aetna™

Group Insurance Plan of Benefits for Sysco Corporation (Control #155797) administered by Aetna International®

Eligibility Provision			
Employee	Regular full-time employees of Sysco Corporation participating in this plan working a minimum of 30 hours per week.		
Dependent	Spouse and children up to age 26, regardless of student status		
PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**In the U.S. Preferred Benefits (In-Network)**	**In the U.S. Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$1,000 per calendar year	$1,000 per calendar year	$2,000 per calendar year
Family Deductible	$2,000 per calendar year	$2,000 per calendar year	$4,000 per calendar year
Prior Plan Credit	Prior plan credit accrued within the last calendar year from previous carrier applies to the current year		
Individual Payment Limit *(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)*	$3,500 per calendar year	$3,500 per calendar year	$7,000 per calendar year
Family Payment Limit *(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)*	$7,000 per calendar year	$7,000 per calendar year	$14,000 per calendar year
Lifetime Maximum	Unlimited		
Inpatient Per Confinement Deductible *(Maximum of 3 per calendar year)*	None	$250	$500
Hospital Services			
Inpatient	10% after deductible	10% after deductible and $250 inpatient per confinement copay	30% after deductible and $500 inpatient per confinement deductible
Outpatient	10% after deductible	10% after deductible	30% after deductible
Private Room Limit	The institution's semiprivate rate		
Pre-certification Penalty *Pre-Certification for certain types of Non-Preferred care received inside the U.S. must be obtained to avoid a reduction in benefits paid for that care. Pre-Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required - excluded amount applied separately to each type of expense. Contact the service center to determine if pre-certification is needed for a procedure.*	No Penalty	No Penalty	$400
Non-Emergency Use of the Emergency Room	10% after deductible	10% after deductible	30% after deductible
Emergency Room	10% after deductible	10% after $150 copay	10% after $150 deductible
Non-Urgent Use of Urgent Care Provider	10% after deductible	10% after deductible	30% after deductible
Urgent Care	10% after deductible	10% after $75 copay	30% after deductible
Physician Services			
Physician Office Visit	10% after deductible	No charge after $25 copay	30% after deductible
Specialist Office Visit	10% after deductible	No charge after $40 copay	30% after deductible
Allergy Testing and Treatment	10% after deductible	No charge after $40 copay	30% after deductible
Allergy Serum and Injection	10% after deductible	10% after deductible	30% after deductible

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PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**In the U.S.** **Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Mental Health Services			
Mental Health Inpatient Coverage *(Unlimited days per calendar year)*	10% after deductible	10% after deductible and $250 inpatient per confinement copay	30% after deductible and $500 inpatient per confinement deductible
Mental Health Outpatient Coverage *(Unlimited visits per calendar year)*	10% after deductible	No charge after $40 copay	30% after deductible
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage *(Unlimited days per calendar year)*	10% after deductible	10% after deductible and $250 inpatient per confinement copay	30% after deductible and $500 inpatient per confinement deductible
Substance Abuse Outpatient Coverage *(Unlimited visits per calendar year)*	10% after deductible	No charge after $40 copay	30% after deductible
Prescription Drug Coverage			
Generic Drugs (365 day maximum supply) includes contraceptives	10% after deductible	$10 copay per month supply (includes Mail Order Drugs)	30% after deductible
Formulary Brand Name Drugs (365 day maximum supply) includes contraceptives	10% after deductible	$40 copay per month supply (includes Mail Order Drugs)	30% after deductible
Non Formulary Generic and Brand Name Drugs (365 day maximum supply) includes contraceptives	10% after deductible	$70 copay per month supply (includes Mail Order Drugs)	30% after deductible

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		In the U.S.	
PLAN FEATURES	**Outside the U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Preventive Benefits			
Routine Children Physical Exams	10% after deductible	No charge	30% after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22 (includes immunizations)			
Routine Adult Physical Exams	10% after deductible up to $1,000 calendar year maximum (includes immunizations, x-rays and labs)	No charge	30% after deductible
Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	10% after deductible	No charge	30% after deductible
Includes 1 exam and pap smear per calendar year			
Routine Mammograms	10% after deductible	No charge	30% after deductible
Unlimited visits per calendar year			
Prostate Specific Antigen (PSA)	10% after deductible	No charge	30% after deductible
Unlimited tests per calendar year			
Routine Digital Rectal Exam (DRE)	10% after deductible	No charge	30% after deductible
Unlimited exams per calendar year			
Colorectal Cancer Screening	10% after deductible	No charge	30% after deductible
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 10 years			
Routine Hearing Exam	10% after deductible	No charge	30% after deductible
Includes one routine exam every 24 months			
Hearing Aids	10% after deductible	10% after deductible	30% after deductible
1 hearing aid per ear to $1,000 maximum per ear every 3 years for child to age 24			
Vision Care			
Routine Eye Exam	10% after deductible	No charge	30% after deductible
(Covered under medical) Includes one routine exam every 12 months			
Vision Care Supplies	No charge up to $200 maximum	No charge up to $200 maximum	No charge up to $200 maximum
Schedule maximums apply every 12 months			

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PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**In the U.S.** **Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Other Services			
Skilled Nursing Facility *(120 days per calendar year)*	10% after deductible	10% after deductible and $250 inpatient per confinement copay	30% after deductible and $500 inpatient per confinement deductible
Hospice Care Facility Inpatient *(30 days lifetime maximum)*	10% after deductible	10% after deductible and $250 inpatient per confinement copay	30% after deductible and $500 inpatient per confinement deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	10% after deductible	10% after deductible	30% after deductible
Home Health Care *(120 visits per calendar year combined, includes Private Duty Nursing)*	10% after deductible	10% after deductible	30% after deductible
Spinal Disorder Treatment *(Unlimited visits per calendar year)*	10% after deductible	No charge after $10 copay	25% after deductible
Speech Therapy *(60 visits per calendar year)*	10% after deductible	No charge after $40 copay	30% after deductible
Short Term Rehabilitation *(Includes coverage for Occupational and Physical Therapies; Unlimited visits per calendar year)*	10% after deductible	No charge after $10 copay	25% after deductible
Diagnostic Outpatient X-ray	10% after deductible	10% after deductible	30% after deductible
Diagnostic Outpatient Lab	10% after deductible	10% after deductible	30% after deductible
Durable Medical Equipment *(Unlimited calendar year maximum)*	10% after deductible	10% after deductible	30% after deductible
Base Infertility Services *(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)*	10% after deductible	10% after deductible	30% after deductible
Comprehensive Infertility Services *(6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction)*	10% after deductible	10% after deductible	30% after deductible
ART Infertility Services *(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).*	10% after deductible	10% after deductible	30% after deductible
Autism	*Autism covered same as any other expense.* Member cost sharing is based on the type of service performed and the place of service where it is rendered.		
Payment for Non-Preferred Providers*	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare

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Services and Programs Included in Your Plan	
	**Employee Assistance Program (EAP)** Our EAP helps members balance the demands of work, life and personal issues. Whether it's finding balance between work and life, dealing with the loss of a loved one, managing anxiety or depression, or parenting advice, EAP offers free, confidential support delivered by qualified counselors. Includes up to 5 counseling sessions per issue per year per enrolled member.
	**Emergency Assistance Services** We make sure members have the support they need during a medical emergency with necessary resources and personalized care. If a medical evacuation is needed, our in-house team focuses on getting members proper care in the most efficient way.
	**International Care Management Program** Led by our clinical Care and Response Excellence (CARE) team, our program supports everything from clinical precertification and pre-trip planning, to acute and chronic care management, and much more. With one-on-one assistance from a clinician, we offer personalized, culturally relevant support no matter where members are in the world.
	**International Maternity Management Program** Offers resources and personalized tools throughout pregnancy, delivery and post-partum care, delivered by our dedicated CARE team. Focused case management for tobacco cessation, pre-term labor, and other pregnancy risk factors.
	**Global Crisis Management Program, powered by WorldAware (Program is underwritten by Aetna Life & Casualty - (Bermuda) Ltd.)** Protects our members by providing security, political and natural disaster coverage, including 24/7 access to personalized safety advice from multilingual representatives. WorldAware's travel security website has extensive country and city intelligence reports to help members understand what risks may be present around the world.
	**Well-being Assessment**** This personalized, online health and wellness program includes a suite of online health coaching programs in addition to a health assessment. The program encourages participants to identify and reduce health risks and improve and maintain healthy lifestyles, with a focus on prevention and long-term success.

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Services and Programs Included in Your Plan	
	**Pharmacy Shipping** We make sure members can fill their prescriptions quickly, safely and easily with our pharmacy shipping solutions. We help coordinate medication management for members preparing for assignments or travel, as well as offering a 90-day supply of maintenance medicine delivered directly to the member's home.
	**Teladoc®**** Gives members access to a national network of certified physicians right at their fingertips, through phone and online-video consultations.
	**24-Hour Nurse Line**** Provides 24-hour telephone, email and chat access to experienced registered clinicians to help members make informed health care decisions on a variety of health topics.
	**Member Offers (discount program)** Our Member offers gives members choice and flexibility in their day-to-day life. They get a variety of discounts on products and services that keep them healthy, fit and help them save money. In addition to offers on personal wellness products and services, we also offer deals on everyday needs such as travel, tickets, car rentals, electronics and more.
Services and resources may vary depending on member location.* * Available to members in the U.S. only*	

Other Health Care (Out-of-Area): When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out-of-pocket maximum(s).

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Passive PPO Dental			
		In the U.S.	
PLAN FEATURES	**Outside the U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$50 per calendar year	$50 per calendar year	$50 per calendar year
Family Deductible	$150 per calendar year	$150 per calendar year	$150 per calendar year
Type A Expense *(Diagnostic & Preventive)*	No charge	No charge	No charge
Type B Expense *(Basic Restorative)*	20% after deductible	20% after deductible	20% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	$1,500	$1,500	$1,500
Orthodontic Treatment *Coverage for Adults and Dependents*	50%	50%	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000
Please refer to your Plan Documents for additional benefit coverages for Types A, B, and C			

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Medical Plan Caveats
This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018. *This plan includes coverage for women's preventive and other preventive health benefits to the extent required under the Affordable care act beginning with plan years starting on or after August 1, 2012.* *Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage, deductibles and copays may be used to satisfy the payment limit. Precertification penalty are excluded from the payment limit.* *There is cross-application between calendar year deductible, out of pocket maximum and lifetime maximum across overseas, in-network and out-of network level of benefits.* *Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).* *In-Network - deductible and coinsurance may apply to pap smears, DRE tests and PSA tests if billed by an independent laboratory provider.* *Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and all female family members. Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.* *For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.* *Copayments and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor.*
* Payment for Non-Preferred Providers *We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.* *As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.* *When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.* *Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.* *You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to* ***www.aetna.com*** *and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.* *This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.*

This plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).

This is only a brief summary of the PPO Medical, Passive PPO Dental benefits available. Some restrictions may apply.

For more specific information about the coverage details, ***including limitations, exclusions and other plan requirements****, please refer to the employee booklet (which will be provided near the time the plan becomes effective).*

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For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、ID カードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.