Summary Plan Description
for the
Sysco Corporation Early Retiree Healthcare Plan

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This booklet, along with the benefit summaries referenced herein, summarizes the main provisions of the Sysco Corporation Early Retiree Healthcare Plan (the “Plan”). The Plan provides the following benefits to eligible individuals:

- Medical/Prescription Drug
- Managed Mental Health
- Dental
- Vision
- Employee Assistance Program

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA) which requires plan administrators to distribute a Summary Plan Description (SPD) to employees, including former employees, covered by the ERISA benefits listed above. The Plan Administrator has determined that the information in this booklet, together with the information contained in referenced benefit summaries for the underlying benefit programs, composes the SPD for the above-mentioned Plan. This booklet is intended to be an easy-to-read reference to help you understand the Plan. It does not describe every feature of the Plan and is not intended to be a full statement of the Plan document. The official terms of the Plan are contained in applicable plan documents as well as any certificates of coverage and insurance policies under which the benefits are provided. Certain terms in the SPD have a special meaning when used in the Plan. These terms are capitalized throughout the SPD and are defined in the Plan document. The official plan documents, certificates, or policies will control in the event of any differences between those documents and the SPD. However, if there is language in the SPD regarding a topic the plan documents, certificates of coverage or policies are silent on, the language in this SPD will govern.

We encourage you to read this booklet and the incorporated documents carefully and share them with your family members. If you have any questions about your benefits, please contact Sysco Benefits Center at 1-800-55-SYSCO or via the web at www.syscobenefits.com.

Sysco Corporation expressly reserves the right to amend or revise any term, provision or benefit under the Plan, this Wrap SPD or to terminate the Plan or any of the benefit programs offered under the Plan at any time in its sole discretion.

About Your Participation

This section includes important information about your participation in the Plan, including eligibility information, when to enroll, when you can make election changes, paying for coverage and when coverage ends.

Who Is Eligible for Coverage?

Eligible Retirees

You are considered an Eligible Retiree and eligible to participate in the Plan if you are:

- An Employee of Sysco Corporation, or an Affiliated Employer, between the ages of 55 and 64 who retires with at least ten (10) years of recognized service,
- Not covered by another group health plan or Medicare, and
- Covered by a Sysco Corporation healthcare program at the time of your retirement

Dependent Eligibility

Your Eligible Dependents can also participate in the Plan if they are covered under your active coverage on your date of retirement. For purposes of this Plan, Eligible Dependents generally include:

- Your legally married spouse (unless legally separated)
- Your biological child, legally adopted child or child that has been placed with you for adoption
- Your stepchild (biological child of your legal spouse)
- Child placed with you for foster care

If you meet eligibility requirements for this plan and you have a spouse covered under your active coverage on your date of retirement, you may continue to cover your spouse under the Early Retiree Healthcare Plan until your spouse reaches age 65. If you reach age 65 first, your coverage will end, but your spouse can continue coverage up to age 65. If you meet eligibility requirements for this plan and you have dependent children covered under your active employee plan on your date of retirement, you can continue to cover the children or your spouse can continue to cover them according to the eligibility guidelines for dependents under the active plan.

Eligible Dependent children are eligible for coverage until the date they attain age 26, regardless of their student status, marital status and whether or not they can be claimed as dependents on your federal tax return. Eligibility for a dependent child may be extended for an unmarried, physically or mentally disable child if the child:

- Is incapable of self-sustaining employment due to a mental or physical disability, is dependent on you for support, and
- Became incapacitated before reaching the maximum age for coverage of dependents under the applicable benefit plan

Proof that the child is disabled must be submitted to the Plan Sponsor no later than 31 days of the child's attaining age 26, or if later, within 31 days of the child first becoming eligible for coverage. Additional proof that the disability continues may be required by Sysco Corporation. For more information, please contact Sysco Benefits Center at 1-800-55-SYSCO or via the web at www.syscobenefits.com.

Dependent children are eligible for coverage under the Plan even if the child is covered under another group health plan, including any military plan.

When you enroll your dependents in the Plan, you acknowledge that all your covered dependents meet the definition of an eligible Dependent under the Plan. Sysco Corporation verifies the eligibility of your enrolled dependents, and you may be required to provide valid documentation for any dependent you choose to enroll in the Plan. If it is determined that anyone you have claimed as your dependent does not meet the dependent eligibility criteria, their coverage will be terminated retroactively back to the date they were first an ineligible dependent under the terms of the Plan. You will be required to repay the Plan for any claims that were paid for any ineligible dependent(s). If it is determined that you intended to defraud the Plan, further action may be taken up to and including termination of your employment with Sysco Corporation.

If both you and your spouse are retirees of Sysco Corporation and eligible under the Plan, only one of you may choose to cover your dependent children. If your spouse who has coverage for the dependent children should lose coverage, you may elect to cover the dependent children provided application for coverage is made within 31 days after the date your spouse loses coverage.

An Eligible Retiree who also qualifies as an eligible spouse of another Eligible Retiree may either (1) elect individual coverage, or (2) elect coverage as a dependent, but not both.

How to Elect Coverage and When Coverage Begins

If you are an Eligible Retiree and you affirmatively elect to participate in the Plan by submitting an enrollment form within 60 days of the end of your coverage as an active employee, your coverage will begin on the first of the month following the end of your active coverage, or your COBRA coverage, if applicable and you elect COBRA continuation coverage upon retirement.

You may obtain a copy of the applicable enrollment form by contacting Sysco Benefits Center at 1-800-55-SYSCO or via the web at www.syscobenefits.com.

You must affirmatively enroll in the Plan within 60 days of the date you first become eligible to participate. If you do not timely enroll within 60 days of eligibility, you will not be eligible to enroll for coverage at a later date. You will be able to add dependents at a later time (due to qualified status change or at open enrollment). Your spouse is eligible to enroll without you if you have met the requirements of the Plan but are not enrolling yourself due to age or other circumstances. In the event of your death, your spouse is eligible to enroll if you have met the eligibility requirements of the Plan. Coverage would be effective the first of the month following your death or following COBRA, if applicable.

Coverage Period

Your initial election will run through December 31 of your first year in the Plan, unless you make a change based on a qualified life status change or other event permitting a mid-year election change.

Elections made during each subsequent Annual Enrollment Period will be in place for the following January 1 through December 31 unless you have a qualified life status change or other event permitting a mid-year election change. You will be advised each year of the proper procedures to follow in order to receive benefits under the Plan and it is important that you read the Annual Enrollment information made available to you by Sysco Corporation as this is how the Plan informs you of what benefit offerings are changing under the Plan and what actions are needed in order to make the elections you want. **If you have been enrolled in the Plan but fail to timely follow the procedures communicated to you in your Annual Enrollment materials, your voluntary coverage under the Plan will end.**

If you enroll in the Plan or change coverage under the Plan during the year because of an event permitting a change, you have 31 days from the effective date of your qualified life status change to make your elections and your new coverage elections will generally go into effect prospectively, but no earlier than the date you request the change. If the qualified life status change is birth or adoption, your elections and your coverage will go into effect retroactively to the date of the event.

Paying for Coverage

If you are eligible for and enroll in coverage under the Plan, you will be responsible for timely remitting your portion of the premium amount as communicated to you by the Plan Administrator. For more information, please contact Sysco Benefits Center at 1-800-55-SYSCO or via the web at www.syscobenefits.com.

Making Changes During the Year

Qualified Life Events

Once you have enrolled in the Plan, you may not change your election during the Plan Year for yourself or your dependents, except under the following circumstances:

- A change in your legal marital status (marriage, divorce or death of your spouse)
- A change in the number of dependents (birth, adoption, or death of a dependent)
- Your dependent satisfying or ceasing to satisfy an eligibility requirement for coverage as a dependent
- A change in employment status for you, your spouse or your dependent
- A change in residence for you, your spouse, or your dependent (the change must affect your eligibility and/or cost for coverage)

Any election changes you make during the year as a result of one of the above events must be consistent with the event. Not every event will permit you to change your elections. Election changes are consistent with a qualified life status change only if the election change is on account of and corresponds with an event that affects eligibility for either you, your spouse, or your dependent under the Plan or your spouse's, or dependent's employer plan.

You must notify Sysco Corporation of the qualified life status change within 31 days of the event by calling the Sysco Benefits Center at 800-55-SYSCO or by clicking the life events tab, and selecting your life event in the Benefits Enrollment System available 24/7 at www.SyscoBenefits.com. If a change is reported outside this time frame, an election change will not be allowed.

Additional Mid-Year Election Change Events

You may also be able to make a mid-year change for other reasons including:

- *Changes required by a judgment, decree or order, including a qualified medical child support order (QMCSO)*, resulting from a divorce, legal separation, annulment or change in legal custody that require group health plan coverage for your child (or foster child who is your dependent). If the order directs you to cover the child, the child (and yourself) will be enrolled in the Plan's group health plan coverage. If the order directs someone other than you (for example, your spouse or former spouse) to cover the child, you may drop group health plan coverage for the child, but only if the other coverage is actually provided. See the "Qualified Medical Child Support Order (QMCSO)" section
- *Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid*. If you, your spouse, or a covered dependent becomes entitled to Medicare or Medicaid (that is, becomes enrolled), you may drop or reduce medical coverage for that individual. If you, your spouse or a dependent loses entitlement to Medicare or Medicaid, you may enroll or increase medical coverage for that individual (and yourself) in the Plan
- *Coverage changes*
  - *Significant curtailment without loss of coverage*. If you or your spouse, or dependent has a significant curtailment of group health plan coverage under the Plan that is not a loss of coverage as described below, you may revoke your election for that Plan option and elect to receive coverage going forward under another Plan option providing similar coverage. A significant curtailment without a loss of coverage includes a significant increase in the deductible, the copay or the out-of-pocket cost sharing limit. Because coverage under the Plan will be considered significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally, in most cases the loss of one particular physician in a network will not constitute a significant curtailment
  - *Significant curtailment with loss of coverage.* If you or your spouse, or dependent has a significant curtailment that is a loss of coverage under the Plan, you may revoke your election for that group health plan option and elect to either: (1) receive coverage going forward under another option, as applicable, providing similar coverage; or (2) drop coverage if no similar option is available
  - *Addition or improvement of a medical benefits coverage option*. If a new medical benefits coverage option is added to the Plan, or if coverage under an existing medical benefits coverage option is significantly improved during a period of coverage, you may revoke your medical benefits coverage option election or enroll in medical benefits under the Plan if not previously enrolled, and elect coverage under the new or improved medical benefits coverage option
- *Change in coverage under another employer Plan*. You may make a prospective change in election that is on account of an corresponds with a change made under another employer's plan provided that the Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other plan
- *Loss of coverage under other group health coverage*. You may make a mid-year election change to add coverage under the Plan for you, your spouse, or dependent if you, your spouse, or dependent loses coverage under any group health coverage sponsored by a governmental institution, including the following:
  - A state's children's health insurance program (SCHIP),
  - A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization,

- A state health benefits risk pool, or
- A foreign government group health plan

Loss or Gain of Eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid

If you are eligible for, but not enrolled in the Plan or your dependent is eligible for, but not enrolled in the Plan, you (and your dependent) may enroll in the Plan, if either of the following conditions is met:

- You or your dependent is covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility and you request coverage under the Plan, not later than 60 days after the date of termination of such CHIP or Medicaid coverage, or
- You or your dependent becomes eligible for CHIP or Medicaid premium assistance subsidy with respect to coverage under the Plan, if you request coverage under the Plan, not later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy

If you enroll yourself, your spouse and/or your eligible dependent children in the Plan due to a loss or gain of eligibility for coverage event described above, Plan coverage will begin the date you request the election change. If, however, you become eligible for Medicaid or CHIP and apply for coverage through the Health Insurance Marketplace, then coverage would be retroactive back to the date you applied, or up to three months earlier in some states.

To request special enrollment or to obtain more information, contact Sysco Benefits Center at 1-800-55-SYSCO.

When Coverage Ends

Once your coverage as an Eligible Retiree has commenced, it will end when one of the following events occurs:

- The first day of the month in which you attain age 65, unless your date of birth is on the first day of the month in which case coverage will terminate on the first day of the month prior to the month in which your birthdate falls
- The first day of the month following the date you become covered under another group health plan or by Medicare
- If you stop making any required contributions, the date through which your last payment covered the date Sysco Corporation no longer makes any required contributions
- The end of the month in which you die
- The date Sysco Corporation terminates the coverage under the Plan

Once coverage has ended for you for any reason, it cannot be reinstated.

Coverage for your Eligible Dependents ends:

- On the date the Eligible Dependent no longer meets the eligibility requirements for coverage as a dependent under the Plan
- At the end of the month in which your dependent dies
- On the first day of the month in which you attain age 65, unless your date of birth is on the first day of the month in which case coverage will terminate on the first date of the month prior to the month in which your birthdate falls
- On the first day of the month in which your Eligible Dependent spouse attains age 65, unless their date of birth is on the first day of the month in which case coverage will terminate on the first date of the month prior to the month in which their birthdate falls
- On the first day of the month following the date the Eligible Dependent spouse becomes covered by another group health plan or Medicare (note: coverage for a dependent child will not end due to coverage by another group health plan or Medicaid)
- For a dependent child, on the date both parent's coverage under the Plan ends or the day before a dependent child reaches the age of 26.
- If the Eligible Retiree ceases making any required contributions coverage will terminate on the date through the last payment made covers
- The date Sysco Corporation no longer make any required contributions
- The date Sysco Corporation terminates coverage under the Plan

Please refer to the terms of specific benefit programs for any questions regarding when your coverage with respect to a specific program may end.

Your Plan Options

As an Eligible Retiree, you may affirmative elect to participate in the Plan which includes the following benefits provided in a bundled format (meaning your election includes all the following benefits; you are not permitted to elect only certain benefits while declining others):

- Medical/Prescription Drug
- Managed Mental Health
- Dental
- Vision
- Employee Assistance Program (EAP)

For More Information

For detailed information about the specific Plan benefits available to you, including covered services, services that are not covered and limitations and exclusions that apply, please refer to the benefit descriptions, evidence of coverage booklets for insured options, certificates and other documents

prepared by the third-party administrators and incorporated by reference into this booklet ("incorporated documents").

Additional Federal Rules and Regulations

This section describes additional Federal rules and regulations that apply to the group health plan benefits offered through the Plan. Please refer to this section along with the incorporated documents when trying to understand what your Plan covers and what limitations and exclusions apply.

Breast Reconstruction Benefits

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under The Women's Health and Cancer Rights Act of 1998.

If you (or a covered dependent) are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans generally cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to (1) less than 48 hours following a vaginal delivery, or (2) less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and healthcare issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order (QMCSO)

The Plan will comply with all the terms of a qualified medical child support order (QMCSO). A medical child support order is an order or judgment from a court or administrative body that directs the Plan to cover a child of a participant under one or more of the participating programs providing group health plan

benefits (e.g., medical, dental vision). Federal law provides that a medical child support order must meet certain form and content requirements in order to be a *qualified* medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's QMCSO procedures that are used in the determination of the validity and administration of the order.

Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Administrator, or its delegate, determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedures for determining whether a medical child support order is valid, please contact Sysco Benefits Center at 1-800-55-SYSCO.

Privacy of Health Information

The receipt, use and disclosure of protected health information by the Plan with respect to group health benefits is governed by regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business employees may receive, use and disclose protected health information in order to carry out the payment, treatment and healthcare operations under the Plan. These entities and individuals may use protected health information for such purposes without your consent or authorization. In addition, your protected health information may be shared with the plan sponsor without your consent or written authorization for administrative purposes. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure.

For more information about the privacy of your protected health information under HIPAA, see the Plan's Privacy Notice, which is posted on the Sysco Benefit Center portal www.syscobenefits.com.

Subrogation and Right of Reimbursement

The Plan's right to obtain reimbursement for certain expenses paid or advanced on your behalf is generally subject to the reimbursement and subrogation provision described in the benefits booklet, certificate or policy to which the benefit relates. In the event that reimbursement and subrogation is not described in the benefits booklet, certificate or policy, then the subrogation rules described below will apply.

If the Plan Administrator determines that a third-party is or may be legally responsible to pay for certain expenses (such as, due to negligence, an intentional act or breach of any legal obligation or because of coverage under an automobile or other insurance policy), the Plan Administrator may direct that such expenses, be advanced to you subject to the following terms and conditions:

- You must advise the Plan Administrator, in writing, within 30 days after you make a demand against a third-party or third-party's insurer, file an administrative claim or file a lawsuit. Such written statement must describe, in sufficient detail, the action that has been taken
- The Plan will be subrogated (substituted) to all of your rights of recovery against any person or organization to the extent of the benefits provided under the Plan. You will cooperate with the

Plan and/or any representatives of the Plan in completing such forms and in giving such information and taking such actions surrounding any accident, illness or injury as the Plan or its representatives deem necessary to fully investigate the incident and secure repayment or recovery

- The Plan will also be granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise
- By accepting benefits under the Plan, the Plan will automatically be granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by you or your representatives, and you consent to such lien and agree to take whatever steps are necessary to help Sysco Corporation secure such lien. By the acceptance of benefits under the Plan, you and your representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of you
- The subrogation and reimbursement rights and liens apply to any recoveries made by you as a result of the illness or injuries sustained, including but not limited to the following:
  - Payments made directly by the third-party, or any insurance company on behalf of the third-party, or any other payments on behalf of the third-party,
  - Any payments, settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of you or any other person,
  - Any other payments from any source designed or intended to compensate you for injuries sustained as the result of negligence or alleged negligence of a third-party,
  - Any workers' compensation award or settlement,
  - Any recovery made pursuant to no-fault insurance, and
  - Any medical payments made as a result of such coverage under any automobile or homeowners insurance policy
- The Plan's recovery will take preference over any other claim against any recovery, and the Plan's recovery will exist and be enforceable regardless of how the settlement, judgment, or other proceeds may be characterized and regardless of whether the recovery makes you whole. More specifically, the Plan's right to recovery will apply regardless of whether the losses were suffered by you, your estate, and/or your legal guardians. The Plan's recovery will not be reduced to reflect any costs or attorney's fees incurred in obtaining a recovery, unless the Plan Administrator gives its prior written authorization
- For the avoidance of doubt, the Plan's recovery will not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine"
- The benefits under the Plan are secondary to any coverage under no-fault or similar insurance
- In the event that you fail or refuse to honor your obligations as described above and in the Plan, then the Plan will be entitled to recover any costs incurred in enforcing the Plan's subrogation terms including but not limited to attorney's fees, litigation, court costs, and other expenses

Right to Recover or Withhold Benefits

The Plan has the right to recover or withhold payments whenever claims or bills are incomplete, inaccurate, or fraudulent.

The Plan may recover any payments made in error or overpayments from one or more of the following:

- Any persons to whom, for whom, or with respect to whom, such payments were made,
- Any other insurance companies,
- Any other organization, or
- The Genetic Information Non-discrimination Act (GINA)

GINA prohibits health coverage discrimination and employment discrimination against employees, including former employees, based on their (or their family members') genetic information.

Genetic information includes:

- You or your family member's genetic tests,
- The request for, or receipt of, genetic counseling or other genetic services by you or your family members, and
- The manifestation of a disease or disorder in an individual's family member

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history will be treated as confidential, as required by HIPAA and GINA.

The Plan will not discriminate on the basis of genetic information. This means that the Plan will not adjust premiums for an employee or any group of similarly situated individuals under the Plan, on the basis of genetic information.

The Plan will not request or require you or your family member to undergo a genetic test. However, your physician may obtain and use information about the results of a genetic test. The Plan may also obtain such information to the extent required in making a determination regarding payment (for example, where payment is made only as to medically necessary treatment and the results of a genetic test are necessary to determine the medical necessity of the services provided). In some circumstances, the Plan may obtain or request genetic information for research purposes (if required by a state for the protection of individuals) or as part of your or your family member's voluntary participation in a research study.

The Plan will not collect genetic information for underwriting purposes, which includes: (1) determination of eligibility (including enrollment and continued eligibility) for benefits under the Plan or coverage (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premiums under the Plan or coverage (including discounts in return for activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits for a group health plan. However, if the Plan conditions the benefit based on its medical appropriateness, which depends on the genetic information, the Plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness.

The Plan will not collect genetic information with respect to any individual before that individual's effective date of coverage under that Plan, nor in connection with the rules for eligibility that apply to that individual.

For more information on genetic information protection and nondiscrimination, contact the Plan Administrator at the address provided in the “Plan Administration” section of this SPD.

How You May Lose Benefits

Under certain circumstances, Plan benefits may be denied or reduced from those described in this SPD. Please refer to those specific benefit descriptions for information on limitations and exclusions that may apply to you and the benefits you may receive from the coverage options. For information on when your Plan coverage ends, refer to the section “When Coverage Ends.”

Claims and Appeals Procedures

The claims and appeal provisions for each benefit program are described in the benefit booklet, certificate or policy to which the benefit relates. In the event that claims and appeals are not described in the benefits booklet, certificate or policy, then the claims and appeal rules described immediately below will apply. For information about receiving benefits from each of the Plan programs in which you are covered, refer to the different claim filing sections in the documents incorporated into this SPD.

Please note that you will not be entitled to challenge a claim decision made by the Claims Administrator in federal or state court or in any other administrative proceeding unless and until the Plan’s claims and appeals procedures (and external review if applicable) have been complied with and exhausted. Additionally, any lawsuit you bring for Plan benefits must be filed within 12 months of the date on which your claim is incurred under the Plan.

Responding to Your Claim

In most cases, as you read through the benefits booklets for the plan programs in which you participate, you will see that Sysco Corporation and the Plan have delegated responsibility for claim determinations to the vendors (including insurers, carriers and third-party administrators) identified in this SPD.

Claim and Appeal Procedures for Group Health Plans

Urgent Care Claims

Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient’s life, health or ability to regain maximum function, or

- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

The Claims Administrator will notify you of its benefit determination (whether adverse or not) within 72 hours after receipt of a claim initiated for **urgent care**. A decision can be provided to you orally, as long as written or electronic notification is provided to you within three days after the oral notification.

If you fail to provide the Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claims Administrator must notify you within 24 hours of receiving your urgent care claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination as soon as possible, but no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours — provided the request is made at least 24 hours before the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

Pre-Service and Post-Service Claims

- For **pre-service claims** (claims that require approval of the benefit before medical, dental or vision care is provided), the Claims Administrator will notify you of its benefit determination (whether adverse or not) within 15 days after receipt of the claim

- For **post-service claims** (claims that are submitted for payment after you receive care), the Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of the claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit
- For **pre- and post-service claims**, the Claims Administrator may be allowed a 15-day extension to make a determination, provided that the Plan Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims Administrator must notify you before the end of the first 15- or 30-day period of the reason(s) for the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information needed to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim

If an extension is necessary for **pre- and post-service claims** due to your failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the Claims Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, or
- Is a communication that names you, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the denial,
- Information sufficient to identify the claim involved, including the date of the service, the healthcare provider and the claim amount (if applicable),
- The specific Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, used in denying the claim and, in the case of a final adverse determination, a discussion of the decision,
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary,
- A description of the Plan's internal and external review procedures, information about how to initiate an appeal, the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on review,
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, or a statement that the decision was based on the applicable items

mentioned above and that copies of the applicable material will be provided upon request, free of charge,

- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided upon request, free of charge,
- For a claims denial involving an urgent care claim, a description of the expedited internal and external review processes applicable to such claims, and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793

If you have any questions about a denied claim, contact the Claims Administrator.

Your Right to Appeal an Adverse Benefit Determination

If you disagree with a decision concerning your claim, you have a right to appeal the claim decision as described below.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination,
  - Is new or additional evidence or rationale the Plan wishes to rely on in making a benefit determination (the Plan must send such information to the participant as soon as it becomes available to the Plan),
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, or
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination

- A review that takes into account all comments, documents, records and other information related to the claim that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate
- A review in which the named fiduciary consults with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for **urgent care**, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination, and
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

Ordinarily, a decision regarding your appeal will be reached within:

- 72 hours after receipt of your request for review of an **urgent care claim**,
- 30 days after receipt of your request for review of a **pre-service claim**, or
- 60 days after receipt of your request for review of a **post-service claim**

If the incorporated documents incorporated into this SPD indicate that a Plan has two levels of appeal, then the reference above to "30 days" in the second bullet would change to "15 days" and the reference to "60 days" in third bullet would change to "30 days". Refer to the incorporated documents for the specific appeal deadlines for your participating programs.

The Claims Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the denial,
- Information sufficient to identify the claim involved, including the date of the service, the healthcare provider and the claim amount (if applicable),
- The specific Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, used in denying the claim and, in the case of a final adverse determination, a discussion of the decision,
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary,
- A description of the Plan's external review procedures and a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such

procedures; including your right to bring a civil action in federal court following a claims denial on review,

- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, or a statement that the decision was based on the applicable items mentioned above and that copies of the applicable material will be provided upon request, free of charge,
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided upon request, free of charge,
- For a claims denial involving an urgent care claim, a description of the expedited external review processes applicable to such claims, and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793

If you have any questions about a denied claim, contact the Claims Administrator as named in the section entitled “Plan Administration”.

Additional Levels of Appeal

The information below on Level 1 and Level 2 appeals apply to participating programs that offer two levels of appeal. To determine if one of the participating programs available to you offers Level 1 and Level 2 appeals, refer to the incorporated documents for the participating programs.

Level 1 Appeals

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review unless your appeal concerns an adverse voluntary predetermination decision or unless the adverse decision can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a physician or provider who has the same license as the provider who will perform or has performed the service.

If your Level 1 appeal concerns an adverse precertification decision, your appeal may be initiated by letter or over the phone. The Claims Administrator requires its claimants to submit all other requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to the Claims Administrator.

If you are appealing an adverse precertification decision (that is, an adverse prospective, concurrent or retrospective review decision) or the denial of any prior approval required by the Plan, the Claims Administrator will provide you with a written response indicating the Plan’s decision within a reasonable period of time appropriate to the medical circumstances but not later than 15 calendar days of the date the Claims Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator will send a written request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these Level 1

appeals without the permission of the claimant. Therefore, the Claims Administrator will make a decision based on the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Claims Administrator will resolve your Level 1 appeal within a reasonable period of time but not later than 30 calendar days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator shall send a written request for the information after receipt of the appeal. After the Level 1 appeal decision is made, you will be notified within five business days in writing by the Claims Administrator of the Plan's decision concerning your Level 1 appeal.

Level 2 Appeals

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal. A level 2 appeal may be submitted by the member of authorized representative within 60 days from the receipt of notice of the Level 1 appeal adverse benefit determination. Level 2 appeals concerning adverse precertification decisions or the denial of any prior approval required by the Plan will be resolved no later than 15 calendar days from the date your Level 2 appeal request was received. All other Level 2 appeals will be resolved no later than 30 business days from the date your Level 2 appeal request was received. After a decision about your appeal has been made, you will be notified in writing of the Plan's decision concerning your Level 2 appeal.

Standard External Appeals

If you receive an adverse benefit determination or a final adverse benefit determination, you may file a request for an external review within four months (or by the first day of the fifth month if there is no corresponding date) after the date of the denial for claims that involve:

- Medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or
- A rescission of coverage

Within five days of receipt of your request, the Plan must conduct a preliminary review to determine:

- If you were covered under the Plan at the time the service was provided,
- If the determination is related to your eligibility for coverage under the Plan,
- If you had exhausted all internal review processes, if required, and
- Whether you had provided all the information and forms necessary to process the claim

The Plan will notify you of your eligibility for an external appeal within five business days of completing the review. If you are not eligible, the Plan will explain the reasons why and provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-3272). If the request is not complete, the Plan must notify you what is needed and allow you to respond with the additional

information within the four-month filing period or within the 48-hour period following notification, whichever is later.

If eligible, the Plan will assign your case to an accredited independent review organization (IRO) to conduct a full independent review of your claim. The Plan is not required to directly contract with the IRO, however. The Plan will be bound by the decision of the IRO. The IRO will notify you in writing that you are eligible for the external review and allow you to submit any additional documentation about your claim within 10 days. The IRO must provide written notice of the final decision on your claim within 45 calendar days. The notice will include:

- A general description of the reason for the request for external review, including the date or dates of service, the healthcare provider and the claim amount (if applicable),
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision,
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision,
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision, and
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, such as judicial review, and including current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PHS Act Section 2793

Upon receipt of a notice of a final external review decision to reverse the adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or paying benefits) for the claim.

Expedited Reviews

Any level of appeal can be expedited if:

- The service at issue has not been performed,
- The service at issue has been denied as experimental/investigative or as not medically necessary, and
- Your physician believes that the standard appeal timeframes could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed

The Claims Administrator, by applying a prudent layperson standard, may also determine that an appeal may be expedited.

Please refer to the incorporated documents for the specific procedures for your Sysco Corporation group health plans.

Expedited Medical (Dental or Vision) Claims: The Claims Administrator will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than 72 hours after the Claims Administrator receives the Level 1 appeal request and will

communicate the decision by telephone to your attending physician or the ordering provider. The Claims Administrator will also provide written notice of the determination to you, your attending physician or ordering provider and the facility rendering the service. The Claims Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits.

The decision will be communicated by telephone to your attending physician or the ordering provider. The Claims Administrator will also provide written notice of the determination to you, your attending physician or ordering provider and to the facility rendering the service. An expedited external review of an appeal must be conducted as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external appeal. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Claims Administrator within 48 hours.

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is later than 180 calendar days after you are notified of the denial or rescission. Level 2 medical claim appeals must be filed within 90 days of receipt of notice of the Level 1 appeal determination. Level 2 clinical prescription claim appeals must be filed within 90 days of receipt of notice of the Level 1 appeal determination. External appeals must be filed within four months of notice of an adverse benefit determination.

Appeals by Participants of ERISA Plans

If you are covered under a Plan that is subject to the requirements of ERISA, you must file a Level 1 appeal before bringing a civil action under 29 U.S.C. 1132 §502(a). (Any lawsuit you bring for Plan benefits must be filed within 12 months of the date on which your claim is incurred under the Plan.) Level 2 appeals, if available, must be exhausted before filing suit for a denied claim. Any statutes of limitations or other defenses based upon timeliness will be temporarily suspended while a Level 2 appeal is pending. You will be notified of your right to file for review if the response to your current appeal level (that is, Level 1) is adverse. Upon your request, the Claims Administrator will also provide you with detailed information concerning Level 2 appeals and, if available, including how Level 2 panelists are selected.

Claim and Appeal Procedures for Disability Plans

The following describes the claim and appeal procedures for the participating programs which provide disability benefits.

Timing of Notification of Benefit Determination

If your claim is denied, you will be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Claims Administrator. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to

matters beyond the Claims Administrator's control and that notification is provided to you, before the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, before the end of the first 30-day extension period, it is determined that, due to matters beyond the Claims Administrator's control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that you are notified, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made will begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled (that is, stopped) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Manner and Content of Notification of Benefit Determination

You will be provided with written notification of any adverse benefit determination with respect to your disability benefits claim. The notification will set forth, in a manner calculated to be understood by you, the following:

- The specific reason or reasons for the adverse determination,
- Reference to the specific Plan provisions on which the determination is based,
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary,
- A description of the review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA(where applicable), following an adverse benefit determination,
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided, free of charge, to you upon request,
- If a Plan exclusion such as medical necessity or experimental treatment was the basis for making an adverse determination, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided, free of charge, to you upon request,
- An explanation of the basis for disagreeing with: (i) the views presented by the healthcare professionals treating you and the vocational professionals who evaluated the claim; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied upon

in making the benefit determination; and (iii) a Social Security Administration disability determination with respect to you,

- If any internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either (i) the Claims Administrator will provide the specific rule guideline, protocol, or other similar criterion; or (ii) the Claims Administrator will include a statement that such rules, guidelines, protocols, standards or other similar criterion do not exist,
- 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 your claim for benefits, and
- The notification will be provided in a culturally and linguistically appropriate manner and the notification will include an offer for language assistance services

Appeals of Adverse Benefit Determinations

Appeals of adverse disability benefit determinations are described as follows.

- You (or your authorized representative) must appeal within 180 days following your receipt of a notification of an adverse benefit determination, and only one appeal is allowed,
- You will be provided with the opportunity to submit written comments, documents, records and/or other information relating to the claim for benefits in conjunction with your timely appeal,
- You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits,
- The review on (timely) appeal will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination,
- No deference to the initial adverse benefit determination will be afforded upon appeal,
- The appeal will be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual,
- Any medical or vocational expert(s) whose advice was obtained in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination,
- In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal will consult with a healthcare professional:
  - Who has appropriate training and experience in the field of medicine involved in the medical judgment, and
  - Who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual

Timing of Notification of Benefit Determination on Review

You (or your authorized representative) will be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is

determined that an extension of time for processing is required, written notice of the extension will be furnished to you before the termination of the initial 45-day period. In no event will such extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made will begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled (that is, stopped) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Manner and Content of Notification of Benefit Determination on Review

You will be provided with written notification of the determination on review. In the case of an adverse benefit determination on review, the notification will set forth, in a manner calculated to be understood by you, the following:

- The specific reason or reasons for the adverse determination,
- Reference to the specific Plan provisions on which the determination is based,
- A statement that you are entitled to receive, upon request and without charge, reasonable access to any document and copies of any document (1) relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (4) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment, without regard to whether the statement was relied on,
- A statement of your right to bring an action under Section 502(a) of ERISA (where applicable) and a description of any applicable contractual limitation periods that apply to bring an action, including the calendar date on which the contractual limitation period expires for the claim,
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request,
- If a Plan exclusion such as medical necessity or experimental treatment was the basis for making an adverse determination, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided, free of charge, to you upon request,
- The following statement: “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” (where applicable),
- A description of any applicable Plan deadline to sue, including the calendar date on which the deadline to sue expires for your claim,

- A discussion of the decision, including an explanation for the basis for disagreeing with or not following: (i) the views presented by the healthcare professional treating you and vocational professional who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a Social Security Administration disability determination regarding you presented by you to the Plan,
- Either (i) the Claims Administrator will provide the specific rule guideline, protocol, or other similar criterion; or (ii) the Claims Administrator will include a statement that such rules, guidelines, protocols, standards or other similar criterion do not exist, and
- The notification will be provided in a culturally and linguistically appropriate manner and the notification will include an offer for language assistance services

Definitions of Terms Used in This Disability Claims and Appeals Procedures Section

The term “adverse benefit determination” means any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in the Plan.

In the case of the term “relevant,” a document, record or other information will be considered “relevant” to your claim if such document, record or other information:

- Was relied upon in making the benefit determination,
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination,
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants, or
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit of your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination

Claim and Appeal Procedures for Non-Group Health Plans and Non-Disability Plans

For information about receiving benefits from non-group health and non-disability participating programs (e.g., life insurance benefits), see the incorporated documents for the applicable benefits. If a Plan does not pay benefits that you believe it should, you can file an appeal as described, at a high level, in this section and in more detail in the incorporated documents.

You must use and exhaust this Plan’s administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the Plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

Time Frame for Claim Determinations

If you receive an adverse benefit determination (such as any denial, reduction or termination of a benefit, or a failure to provide or make a payment), the Claims Administrator will notify you of the adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be extended for up to 90 days, if the Claims Administrator both determines the extension is necessary due to matters beyond the control of the Plan and notifies you, before the initial 90-day period expires, of the reason(s) requiring the extension of time and the date by which the Plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based,
- The unresolved issues that prevent a decision on the claim, and
- The additional information needed to resolve those issues

You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the Plan's time frame for making a benefit determination is tolled (that is, stopped) from the date the Plan Administrator sends you the extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- References to the specific Plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary,
- A description of the Plan's appeal procedures and the time limits applicable to those procedures (including a statement of your right to bring a civil action under ERISA after an appeal of an adverse determination),
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination will be provided free of charge to you upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You or your authorized representative has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination,
  - Is new or additional evidence or rationale the Plan wishes to rely on in making a benefit determination (the Plan must send such information to the participant as soon as it becomes available to the Plan),
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, or
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Request a review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination,
- Request a review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor by that person's subordinate,
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual, and
- Know the identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision

The Claims Administrator must notify you of the Plan’s benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review by the Plan, unless the Claims Administrator determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 60-day period. The notice of the extension must indicate the special circumstances and the date by which the Claims Administrator expects to render the determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the Plan's time frame for making a benefit determination on review is stopped from the date the Claims Administrator sends you the extension notification until the date you respond to the request for additional information.

The Claims Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination,
- References to the specific Plan provisions on which the benefit determination is based,
- 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 your claim,
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures and a statement of your right to bring an action under ERISA,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or notice that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination will be provided free of charge upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

Important Plan Information

Plan Administration/Interpretation

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility of benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final, conclusive and binding on all parties and generally will not be overturned by a court of law. Any determination by the Plan Administrator shall be given deference in the event the determination is subject to judicial review.

Plan Document

This SPD (meaning this document and the incorporated documents) is intended to help you understand the main features of the Plan. It should not be considered a substitute for the official Plan documents, which govern the operation of the Plan. Those documents set forth all of the details and provisions concerning the Plan and is subject to amendment. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official plan documents, the text of that official plan documents will determine how questions will be resolved. To request a copy of the official Plan documents, please contact the Plan Administrator.

Right to Amend or Terminate the Plan

It is Sysco Corporation's intent that the Plan will continue indefinitely. However, the Plan sponsor has the right to amend, modify, suspend or terminate the Plan, including any benefits under the Plan, in whole or in part, at any time and for any reasons. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the Plan to the extent permitted by law. No verbal or written representation contrary to this statement will be binding upon the Plan.

Any amendment, however, may not deprive you of any benefits to which you are entitled prior to the effective date of the amendment. If the Plan is modified, any claims incurred prior to the effective date of modification will be paid in accordance with the Plan in effect at that time. Any expense incurred after the amendment date will be paid in accordance with the new Plan provision.

In the event of termination of the Plan, or any benefits under the Plan, any eligible claims incurred before the date of termination will be paid to the extent of available assets, if submitted to the Claims Administrator within a reasonable period of time, as established by the Plan Administrator. Any claims incurred after the date of termination will not be considered for payment.

Sysco Corporation's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to revise the amount of participant contributions. Participants will be notified of any material modification to or termination of the Plan.

Limitation on Assignment

To the extent permitted or required by law, your and your dependents' and beneficiaries' rights and interests under the Plan will not be subject to attachment or garnishment or other legal process by any creditor, nor will you (or any dependent or beneficiary) have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which they may expect to receive, contingently or otherwise, under the Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder will be void. Notwithstanding the foregoing, the Plan Administrator may pay Plan benefits directly to the provider of services. Such payment shall fully discharge the Plan Administrator from further liability under the Plan.

Limitation of Rights

No employee (including former employee) beneficiary, or other person will acquire, by reason of the Plan, the SPD, or any other Plan program document, any right in or title to any assets, funds or property of the Company. No employee, officer, director or agent of the Company guarantees in any manner the payment of Plan benefits.

Representations Contrary to the Plan

No employee, officer, or director of the Company has the authority to alter, vary or modify the terms of the Plan or any participating programs except by means of an authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan or a Plan program, or its written amendments, shall be binding upon the Plan, the Plan Administrator, or the Company.

Payment to Guardian or Custodian

If the Plan Administrator or Claims Administrator finds that any person entitled to receive benefits under the Plan is unable to care for their affairs due to physical illness, infirmity, or mental incompetence, or because the person is a minor, any benefits or payments owed to such person may be paid to the person's legal representative or custodian, or to a spouse or domestic partner, child, parent, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment.

Receiving Advice

Sysco Corporation cannot advise you regarding tax, investment or legal considerations related to the Plan. Therefore, if you have questions regarding benefit planning, you should seek advice from an appropriate personal advisor (e.g., legal counsel, tax advisor, investment advisor).

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

With respect to ERISA covered benefits, ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration,

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies, and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report

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 the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit 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 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 that is denied or ignored, in whole or in part, you may file a suit in a state or federal court — but only after you have exhausted the Plan's claims and appeals procedure as described in the "Claims and Appeals Procedures" section. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's 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 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 the Plan, 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 (EBSA), 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 at 866-444-EBSA (3272), logging on to www.dol.gov, or contacting the EBSA field office nearest you.

Plan Administration

This information about the administration of the Plan and its Plan programs is provided in compliance with ERISA to the extent that ERISA is applicable to such Plan programs. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your plan.

Details About Plan Administration	
Plan Sponsor/Plan Administrator	Sysco Corporation 1390 Enclave Parkway Houston, TX, 77077-2099
Employer Identification Number	74-1648137
Official Plan Name and Number	Sysco Corporation Early Retiree Healthcare Plan (Plan 503)
Plan Year	January 1 through December 31
Type of Plan	The plan is a welfare benefit plan providing the following benefits to eligible individuals: medical, prescription drug, managed mental health, dental, vision, and EAP
Agent for Service of Legal Process	Sysco Corporation 1390 Enclave Parkway Houston, TX 77077-2099 Legal process can also be served on the Plan Administrator
Plan Funding	The benefits under the Plan are provided on both self-funded and insured benefits as identified below. Self-funded benefits under the Plan are paid from participant contributions, as applicable, and from the general assets of Sysco Corporation, as needed. Sysco Corporation has contracted with the vendor(s) named below as insurers and third-party administrators to administer the benefits under the Plan.

Details About Vendors	
Medical, Prescription Drug and Managed Mental Health Benefits	Aetna (Early Retiree PPO and Detroit PPO) 833-361-0223 www.aetna.com Blue Care Network of Michigan (HMO) 800-662-6667 www.bcbsm.com
Dental Benefits	Aetna 833-361-0223 www.aetna.com
Vision Benefits	Vision Service Plan (VSP) 800-877-7195 www.vsp.com
Employee Assistance Programs	Aetna 833-361-0223 www.aetna.com