10 copay for group therapy	70% of R&C after deductible	100% after $25 specialist copay per individual therapy visit; $10 copay for group therapy	80% of R&C after deductible
Therapies						
Outpatient physical and occupational therapy	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
	40 visits per year, combined for both therapies					
Speech therapy	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
	20-visit limit for in-network and out-of-network					

Benefits and Services	Option 80		Option 90		Option 100	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Cardiac rehabilitation therapy*	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
	20-visit limit for in-network and out-of-network					
Pulmonary rehabilitation therapy*	100% after $40 specialist copay per visit	60% of R&C after deductible	100% after $30 specialist copay per visit	70% of R&C after deductible	100% after $25 specialist copay per visit	80% of R&C after deductible
	30-visit limit for in-network and out-of-network					
Other Services						
Prescription drugs	Refer to the Prescription Drug Program section.					
Urgent care center	100% after $25 copay	60% of R&C after deductible	100% after $25 copay	70% of R&C after deductible	100% after $25 copay	80% of R&C after deductible
Durable medical equipment (DME) and prosthetic appliances*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
	Includes foot orthotics. Notification Call to UHC required if over $1,000. Aetna will request additional information based on claim specifics.					
Organ transplants*	Coordinated by the administrator resource networks. Call your plans for coverage information.					
Hospice care* *Six-month maximum benefit*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Home health care* *Prior hospital stay not required*	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	100%	80% of R&C after deductible
Extended care or skilled nursing facility* *Prior hospital stay not required*	80% after $250 copay per admission	60% of R&C after $500 copay per admission	90% after $250 copay per admission	70% of R&C after $500 copay per admission	100% after $100 copay per admission	80% of R&C after $200 copay per admission
	Copay waived if admitted from hospital stay. 120 days per year limit for in-network and out-of-network.					

*This service requires Care Coordination and must be pre-certified in order to receive full benefits. If you use a network provider, your provider will handle the details.

Other Covered Services

This section describes, in general terms, the benefits that most PPO Plans cover. See "Benefits Covered by the Preferred Provider Organizations (PPOs)" on page 44 for specific information on the benefits available for your PPO Plan.

Maternity and Newborn Benefits

Remember to add your newborn as a dependent

Be sure to add your baby to your coverage within 31 days of the birth by contacting the Benefits Center at 1-800-523-2309 or www.mydiageobenefits.com. See *Life Events* for more information.

If you or a dependent has medical expenses related to the birth of a child, the plans will pay hospital or birthing center and doctor or nurse midwife expenses the same as for any other medical condition.

The PPO Plans pay benefits for 48 hours in the hospital or birthing center for a vaginal delivery, and 96 hours in the hospital for a cesarean delivery. Additional time in the hospital requires a notification call. If the newborn is admitted after birth, a separate hospital copay will apply.

Mental Health and Substance Abuse

If you feel that you or a family member needs help with a mental health or substance abuse issue, call EAP care managers at 1-888-231-4886 available 24 hours a day. If it is an emergency (a person is a threat to him or herself or to others), go to the closest medical facility and notify your plan within 48 hours.

UnitedHealthcare

Mental health and substance abuse benefits are coordinated with a division of UHC called United Behavioral Health (UBH).

Your call to UBH satisfies the notification requirement for mental health or substance abuse treatment. UBH will coordinate your care to ensure maximum coverage. If you receive care without contacting UBH, benefits will be reduced to 50%.

Aetna

Mental health and substance abuse benefits are coordinated and integrated with the health plan. To receive pre-notification approval, call Aetna at 1-800-562-2955 and follow the phone prompts.

What constitutes a surgical procedure?

Any cutting, suturing, correcting of fractures, reducing dislocations, taping, and removing stones or foreign bodies by endoscopic means.

Multiple Surgical Procedures

If more than one surgical procedure is performed at the same time, benefits may be limited to:

- 100% of R&C expenses for the main procedure
- 50% of R&C expenses for the second procedure
- 25% of R&C expenses for additional procedures

Outpatient Physical and Occupational Therapy

Coverage for outpatient physical and occupational therapy is limited to three treatment modalities for each body part during any one visit, up to 40 combined visits each calendar year.

Reconstructive Surgery

Reconstructive surgery is covered to improve functional impairment as a result of:

- Birth defect
- Sickness
- Surgery to treat a sickness or accidental injury
- Accidental injury that occurs while the patient is covered by the Diageo NA Plans

Mastectomy

Mastectomy treatment will be covered for the breast on which the mastectomy has been performed, and the other breast to produce a symmetrical appearance. Coverage is also provided for prostheses. In addition to reconstructive surgery, the plans also covers treatment for phases of post-mastectomy surgery, including swelling associated with the removal of lymph nodes.

Speech Therapy

Speech therapy must be provided by a licensed speech therapist and intended to restore speech that was lost as a result of:

- Surgery, radiation therapy, or other treatment that affects the vocal chords
- Cerebral thrombosis (cerebral vascular accident)
- Brain damage due to an accidental injury or organic brain lesion (aphasia)
- Accidental injury that occurs while the patient is covered by the Diageo NA Plans
- Congenital anomalies, such as cleft lip or palate

Speech therapy is covered for children under age three whose speech is impaired due to:

- Infantile autism
- Developmental delay or cerebral palsy
- Hearing impairment
- Congenital anomalies, such as cleft lip or palate

Emergency Room Treatment

The emergency room should only be used for acute medical conditions caused by an accident, or the sudden onset of a severe or suspected severe illness.

Some examples of acute conditions are:

- Suspected heart attack
- Sudden asthma attack
- Convulsions
- Loss of blood
- Blood or food poisoning
- Broken bones

Examples of non-acute conditions are:

- Colds
- Sore throats
- Stomach aches
- Flu

If you are admitted through an emergency room to a non-network hospital, claims will be paid based on R&C charges.

Emergency Hospital Admission

If you or a family member is admitted to the hospital as a result of an emergency, you must notify Care Coordination as soon as reasonably possible. If the emergency occurs on a weekend, you must place the Notification Call within 72 hours of the hospital admission.

Medical Benefits Not Covered by Preferred Provider Organizations (PPOs)

The following are examples of expenses not covered under the PPO Plans:

- Breast reduction surgery
- Charges above R&C amounts
- Charges for the completion of claim forms, or failure to keep an appointment
- Charges from a provider who would waive deductible or coinsurance payments
- Cosmetic or reconstructive surgery unless the direct result of an accident that occurred while covered by these plans, or the result of a congenital malformation or surgery causing functional impairment
- Dental treatment (plans cover treatment for accidents and TMJ)
- Educational services
- Expenses for ineligible providers, including but not limited to: Christian Science practitioners; pastoral counselors; exercise, sports and massage therapists; lactation consultants
- Health club memberships, weight loss clinics, and similar programs
- Inpatient private-duty nursing
- Liposuction
- Medical charges covered by any other plan or Worker's Compensation
- Medical expenses incurred outside the U.S. for treatments that are not approved procedures in the U.S. (e.g., Laetrile cancer treatments in Mexico)
- Mental health and substance abuse expenses not approved by the plan
- Nursing home charges and expenses for custodial care
- Organ transplants, unless approved through the plan

- Personal convenience items such as first aid kits, air conditioners, dehumidifiers, air purifiers, exercise equipment, orthopedic mattresses, home or automobile modifications, or other similar items, even if recommended by a doctor
- Professional care by a close relative
- Radial keratotomy or other surgery designed to correct your vision
- Routine eye exams, eyeglasses, and contact lenses (The Vision Service Plan provides reduced rates for many eye care services. See *Vision Service Plan* for details.)
- Services not ordered by a doctor or recognized as safe and effective for the stated diagnosis
- Services received after the date your coverage ends
- Treatment and supplies considered experimental, investigative, or unproven in nature
- Treatment or surgery to change gender
- Treatment received before you were a member of the plan
- Vocational rehabilitation, and recreational or educational therapy

Filing Out-of-Network Medical and Prescription Claims

You or your medical provider will need to submit a claim form each time you or a family member receives medical care out-of-network.

Claims must be submitted within 15 months of the date of service. For example, if you are hospitalized in June 2008, you must submit your claim by September 2009.

Claim forms are available from the plans, in the Forms library on Diageo One, or from your Human Resources Representative.

Include your name, Social Security number, and Policy number on each claim form. Send your completed claim forms and appropriate receipts or attachments to the appropriate plan.

For UHC members:

UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800

For Aetna members:

Aetna
PO Box 981106
El Paso, TX 79998-1106

For Prescriptions:

Medco Health Solutions, Inc.
PO Box 14711
Lexington, NY 40512

You may request that your plan send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com** or **www.aetna.com** for your respective claim administrator.

Questions?

If you have questions about your medical benefits or need claim forms, UnitedHealthcare members call 1-888-697-9063 or Aetna members call 1-800-562-2955 and follow the phone prompts. For questions regarding prescription coverage call Medco at 1-800-711-0917. Current participants can log on to the plans websites at **www.myuhc.com, www.aetna.com,** or **www.medco.com** respectively. Claim forms are also available in the Forms library on Diageo One, or from your local Human Resources Representative.

To contact United Behavioral Health (UBH), call 1-888-231-4886.

Health Management Organizations (HMOs)

Diageo NA offers Health Maintenance Organizations (HMOs) to eligible employees. The HMOs available to you will depend on your home ZIP code.

HMOs are comprised of a network of managed care providers. There are no annual deductibles to meet and no claim forms to file. Generally, there is no coverage for care received outside of the HMO network unless you receive treatment for a true emergency, or your PCP refers you to an outside provider approved by the HMO. Contact your HMO to determine specific out-of-network coverage.

This section is a general description of how HMOs work. For specifics on the HMO you are enrolled in, see “HMOs” on page 58 or contact your HMO directly.

How a Typical HMO Works

Generally, an HMO will cover only care that you receive from health care providers who participate in the HMO’s network. (There are exceptions for emergency situations.) If you enroll in an HMO, you must use only those physicians, hospitals, and other providers who participate in that HMO’s network. If you do not use participating providers, except in an emergency, the HMO will not cover that care, and you will be responsible for paying the full cost of that care.

Diageo NA national HMOs do not require a PCP election and you may see a Specialist without a referral from a PCP. It is recommended that you still discuss your care options with your primary doctor prior to visiting a specialist. You will find PCPs listed in your HMO’s provider directory, which you can access from your HMO’s website or by calling the phone number on your ID card.

HMOs generally do not require you to file claims or pay a deductible before the HMO pays benefits. Instead, you pay a copay at each doctor or specialist visit, but you must stay in the HMO’s network. You will receive an HMO ID card from the HMO you elect that contains your name, ID number, and any covered dependents. You may be required to present this card at any doctor or specialist office visit.

The specific services that are covered will vary depending on the HMO you select. You can find more information about each HMO in the “HMOs” on page 58 or by contacting the HMO provider directly.

Network Coverage

HMOs feature a network of selected doctors and hospitals that have agreed to provide medical care to plan participants. When you enroll in most HMOs, you select a PCP from their network. Generally, you must see your PCP first for your treatment to be covered, so that he or she can coordinate your care. The national HMOs do not require a PCP referral, however, it is recommended that you still discuss your care options with your primary doctor prior to visiting a specialist.

Primary Care Physicians (PCP)

Some HMOs require you to elect a PCP when you enroll in your benefits. Your PCP acts as a guide to provide and coordinate all of your care. If your PCP finds that you need special care, he or she will refer you to specialists and facilities that are part of your HMO's network.

When you enroll, every covered family member usually selects a primary care physician (although not required for the National HMOs). You can find PCPs listed in your HMO's provider directory or in the HMO's plan summary. If you like, you may select a different PCP for each family member.

Your PCP can be a general practitioner, an internist, or a family practitioner. You may choose a pediatrician to be your children's PCP. In some HMOs, women may select a gynecologist for their routine gynecological checkups, in addition to choosing a PCP for other health care needs.

If You Need a Specialist

In the national HMOs, you do not need a PCP referral to see a specialist or referrals are not required for certain kinds of specialist care as long as the specialist is part of the HMO network.

If you are enrolled in Kaiser, you should consult directly with the plan to determine situations that require a referral. Otherwise if you go to a specialist without one, you may be responsible for the full cost of your care.

How Benefits Are Paid

With HMOs, you generally don't need to file claims for benefits. You generally pay only a copay each time you receive care. The plan covers the remainder of the cost.

The copay varies based on what services you receive and what your HMO offers. For example, the copay for specialist care is often higher than the copay for care from your PCP. There is often a higher copay for care provided in an emergency room, but this copay is waived if you have to be admitted to the hospital.

Copay

A copay is a predetermined fee (fixed dollar amount) that you pay for certain health care services.

Occasionally, you may be billed directly for covered services (such as laboratory tests or emergency care) that are authorized by your PCP. If that happens, contact your HMO for directions for filing a claim for benefits.

Remember, except in emergency situations, the HMO only covers care received from providers who are part of the HMO network. You must have HMO approval for several types of care, such as some specialist visits or inpatient care. The easiest way to ensure that you have the necessary approval is to have your PCP coordinate all the care you receive. If you are unsure about whether your care is approved and will be covered, contact the HMO.

Maximum Benefits

For most services, there is no annual or lifetime limit on the amount of benefits you receive from health care providers in your HMO's network. Limits may apply for certain kinds of care, and these limits are often defined in terms of how often you can receive the care within a fixed time period (or, for inpatient care, how many days of inpatient care are covered). See "HMOs" on page 58 or contact the HMO provider for more information about these limits.

International Assignees

Contact Aetna Global Benefits at 1-800-231-7729 or **www.aetna.com/agb.**

Benefits Covered by HMOs

In an HMO, you must use providers and facilities that participate in the plan's network. If you do not, you will be responsible for the full cost of your care, except in an emergency.

If your HMO doctor recommends a service that is not covered by your HMO, but he or she feels that service is appropriate, he or she should notify you in advance that the HMO may not cover the care.

Routine Care

Our HMOs cover preventive care services and health screenings. Such services may include:

- Routine physical exams, including well child care and adult care
- Routine health screenings, including gynecological exams, mammograms, sigmoidoscopy, colonoscopy, and PSA (prostatic-specific antigen) screenings
- Routine eye exams
- Routine hearing exams

Hospital Care

Generally, care in a hospital that is part of the HMO's network, both inpatient and outpatient, requires a copay. After your copay, hospital care is covered at 100% for covered services. If you use a network provider or lab but are not referred by your PCP, you may be required to pay for the services. Hospital services generally require a referral or advance approval (also known as "pre-certification") from your HMO. Your PCP usually coordinates this advance approval.

Maternity Care

Our HMOs cover physician services and hospital care for both the mother and the newborn child, including prenatal care, delivery, and post-natal care. Generally, you will be responsible for a copay for your first visit to a participating obstetrician. However, you will not pay a copay for the remaining visits during your pregnancy.

The mother and newborn child are generally covered for a minimum of 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section. The HMOs provide coverage for home health care visits if your doctor determines (with the mother's consent) that you and your child may be safely discharged after a shorter stay.

State Maternity Laws

The 48/96-hour minimum stay after childbirth is required by federal law. State laws may provide additional requirements for maternity coverage. Contact your HMO for details on whether your state's requirements supersede the federal requirements.

Emergency Care

Most HMOs define a medical emergency as a sickness or injury that, without immediate medical attention, could place a person's life in danger or cause serious harm to bodily functions. Examples of emergencies include an apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries.

Most HMOs require a copay for each emergency room visit. If you are admitted to the hospital, in most cases the copay is waived. Non-emergency services provided in an emergency room are not covered.

If you have a life-threatening situation, go to the nearest emergency room. Show your HMO ID card to the hospital admissions staff. To ensure you receive benefits, most HMOs require that you notify the HMO within two days of the emergency. If you do not notify the HMO, the HMO may not cover the cost of the care. This means you may be responsible for the full cost of your care.

See "HMOs" on page 58 or contact your HMO directly for more information, including their definition of a true medical emergency.

Important emergency room information

If you go to a hospital emergency room and your condition is not an emergency or if you do not notify your HMO about the emergency within the required time frame, your benefits may be reduced or not paid at all.

Benefit Limitations

Covered services, exclusions, and limitations vary by HMO. It is important to check directly with the HMO before enrolling to ensure that you fully understand the provisions of the plan.

HMOs

Availability	Nationally	California - ONLY
Carriers	**UnitedHealthcare** **1-888-697-9063** **www.myuhc.com** **Aetna** **1-800-424-4047 www.aetna.com**	**Kaiser Permanente (North and South)** **1-800-464-4000** **www.kaiserpermanente.org**
Plan Provision		
Doctors' Services		
Office visits	**PCP:** 100% after $15 copay per visit **Specialist:** 100% after $30 copay per visit (no referral required)	Kaiser North: 100% after $20 copay per visit Kaiser South: 100% after $15 copay per visit
Routine physicals (adult, pediatric & OB/GYN)	100% (one exam per year)	100% (one exam per year)
Hospital Services		
Inpatient	$100 per day, $500 maximum	Kaiser North: 100% after $200 copay per admission Kaiser South: 100% after $100 copay per admission
Outpatient	$100 copay	Kaiser North: 100% after $20 copay Kaiser South: 100% after $15 copay
Physician Hospital Services	$100 per day, $500 maximum	100%
Maternity Services		
Hospital services*	$100 per day, $500 maximum	Kaiser North: 100% after $200 copay per admission Kaiser South: 100% after $100 copay per admission
Physician services**	100% after $30 copay (initial visit **only**)	100% after $5 copay per visit
Emergency Room	$100 copay per visit	Kaiser North:100% after $75 copay (waived if admitted) Kaiser South: 100% after $50 copay (waived if admitted)
Urgent Care Centers	$25 copay per visit	Kaiser North: 100% after $20 copay at Kaiser facility Kaiser South: 100% after $15 copay at Kaiser facility
Lab Tests/X-rays	100%	100%

Availability	Nationally	California - ONLY
Carriers	**UnitedHealthcare** **1-888-697-9063** **www.myuhc.com** **Aetna** **1-800-424-4047 www.aetna.com**	**Kaiser Permanente (North and South)** **1-800-464-4000** **www.kaiserpermanente.org**
Plan Provision		
Mental Health Care		
Inpatient	$100 per day, $500 maximum	Kaiser North: 100% after $200 copay per admission Kaiser South: 100% after $100 copay per admission
Outpatient	100% after $30 copay individual per visit, $10 group	Kaiser North: 100% after $20 copay per visit for individual therapy; $10 copay per visit for group therapy Kaiser South: 100% after $15 copay per visit for individual therapy; $7 copay per visit for group therapy
Substance Abuse Treatment		
Inpatient	$100 per day, $500 maximum	Hospitalization: Kaiser North: 100% after $200 copay per admission Kaiser South: 100% after $100 copay per admission Detoxification Services: $100 copay per transitional residential recovery
Outpatient	$30 per individual therapy	Kaiser North: 100% after $20 copay per visit for individual. therapy; $5 copay per visit for group therapy Kaiser South: 100% after $15 copay per visit for individual therapy; $5 copay per visit for group therapy
Prescription Drugs		
Retail	30-day supply at a participating pharmacy	At Kaiser participating pharmacy **only**:
	Tier 1 – $10 copay Tier 2 – $30 copay Tier 3 – $50 copay	Kaiser North: $10 copay generic; $25 copay brand name up to 30-day supply Kaiser South: $10 copay generic; $20 copay brand name up to a 30-day supply
Mail Order *(90-day supply)*	Tier 1 – $25 copay Tier 2 – $75 copay Tier 3 – $125 copay	2 times copay for 100-day supply
Maximum Benefits	Unlimited	Unlimited

* Semi-private room and board

** Includes pre- and post-natal care for mother plus care for baby during hospital stay