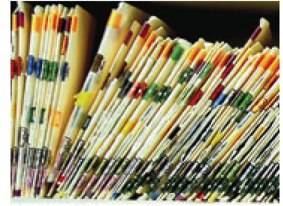
Administration

Many of the benefit plans provided by Diageo North America, Inc. (Diageo NA) are subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This section includes important information about the legal requirements, administration, and your rights under each of the Diageo NA benefit plans.



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General Plan Information

The Company

Where “Company” or “Diageo NA” is used throughout Your Employee Benefits, it means Diageo North America, Inc., and the employees who are covered by the benefits described in this Summary Plan Description.

Diageo NA Employer ID Number 06-1067908

Plans’ Sponsor and Administrator:

Employee Benefits Administration Committee (EBAC)
Diageo North America, Inc.
801 Main Avenue
Norwalk, CT 06851
1-203-229-2100

The EBAC as Plan Administrator has full discretionary authority to interpret and apply the provisions of the plans and this SPD. While the SPD is intended to be complete and accurate, remember that it is only a summary of the plans’ provisions. In interpreting this SPD, the Plan Administrator will rely on the governing plan documents. In the event of any conflict between this SPD and its governing documents, the plan documents will always control. The explanations in the SPD cannot alter, modify, or otherwise change the controlling plan documents, nor can any rights accrue by reason of any statements or omissions in the SPD.

With the exception of denied claims which may be appealed as described in the following sections, the Plan Administrator’s decisions regarding the interpretation of the plan documents and SPD are conclusive and binding on all persons. The Plan Administrator may, however, delegate some of its interpretation and decision-making authority to the insurer or claims administrator for the plans. Benefits under the plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

Plan Year

All plans are administered on a calendar year basis, January 1—December 31.

Agent for Legal Process

In the event that any legal action is necessary, Diageo NA has designated the following to serve as agent for service of legal process:

Senior Vice President and General Counsel
Diageo North America, Inc.
801 Main Avenue
Norwalk, CT 06851

Service may also be made on the Plan Administrator or Plan Trustees.

The Company is required to file annual reports (Form 5500) with the Employee Benefits Security Administration (EBSA) under the Department of Labor.

Sources of Plan Information

Official Plan Name/ Common Plan Name	Plan Number	Type of Plan	Administrator, Provider, or Trustee
Diageo NA Group Insurance Plans	501	ERISA	
Medical Plan		Self insured Welfare	Claims administered by: UnitedHealthcare Insurance Company 450 Columbus Boulevard Hartford, CT 06115
Prescription Plan		Self insured Welfare	Express-Scripts 225 Summit Avenue Montvale, NJ 07645
Dental Plan		Self insured Welfare	Claims administered by: Delta Dental Plan of New Jersey P.O. Box 222 Parsippany, NJ 07054
Vision Service Plan		Insured/Welfare	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
Life Insurance/AD&D and Business Travel Accident Plans		Insured/Welfare	Hartford Life P.O. Box 2999 Hartford, CT 06104
Health Care and Dependent Care Flexible Spending Accounts		Welfare	Claims administered by: UnitedHealthcare Insurance Company 450 Columbus Boulevard Hartford, CT 06115
Diageo NA Short-term Disability Plan (STD)		Self insured Welfare	Claims administered by: Hartford Life P.O. Box 2999 Hartford, CT 06104 Benefits paid by Diageo NA's operating assets
Diageo NA Long-term Disability Plan (LTD)		ERISA Insured/Welfare	Hartford Life P.O. Box 2999 Hartford, CT 06104
The Diageo North America, Inc., Savings Plan (401(k) Plan)	001	Defined Contribution Plan	Trustee: Fidelity Management Trust Company 300 Puritan Way Marlborough, MA 01752
The Diageo North America, Inc., Cash Balance Pension Plan (Cash Balance Plan)	002	Defined Benefit Pension Plan	Trustee: The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675

If you would like to see a copy of a plan document or reports that the Company submits to the government, you may do so during normal working hours or by contacting your Human Resources Representative. You may request a copy of a plan document by writing to the Plan Administrator. A copy will be sent to you within 30 days of receipt of your written request. The Company may charge you for the cost of making the copies. You may also request information from the Employee Benefits Security Administration at the address listed below:

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

Your ERISA Rights

As a participant in the Diageo North America, Inc., benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants are entitled to:

Receive Information about Your Plans and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

You will receive a summary of the plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plans as a result of a qualifying event (life status change). You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plans for the rules regarding your COBRA continuation coverage rights.

You are also entitled to the reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) following your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare or pension benefit, or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under one of the plans is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, you must use the plans' appeal process. If your claim for benefits is ultimately denied in whole or in part after completing the plans' appeal process, you may file suit in a Federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plans, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the **Employee Benefits Security Administration, U.S. Department of Labor**, listed in your telephone directory or the Division of Technical Assistance and Inquiries.

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Legal Plan Documents

Your Employee Benefits is a summary plan description (SPD) of the Diageo NA benefit plans. It describes the essential features of the legal plan documents that govern each plan's operations. If the material in this SPD is inconsistent in any way with the provisions of the applicable plan document, the provisions of the plan document are the controlling and final authority.

Benefit Plans Are Not a Contract of Employment

The benefit plans are not a contract of employment between you and the Company and grant no rights of continued employment to you or any other participant.

Interpretation of Plan Provisions Are Not Binding

Interpretation of the provisions of Your Employee Benefits or the plan documents made by persons other than the EBAC or those to whom it has delegated authority are without force or effect.

Assignment of Benefits

The benefit plans summarized in this SPD are used exclusively to provide benefits to you and your eligible dependents. Neither you nor Diageo NA can assign, transfer, or attach your benefits, or use them as collateral for a loan, except as described below.

Assigning Pension or 401(k) Benefits to Another Party

If you become separated or divorced, certain court orders, called Qualified Domestic Relations Orders (QDRO), could require that part of your Cash Balance Pension or 401(k) Plan benefit be paid to someone else; for example, your current/former spouse or children. If the EBAC determines that the court order qualifies as a QDRO, payment to your current/former spouse or children, will be made according to the order, and the corresponding plan provisions. You may request and receive, without charge, a copy of the plan's procedures for evaluating a domestic relations order. You will be notified if the plan receives a domestic relations order in your name.

Modification, Amendment, or Termination of the Plans

Currently, the Company expects to continue the benefit plans indefinitely. The Company, however, fully reserves the right through action by its Board of Directors or the EBAC to modify, amend, or terminate the plans at any time and for any reason. If the plans are modified, amended, or terminated, active and/or retired employees may not receive benefits as described in this SPD or as described in other materials that may have been provided to you from time to time. You may instead be entitled to receive different benefits, benefits under different conditions, or benefits may cease.

Request for Review

If your claim for benefits described in this SPD is denied (see "Long-term Disability Plan" on page 198, "Life Insurance/AD&D/Business Travel Accident Plans" on page 198 and "Health Care Plans" on page 186), you are entitled to request a review of the decision from the Plan Administrator as follows:

Step One: Appeal to Plan Administrator

- Send your written request for review, including reasons you believe you are entitled to benefits, together with any supporting documents, to:

  Benefit Plan Administrator
  c/o Total Rewards
  Diageo North America, Inc.
  801 Main Avenue
  Norwalk, CT 06851

- The Plan Administrator will provide written notification within 90 days after receiving the request for review. The notice will explain:
  - The reason for the denial;
  - The plan provisions on which the decision is based;
  - An explanation of any additional material or information that may be necessary to process your claim, together with the reason why such information is necessary; and
  - The procedure for requesting an appeal of the Plan Administrator's decision.
- If special circumstances require more than 90 days for processing your request for review, you will be notified of that fact, in writing, within 90 days after the Plan Administrator has received your request. The notice will explain the special circumstances that make an extension necessary and indicate a date when the final decision is expected to be made. The extension may be made for up to an additional 90 days.

If you receive no response from the Plan Administrator within 90 days after a request for review (or the 90-day extension period), you may consider your request denied and proceed to Step Two just as though you have received a denial notice.

Step Two: Appeal to the Employee Benefit Administration Committee (EBAC)

- Your appeal must be in writing to:

  The Employee Benefits
  Administration Committee
  Diageo North America, Inc.
  801 Main Avenue
  Norwalk, CT 06851

- You or your authorized representative may review any relevant documents and submit additional information as may be appropriate. You may also submit, in writing, the reasons that you think your claim should not be denied, including the reasons you believe you are entitled to benefits, together with any other supporting documents.

- Within 60 days after the date of your appeal is received, the EBAC will review the appeal. It will review all documents and information submitted and may request additional information and/or documents from Diageo NA personnel, its benefits providers, legal counsel, or other individuals relevant to the appeal. The Committee will send its decision, in writing, to the person requesting the review, including the specific reasons for the decision and references to the plan provisions on which it is based.
- If special circumstances require more than 60 days to review your appeal, the total review time may be extended to 120 days. If you do not receive a final decision within 120 days of your appeal, you may consider your appeal denied.

Health Care Plans

Administrative services for the health care plans are provided by:

Medical Plan

UnitedHealthcare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115
1-860-702-5000

Prescription Drug Program

Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512
800-711-0917

Dental Plan

Delta Dental Plan of New Jersey
P.O. Box 222
Parsippany, NJ 07054
1-877-738-3384

These administrators do not insure your benefits. The above plans are self insured by the Company. This means that the Company funds benefits for these plans from its general assets.

No contracts of insurance exist with respect to benefits under these plans, and no insurance company insures your benefits.

Request for Review of Health Care Claims

If you wish to request a review of a medical, prescription, or dental claim, send your written request for review, including the reasons you believe you are entitled to benefits, together with all supporting documents to either UnitedHealthcare (medical and prescription) at:

UnitedHealthcare Appeals
P.O. Box 740816
Atlanta, GA 30374-0816

Or Medco by calling Member Services at 1-800-711-0917, or Delta Dental at:

Delta Dental of New Jersey
1639 Rte 10
Parsippany, NJ 07054

If you are not satisfied with their response, you may send your "request for review" to:

Benefit Plan Administrator
c/o Total Rewards
Diageo North America, Inc.
801 Main Avenue
Norwalk, CT 06851
or fax your claim to: 1-203-229-7005

The Plan Administrator will notify you as follows:

Urgent Care Claim

Urgent care means any claim for medical care or treatment where denial of such care could seriously jeopardize your life or health or your ability to regain maximum function; or in the opinion of a physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Your treating physician can designate a claim for urgent care.

A claim will be considered to be an urgent care claim if an individual acting on behalf of the plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, determines the claim to be an urgent care claim. Also, any claim that a physician with knowledge of the claimant's medical condition determines is an urgent care claim within the meaning of this section shall be treated as a claim involving urgent care for the purposes of this section.

You will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible, but not later than 72 hours after your claim is received. However, if you do not provide sufficient information to determine whether benefits are payable under the plan, the Plan Administrator will notify you as soon as possible, but no later than 24 hours after receipt of the claim. You will have at least 48 hours to provide the necessary information. The Plan Administrator will notify you of its determination (whether favorable or unfavorable) as soon as possible, but no later than 48 hours after the Plan Administrator receives the additional information required (or, if earlier, the date by which the Plan Administrator required you to submit the additional information). If your claim is being denied, you will receive notice of the denial as described below. The initial notice of denial of your urgent care claim may be provided orally, provided that written notification is provided to you within three days after the oral notification.

Concurrent Care Decisions

This section applies if you have already received approval for an ongoing course of treatment to be provided over a period of time or a specified number of treatments.

- Reduction/Termination in Course of Treatment: Any decision to reduce or terminate a previously approved course of treatment (unless the Plan is being terminated altogether) will be considered a denial of a claim for benefits. You will receive sufficient advance written notice of the reduction or termination to allow you to obtain a review of the decision before the course of treatment is reduced or eliminated. The notice will be provided as described below.

- Requesting an Extension of a Course of Treatment: If you wish to request an extension of a course of treatment beyond the initial period of time or number of treatments for which you previously received approval, and if the request involves urgent care, you must make such request at least 24 hours prior to the expiration of the previously-approved course of treatment. You will be notified in writing of the decision whether to extend your course of treatment as soon as possible, but no later than 24 hours after receipt of your request. If your request does not involve urgent care, your claim will be treated as a regular pre-service claim. If your request is being denied, you will receive notice as described below.

Pre- and Post-Service Claims

A **Pre-Service Claim** is a claim for a benefit under a group health plan that requires prior approval from the plan in order to ensure full benefit coverage.

A **Post-Service Claim** is a claim for a benefit under a group health plan that does not require pre-approval before receiving care.

If your claim under the plan is totally or partially denied, you will be notified of the decision, after the Plan Administrator's receipt of your claim within the time limit shown below for the type of claim submitted:

Initial Notification Period by Type of Claim		
Urgent Care	***Pre-Service***	***Post-Service***
72 hours	15 days	30 days

A decision regarding your request for the Plan to approve an on-going course of treatment will be made far enough in advance of the proposed reduction or termination of treatment to allow you to appeal before the benefit is reduced or terminated.

Under special circumstances, the notification period may be extended for the time period shown below for the type of claim submitted:

Extension of Initial Notification Period by Type of Claim		
Urgent Care	***Pre-Service***	***Post-Service***
24 hours	15 days	15 days

If an extension is required, you will be notified of the special circumstances involved and the date by which the Plan Administrator expects to render a final decision. If the extension of time is required because you failed to provide information necessary to decide the claim, the notice of extension will describe the additional required information and you will be notified of the deadline for providing the specified information.

If your claim is denied, the Plan Administrator will provide you with a written or electronic notification of an adverse benefit determination. The notice will:

- Provide the specific reason(s) for the denial
- Refer to the specific plan provisions on which the denial is based
- Describe any additional information necessary for you to complete your claim and explain why such information is necessary

- Describe the plan's review procedure and the time limits that apply to your right to appeal, including your right to bring a civil action under federal law following an adverse benefit determination on review
- If the plan relied on a specific internal rule or guideline to make the adverse determination, provide (1) an explanation of the rule or guideline, or (2) a statement that a specific rule or guideline was relied upon and that a copy of the rule will be provided to you free of charge upon request
- If the adverse determination is based on medical necessity, experimental treatment, or similar exclusion or limit, provide either an explanation of the clinical judgment for the determination or a statement that such an explanation will be provided free of charge upon request
- In the case of an adverse determination for urgent care, describe the expedited review process applicable to such claims.

In the case of an adverse benefit determination involving a claim for urgent care, the information described above may be provided to you orally within the permitted time frame provided that written or electronic notification is furnished to you no later than three days after such oral notification.

Appealing a Benefit Denial

You or your authorized representative may request a review of a denied claim by submitting a written request for review to the Plan Administrator within 180 calendar days after you receive a notice of the decision. When requesting a review, you may submit written comments, documents, records, and other information relating to your claim. In addition, you will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. The review will be conducted by a person who was not involved in the initial benefit decision (and who is not a subordinate of such individual), and will not defer to the initial benefit decision. The reviewer will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision.

If your claim was denied due to a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the same person consulted in connection with the initial benefit decision (nor be the subordinate of that person). The decision on review also will identify any medical or vocational experts who advised the plan in connection with your benefit decision, even if the advice was not relied upon in making the decision.

You must be notified of the Plan Administrator's benefit determination upon review of a denied claim within the time period specified below based on the type of claim:

Notification Period for Benefit Determination Upon Review by Type of Claim		
Urgent Care	***Pre-Service***	***Post-Service***
72 hours	Within a reasonable period of time appropriate to the Medical circumstances, but no later than 30 days	Within a reasonable period of time, but no later than 60 days

You will be provided written or electronic notification of the Plan Administrator's decision. The notification will:

- Provide the specific reason for the adverse determination
- Refer to the specific plan provisions on which the benefit determination is based
- Include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits
- Include a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures, and a statement regarding your right to bring an action under Federal law
- If the plan relied on a specific internal rule or guideline to make the adverse determination, provide (1) an explanation of the rule or guideline, or (2) a statement that a specific rule or guideline was relied upon and that a copy of the rule will be provided to you free of charge upon request
- If the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit, provide (1) an explanation of the clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided to you free of charge upon request
- You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency
- The Plan Administrator's decision on review is final.

No Vested Rights to Benefits

While the Company currently provides medical, prescription drug, vision, and dental benefits to employees and retirees, employees and retirees have no vested right to such benefits. The Company may withdraw or modify such benefits at any time in its sole discretion.

Family and Medical Leave Act (FMLA)

FMLA provides certain employees with up to 12 weeks of unpaid, job-protected leave per year for certain family and medical reasons.

It requires that group health benefits be maintained during the leave. For additional information, contact your Human Resources Representative or log on to Diageo One.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If your health care coverage ends, you become eligible for COBRA, or you lose COBRA coverage, you will receive a certificate, at no charge, confirming the period during which you were covered under the Diageo NA health plans. This certificate may enable you to avoid exclusions for pre-existing conditions under your new medical coverage.

HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA's pre-existing condition limitations coordinate with COBRA's rules regarding termination of health care coverage. If you become covered by another group health plan and that plan contains a pre-existing condition limitation, your COBRA coverage cannot be terminated, unless the other plan's pre-existing condition limitation does not apply to you because of HIPAA's restrictions on pre-existing condition limitations.

HIPAA Privacy Rules

The Medical Plan and Health Care Spending Account are subject to the health care privacy rules established by HIPAA. The HIPAA Privacy Rules require the benefit administrators to take certain precautions in using and disclosing specified information about your health and that of your dependents and place limitations on the disclosure of such information to the Company and other third parties. You can obtain more information from the HIPAA Privacy Notice that has been provided to you. You may request a copy of the Privacy Notice from your Human Resources Representative.

Qualified Medical Child Support Orders (QMCSO)

The Plan Administrator is required to comply with a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

A medical child support order is a judgment, order, or decree that is made under State domestic relations law and provides for child support or health benefit coverage for an "alternate recipient." An alternate recipient is a child of a participant under a group health care plan who is recognized under the order as having the right to enrollment under the plan with respect to the participant. A medical child support order that is "qualified" creates or recognizes the right of the "alternate recipient" to receive benefits for which the participant is eligible under a group health plan. The order is recognized as "qualified" by the Plan Administrator of the group health plan when it includes certain information that meet the QMCSO statutory requirements.

In addition, a properly completed NMSN issued by a State child support enforcement agency must be treated as a QMCSO. You may request and receive, without charge, a copy of the plan's procedures for evaluating such orders or notices. You will be notified if the plan receives a medical child support order or notice in your name. If you are in the process of getting a divorce and have questions about QMCSOs or NMSNs, please contact the Plan Administrator.

Coordination of Benefits (COB)

If in addition to our plans, you or your dependents are eligible to receive benefits from another medical, vision, or dental group plan, or "no-fault" automobile insurance, we will coordinate benefits with the other plans to prevent overpayment. This also applies if you and your spouse both work for Diageo NA.

Primary and Secondary Plans

The plan that pays benefits first is the primary plan; the other plan is the secondary plan. If our plan is primary, we will pay our full plan benefits, and then you may submit your claim to the secondary plan to determine whether additional benefits will be paid to you.

If our plan is secondary, the total payment from all plans cannot be more than what our plan would normally pay in benefits if it was the primary plan. In addition, our plan will only pay for expenses covered by our plan. If the other plan covers a service that we do not cover, we will not coordinate benefits on that particular expense.

For example, your spouse has coverage under his/her employer's plan and is also a dependent under our PPO Option 90 Plan. If he/she goes to a network chiropractor, our plan would normally pay 100% of the expenses after a $30 copay. If your spouse's plan pays 75% for the visit, our plan will pay the additional 25% balance (after the copay). If your spouse's plan does not cover chiropractic care, our plan will pay the full amount (after the copay). Your spouse needs to first submit the claim to his/her plan, and then to our plan.

The following criteria determine which plan is primary:

A plan that does not coordinate with other plans is always the primary plan.

The plan covering the person as an employee is the primary plan; the plan covering the person as a dependent is the secondary plan.

When our plan and another plan cover a dependent child, the primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year, but if both parents have the same birthday, the plan which has covered the parent for the longest time is the primary plan. If the other plan does not have the birthday rule, the other plan's rule will determine which plan is primary.

For dependent children of divorced or legally separated parents, they will be covered first by the parent who has primary financial responsibility. If, however, the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, then that parent's plan is the primary plan.

If during coordination of benefits, payments are made in error or a claim is overpaid, the plan will have the right to recover the overpayment from any person or organization. The plans' liability for expenses arising out of an automobile accident is based on the type of automobile insurance law enacted by the covered person's state. Currently there are three types of state automobile insurance laws:

- No-fault automobile insurance laws
- Financial responsibility laws
- Other automobile liability insurance laws

It is the plans' general intent not to pay expenses resulting from automobile accidents.

Subrogation

As a condition to participating in and receiving benefits under these plans, covered persons and their dependents agree:

- To reimburse the plans for any such benefits paid, to or on their behalf, when said benefits are recovered, in any form from any person or his insurer, corporation, entity, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or fund.
- Without limiting the preceding, to subrogate the plans to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or entity who has or may have caused, contributed to or aggravated the injury or condition for which the covered person(s) and/or their dependent claims an entitlement to benefits under the plans, and to any claims, causes of action or rights they may have against any other no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("coverage"). In the event a covered person or a dependent settles, recovers or is reimbursed by any third party or coverage, the covered person or dependent agrees to hold any such funds received in trust for the benefit of the plans, and to reimburse the plans for all benefits paid or that will be paid as a result of an injury or condition.
- The covered person and dependent(s) agree that they will make a decision on pursuing any and all third parties and coverage within 30 days of the date of the accident or occurrence which led to the injury or condition for which plan benefits are being sought, and within the 30 days will so notify the plans in writing. In the event the covered person decides not to pursue any and all third parties or coverage, or fails to notify the plans within 30 days of the accident or occurrence of its intent to do so, the covered person and any dependents authorize the plans to pursue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims, and agree to fully cooperate with the plans in the prosecution of any such claims.

The plans will not pay or be responsible, without their written consent, for any fees or costs associated with a covered person or a dependent pursuing a claim against any third party or coverage.

Coordination of Benefits with Medicare

If you are an active employee age 65 or older, or if your spouse is age 65 or older, you and/or your spouse are covered by the health care plans on the same basis as an employee or spouse under age 65. Our plans are your primary coverage, and Medicare is your secondary coverage.

To ensure that you receive all possible benefits, you need to apply for Medicare at least three months before your 65th birthday.

If you do not sign up for Medicare when you are first eligible, you may have to pay a higher Medicare premium, and enrollment periods may be limited. Our plans will pay benefits as if you are covered by Medicare, regardless of whether you are enrolled in Medicare.

As of January 1, 2006, the federal government offers all Medicare-eligible persons prescription drug coverage under Medicare Part D. As an active employee over age 65, you (your spouse) are covered by the Diageo Prescription Drug Program, and you should **not** enroll for Medicare Part D.

You should know that if you drop or lose your coverage under the Diageo Prescription Drug Program and don't promptly enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

Continuing Coverage through COBRA

Federal law requires that under certain circumstances your spouse and dependents may elect to have medical, dental, or vision coverage continued in a number of situations that would otherwise result in termination of coverage. While not required by law, this continued coverage also will be offered to domestic/civil partners and same-sex spouses. However, the full cost of such continued coverage plus an additional 2% to cover administrative costs must be paid by the person continuing coverage.

Events Permitting Continued Coverage

Certain events will result in eligibility for continued coverage under the medical, dental, and/or vision plans by you, your spouse/ domestic partner, and/or children. These events are known as "Qualifying Events." If your employment with Diageo NA ends (for reasons other than gross misconduct) or if your hours are reduced to the point where you would not ordinarily be covered by the plans, you may continue the coverage you had in effect as of your date of termination for up to 18 months following the month in which your termination occurs.

If you are totally and permanently disabled when you leave the Company (or within 60 days of coverage continuation), and qualify for Social Security benefits, you may continue your coverage an additional 11 months for a total of 29 months. You must pay 102% of the full cost of coverage for the additional 11 months of coverage. You must notify the Company of your disability before the first 18 months of continued coverage has expired.

If one of the following events occurs, your spouse/partner, and children's coverage may be continued for up to 36 months: (Domestic partners and their children are not eligible for COBRA if you die)

- Your death prior to termination of employment or retirement

  Your spouse (and any children) may continue coverage for up to 36 months; if there is no spouse, or your spouse is not eligible for coverage, your children may continue coverage for up to 36 months.

- Your divorce, legal separation, or dissolution of a partnership prior to termination of employment or retirement

  Your spouse/ partner (and any children) may continue coverage for 36 months; if your spouse/partner is not eligible for coverage, your children may continue for up to 36 months.

- You choose to elect Medicare as your primary coverage upon becoming eligible
- Your spouse/partner (and any children) may continue coverage for up to 36 months; if your spouse/partner is not eligible for coverage, your children may continue coverage for up to 36 months.
- Your child ceases to be a dependent as defined by the plan
- Your child may continue coverage for up to 36 months.

Events that End COBRA Coverage

COBRA coverage will end automatically as of the date that any one of the following situations occurs:

- The Company stops providing medical benefits to its employees.
- The required premiums are not paid on a timely basis.
- Where continued coverage is provided due to your termination of employment with the Company, as of the date when continued coverage has been provided for 18 months. (In the case of disability, as of the date when continued coverage has been provided for 29 months.)
- Where continued coverage is provided to your spouse/partner and/or children due to reasons other than your termination, as of the date when continued coverage has been provided for 36 months.
- With respect to you, your spouse/partner, or children, the date that you, your spouse/domestic partner, or children, respectively, become covered under another medical, dental, or vision plan as a result of employment, reemployment, remarriage, or other reason. You may, however, continue COBRA coverage if any new coverage contains a limitation on a pre-existing condition that you or a dependent may have until that condition is covered by the new plan or until the applicable 18- or 36-month continuation period ends. Coverage during the time of this pre-existing limitation covers only expenses related to the pre-existing condition as covered by the Company's plan. The cost is the current group rate plus 2% for administration.
- You, your spouse/partner, or children become eligible for Medicare.

Notice Requirement

If your spouse or child qualifies for continuation of coverage due to a Qualifying Event such as divorce, legal separation, or ceasing to meet the definition of a dependent under the plans, you must notify your Human Resources Representative or log on to Diageo One to initiate the process. This notice should be given prior to the Qualifying Event, or as soon as possible thereafter (but not more than 60 days after the Qualifying Event).

When the Plan Administrator receives notice of a Qualifying Event, it must notify Qualified Persons of their right to continue coverage, their obligations and costs.

Election Requirement

Each Qualified Person must make written election on the forms provided within 60 days after the later of:

- The date coverage would otherwise end if no continuation was elected; or
- The date the Company's written notice was sent.

The election form must be sent to United HealthCare within the stated 60-day period; otherwise, the continuation option expires. Any qualified person who fails to make his or her election to continue coverage within the 60-day period will not be permitted to continue any level of coverage. You can visit their website at **www.uhcservices.com**. Send all forms to:

United HealthCare
PO Box 713082
Cincinnati, OH 45271

Initial Premium

The first premium payment must be made within 45 days after you have elected COBRA coverage.

Military Leaves of Absence

If you are on an approved military leave of absence, you and your covered dependents may continue coverage up to 12 months at the employee rate. Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you and your covered dependents will be entitled to elect COBRA coverage if you are unable to work after 12 months because of duty in the "Uniformed Services." Uniformed Services are the Armed Forces; the Army National Guard, and the Air Force National Guard when engaged in active duty training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and other categories of personnel designated by the President of the United States in time of war or emergency. This extended coverage will last not more than 18 months and cannot be extended for any reason. In addition, upon return from Uniformed Services, you or your covered dependents will generally be eligible to automatically resume plan coverage. All rights guaranteed by USERRA are dependent on the Uniformed Service ending honorably.

In general, the rights guaranteed by USERRA do not apply if the total length of your military leave exceeds five years.

Short-term Disability Plan

Short-term Disability benefits are self-funded by the Company and are administered by:

Hartford Life
P.O. Box 2999
Hartford, CT 06104

Request for Review

To request a review of a denial of a Short term Disability claim, follow these steps:

Step One: Appeal to Claims Administrator

Hartford Life
Attn: Disability Claim Appeal Unit
Business Management Services—B2E
P.O. Box 2999
Hartford, CT 06104

If your claim is wholly or partially denied, you will be notified of the decision within 45 days after the Claim Administrator's receipt of your claim. Under special circumstances, the notice period may be extended for 30 days.

If an extension is required, you will be notified of the special circumstances involved and the date by which the Claims Administrator expects to render a final decision. If the Claims Administrator determines that a decision cannot be made within the original 30-day extension, the notice period may be extended for another 30 days. If a second 30-day extension is required, you will be notified of the special circumstances involved and the date by which the Claims Administrator expects to make a decision. If the extension of time is required because you failed to provide information necessary to decide the claim, the notice of extension will describe the additional required information and you will be allowed at least 45 days from receipt of the notice of extension to provide the specified information.

If your claim is denied, the Claims Administrator will provide you with a written or electronic notification of any adverse benefit determination. The notice will:

- Provide the specific reason(s) for the denial
- Refer to the specific plan provisions on which the denial is based
- Describe any additional information necessary for you to complete your claim and explain why such information is necessary
- Describe the plan's review procedure and time limits that apply to your right to appeal, including your right to bring a civil action under Federal law following an adverse benefit determination on review
- If the plan relied on a specific internal rule or guideline to make the adverse determination, provide (1) an explanation of the rule or guideline, or (2) a statement that a specific rule or guideline was relied upon and that a copy of the rule will be provided to you free of charge upon request.
- Within 180 days after you receive a notice of the decision on your claim, you or your authorized representative may request a review of a denied claim by submitting a written request for review to the Employee Benefits Administration Committee (EBAC).

Step Two: Appeal to the Employee Benefit Administration Committee (EBAC)

- Your appeal must sent be in writing to:

The Employee Benefits Administration Committee
Diageo N.A., Inc.
801 Main Avenue
Norwalk, CT 06851

- You or your authorized representative may review any relevant documents, and submit additional information as may be appropriate. You may also submit, in writing, the reasons that you think your claim should not be denied including the reasons you believe you are entitled to benefits, together with any other supporting documents.
- Within 60 days after the date of your appeal is received, the EBAC will review the appeal. It will review all documents and information submitted and may request additional information and/or documents from Diageo NA personnel, its benefits providers, legal counsel, or other individuals relevant to the appeal. The Committee will send its decision, in writing, to the person requesting the review, including the specific reasons for the decision and references to the plan provisions on which it is based.
- If special circumstances require more than 60 days to review your appeal, the total review time may be extended to 120 days. If you do not receive a final decision within 120 days of your appeal, you may consider your appeal denied.

Long-term Disability Plan

The Long-term Disability Plan is insured by:

Hartford Life
P.O. Box 2999
Hartford, CT 06104
Policy #GLT-674795

Request for Review

The process for requesting a review of a denial of a Long-term Disability claim is the same as for Short-term Disability.

Life Insurance/AD&D/Business Travel Accident Plans

The Life Insurance/AD&D/Business Travel Accident Plans are insured by:

Hartford Life
P.O. Box 2999
Hartford, CT 06104

The group policies are on file and may be examined by contacting your Human Resources Representative.

The insurance company will determine all benefit payments according to the provisions described in this SPD and the terms and conditions of the group policy. Premiums are determined by the insurance company. The insurance is effective only if the person concerned is eligible, becomes insured and remains insured in accordance with the terms and conditions of the policy.

Policy Numbers

Basic, Supplemental, Dependent Life, and AD&D Insurance - 674795

Business Travel Accident Insurance - ETB 7093

Request for Review

The process for requesting a review of a Life Insurance/AD&D/Business Travel Accident claim denial is the same as outlined in Steps One and Two in "Request for Review" on page 185. The only difference is that you should send your written request for review to:

Hartford Life
Group Life Claims
P.O. Box 2999
Hartford, CT 06104

401(k) Plan

Top Heavy Provisions

As required by law, alternate plan provisions go into effect if the plan becomes "top heavy." The plan is top heavy if more than 60% of the account balances relate to key employees. Key employees include Company officers and highly-paid employees. You will be notified if the plan becomes top heavy.

If the Plan Ends

In addition to the provisions for modification, amendment, and termination of the plan as described in "Modification, Amendment, or Termination of the Plans" on page 184, if the plan is terminated, you will automatically become 100% vested in the value of your 401(k) Plan account if the plan contains an Employer match or Profit-Sharing contribution.

Additional Information

The EBAC has the authority to establish investment fund policies and objectives.

Most expenses of administration, including the expenses and compensation of the 401(k) Plan's Trustee and any counsel employed by the Trustee, are paid by the Company. Brokerage commissions, transfer taxes, and other charges and expenses in connection with the purchase or sale of securities are charged against the trust fund and added to the cost of such securities or deducted from the proceeds thereof, as the case may be.

However, there are certain expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to you. For example, if you are married and get divorced, the plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other participants) because they are directly attributable to your benefit under the plan. After you terminate employment with the Company, the plan may charge your account for your pro rata share of the plan's administration expenses, regardless of whether the Company pays some of these expenses on behalf of current employees.

The Company, from time to time, may change the manner in which expenses are allocated and which plan expenses will be paid directly from an individual participant's account rather than from the accounts of all participants.

The 401(k) Plan is a participant-directed individual account plan under ERISA section 404(c), and the 401(k) Plan fiduciaries, including the EBAC, may be relieved of liability for any losses which are the direct and necessary result of investment instructions given by participants.

Although the Trustee is independent, it is simply a "directed trustee." This means that it acts solely on instructions from plan participants and beneficiaries authorized to direct it and does not make discretionary fiduciary decisions about the plan or the investment options and does not monitor the performance of the investment options.

Cash Balance Plan

Top-Heavy Provisions

As required by law, if you are covered by the Cash Balance Plan, alternate plan provisions go into effect if the plan becomes "top heavy." The plan is top heavy if more than 60% of the account balances relate to key employees. Key employees include Company officers and highly-paid employees. You will be notified if the plan becomes top heavy.

Management of Pension Funds

All pension contributions made by the Company are deposited in a trust that is maintained by the plan. The assets of this trust fund are used to pay plan benefits to participants and beneficiaries. The trustee is:

The Northern Trust Company of Chicago
50 South LaSalle Street
Chicago, Illinois 60675

The plan provides that the fund be valued and audited once each year by a certified public accountant. A statement of the audit results is available for inspection at the Company headquarters.

Future of the Pension Plan

The Company expects the plan to continue in existence for your benefit in future years. If, however, for any reason the plan should be discontinued, assets of the trust fund necessary to pay benefits under the plan will belong to the active and retired employees as provided in the plan. None of the assets in the trust fund can go back to the Company until all of the plan's benefit obligations are met in full.

If the Plan Ends

If the plan is terminated, plan assets will be allocated in priority categories according to the law, as described below. The benefits allocated to you will be 100% vested as of the plan termination date, to the extent plan assets are sufficient. If the Company is dissolved, the plan will terminate as of the date of dissolution. If there is a partial termination of the plan affecting you, you will become 100% vested in the plan.

Distribution of Benefits

When terminating the plan, the Company will notify the Internal Revenue Service (IRS) and the Pension Benefit Guaranty Corporation (PBGC). Once the necessary approvals have been received, plan benefits will be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, funds will be allocated in this order:

1. Benefits to retirees, surviving spouses, and other beneficiaries of retirees, and spouses of participants who died before retirement but with a pre retirement survivor option in effect.

   To qualify for benefits in this category, retirees, spouses, or beneficiaries must already have been receiving, or have been eligible to receive benefits, for at least three years before plan termination. (This includes active employees who were eligible to retire at least three years before plan termination.) The benefit paid will be the smallest benefit you received during the five-year period ending on the plan termination date.
2. Benefits to retirees, surviving spouses, and other beneficiaries who began receiving benefits within three years of plan termination, and active employees who could have retired and begun receiving benefits within that time. This category also includes vested active employees who left with eligibility for deferred vested benefits.
3. All other accrued benefits. If full benefits cannot be paid under any of the above categories, payments will be made on a pro-rata basis as prescribed by law.

Mergers, Consolidations, or Transfers

If the plan is merged, consolidated, or plan assets are transferred to another plan, your current accrued benefit will be protected. Your accrued benefit under the new plan, immediately after the changes, would at least equal the amount you would have been entitled to if the Plan had been terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors. The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the Company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop you when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the plan has and how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator or contact the PBGC's at 1-202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 1-202-326-4000. You may also contact PBGC at:

Technical Assistance Division
1200 K Street
N.W., Suite 930
Washington, D.C. 20005-4026

Additional information about the PBGC's pension insurance program is available through the PBGC's website on the internet at **www.pbgc.gov.**