Summary Plan Description

for the

Sysco Corporation Group Benefit Plan

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This booklet, along with the benefit summaries provided by applicable administrators and vendor referenced herein, serves as the Summary Plan Description ("SPD") for health and insurance benefits for specified U.S. employees of Sysco Corporation ("Sysco") and its participating subsidiaries (collectively, the "Company"), effective January 1, 2025. An SPD is a legally required document that provides a comprehensive description of benefits plans and their provisions. Sysco reserves the right to change or discontinue, at any time, any or all of the benefits coverage or programs described here.

The Sysco Corporation Group Benefit Plan (the "Plan") provides the following benefits:

- Medical
- Prescription Drug
- Dental
- Vision
- Life Insurance (basic, supplemental employee, spousal life, child life)
- Supplemental Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term Disability*
- Long-Term Disability
- Group Accident plan
- Group Critical Illness
- Group Hospital Indemnity
- Business Travel Accident Insurance (basic and supplemental)
- Group Legal Benefits
- Employee Assistance Program

**These benefits are not considered ERISA benefits but are included in this document purely for your reference and convenience.*

In addition to the benefits provided under the Plan as listed above, Sysco also sponsors the Sysco Corporation Section 125 Cafeteria Plan ("the Cafeteria Plan") which provides you with the opportunity to pay for benefits on a pretax basis. This booklet will provide general information around the benefits provided under the Cafeteria Plan, which include:

- Health Care Flexible Spending Account (Health Care FSA) – general and limited use
- Dependent Care Flexible Spending Account (Dependent Care FSA)*
- Health Savings Account*

**These benefits are not considered ERISA benefits, but are included in this document purely for your reference and convenience.*

This booklet is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws and regulations. To the extent applicable, the Plan will be interpreted and administered in accordance with ERISA, the U.S. Internal Revenue Code and applicable regulations and laws. This booklet has been written, to the extent possible, in nontechnical language to help you understand the basic terms and conditions of the benefits plans. The booklet 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. The official plan documents, certificates, or policies will control in the event of any differences between those documents and this SPD. However, if there is language in this SPD regarding a topic the plan documents are silent on, the language in the SPD will govern.

This booklet provides no guarantee that you are eligible to participate in every benefit or program. Each benefit under the Plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Sysco in no way guarantees the payment of any benefit that may be due or becomes due to any person under the Plan.

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 expressly reserves the right to amend or revise any term, provision or benefit under the Plan, this 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 Employees – Non-Union

You are eligible to participate in the Plan if you are a non-union employee of Sysco or one of its subsidiaries that has adopted the Plan, and you are regularly scheduled to work 30 hours or more per week.

Note: If you are a resident of Hawaii, you are eligible to participate in the Plan if you are a non-union employee regularly scheduled to work 20 hours or more per week.

Eligibility for each benefit within the Plan depends on your employment status and your work classification and is subject to the terms and conditions for each plan program.

Eligible Employees – Union

You are eligible to participate in the Plan if you are a member of a collective bargaining unit that has adopted the Plan. As a collectively bargained employee, you may be subject to additional requirements set forth in your applicable collective bargaining agreement.

Eligibility for each benefit within the Plan depends on your employment status and your work classification and is subject to the terms and conditions for each plan program.

Eligibility – Family and Medical Leave Act (FMLA)

An eligible employee who is on FMLA Leave shall be considered to remain an eligible employee throughout the period of such FMLA leave subject to further provisions of this Plan and applicable provision of any underlying plan benefit program.

Special Eligibility Rules for Part-time, Temporary or Seasonal Employees

If you are classified as a part-time or temporary employee and you average at least 30 hours of service per week during the 12-month “initial measurement period” that begins on your first day of employment, you will be eligible

for medical, dental and vision benefits for the 12-month coverage period that begins on the first day of the month coincident with or next following your 13-month anniversary.

If you are an ongoing part-time, temporary or seasonal employee reasonably expected to work less than 30 hours of service per week and average at least 30 hours of service per week during any "standard measurement period" (the 12-month period that begins on October 15 and ends on October 14 of the following calendar year), you will be eligible for medical, dental, and vision benefits for the following Plan Year. If you are classified as a seasonal employee and are reasonably expected to work at least 30 hours of service per week and you are offered a permanent position with Sysco or one of its participating subsidiaries during the 12-month "initial measurement period" that begins on your first day of employment, you will be eligible for medical, dental and vision benefits for the 12-month coverage period that begins on the first day of the month coincident with or next following your 13-month anniversary. If you transfer to a permanent position during any "standard measurement period" (the 12-month period that begins on October 15 and ends on October 14 of the following calendar year), you will be eligible for medical, dental, and vision benefits for the following plan year.

Dependent Eligibility

Your eligible dependents can also participate in the coverage you elect, provided you enroll them in a timely manner. Eligible dependents generally include:

- Your legally married spouse
- Your eligible Domestic Partner (same or opposite sex)
- Your eligible children – an employee's children and the children of their spouse or Domestic Partner can be covered until the end of the month in which they turn age 26 (or 26 and older if certified as mentally or physically disabled and unable to support themselves), regardless of their student status, marital status and whether or not they can be claimed as dependents on your federal tax return

When you enroll your dependents in the Plan, you acknowledge that all your covered dependents meet the definition of eligible dependents based on the terms and conditions of the Plan. Sysco verifies the eligibility of your enrolled dependents, and you may be required to provide valid documentation such as name, date of birth, Social Security number and, if over age 26, whether the child has a mental or physical disability. 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 to the date they were first covered under 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 and prosecution.

About Your Eligible Children

Your children who are under age 26 (or 26 and older if certified as mentally or physically disabled and unable to support themselves) are generally eligible for coverage. Eligible children include:

- Biological children
- Spouse's or Domestic Partner's biological children
- Stepchildren
- Legally adopted children
- Any child for whom you are the court-ordered legal guardian in accordance with the laws of the state in which you reside

- Children named in a qualified medical child support order (QMCSO) requiring you to provide coverage
- Children who are age 26 or older, if certified as mentally or physically disabled and unable to support themselves financially. Eligible disabled children must have been disabled and covered by the Plan before reaching age 26. Before your disabled dependent reaches age 26, you must submit certification from the disabled dependent's healthcare provider to determine if your dependent meets the criteria for a disabled dependent under the Plan. If your dependent reaches age 26 before your certification is approved, any claims will be denied until a determination is made

Note: An eligible Domestic Partner's child(ren) can only be enrolled in coverage if your Domestic Partner is also enrolled in coverage.

Specific benefit programs may contain different or additional requirements for child coverage. Please refer to the specific benefit booklets for additional information.

About Your Domestic Partner

An eligible Domestic Partner is generally defined as a same- or opposite-sex domestic partner meeting the following criteria.

- You have entered into a state-recognized same- or opposite-sex civil union or registered domestic partnership, or
- You have not entered into a state-recognized same-or opposite-sex civil union or registered domestic partnership, and you and your partner:
  - Are at least 18 years of age and mentally competent to consent to a contract
  - Are financially interdependent
  - Are each other's sole domestic partners
  - Are living together and share the common necessities of life
  - Are not so closely related that marriage would otherwise be prohibited
  - Are not legally married to, or the domestic partner of, another person either under statutory or common law

Specific benefit programs may contain different or additional requirements for domestic partner coverage. Please refer to the specific benefit booklets for additional information.

If You and an Eligible Family Member Both Work at Sysco

If you and your spouse/Domestic Partner both work at Sysco and are both eligible to enroll in the benefits offered under the Plan. you can select one of the below enrollment options:

- You may enroll independently/separately in Sysco benefits, or
- You may cover your spouse/Domestic Partner as an eligible dependent under your plan (or vice versa)

Note: You cannot elect both option 1 and 2 above. A Sysco colleague cannot be covered twice under any Sysco benefit program, including supplemental life insurance.

In addition, your child(ren) cannot be covered as a dependent by both you and your spouse or Domestic Partner. Only one of you can cover your eligible child(ren).

If you have a child that also works at Sysco as a benefits eligible employee, they cannot be covered twice in the Plan. You can choose to cover your child as an eligible dependent, or your child can elect employee only coverage under the Plan. This is applicable to all benefits under the Plan, including supplemental life insurance.

When Coverage Begins

If you are a new, full-time employee enrolling during the plan year, coverage for benefits under the Plan, including for you and your eligible dependents will begin the first of the month on or after 31 days from your date of hire, unless otherwise provided in an applicable collective bargaining agreement. However, for employees who reside in Hawaii, medical insurance will begin four weeks from the date of hire.

Part-time employees are not eligible for benefits offered under the Plan.

Part-time employees who become full-time employees become eligible on the first of the month on or after the status change from part-time to full-time, if the employee has already met the waiting period requirement. If the employee transitioning from part-time to full-time has not met the waiting period requirement, they would follow the new hire waiting eligibility rules back to the original hire date.

Collectively bargained employees who transition to a non-collectively bargained employee will be eligible for benefits under the Plan on the day they are classified by Sysco as a non-collectively bargained employee and are otherwise eligible for benefits under the Plan.

In situations where due to the terms of a newly negotiated collective bargaining agreement, a collectively bargained employee becomes eligible for benefits under the Plan, such coverage will begin on the effective date of the new collective bargaining agreement if all other eligibility requirements are met for the appliable benefits under the Plan.

Reemployment – Full-time employee

If you terminate employment but are re-employed by Sysco or one of its subsidiaries as an eligible employee, you must complete the applicable waiting period before you become eligible to re-enroll in the Plan. You must complete the re-enrollment process in the manner and by the deadline established by the Plan Administrator. However, if you are rehired within 31 days and within the same Plan Year after terminating employment, your elections under the Plan will remain unchanged and will become effective on the date of rehire.

Reemployment – Part-time, temporary and seasonal employees eligible for health benefits at time of termination (see Special Eligibility Rules for Medical, Dental and Vision)

If you terminate employment but are rehired within 31 days of your termination date and in the same Plan Year, your elections for medical, dental and vision benefits will be reinstated with your prior benefits eligibility date. If you are rehired after 31 days, you will be considered a new hire for benefit eligibility purposes.

Coverage Period

For most benefits, your initial election will run through December 31 unless you experience a qualified change in status or other event permitting a mid-year election change.

If you do not make an election for benefits under the Plan as a new hire (including an election of no coverage) within 31 days of your hire date, you will not be able to elect coverage until the next annual enrollment period, unless you have a qualified change in status or other event permitting a mid-year election change.

If you enroll in the Plan during the annual enrollment period, coverage for you and your eligible dependents will begin on January 1 and remain in effect through December 31 unless you have a qualified change in status or other event permitting a mid-year election change. It is important that you read the Annual Enrollment information

made available to you by Sysco 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 benefit elections.

According to IRS rules, you can change your elections during the year only if you have a qualified change in status event or if you experience an event permitting a mid-year election change (see the section "Making Changes During the Year" for details). 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 date of a qualified change in status to enroll in or change your coverage in connection with the qualified change in status. Coverage elections will generally go into effect on the first day of the month following the change in status. However, if the qualified change in status is a birth or adoption, your elections and your coverage will go into effect retroactively to the date of the qualifying event.

Default Coverage

If you do not make elections under the Plan as a new, full-time hire, you will be defaulted into the following benefit plans:

- Basic Life
- Basic AD&D
- EAP
- Basic LTD
- Basic STD

Paying for Coverage

Sysco contributes toward the cost of medical and dental coverage for you and your dependents. You will find the cost to enroll in all coverage categories by contacting the Sysco Benefits Center at 1-800-55-SYSCO or via the web at www.syscobenefits.com. Your contribution for medical coverage will depend on the amount of your benefits eligible pay and your coverage category. Please note that if your coverage begins during a pay period, your contributions will not be prorated based on having coverage for only part of the pay period.

Tobacco Surcharge

If you enroll in Sysco medical coverage, you will have the opportunity to complete the Tobacco Attestation. If you attest that you are a tobacco user, a $50 monthly surcharge will be added toward the cost of your medical plan coverage. You are considered to be a tobacco user if you use nicotine or any tobacco products, including cigarettes, cigars, e-cigarettes, pipes, chewing tobacco, snuff or other similar products This surcharge is not applicable for your spouse and/or dependents, regardless of their tobacco usage.

If, prior to December 1 of the current calendar year, you certify that you have successfully stopped using tobacco products and have remained tobacco-free for at least three months, the surcharge will be removed as soon as administratively possible. Additionally, you will receive a refund for any tobacco surcharge payments applied during the current calendar year also as soon as administratively possible.

In the event that you resume using tobacco products, you are required to notify Sysco, and the tobacco surcharge will be reinstated. Failure to accurately report your tobacco usage may result in loss of your medical benefits.

Tax Considerations

As identified in the charts above, some of your benefits are deducted from your paycheck on a pre-tax basis, which lowers your taxable income and, therefore, the amount of income tax you must pay. However, these pre-tax contributions may be subject to state or local income taxes in certain jurisdictions. Some benefits like supplemental

life and AD&D insurance are paid with after-tax dollars.

Taxation of Domestic Partner Benefits

If you enroll your eligible Domestic Partner and his or her child(ren), the cost of their Plan coverage will be deducted from your paycheck on an after-tax basis (with regard to federal and most state taxes) unless the partner and/or his or her child(ren) qualify as your tax dependent under the Internal Revenue Code. However, due to tax law requirements, you may be required to pay Federal income and Social Security taxes on the full Sysco paid portion of the coverage for your Domestic Partner and/or your Domestic Partner's child(ren). This amount will be included in your gross income as imputed income and reported on your W-2 form. Please consult with your tax advisor to discuss your individual circumstances before enrolling your eligible Domestic Partner and/or his or her child(ren) in any of the applicable plan benefit programs.

Making Changes During the Year

Qualified Life Events

To comply with IRS rules, you may make coverage changes during the year only if you experience a change in your family or employment status (referred to as a "Qualified Life Event") or if you experience a different event permitting a mid-year election change. Approved Qualified Life Events under the Plan generally include:

- Marriage, divorce, or legal separation
- Entry or dissolution of a domestic partnership
- Addition of a dependent through birth, adoption or court-ordered legal guardianship
- Death of a spouse, Domestic Partner, or dependent
- The loss of coverage eligibility for a dependent child who, for example, becomes ineligible due to age
- The death of a spouse or dependent child
- You, your spouse, Domestic Partner or your child (up to age 26) change from benefits-eligible to benefits-ineligible status or vice versa
- Solely with respect to the Dependent Care Spending Account Program, any change in the number of qualifying dependents as defined in the Internal Revenue Code or changes in the cost of a day care provider or dependent care costs
- A change in employment status for you, your spouse, your Domestic Partner or your dependent including:
  - A termination or commencement of employment (note: If you terminate and are rehired in the same calendar year (but more than 31 days after your termination date), you will be able to make new benefit elections. However, if you are rehired within 31 days of your termination date, your most recent benefit elections will be reinstated)
  - A change in work schedule resulting in an employee becoming (or ceasing to be) eligible for certain participating programs
- A change in residence for you, your spouse, your Domestic Partner 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 Qualified Life Events must be permitted by law and consistent with the event. Election changes are consistent with a Qualified Life Event only if the election change is on account of and corresponds with an event that affects eligibility for either you, your spouse, your Domestic Partner, or your dependent under the Plan or your spouse's, or dependent's employer plan. For example, if the Qualified Life Event is your divorce, the death of your spouse, Domestic Partner or

dependent, or a dependent ceasing to satisfy the Medical Program's eligibility requirements, the corresponding election change would be to drop Medical Program coverage for (1) the spouse involved in the divorce (in the case of your divorce), (2) the deceased spouse, Domestic Partner or dependent (in the case of your spouse's or dependent's death), or (3) the dependent that ceased to satisfy the Medical Program's eligibility requirements.

In addition, if you, your spouse, your Domestic Partner and/or your dependent become eligible for coverage under your spouse's plan, your Domestic Partner's plan or your dependent's employer plan as a result of a change in marital, domestic partner or employment status, you may drop coverage for any individual (including yourself) — but only if the individual actually becomes covered under the other employer's plan.

You must notify Sysco of the Qualifying 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 timeframe, an election change will not be allowed.

Additional Mid-Year Election Change Events

You may also be able to make a mid-year change in your group health plan elections (meaning your elections regarding Medical, Prescription Drug, Dental, Vision and Health Care Spending Account programs, as applicable) for other reasons including:

- *Changes consistent with the special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).* See the "HIPAA Special Enrollment Rights" section
- *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
- *Cost change*s. A cost increase or decrease as described below refers to an increase or decrease in the amount of your elective contributions
  - *Automatic changes*. If the cost of your group health plan increases (or decreases) during a period of coverage, and the Plan Administrator (as defined in the "Plan Administration" section of this SPD), in its sole discretion, determines that the cost increase (or decrease) is not significant, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the Plan
  - *Significant cost changes*. If the cost charged to you for a group health plan option significantly increases or decreases during a period of coverage, you may make a corresponding Plan election change. For example, you can begin participation in the Plan option with a decrease in cost. In the case of a cost increase, you can: (1) revoke your election for that Plan option and receive coverage going forward under another Plan option providing similar coverage; or (2) drop coverage if no other Plan option providing similar coverage is available
- *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. A loss of coverage means a complete loss of the Program, such as the elimination of a Medical Program option. In addition, the Plan Administrator, in its discretion, may treat the following as a loss of coverage:
  - A substantial decrease in the medical care providers available under the Medical, Dental or Vision Program (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a preferred provider network),
  - A reduction in benefits for a specific type of medical condition or treatment with respect to which you, your spouse, your Domestic Partner or your dependent is currently in a course of treatment, or
  - Any other similar fundamental loss of coverage

- *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 and corresponds with a change made under another employer's plan provided that (a) the other plan permits participants to make an election change that would be permitted under regulations under Section 125 of the Internal Revenue Code or (b) 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, your Domestic Partner or dependent if you, your spouse, Domestic Partner 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.

Revocation Due to Enrollment in the Marketplace

You may revoke your medical coverage election in order to obtain coverage through the Health Insurance Marketplace (Marketplace) under the following conditions:

- You are seeking to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period; and

- You enroll, along with any related dependents who cease coverage due to the revocation, in a Marketplace plan effective immediately following the revocation.

Sysco may rely on the reasonable representation of an employee who is enrolling in Marketplace coverage that the employee and dependents have enrolled or intend to enroll in a Marketplace plan that is effective immediately following the revocation (that is, there is no gap in coverage).

You may revoke your medical coverage election due to a reduction in hours of service under the following conditions:

- You must have been in an employment status in which you were reasonably expected to average at least thirty hours per week and there has been a change in your employment status so that you are reasonably expected to work less than thirty hours per week, even if the reduction does not result in You ceasing to be eligible under the Plan; and
- You intend to enroll yourself, and any other spouse, Domestic Partner or dependent who cease coverage due to the revocation, in another plan that provides minimum essential coverage, with the new coverage to be effective no later than the first day of the second month following the month that includes the revocation of coverage.

Sysco may rely on the reasonable representation of an employee that the employee and related spouse and dependents have enrolled in or intend to enroll in another plan that provides minimum essential coverage within the timeframe described above.

HIPAA Special Enrollment Rights

The official HIPAA Special Enrollment Rights Notice is distributed to employees each year during the annual enrollment period. It is also provided to new hires at or before the time the employee enrolls for the first time. The information about HIPAA Special Enrollment Rights is also provided here in this SPD for ongoing reference. To request special enrollment or obtain more information, contact Sysco Benefits Center at 1-800-55-SYSCO.

If you are declining Plan enrollment for yourself or your dependents (including your spouse or Domestic Partner) because of other health insurance or group health plan coverage and you submitted any written verification that may have been requested from you as described below at the time coverage was declined, you may be able to enroll yourself and your dependents in the Medical, Prescription Drug, Dental, Vision and Health Care Spending Account programs, or switch medical benefit options under this Plan, if you are otherwise eligible to enroll, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other non-COBRA coverage). However, you must request enrollment within 31 days after the date you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of eligibility for coverage includes:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death of an employee, termination of employment, reduction in the number of work hours of employment,
- In the case of coverage offered through an HMO — or other arrangement — loss of coverage because an individual no longer resides, lives or works in the service area (whether or not it was the individual's choice), and with respect to an HMO in the group market, no other benefit package is available to the individual,
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that

includes the individual, and

- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.

However, loss of eligibility for other coverage **does not include** a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis,
- Voluntary disenrollment from a plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

If you enroll yourself, your spouse, your Domestic Partner and/or your eligible dependent children in the Medical, Prescription Drug, Dental, Vision and Health Care Spending Account programs, as applicable, due to a "loss of eligibility for coverage" event as described above, Medical, Prescription Drug, Dental, Vision and Health Care Spending Account programs coverage, as applicable, will begin the date you request the election change. Your contribution rate will increase at the time the coverage begins.

Gaining a New Dependent

If you have a new dependent as a result of marriage, establishment of a domestic partner relationship as defined by this Plan, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in Medical, Prescription Drug, Dental, Vision, and Health Care Spending Account programs coverage, as applicable, or switch medical coverage options under this Plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you are not enrolled in the Medical, Prescription Drug, Dental, Vision and Health Care Spending Account programs coverage as an employee, as applicable, you also must enroll in the Plan when you enroll any of these dependents. And, if your spouse or Domestic Partner is not enrolled in the Medical, Prescription Drug, Dental, and Vision programs, as applicable, you may enroll your spouse or Domestic Partner in the Medical, Prescription Drug, Dental, and Vision programs, as applicable, when you enroll a child due to birth, or adoption.

Change becomes effective on the first of the month following the qualifying event date. However, in certain circumstances such as birth or adoption of a child, or as a result of a court order, coverage will become effective on the date of the qualifying event.

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

If you (the employee) are eligible for, but not enrolled in, the Medical, Prescription Drug, Dental, and Vision programs, as applicable, or your dependent is eligible for, but not enrolled in, the Medical, Prescription Drug, Dental, and Vision programs, as applicable, you (and your dependent) may enroll in the Medical, Prescription Drug, Dental, and Vision programs, as applicable, or switch medical benefit options under this Plan, if either of the following conditions are 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 Medical, Prescription Drug, Dental, and Vision programs, as applicable, 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 Medical, Prescription Drug, Dental, and Vision programs, as applicable, if you

request coverage under the Medical, Prescription Drug, Dental, and Vision programs, as applicable, 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, your Domestic Partner and/or your eligible dependent children in the Medical, Prescription Drug, Dental, and Vision programs, as applicable, due to a loss or gain of eligibility for coverage event described above, Medical, Prescription Drug, Dental, and Vision programs, as applicable, 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 obtain more information, contact Sysco Benefits Center at 1-800-55- SYSCO.

When Coverage Ends

In general, coverage under the Plan and your participation in the Flexible Spending Accounts (FSAs) will end when one of the following events occur:

Event	Applicable to	Date Coverage Ends
Your Employment is Terminated	• Employee • Spouse / Domestic Partner • Child(ren)	• On the date of termination or the date in which the colleague is no longer employed • Health Care FSA (general and limited purpose) reimbursements can only be submitted for claims incurred from January 1 through the date of termination unless subject to COBRA continuation provisions • Dependent Care FSA reimbursements can only be submitted for claims incurred from January 1 through your date of termination
You Cease to be an Eligible Employee	• Employee • Spouse/ Domestic Partner • Child(ren)	• On the date you are no longer an eligible employee
You Fail to Pay Required Contributions	• Employee • Spouse/ Domestic Partner • Child(ren)	• The date established by the Plan Administrator
You Pass Away	• Spouse/ Domestic Partner • Child(ren)	• The last day of the month of the date of death, with the exception of FSA and HSA which terminates on the date of death
Sysco Terminates the Plan or a Specific Benefit under the Plan	• Employee • Spouse/ Domestic Partner • Child(ren)	• If the entire Plan is terminated, the date of termination of the Plan • If a specific benefit under the Plan is terminated, the date of the termination of that specific benefit

Your Dependent Ceases to be an Eligible Dependent	• Spouse (for example, if you divorce or legally separate) • Domestic Partner (for example, if you terminate your domestic partner relationship) • Child(ren) (for example, if they reach the limiting age	• When a child dependent is turning age 26, coverage will terminate at 11:59pm on the last day of the month in which they turned age 26; for all situations coverage ends on the date the individual ceases to be an eligible dependent under the terms of 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 HSA is owned by you. Upon termination, you can continue to spend existing available funds for qualifying medical expenses but cannot make contributions unless you enroll in another qualifying high deductible health plan.

You may be eligible to continue your Sysco group health plan coverage (e.g., medical, dental, vision, health FSA, HRA, and/or EAP) through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) (see the "Continuation of Coverage Rights under COBRA" section). You may also be able to continue coverage if you are on military leave (see the "Continuation of Coverage for Employees in the Uniformed Services" section) or if you are on an approved Family and Medical Leave Act (FMLA) leave (see the "Continuation of Coverage While on a Family and Medical Leave" section).

Your Plan Options

As an eligible employee, you are automatically enrolled in basic life, basic accidental death and dismemberment (AD&D), short-term disability (STD), long-term disability (LTD) and employee assistance program (EAP) coverage. As an eligible employee, you can choose to enroll in the following benefits:

- Medical
- Prescription Drug
- Dental
- Vision
- Healthcare Flexible Spending Account (HCFSA) (general purpose or limited use)
- Dependent Care Flexible Spending Account (DCFSA)
- Health Savings Account (HSA) (if also enrolled in a qualifying high deductible health plan)
- Supplemental Accidental Death & Dismemberment
- Supplemental Life (employee, spouse/Domestic Partner and/or child)
- Group Legal
- Group Accident plan
- Group Critical Illness
- Group Hospital Indemnity Insurance

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"). Together, this booklet and the incorporated documents constitute the Summary Plan Description for the Plan.

Health Savings Account (HSA)

Sysco offers a medical coverage option under the Plan that qualifies as a high deductible health plan as defined by the IRS. If you enroll in the high deductible health plan option under the Plan, you may be eligible to contribute to a tax-advantaged HSA. If you do not enroll in the high deductible health plan, by law you cannot establish an HSA. The HSA is a personal savings account that belongs to you, and you do not forfeit funds that you do not use by year- end. Instead, HSA funds remaining in your account will roll over to the following year.

HSA Contributions

If you open an HSA, you may elect to make contributions to your HSA through automatic pre-tax payroll deductions. You can also make contributions directly to your HSA on an after-tax basis. If you make pre- tax contributions through payroll deductions, you may elect, on a prospective basis only, to change the amount you contribute to your HSA at any time during the year. Contribution elections or changes will be effective as soon as administratively possible. If you are entitled to an HSA contribution(s) from Sysco, the contribution(s) will also be made through the Plan and will be subject to the requirements of Internal Revenue Code Section 125. The HSA is not an ERISA plan and, therefore, the administrative information provided elsewhere in this booklet does not apply. The HSA is provided in this booklet for your convenience only.

The IRS determines the total maximum amount (for employer and employee combined) that can be contributed to an HSA each year. The contribution limit is based on the coverage level you choose under the high deductible health plan (i.e., employee only or family coverage), up to IRS annual limits. If you are between ages 55 and 65 and not enrolled in Medicare, you can make additional catch-up contributions. Consult your personal tax advisor to determine your annual contribution limit.

HSA Expenses

The IRS defines the type of health care expenses that are eligible to be paid from an HSA. The HSA can be used to pay current and future qualified health care expenses (such as deductibles and coinsurance) on a tax-free basis for yourself and your spouse or any tax dependents. You can pay your tax dependents' eligible expenses even if they are participating in a different health care plan that is not a high deductible plan, as long as you claim those dependents on your federal income tax return.

You can also pay your eligible expenses after you no longer participate in a high deductible health plan, even if you have other non-high deductible health plan coverage. There is no limit on what you can withdraw in any one year, but you can only withdraw up to the balance in your account. IRS Publication 502 will help you to determine whether a health care expense qualifies for reimbursement from an HSA.

You may also withdraw HSA money for a purpose other than paying eligible health care expenses. If you do, you must pay federal income tax on the withdrawal and, if you're under age 65, a penalty tax on the amount withdrawn. The penalty does not apply if you are age 65 or older or if you are disabled, but ordinary income taxes continue to apply.

Unused funds roll over from calendar year to calendar year. You take the account with you if you leave Sysco or

retire.

For more information, contact Sysco Benefits Center at 1-800-55-SYSCO or your personal tax advisor.

Eligibility to Contribute to the HSA

Federal tax law imposes strict limits on which individuals are eligible to contribute to HSAs. You are eligible to contribute to the HSA under the following circumstances:

- You are enrolled in a “high-deductible” medical coverage option through Sysco;
- You are not enrolled in Medicare, Medicaid, or Tricare;
- You have not received services from the Veteran's Administration within the preceding three months;
- You are not covered under a general-purpose health FSA or health reimbursement arrangement (“HRA”);
- Your spouse is not enrolled in a general-purpose health FSA, where your spouse could claim your medical expenses under that plan; and
- You cannot be claimed as a dependent on another person's income tax return

A health FSA reimburses all IRS-approved medical expenses. If you wish to contribute to a health FSA while contributing to the HSA, Sysco offers the Limited Use Health FSA, which is considered a “limited purpose” FSA. (See “Health Care and Limited Use Health FSAs” for complete details). The Limited Use Health FSA is designed to allow you to maintain your eligibility to contribute to the HSA. Consult your personal tax advisor for additional information about your eligibility to contribute to an HSA.

General Purposes Health Care Flexible Spending Accounts and Limited Use Health Care Flexible Spending Accounts

You may choose to participate in the Limited Use Health Care FSA or the General-Purpose Health Care FSA. These accounts can be used to reimburse yourself with pre-tax dollars for you and your eligible tax dependents’ qualifying healthcare expenses.

The Limited Use Health Care FSA and General-Purpose Health Care FSA are accounts that allow you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the respective account. This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, copayments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees.

Covered Expenses

Limited Use Health Care FSA

- Only dental and vision expenses are covered until you reach the IRS statutory deductible amount
- Examples of eligible healthcare expenses include most healthcare expenses that are not already covered by any medical, dental, and vision plans, including deductibles, coinsurance and copays, and expenses that exceed reasonable and customary limits

- You can even use the Limited Use Health Care FSA to pay expenses incurred by an eligible tax dependent that is not covered under the Plan, such as a legal spouse who has their own coverage elsewhere

General Purpose Health Care FSA

- You can be reimbursed for healthcare expenses that the Internal Revenue Service considers deductible for federal income tax purposes, except that:
  - The expenses must be *incurred* in the calendar year you enroll
  - You cannot be reimbursed for healthcare premiums, even though they are tax deductible
- Examples of eligible healthcare expenses include most healthcare expenses that are not already covered by any medical, dental, and vision plans, including deductibles, coinsurance and copays, and expenses that exceed reasonable and customary limits
- You can even use the account to pay expenses incurred by an eligible dependent who is not covered under Sysco benefits, such as a legal spouse who has their own coverage elsewhere
- Neither you nor your tax dependents may contribute to an HSA while covered under the General-Purpose Health Care FSA

Eligible Dependents

For purposes of both the General-Purpose Health Care FSA and the Limited Use Health Care FSA, your eligible dependents are your tax dependents, as defined by the IRS. Consult your tax advisor for more information about which of your family members are eligible to have their expenses reimbursed from your account.

Use It or Lose It

Under IRS rules, if you do not use all of your Limited Use Health Care FSA and/or General-Purpose Health Care FSA contributions for eligible expenses, you forfeit the money you contributed to it (see the *Carryover Provision* section for an exception) that you do not use by year-end. Plan carefully, because you cannot change the amount of your contributions to the Limited Purpose Health Care FSA and/or General-Purpose Health Care FSA during the year except in limited circumstances as determined by Sysco in accordance with IRS guidelines. Because you forfeit any money remaining that you do not use by year end, estimate conservatively.

There are three possible ways to forfeit money in your FSA:

- Overestimate the reimbursable expenses you'll have during your participation each calendar year
- Miss the claim filing deadline for each calendar year, which is March 31 of the following year
- Do not re-enroll in the FSA for the following year

To avoid forfeiting money, take the time to estimate your anticipated health care expenses before you make your Limited Use Health Care FSA and/or General-Purpose Health Care FSA elections. It helps to review your previous year's expenses and compare them with your expected expenditures for the coming year. You should then contribute only a conservative estimated amount of the expenses you expect to have during the calendar year in which you are a participant.

By law, the money in your Limited Use Health Care FSA and/or General-Purpose Health Care FSA must be kept separate from any money contributed to your Dependent Care FSA, if applicable. If you have an unspent balance in one account, you cannot use the money to reimburse claims in your other account. For example, you can't use

money in your Limited Use Health Care FSA and/or General-Purpose Health Care FSA to reimburse for day care expenses. You also may not transfer money between a Limited Use Health Care FSA and/or General-Purpose Health Care FSA and a Dependent Care FSA.

Carryover Provision

Participants who are active as of the last day of the plan year may carryover up to the maximum IRS allowed limit (e.g., $660 for 2025) of any balance remaining at the end of the plan year to be used for reimbursement of qualifying health care expenses incurred during the subsequent Plan year. The carryover provision does NOT apply to the Dependent Care FSAs. Any balance over the statutory maximum allowed carryover limit will be forfeited. If you do not re-enroll in the Limited Use Health Care FSA and/or General-Purpose Health Care FSA in the subsequent plan year, any remaining funds will not be eligible for a carryover and will be forfeited, make sure you plan accordingly.

Filing a Claim

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator by March 31 after the Plan Year. Any claims for reimbursement after that date will not be eligible for reimbursement by the Claims Administrator.

See the section entitled *Plan Administration* below for the name and contact information for the Claims Administrator.

Debit Card

When you enroll in the Limited Use Health Care FSA and/or General-Purpose Health Care FSA, you will receive a debit card from the Claims Administrator. You can use this card to pay for eligible expenses.

When using your debit card, the date your card is swiped is considered your date of service. Therefore, you should not be using your card to pay for expenses incurred in a prior Plan Year, only the current Plan Year. If you have claims from a prior Plan Year, please pay out-of-pocket and submit a claim on the Claims Administrator's website.

If you incur an eligible health care expense that cannot be paid with the debit card, file a claim form by March 31 of the following year. You will receive your reimbursement by check or direct deposit (if you have registered for this option on the Claims Administrator's website). Faxed copies of claim forms and receipts are accepted.

In the event that the Claims Administrator becomes aware of an improper payment through use of an employee's debit card, Federal law requires the Plan to try to recoup the money using the following progressive correction procedures:

- The Claims Administrator will send a letter to the employee indicating that the employee must pay back on an after-tax basis, an amount equal to the improper payment;
- If repayment is not made as described above, Sysco will withhold the amount of the improper payment from

the employee's wages or other compensation, on an after-tax basis, to the extent consistent with applicable law;

- If any portion of the improper payment still remains outstanding after attempts to recover the amount as described above, the Claims Administrator will utilize a claims substitution or offset approach to resolve improper payments, such as reducing the reimbursement for a subsequent, substantiated expense claim by the amount of the improper payment, as described in the example below:

Example: If Employee has received an improper payment of $200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement will be made until the improper payment is fully recouped. So, if Employee has received an improper payment of $200 and subsequently submits a substantiated claim for $250 incurred during the same coverage period, Employee will only receive a reimbursement of $50. The remaining $200 will be applied to recover the outstanding improper payment.

In addition to the above correction procedures, the Claims Administrator will also deny access to the debit card until the improper payment is repaid. If deactivation of the debit card occurs, the employee must request payments or reimbursements of medical expenses through other methods (e.g., by submitting receipts or invoices from a merchant or service provider showing the employee incurred a qualified health care expense).

Finally, if all of the above procedures are unsuccessful, or otherwise unavailable, the employee shall reimburse Sysco or the amount of the improper payment, and Sysco will treat the payment as any other business payment which may result in the payment being taxable to the employee.

When an Expense is Incurred

An expense is incurred on the date the service is actually provided, not the date it is billed or paid. So, if you visit the doctor, you can file for reimbursement immediately. If you pay expenses in advance, you cannot be reimbursed until the services are actually provided.

Partial-Year Eligibility

If you join Sysco mid-year, you cannot submit a claim for an expense that was incurred before your coverage is effective. If you leave Sysco mid-year, your participation will end; however, you may continue participation on an after-tax basis through COBRA and continue to submit eligible health care expenses. If you choose not to elect COBRA and you still have money in your account when your participation ends, you can claim reimbursement for any expenses you incurred (prior to your participation end date) by March 31 of the following year.

Contribution Limits

Sysco will communicate the annual minimum and maximum contribution amounts to you before or during each annual open enrollment period.

Reimbursable Healthcare Expenses

The IRS strictly defines the expenses that can and cannot be reimbursed through an FSA. Generally, any healthcare expenses that would qualify as a deduction on your federal income tax return (except for premiums for healthcare coverage and long-term care services) qualify as eligible health care expenses under the FSA, provided they are not reimbursed through a healthcare plan.

You may want to contact the IRS to receive IRS Publication 502: Medical and Dental Expenses. While certain sections of the Publication do not apply for purposes of the Health Care FSA, you may find the section entitled

"What Medical Expenses are Deductible" helpful in that it contains information on expenses which are deductible on your federal tax return and which may be eligible health care expenses for the Health Care FSA. You can download the Publication through the IRS website at www.irs.gov.

Examples of Eligible Healthcare Expenses

Here are some of the expenses that may be eligible for reimbursement:

- Annual deductibles
- Medical, prescription drug, dental, or vision care copays and coinsurance
- Any other eligible charges not fully covered under any health care plan, such as amounts that exceed the reasonable and customary charge
- Eye exams, eyeglasses, and frames
- Contact lenses including all necessary supplies and equipment
- Hearing exams, aids, and repairs
- Special telephone and television equipment for the deaf
- Guide dog or other animal or human guide used by a visually impaired or hearing-impaired person
- LASIK surgery and radial keratotomy
- Routine physical examinations
- Special treatment programs (for example, a cardiovascular fitness program prescribed by a physician)
- Medical devices, including durable medical equipment and supplies
- Orthodontia expenses
- Childbirth classes for the mother who is covered under the plan
- Weight-loss programs for treatment of obesity when diagnosed by a physician
- Smoking-cessation programs and related prescription drugs (but not over-the-counter nicotine gum and patches
- Eligible over-the-counter medications (pain relievers, cold medications, antacids, allergy medications)
- Feminine hygiene products

Examples of Ineligible Healthcare Expenses

You cannot use the Health Care FSA to be reimbursed for:

- Expenses that would not be eligible for deduction on your federal income tax return
- Premium contributions for healthcare coverage provided by Sysco or for any other healthcare coverage, including COBRA premiums and Medicare
- Expenses you claim as deductions on your federal income tax return
- Expenses reimbursed by any other health care plan, including Medicare and Medicaid
- Cosmetic surgery (unless necessary to eliminate a deformity related to a birth defect, a personal injury resulting from an accident or trauma, a disfiguring disease, or reconstructive surgery after a mastectomy)

- Cosmetic dentistry
- Long-term care (LTC) expenses, including premiums for LTC insurance
- Lodging expenses while receiving medical treatment away from home that exceeds $50 per person/night
- The cost of food, clothing, and education
- Health club dues or membership fees
- Exercise equipment, hot tubs, whirlpool baths, and swimming pools (exercise equipment and hot tubs may be reimbursable with a physician's statement)
- Marriage or family counseling
- Funeral or burial expenses
- Maternity clothes or diaper services
- Nursing care for a normal, healthy baby
- Expenses you incur while you are not a participant in the Health Care FSA

Dependent Care Flexible Spending Account (DCFSA)

The DCFSA offers you a convenient, pre-tax method to pay for eligible dependent care expenses for an eligible dependent adult or child. You can use your DCFSA account to pay for eligible dependent care expenses that enable you (and your spouse if you are married) to work (or actively look for paid work or attend school full-time).

This program is intended to reimburse you for eligible day care and elder care expenses. **This program does not reimburse health care expenses for your dependents.**

You may be able to save money and lower your overall out-of-pocket costs by using a DC FSA to pay these expenses with pre-tax dollars.

The DCFSA is not subject to ERISA.

Contribution Limits

If you choose to participate, the minimum annual contribution is $100. The maximum annual contribution is $5,000 (or $2,500 if you are married and file your tax return as "married filing separately").

The maximum annual contribution limit for employees defined as "Highly Compensated Employees" under the Internal Revenue Code is $2,000 (see *Contribution Limits for Highly Compensated Employees* for more information).

Special Guidelines

There are IRS guidelines that affect how much you can contribute to your DCFSA:

- The amount of your contribution cannot be greater than your income or your spouse's income, whichever is lower. So, if your spouse earns less than $5,000 a year, you cannot contribute more than their income to the DCFSA
- If your spouse is a full-time student and has no income or is disabled, your spouse is considered to have income of $250 a month for one child or $500 a month for two or more children in each month that they are a full-time student or incapable of self-care. If your spouse is a full-time student for the entire year, the most you can contribute to the DCFSA is $3,000 for one eligible dependent and $5,000 for two or

more eligible dependents

- If you are married and file a joint tax return, and you and your spouse both participate in a DCFSA, the most you can contribute together in one year is $5,000. For example, if your spouse contributes $1,000 to their employer's DCFSA, you can contribute up to $4,000 to your DCFSA
- If you are married and file separate tax returns, the maximum you can each contribute to your respective DCFSA is $2,500

Contribution Limits for Highly Compensated Employees

Discrimination testing is required on an annual basis to assure the plan has been implemented to the benefit of all employees and is not discriminating in favor of Highly Compensated Employees (HCEs). These tests may be performed throughout the year to ensure that the DCFSA will pass the official test at the end of the year. If the DCFSA fails discrimination testing, HCE participation in the DCFSA may be impacted. Sysco reserves the right to unilaterally reduce your annual DCFSA election amount to comply with IRS nondiscrimination requirements.

Eligible Dependents

For purposes of the DCFSA, eligible dependents include:

- Children under age 13 whom you are entitled to claim as exemptions on your federal income tax return (if you are divorced or separated, see below), and
- Any dependent age 13 or older whom you are entitled to claim for federal income tax purposes, who is in your household at least eight hours a day for more than half the year, and who is physically or mentally incapable of self-care

In general, you must claim an exemption on your federal income taxes for a child under age 13 to be your eligible dependent under the DCFSA; however, if you are the custodial parent (even if you do not claim the exemption), your child will be treated as your eligible dependent under the DCFSA. If you are the non- custodial parent, your child is not an eligible dependent under the DCFSA. If you are divorced or separated and you share custody of the child, the child is an eligible dependent under the DCFSA if you have custody of the child for the greater portion of the year.

Partial-Year Eligibility

Unlike the Limited Use Health Care FSA and/or General-Purpose Health Care FSA, the DCFSA does not allow you to continue your participation through COBRA. If your participation in the DCFSA stops for any reason, you cannot make additional contributions to your account. If you still have money in your account when your participation ends, you can claim reimbursement for any expenses you incur (prior to your participation end date) by March 31 of the following year. Any unused contributions will be forfeited.

For employees who terminate employment and are re-hired: If you become an active employee within 30 days of your termination date, your elections are reinstated to the same levels they were before your termination.

If it has been more than 30 days since your termination date, you will be permitted to re-elect your level of participation.

When an Expense is Incurred

An expense is incurred on the date the services are actually provided, not the date they are billed or paid. If you pay for expenses in advance, you cannot be reimbursed until the services are actually provided. For instance, if

you pay for day care on the first of each month, you cannot be reimbursed until the end of the month, after services have been rendered.

How Claims are Processed

You must file claim forms by March 31 of the following year in order to be eligible for reimbursement. Your reimbursement will be sent to you or may be direct deposited into your bank account pursuant to the terms and procedures established by the Claims Administrator. See the section below entitled *Plan Administration* for the name and contact information for the Claims Administrator.

Reimbursable Dependent Care Expenses

To qualify for reimbursement, the dependent care expense must be necessary to allow you to work or look for work. If you're married, your spouse must be employed (or looking for employment) outside the home, be physically or mentally incapable of self-care, or be a full-time student for at least five months during the calendar year.

Dependent Care may be provided in your home or in a day care center. The day care center must be licensed if it cares for six or more people. If the care provider is a relative, they must be someone other than your spouse, your child under age 19 or anyone you or your spouse could claim as a dependent on your income tax return.

Examples of Eligible Dependent Care Expenses

You can use the Dependent Care FSA for the same employment-related expenses that qualify for the federal tax credit. You may want to contact the IRS to receive IRS Publication 503: Child and Dependent Care Expenses, which contains information on expenses which are deductible on your federal tax return, and which may be eligible expenses for the DCFSA. You can download the publication through the IRS website at www.irs.gov.

Here's a list of some common expenses that can be reimbursed from the DCFSA:

- Care at licensed nursery schools or day camps (not expenses for kindergarten or above, or overnight camps). To qualify, the school or center must comply with state and local laws and receive a fee for its services if it cares for seven or more children,
- Payment to a housekeeper who is also responsible for providing day care,
- Payment to someone who provides care in your home as well as related taxes you pay on that person's behalf,
- Care provided at an adult day care facility (but not expenses for an overnight nursing home facility),
- Care provided by before-school or after-school programs, and
- Care provided inside or outside your home by anyone (other than your spouse, a person you list as your dependent for income tax purposes, or your child under age 19).

Examples of Ineligible Dependent Care Expenses

Here is a list of some of the more common ineligible expenses which cannot be reimbursed from the DCFSA:

- Medical expenses incurred by eligible dependents,
- Amounts paid for the care of a person in a nursing home or convalescent facility,
- Amounts paid to your spouse or child under the age of 19 for day care services (for example, you cannot

be reimbursed for payments to one of your teenage children to care for your younger children),

- Cost of food, clothing, shelter, insurance, medical treatment, or vacations of a qualified dependent,
- Payment for care that is not necessary for you to work (for example, a babysitter while you go to the movies),
- Activity fees, late payment fees, supply fees,
- Child support payments,
- Transportation to and from the day care site,
- Education expenses for any child in or beyond kindergarten,
- Items you intend to claim as a credit for federal tax purposes,
- Expenses for services that have not yet been provided (e.g., prepaid day care expenses),
- Overnight camp expenses, or
- Expenses you incur while you are not a participant in the Dependent Care FSA.

Other Rules

Before you decide whether or not to participate in a DCFSA, here are some additional facts you should know:

- When you participate in a DCFSA, your contributions can only be used for expenses that are actually incurred during January 1 through December 31. (If you join the DCFSA mid-year, your account cannot reimburse expenses incurred prior to the date you joined the Plan)
- Expenses incurred in the following year cannot be paid out of your previous year's account balance
- The IRS requires that any money left in your DCFSA at the end of the calendar year be forfeited. You cannot carry an unused balance from one year to the next
- The DCFSA is a completely separate account from the Limited Use Health Care FSA and/or General-Purpose Health Care FSA. You cannot transfer money from one account to the other
- Expenses reimbursed under the DCFSA coordinate with those covered under the Federal Dependent Care Tax Credit
- You have until March 31 of the following year to file claims for reimbursement

Rules that Apply to Group Health Plan Benefits

This section describes rules that apply to the group health plan benefits offered through the Plan, as applicable. Please refer to this section along with the incorporated documents when trying to understand what your Plan covers and what limitations and exclusions apply. The group health plan benefits include medical, prescription drug, dental, vision, health care flexible spending accounts (general purpose and limited use) and the Employee Assistance Program.

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a Federal law that includes the No Surprises Billing Act as well as the provider transparency requirements that are described below. You may request a paper copy of the Notice from your health plan by calling the number on your ID card.

Protections Against Surprise Medical Bills

Under federal law (the No Surprises Act of the Consolidated Appropriations Act, 2021), you will be protected from "surprise medical billing" or "balance billing" when you receive emergency care or treatment from an Out-of-Network health care provider at an In-Network hospital or ambulatory surgical center. Surprise medical billing is when you receive services at an In-Network facility from an Out-of-Network provider and the member later receives a bill for Out-of-Network services. Balance billing is when you receive care from an Out-of-Network provider who bills you for the difference between the provider's normal charge and the allowable amount under the Plan. This applies in addition to the cost sharing you must pay (such as a deductible, copayment or coinsurance) under the Plan.

Under federal law, you are protected from balance billing for the following services. These services will be referred to as "protected services."

- *Emergency services*: If you have an emergency medical condition and receive emergency services from an Out-of-Network provider or facility, the most the provider or facility may bill you is the Plan's In-Network cost-sharing amount (such as deductibles, copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may receive after you are in stable condition, unless you provide written consent to give up protections not to be balance billed for these post-stabilization services.
- *Certain services at an In-Network hospital or ambulatory surgical center:* When you receive services from an In-Network hospital or ambulatory surgical center, certain providers may be Out-of-Network. In these cases, the most those providers may bill you is the Plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up protections not to be balance billed.
- *Air ambulance:* If you have an emergency medical condition and receive emergency transport through an Out-of-Network air ambulance service, the most the provider may bill you is the Plan's In-Network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency air ambulance services.

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was In-Network). The Plan will pay Out-of-Network providers and facilities directly the "Out-of-Network rate" as required by section 2799A-1 of the Public Health Service Act. You're never required to give up your protection from balance billing. You also aren't required to receive care Out-of-Network. You can choose a provider or facility in the Plan's network.

If you receive a balance bill for a protected service, you will need to contact the Claims Administrator at the customer service telephone number listed on your ID card. Upon such notification, the Claims Administrator will resolve the balance billing.

Additionally, for the protected services listed above, the Plan will:

- Cover emergency services without requiring prior authorization and without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits (to the extent consistent with benefits for an emergency medical condition), an affiliation or waiting period, or applicable cost sharing,
- Base the amount you pay for the provider or facility on the In-Network cost-sharing amount (regardless if the provider or facility is Out-of-Network), and
- Count any amount you pay for the Out-of-Network services towards your In-Network deductible and out-of-pocket maximum.

Transparency Requirements

The Plan provides the following information on its website at www.syscobenefits.com

- Protections with respect to Surprise Billing claims by providers;
- Estimates on what Out-of-Network providers may charge for a particular service;
- Information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements.

Upon request, the Plan Administrator or the Claims Administrator will provide you with a paper copy of the type of information you request from the above list.

The Claims Administrator, either through its price comparison tool on www.myuhc.com or through Member Services at the phone number on the back of your ID card, will allow you to get:

- Cost sharing information that you would be responsible for, for a service from a specific network provider;
- A list of all Network Providers, updated at least every 90 days;
- Cost sharing information on an Out-of-Network provider's services based on the Claims Administrators reasonable estimate based on what the health plan would pay an Out-of-Network provider for the service.

In addition, the Claims Administrator will provide access through its website to the following information:

- Network negotiated rates;
- Historical Out-of-Network rates; and
- Drug pricing information.

Continuity of Care

In certain circumstances, if you are receiving continued care from an In-Network provider or facility, and that provider's network status changes from In-Network to Out-of-Network, you can continue to receive care from the provider at the In-Network cost-sharing amount for up to 90 days from the date you are notified of your Provider's termination, unless otherwise indicated below. This will apply if you are: (1) undergoing treatment for a serious and complex condition, (2) pregnant and undergoing treatment for the pregnancy, through your first postpartum visit, (3) receiving inpatient care, (4) scheduled to undergo urgent or emergent surgery, including postoperative or (5) terminally ill (having a life expectancy of 6 months or less) and receiving treatment for the illness from the provider. Please contact your medical benefit provider if you need transitional care.

Women's Health and Cancer Rights Act Notice

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.

Newborns' and Mothers' Health Protection Act Notice

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 less than 48 hours following a vaginal delivery or 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).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that if group health plans and health insurance issuers decide to provide mental health or substance use disorder benefits, they must ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Qualified Medical Child Support Order (QMCSO)

The Plan will comply with all the terms of a 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 employee generally in the case of divorce 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 *QMCSO*. When an order is received, each affected participant employee and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and will receive, at no cost, 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 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 ("PHI") in order to carry out the payment, treatment and health care operations under the Plan. These entities and individuals may use protected health information for such purposes without your consent or authorization. In addition, your PHI may be shared

with the plan sponsor without your consent or written authorization for administrative purposes. If your PHI 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 PHI 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 immediately below will apply.

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "you" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non- economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan, or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery

funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Coordination of Benefits If You Are Covered by More Than One Group Health Care Plan

In situations where you have other primary coverage, the group health benefits under the Plan generally have provisions to ensure that payments from all of your group health care plans do not exceed the amount the Plan would pay if it were your only coverage.

The rules described in this section generally apply to the group health benefits under the Plan. The incorporated documents that are also part of this SPD may include additional, and more specific, rules on coordination of benefits. Please review those vendor documents incorporated into this SPD for additional information on coordination under your Plan program.

Nonduplication of Benefits

The purpose of the Plan is to help you pay for those costs that you and your covered dependents incur for

necessary medical services and supplies. Some Plan participants have additional medical coverage. For instance, you may be covered as an employee at Sysco and as a dependent under your spouse's or employer's group health care plan.

Sometimes expenses are covered by more than one group health care plan and total benefits could exceed the actual expense. That's why the Plan has a nonduplication provision which coordinates benefits from other group health care plans to guard against health care overpayments.

"Group health care plan" means medical, prescription, dental, and vision coverage under a plan made available by an employer other than Sysco, or a participating subsidiary, or coverage provided under a governmental program or provided by statute (other than Medicare or Medicaid).

These plans include pre-payment plans such as a managed network option, group association coverage for an employee or dependent made available by an employer, or student coverage obtained through an educational institution above the high school level. Coverage required by statutes such as no-fault automobile insurance laws (in states where coordination is permitted) is also included.

A group health care plan as described above excludes any personal policy you may have and does not apply to any such policy. To obtain all the benefits for which you are eligible, claims should be filed with each of your sources of coverage.

Which Plan Pays First

In order to pay claims, the Plan must determine which group health care plan is primary and which plan is secondary. When there are two sources of coverage, one of the plans is considered primary and pays its benefits first calculated according to the terms of the applicable plan and will not be reduced due to benefits payable under other plans. Then the other plan (called the secondary plan) may pay benefits depending on the provisions of its plan. You will have to give information about any other plans when you file a claim.

The following rules are used to determine which plan is primary:

- If the other plan does not have a coordination of benefits provision, it will pay benefits in full before this Plan pays benefits
- The plan that covers the person as an employee will pay benefits in full before the plan that covers the person as a dependent
- For children's expenses, the plan of the parent whose birthday (month and day) occurs earlier in the calendar year will pay first; provided, however, that a plan that does not have a birthday rule provision will pay first
- When parents have the same birthday (month and day), the plan of the parent who has been covered longer under the plan will pay first
- When parents are separated/divorced, the plan covering the dependent children of the parent with custody, if the parent has not remarried, will pay benefits first, unless there is a court decree directing otherwise. If the parent with custody has remarried, the benefits will be paid in the following order:
  - The plan which covers the dependent children of the parent with custody;
  - The plan which covers the children as dependents of the stepparent married to the parent with custody;
  - The plan which covers the children as dependents of the parent without custody; and
  - The plan which covers the children as a dependent of the stepparent married to the parent without

custody

- When parents have joint custody, the plan covering the parent who has financial responsibility for the children's health care expenses will pay first
- The plan that covers a person as an employee or as that employee's dependent will pay benefits in full before a plan covering a person as a laid off or retired employee or as that employee's dependent
- The plan covering the person as an active employee, is primary over the plan covering the person under state or federal continuation coverage (e.g., COBRA)
- The plan that covers the person as an active employee (not as a laid-off employee or retiree) is primary over the plan that covers a person as a laid-off employee or retiree
- A plan that covers the person as an employee or retiree will generally be primary to a plan that covers the same person as a dependent. However, if the person is a Medicare beneficiary and, as a result of the Medicare Secondary Payer rules, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (for example, a retiree), then the order of benefits is reversed so that the plan covering the person as an employee or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan

If these rules do not decide which plan's benefits are payable first, the plan that has covered the person for the longest time will be primary.

Important Reminder

Covered services and benefit levels under Medicare are subject to change by the federal government. Contact your local Social Security office or log on to www.medicare.gov to obtain the most recent information on Medicare costs and coverages.

How Benefits Are Determined

When the Plan is the primary payer of health care benefits, it will determine its normal benefit without regard to the other plan. When the Plan is the secondary payer of health care benefits, it will determine its normal benefit, and then subtract the benefit you receive from the primary payer.

If the Plan would normally pay more than the other plan, you can receive the difference. If the normal benefit from the Plan is less than, or the same as, the other plan's benefit, you will not receive any benefit from the Plan.

For example, if you submit a claim of $1,000 to your spouse's plan and it pays $800, and the Plan would normally pay $900, you may receive $100 from the Plan. However, if the Plan would pay $800, you would receive nothing from the Plan.

After it is determined which plan pays benefits first, you will need to submit your initial claim to that plan. After the first plan pays your benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You will need to include a copy of the written explanation of benefits (EOB) from your primary plan.

Coordination With Medicare

Benefits for Individuals Who Are Entitled to Medicare

If you (or one of your dependents) are entitled to Medicare benefits, the following rules apply:

The medical benefits under the Plan is the **primary payer** – in other words, your claims go to the Plan first – if

any of the following apply:

- You are employed by Sysco or an affiliate, or are enrolled as a legal spouse of an active employee and you (or your covered spouse) first become entitled to Medicare benefits because of age,
- You are employed by Sysco or an affiliate, or are enrolled as a family member of an active employee and you (or your covered family member) first become entitled to Medicare benefits because of disability, or
- You (or your covered family member) first become entitled to Medicare benefits because you (or your covered family member) have end-stage renal disease. In this case, the Plan is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer. This rule applies regardless of whether or not you have current employment status with Sysco or one of the participating employers in the Plan

The Plan pays **secondary** and Medicare is the primary payer if you (or your covered family member) are entitled to Medicare, you (or your covered family member) do not have end-stage renal disease and you do not have current employment status with Sysco or a participating employer in the Plan. If you terminate employment with Sysco and elect to continue your medical coverage pursuant to COBRA, the Plan will pay **secondary** to Medicare. (See "Part B Enrollment" below)

If you (or your legal spouse) are over age 65 and the Plan would otherwise be the primary payer because you are still working, you or your spouse may also enroll in Medicare and decline medical benefit coverage under the Plan. If you are working and you (or your spouse) continue to receive coverage under the Plan and also decide to enroll in Medicare, the Plan will pay primary and Medicare will pay secondary. If you are working and elect Medicare, the Plan cannot, by law, pay benefits secondary to Medicare, except for certain individuals with end-stage renal disease.

Remember, enrollment in Medicare is not always automatic. You may have to apply for it with your local Social Security office.

Benefits for Disabled Individuals

If you lose current employment status at Sysco or with one of the participating employers in the Plan because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you will generally be automatically enrolled in Medicare Parts A and B after you have received disability benefits for 24 months. Medicare Part A provides inpatient hospitalization benefits and Medicare Part B provides outpatient medical benefits, such as doctor's office visits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, primary payer status depends on whether an individual is covered under an employer plan due to current employment status of the employee. An employer plan generally is the primary payer for the disabled individual if the employee connected to the coverage is considered to have current employment status with the employer. Medicare generally is the primary payer for the disabled individual if the employee connected to the coverage is no longer considered to be in current employment status. If Medicare is the primary payer and pays less than the current benefit allowable by the medical benefit under the Plan, the Plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the medical benefit under the Plan considers eligible, the Plan will pay up to its normal benefit amount after you meet the calendar year deductible, if any.

Part B Enrollment

You can delay Part B enrollment without penalty only while you or your spouse is still actively working for the employer that provides your health insurance. However, if you receive COBRA continuation coverage or retiree benefits, you are, by definition, no longer working for Sysco or an affiliate. As such, if you wait until COBRA coverage expires before enrolling in Part B, you will not qualify for a special enrollment period. Instead, you will have to wait until the general enrollment period that runs from January 1 to March 31 each year, with coverage not beginning until the following July 1.

In addition to delayed enrollment, you will likely be required to pay late penalties for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B but did not sign up for it. In other words, your delayed enrollment in Medicare will impact your monthly premium. Therefore, we encourage you to enroll at least eight months prior to the month after your active employment ends to avoid having to pay a late enrollment penalty.

When Medicare is the primary payer (or would be the primary payer if you enrolled), no benefits will be payable under the Plan's medical benefits for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

The Genetic Information Non-discrimination Act (GINA)

The Genetic Information Nondiscrimination Act prohibits health coverage discrimination and employment discrimination against 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 or contributions 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 booklet and in specific benefit descriptions incorporated by reference into this booklet. 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.”

Cancellation or discontinuance of coverage is permitted if it has only a prospective effect on coverage or it’s effective retroactively due to failure to pay required premiums or contributions or as otherwise described below.

Rescission

Rescission of coverage is cancellation or discontinuance of coverage retroactively for reasons other than failure to pay required premiums or contributions. For example, rescission of coverage may be permitted in limited circumstances such as fraud or the intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with written notice at least 30 days before the date of rescission.

Continuation of Your Group Health Plan Coverage

You may be able to continue coverage under the Sysco medical, prescription drug, dental, vision and employee assistance program (EAP) options under certain conditions. Limited continuation rights may also be available with a Limited Use Health Care FSA and/or General-Purpose Health Care FSA.

Continuation Coverage Rights under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Sysco medical, prescription drug, dental, vision, EAP, and FSA options under the Plan. **This SPD section generally explains COBRA continuation coverage, when it may become available to you and your covered dependents, and what you need to do to protect the right to receive it.** Refer to the section “Continuing Your Health Care Flexible Spending Account under COBRA” for the special rules that apply to continuing participation in those accounts under COBRA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. COBRA continuation coverage can become available to you when you would otherwise lose coverage under a group health plan because of a qualifying event. It can also become available to your spouse and dependent children who are covered under a plan when they would otherwise lose such coverage because of a qualifying event. Although COBRA does not apply to domestic partners, Sysco allows Domestic Partners to continue coverage under the same rules as applicable to the employee, spouse and dependent children.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan (medical, prescription drug, dental, vision, EAP and Limited Use Health Care FSA and/or General-Purpose Health Care FSA) coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse/Domestic Partner and your dependent children could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Events

If you are an **employee**, you will become a qualified beneficiary if you lose coverage under one of the medical, prescription drug dental, vision or EAP options because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct

If you are the **spouse of an employee,** you will become a qualified beneficiary if you lose coverage under one of the medical, prescription drug, dental, vision or EAP options because any of the following qualifying events happens:

- Your employee-spouse dies,
- Your employee-spouse's hours of employment are reduced,
- Your employee-spouse's employment ends for any reason other than their gross misconduct,
- You become divorced or legally separated from your employee-spouse, or
- Your employee-spouse becomes entitled to Medicare

If you are the **domestic partner of an employee**, you will be provided COBRA-like benefits if you lose coverage under one of the medical, dental, vision or EAP options because any of the following qualifying events happens:

- Your domestic partner's hours of employment are reduced, or
- Your domestic partner's employment ends for any reason other than his or her gross misconduct

Your **dependent children** will become qualified beneficiaries if they lose coverage under one of the medical, prescription drug, dental, vision or EAP options because any of the following qualifying events happens:

- The parent-employee dies,

- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than their gross misconduct,
- The parents become divorced or legally separated,
- The child stops being eligible for coverage under the Plan as a "dependent child," or
- The parent-employee becomes entitled to Medicare

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

Giving Notice of Initial COBRA Qualifying Event

The Plan will offer COBRA continuation coverage to qualified beneficiaries, or COBRA-like benefits to Domestic Partners, only after Sysco has been timely notified that a qualifying event has occurred.

When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), Sysco will notify the COBRA Administrator of the qualifying event within 30 days of the qualifying event.

When the qualifying event is your divorce or legal separation, termination of a qualifying domestic partner relationship, or a dependent child losing eligibility for coverage as a dependent child, you must notify the COBRA Administrator within 60 days after the later of: 1) the date of qualifying event or 2) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice by calling Sysco Benefits Center at 1-800-55-SYSCO or you may send written notice to:

Sysco Benefits Center Dept 05728
PO Box 64116
The Woodlands, TX 77387-4116

How COBRA Continuation Coverage Is Provided

Once Sysco Benefits Center receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses/Domestic Partner, and parents may elect COBRA continuation coverage on behalf of their children.

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse/partner or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. A spouse/partner or dependent child may elect different coverage from that chosen by the employee.

Coverage for COBRA beneficiaries is treated the same as coverage for active employees. If coverage under a plan is changed for active employees, the same changes will be provided to individuals receiving COBRA continuation coverage through the plan. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods if a qualified life status change occurs or at other times under the Plan to the same extent that active employees may do so.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of group health coverage. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee's covered spouse/Domestic Partner and dependent children generally lasts for up to a total of 18 months from the date of the qualifying event or loss of coverage, whichever is later. For information on the different rules that apply to continuation of Limited Use Health Care FSA and/or General-Purpose Health Care FSA participation, refer to the section "Continuing your Health Care Flexible Spending Account under COBRA."

When the qualifying event is the death of the employee, or your divorce or legal separation or termination of a qualifying domestic partner relationship, COBRA continuation coverage for the employee's spouse and/or dependent children (but not the employee) lasts for up to a total of 36 months from the date of the qualifying event or loss of coverage, whichever is later. Also, the employee's dependent children are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of the Plan.

There are three ways in which the 18-month period of COBRA continuation coverage due to the employee's termination of employment or reduction of work hours can be extended.

- **Employee's Medicare Entitlement Occurs Before a Qualifying Event That Is Employee's Termination of Employment or Reduction of Work Hours:** When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, and the employee becomes entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the qualifying event (even if Medicare entitlement was not a qualifying event for the employee's spouse/Domestic Partner or dependent children because their coverage was not lost), COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee's Medicare entitlement. For example, if the employee becomes entitled to Medicare eight months before the date on which employment terminates and coverage is lost, COBRA continuation coverage for the employee's covered spouse/Domestic Partner and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

- **Disability Extension:** If you, your spouse/Domestic Partner or any of your dependent children covered under the Plan are determined by the Social Security Administration (SSA) to be disabled on the date of the employee's termination of employment or reduction of work hours, or at any time during the first 60 days of COBRA continuation coverage due to such qualifying event, each qualified beneficiary (whether or not disabled) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this disability extension, **you must notify the Sysco Benefits Center in writing of the person's disability status BOTH:** 1) within 60 days after the latest of: i) the date of the disability determination by the SSA, ii) the date on which the qualifying event occurs, iii) the date on which you lose (or would lose) coverage under the Plan, or iv) the date on which you are informed of both the responsibility to provide this notice and the Plan's procedures for providing such notice to the Sysco Benefits Center, **AND** 2) before the original 18-month COBRA continuation coverage period ends. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Sysco Benefits Center in writing within 30 days after this determination. Any notice of disability that you provide must include: i) the name and address of the disabled qualified beneficiary, ii) the date that the qualified beneficiary became disabled, iii) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage, iv) the date that the Social Security Administration made its determination, v) a copy of the Social Security Administration's determination, and vi) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.
- **Second Qualifying Event Extension:** If the employee's spouse/Domestic Partner, and/or dependent children experience a second qualifying event while receiving the initial 18 months of COBRA

continuation coverage, the employee's spouse and dependent children (but not the employee) can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months**, if timely notice of the second qualifying event is given to the Plan. This extension may be available to the employee's spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. If a second qualifying event occurs at any time during the 29-month disability continuation period (as described above), then each qualified beneficiary who is the employee's spouse or dependent child (whether or not disabled) may further extend COBRA continuation coverage for seven more months, for a total of up to 36 months from the employee's termination of employment or reduction of work hours (or the date coverage is lost, if later).

You must notify Sysco Benefits Center within 60 days of the date of the second qualifying event by calling 1-800-55-SYSCO or submitting your written notice to:

Sysco Benefits Center Dept. 05728
PO Box 64116
The Woodlands, TX 77387-4116

If these procedures are not followed or if the notice is not provided in writing to Sysco Benefits Center within the required 60-day period, you will not receive an extension of COBRA continuation coverage due to a second qualifying event.

The table below provides a summary of the COBRA provisions outlined in this section.

Maximum Continuation Period				
Qualifying Events That Result in Loss of Coverage	**Employee**	**Spouse**	**Child**	**Domestic Partner**
Employee's reduction of work hours (for example, full-time to part-time)	18 months	18 months	18 months	18 months
Employee's termination of employment for any reason (other than gross misconduct)	18 months	18 months	18 months	18 months
Employees or Employees' covered spouse or dependent child is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation coverage that begins as a result of termination of employment or reduction of work hours	29 months	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months	36 months

Employee and spouse divorce or termination of qualifying domestic partner relationship	N/A	36 months	36 months	36 months
Employee becomes entitled to Medicare within 18 months before termination of employment or reduction in work hours (even if such Medicare entitlement was not a qualifying event for the covered spouse or dependent child because their coverage was not lost).	N/A	36 months	36 months	36 months
Child no longer qualifies as a dependent child under the terms of a Sysco group health plan	N/A	N/A	36 months	N/A

Electing COBRA Continuation Coverage

You and/or your covered spouse/Domestic Partner and dependent children must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered spouse/Domestic Partner and dependent children would lose coverage under the Plan as a result of the qualifying event, or
- The date Sysco notifies you and/or your covered spouse/Domestic Partner and dependent children of your right to choose to continue coverage as a result of the qualifying event

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the premium cost to the Plan (including

both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Form is postmarked, if mailed). If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. Payment is considered made on the date it is sent to the Plan (the postmark date, or the date entered on the check if the postmark is unreadable).

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. Payments are due on the first of each month, although you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage, but then fail to make an initial or periodic payment before the end

of the 45- or 30-day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when the first of the following occurs:

- The applicable 18-, 29- or 36-month COBRA continuation coverage period ends
- Any required premium is not paid on time
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by Sysco
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare
- In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second qualifying event has occurred
- Sysco ceases to provide any group health plan for its employees

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your Health Care Flexible Spending Account under COBRA

Generally, if the benefit still available to you from a Limited Use Health Care FSA and/or General-Purpose Health Care FSA as of the date of a qualifying event is greater than the COBRA premium for the rest of the Plan year, you may continue your participation under COBRA. Continuing contributions will be made on an after-tax basis for the remainder of the Plan year in which a qualifying event occurs.

You will not be able to continue your participation in a Limited Use Health Care FSA and/or General- Purpose Health Care FSA under COBRA if, for the Plan year in which the qualifying event occurs, the COBRA premium for the rest of the Plan year is greater than the benefit still available to you as of the date of the qualifying event.

In no event will you be able to elect Limited Use Health Care FSA and/or General-Purpose Health Care FSA participation for any Plan year following the year in which the qualifying event occurs, even if your COBRA continuation period is still in effect for your medical, dental and/or vision coverage.

You will be required to follow all of the notice, election, payment and termination provisions applicable to the medical, dental and vision options above.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your

family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

With regard to Medicare, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning the Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights, as well as the rights of your spouse/Domestic Partner and dependent children, you should keep Sysco Benefits Center Enrollment informed of any changes in the addresses of your spouse/Domestic Partner and/or dependent children. You should also keep a copy for your records of any notices you send to Sysco Benefits Center.

Plan Contact Information

For more information on your continuation rights under COBRA, please contact the Sysco Benefits Center at 1-800-55-SYSCO or www.syscobenefits.com.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA) guarantees certain rights to eligible employees who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in

active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Under USERRA, the maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24 months after the leave begins or the day the leave ends. When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. **Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.**

If you are called to perform military service for more than 179 days, you will be able to take your unused Limited Use Health Care FSA and/or General-Purpose Health Care FSA balance as a taxable cash distribution by the last day of the Plan Year.

Military Absence of 30 Days or Less

Coverage for employees on military absence and their dependents who are covered under the Plan will remain in effect for the duration of any leave of 30 days or less. If the employee elects to take available paid time off, the employee premiums will be deducted from their paycheck. If the employee elects to take unpaid leave active benefits would remain for up to 30 days with payments made directly to the third-party administrator. the employee elects not to continue to pay the premium, coverage terminates 30 days after the effective date of the leave of absence and would be reinstated upon return from leave.

Military Absence of More Than 30 Days

Coverage for employees on military absence and their dependents who are covered under the Plan may continue coverage through COBRA. If the employee elects not to continue coverage through COBRA, coverage terminates at the end of the pay period in which the leave of absence is effective. Upon return from unpaid leave, coverage will be reinstated without a waiting period.

For all inquiries relating to military leave, please contact Sysco Benefits Center at 1-800-55-SYSCO. In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days,
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days, or
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days

Continuation of Coverage While on a Leave of Absence (Non-FMLA)

When on a company-approved unpaid leave of absence, the health care benefit coverage provided before the leave was taken will be terminated and a COBRA notice will be triggered. Sysco also allows you to continue your other coverages, such as life and AD&D insurance (both basic and supplemental, Long-Term disability, Limited Use Health Care FSA and/or General-Purpose Health Care and DCFSA.

If you take a paid leave of absence, the cost of coverage will continue to be deducted from your pay on a pre-tax basis.

If you take an unpaid leave of absence, medical, dental, vision, and prescription drug coverage for you and your dependents would continue, if you elect COBRA. Note that your monthly contributions during an unpaid leave are made on an after-tax basis and are paid directly to the third-party administrator.

If you take an unpaid leave of absence, you may also revoke your election to participate in any group health benefit offered under the Plan for the remainder of the Plan Year. Any such revocation must be made in accordance with procedures established by the Plan Administrator. Upon your return from leave, you may elect to be reinstated in the Plan on the same terms that applied prior to your leave.

Continuation of Coverage While on a Family and Medical Leave of Absence (FMLA)

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of unpaid leave each year for serious illness, the birth or adoption of a child, or to care for a spouse's child, or parent who has a serious health condition. State laws may allow for longer leaves, and your benefits may continue during those leaves. State laws may mandate a different leave period. Contact Sysco Benefits Center (800-50-SYSCO) for additional information.

If you take a paid leave of absence, the cost of coverage will continue to be deducted from your pay on a pre-tax basis.

If you take an unpaid leave of absence that qualifies under FMLA, medical, dental, vision, and prescription drug coverage for you and your dependents may continue as long as you continue to contribute your share of the cost of coverage during the leave. Note that your monthly contributions during an unpaid leave are made on an after-tax basis and are paid directly to the third-party administrator.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work provided you make your required contributions.

If you do not return to work at the end of your FMLA leave, or your employment is terminated while you are on an FMLA leave, you will be entitled to purchase COBRA continuation coverage for your medical, dental, vision, prescription drug and EAP benefits.

When You Can Take FMLA Leave

Eligible employee can take FMLA leave for the following reasons:

- For the birth and care of your newborn child or a child who is placed with you for adoption or foster care
- For the care of a spouse, child or parent who has a serious health condition
- For your own serious health condition
- For "any qualifying exigency" (a qualifying urgent situation or pressing need) arising out of the fact that the spouse, son, daughter or parent of the employee is on active duty or called to active-duty status as a member of the National Guard or Reserves in support of a contingency operation.

Military Caregiver Leave under FMLA

An eligible employee who is the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. An eligible employee can also take leave to care for certain veterans with a serious illness or injury incurred

or aggravated in the line of duty while on active duty and that manifested itself before or after the veteran left active duty. Military caregiver leave is also allowed for an eligible employee to care for current service members with serious injuries or illnesses that existed prior to service and that were aggravated by service in the line of duty while on active duty.

Military caregiver leave is available during a single 12-month period during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave. See U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA (https://www.dol.gov/whd/fmla/).

Depending on the state you live in, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

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 the benefits booklets for the plan programs in which you participate, you will see that Sysco 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 health care 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 health care 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 health care 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 health care 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.

The above-mentioned external appeals process, as well as the external appeals processes set forth in applicable vendor booklets/documents, applies to adverse benefit determinations related to surprise medical billing (sometimes referred to as “balance billing”) for select services as provided under the Consolidated Appropriations Act, including whether surprise medical billing prohibitions apply to the item or services at issue.

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 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 the Employee Retirement Income Security Act of 1974 (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 the Employee Retirement Income Security Act of 1974, as amended ("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 health care

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 health care 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 health care 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 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 health care 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 solely responsible for 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 administrator ("Claims Administrator"). 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 Claims Administrator) 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'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'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 employee contributions. Employees 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.

Your Employment

This SPD (including this document and the incorporated documents) provides detailed information about the Plan and the Plan programs and how they work. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Plan should not be interpreted as an implied or express contract or guarantee of employment. Nothing in the Plan shall restrict the right of the Company to terminate the employment of any employee or other person at any time. The Company's employment decisions are made without regard to benefits to which you are entitled upon employment. Your right to any payment is determined solely under the Plan's provisions.

Limitation of Rights

No 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 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 the Employee Retirement

Income Security Act of 1974, as amended (ERISA). Please note that the following benefits are not subject to ERISA's requirements: Dependent Care FSA, Commuter Benefit Program, Health Savings Accounts, Back-Up Child Care, ID Theft, Weight Watchers and fitness reward.

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

Continue Group Health Plan Coverage

Continue group health coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

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 the Employee Retirement Income Security Act (ERISA) of 1974, as amended, to the extent that ERISA is applicable to such Plan programs. Information about the administration of the following Plan programs is given for your convenience although the benefits are not governed by ERISA: Short-Term Disability, Dependent Care FSA, Health Savings Accounts. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your plan.

Plan Administration	
Plan Sponsor	Sysco Corporation 1390 Enclave Parkway Houston, TX, 77077-2099
Plan Administrator	Sysco Corporation 1390 Enclave Parkway Houston, TX, 77077-2099
COBRA Administrator	Bswift 800-55-SYSCO
Employer Identification Number	74-1648137
Details About Plan Administration	
Official Plan Name and Plan Number	Sysco Corporation Group Benefit Plan (Plan 501)
Plan Year	January 1 through December 31
Type of Plan	Each plan is a welfare benefit plan providing the following benefits to eligible individuals: Medical, prescription drug, dental, vision, health care FSA (general purpose and limited use), dependent care FSA, Health Savings Account, EAP, life and AD&D insurance (basic and supplemental), short- term disability, long-term disability, accident, critical illness, hospital indemnity and group legal benefits. Not all benefits listed herein are subject to ERISA.
Agent for Service of Legal Process	General Counsel Sysco Corporation 1390 Enclave Parkway Houston, TX 77077-2099
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 employee contributions, as applicable, and from the general assets of Sysco, as needed. Employees pay the full cost of some benefits under the Plan as outlined below. Sysco 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 and Prescription Drug Benefits	Self-funded	Aetna 833-361-0223 www.aetna.com
	Insured	Blue Care Network of Michigan 800-662-6667 www.bcbsm.com
	Insured	Health Alliance Medical Plans 313-872-8100 www.hap.org
	Insured	Hawaii Medical Services Association 800-948-6111 www.hmsa.com
	Insured	Kaiser Foundation Health Plan Inc. 800-464-4000 www.kp.org
	Insured	Kaiser Foundation Health Plan of the Northwest 800-813-2000 www.kp.org
	Insured	Kaiser Foundation Health Plan of Hawaii 800-966-5955 www.kp.org
	Insured	StayWell Insurance 671-477-5091 www.staywellguam.com
	Insured	Aetna International 800-231-7729 813-775-0190 (collect) www.aetnainternational.com
Dental Benefits	Insured	Aetna 833-361-0223 www.aetna.com
Vision Benefits	Self-funded	Vision Service Plan (VSP) 800-877-7195 www.vsp.com

Details About Vendors		
Health Care FSA (General and Limited Use) Dependent Care FSA* Health Savings Account* ***Not subject to ERISA**	N/A	Inspira 844-729-3539 inspirafinancial.com
Long-Term Disability	Insured	The Hartford 877-215-3440 www.mybenefits.thehartford.com
Life Insurance (employee basic life and supplemental employee, spouse/Domestic Partner and child(ren) life insurance)	Insured	MetLife 800-638-6420 www.metlife.com/info/sysco/
Accidental Death and Dismemberment (employee basic and supplemental)	Insured	MetLife 800-638-6420 www.metlife.com/info/sysco/
Accident Insurance	Insured	Aetna 833-361-0223 www.aetna.com
Critical Illness Insurance	Insured	Aetna 833-361-0223 www.aetna.com
Hospital Indemnity	Insured	Aetna 833-361-0223 www.aetna.com
Employee Assistance Programs	Insured	Aetna 888-238-6232 www.resourcesforliving.com
Legal Benefits	Insured	ARAG 800-247-4184 www.araglegal.com