2009 Group Benefits Summary

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SYSCO®

SYSCO My Benefits
The Right Ingredients

What's Inside

Summary of Material Modifications

SYSCO Corporation Group Benefit Plan— Important Plan Design Changes Effective January 1, 2009

This document summarizes information about the benefits provided through the SYSCO Group Benefit Plan (plan number 501) and is part of its Summary Plan Description (SPD). This document modifies the 2007 SPD and should be kept with your copy of the SPD. If there is a conflict in the description of the benefits provided in this summary and the description in the 2007 SPD, benefits will be paid consistent with the plan design changes included in this summary.

In the event that there is any conflict between the provisions of the Plan, a constituent plan or any HMO contracts and the terms of this summary, the provisions of the Plan, the constituent plan or the HMO contracts, as applicable, will control.

In this booklet, the term "SYSCO" collectively refers to SYSCO Corporation and those subsidiaries of SYSCO Corporation that have voluntarily elected to participate in SYSCO Corporation's Group Benefit Plan.

For More Information

This *Group Benefits Summary* contains basic descriptions of your SYSCO Group Benefits. The summary is designed to help you make enrollment decisions now and to provide a quick reference to your benefits throughout the year. Please keep this guide handy so that you can refer to it when necessary.

Summary Plan Descriptions:

For full descriptions of SYSCO's Group Benefits, you should refer to the Summary Plan Descriptions.

A copy of SYSCO's Summary Plan Descriptions can be found on our benefits website at https://myinfo.sysco.com. If you do not have internet access, you can request a copy of the Summary Plan Descriptions from your local benefits department.

Contact the Claims Administrator:

You can also easily access SYSCO's benefit claims administrators. SYSCO's convenient Benefits Hotline—1-800-55-SYSCO (1-800-557-9726)—will connect you directly to the benefit claims administrator you need.

Administrator	Phone Number
Blue Cross and Blue Shield of Illinois (BCBSIL) PPO and Traditional Medical Programs	1-800-55-SYSCO Option 1
BCBSIL Health Coach Line	1-800-55-SYSCO Option 1 or 1-877-471-7030
Medco Prescription Drugs	1-800-55-SYSCO Option 2
VSP Vision	1-800-55-SYSCO Option 3
United Behavioral Health's Employee Assistance Program & Managed Mental Health	1-800-55-SYSCO Option 4 or 1-800-622-7276
MetLife Dental	1-800-55-SYSCO Option 5
CONEXIS Flexible Spending Accounts	1-866-279-8385

Each of SYSCO's benefit administrators has a website with extensive information about your benefits, discounts, health, and well-being. To visit any of the websites, log on to https://myinfo.sysco.com, click on the benefits administrator's name and you will be linked to the website.

Who is Eligible?

Active, eligible employees regularly scheduled to work 30 hours or more each week are eligible for SYSCO's Group Benefits. Employees who are temporary or seasonal, and individuals who are not on SYSCO's payroll, are not eligible employees and are not eligible to participate in SYSCO's Group Benefit Plan.

You can enroll your eligible dependents for coverage under several of the benefit plans. Dependents become eligible for coverage on the same day you become eligible; or, if your enrollment is already in effect and you want to add a new dependent, please see the Summary Plan Description for effective dates.

Your eligible dependents may include:

* Your legal opposite-sex spouse
* Your biological or legally adopted child
* A child that has been placed in your home for adoption
* A stepchild, foster child or any other child living with you, dependent on you for financial support and claimed on your federal income tax return *(a Special Dependent Questionnaire must be completed and approved).*

An unmarried dependent child is eligible up to 19 years of age. Eligibility may be extended to age 24 if the dependent is unmarried and attending an accredited college or university, high school, vocational or technical school on a full-time basis. Students taking fewer than 12 credit hours may be covered, under special circumstances, if the school or the primary care physician states in writing that the student is working to capacity. Dependents between the ages of 19 and 24 must provide Blue Cross and Blue Shield of Illinois documentation showing full time student status twice a year, spring and fall.

Eligibility for dependent child status may be extended for an unmarried physically or mentally disabled child, regardless of age, provided the disability started by or before age 19 (age 24 if unmarried, full time student). See your local benefits department for more information.

It is your responsibility to confirm and verify that an individual meets the definition of a dependent.

When Does Coverage Begin?

For new hires, your eligibility date is the first day of the month coincident with or next following two full, continuous calendar months of employment. Some groups may have additional eligibility requirements. When you enroll at open enrollment, benefits will be effective the following January 1. For benefits requiring approval, such as additional life insurance, the effective date is the approval date, if after January 1.

What Level of Coverage Do You Need?

Under the medical, dental and vision plans, you choose one of four levels of coverage:

* Employee Only (just you)
* Employee + Spouse (you plus your eligible spouse)
* Employee + Children (you plus one or more eligible children)
* Employee + Family (you plus your eligible spouse plus one or more eligible children)

This gives you the flexibility to choose just the right coverage for you and your eligible dependents.

Coverage Changes During 2008

The IRS regulates how you may add and drop coverage under benefit programs. Once each calendar year, during an open enrollment period, you will be given the opportunity to select benefits for the coming plan year (which is from January 1–December 31 of each year). The decisions you make during open enrollment will remain in effect throughout the plan year—unless you experience a qualified change in status. A qualified change in status may include:

- Marriage
- Divorce or legal separation
- Birth or adoption of a child or placement for adoption
- Death of your spouse or other covered dependent
- Change of dependent status (such as your child is no longer a full-time student)
- Loss of coverage (such as your spouse loses his or her job and benefits)
- Spouse begins employment (or goes from part-time to full-time status) resulting in eligibility for benefit coverage
- End of coverage (if you declined coverage for yourself or your dependent(s) during enrollment because you had other health insurance coverage and that coverage ends)

Your benefit changes must be made within 31 calendar days of the date of the qualified change in status and must be consistent with the nature of the event. Proof of the event will be required (for example, certified copy of the marriage certificate). You must notify your local benefits department and follow proper enrollment procedures. Calling the insurance provider is not considered enrollment.

Pre-Existing Conditions

SYSCO's PPO and Traditional health care programs contain a pre-existing condition exclusion provision. You will want to keep this in mind when you are considering your healthcare coverage options.

- A pre-existing condition is defined as a condition that entailed medical advice, diagnosis, care or treatment during the six months prior to your enrollment date in the SYSCO plan.
- Expenses will be covered after twelve consecutive months from the enrollment date of the person (even if treatment has been received for the pre-existing condition).

Pregnancy is not considered a pre-existing condition.

You may be able to lessen or eliminate the pre-existing condition exclusion period if you were previously covered by a group or individual health plan and you provide proof of that coverage. You must have had 12 months of prior coverage without a 63-day break in coverage (last day of coverage with prior plan to the day you start with SYSCO for new hires) to completely offset the exclusion period. The prior coverage is credited on a month-for-month basis. For example, if you had four months of creditable coverage with a previous plan, you would be given four months' credit under SYSCO's plan and then you would only have an eight-month exclusion.

If you elect the PPO or Traditional Program, you will need to submit proof of prior coverage or a HIPAA certificate to Blue Cross and Blue Shield of Illinois:

Blue Cross and Blue Shield of Illinois
SYSCO FSU
3405 Liberty Drive
Springfield, IL 62704

Fax: 1-217-698-2816

Decision 1: Medical Program

SYSCO offers the following medical plan options for coverage in 2008.

- Premium PPO Option
- Value PPO Option
- Traditional Program (for out-of-area participants only)
- HMOs (available at select locations)
- Waive coverage

The PPO and Traditional Programs include prescription drug and mental health benefits.

How the PPO Options Work

A PPO is a network of doctors, hospitals and other health care providers that have agreed to offer services at lower, discounted rates to their participants. With a PPO, you do not need a referral through a primary care physician. If you choose a network provider, you'll receive the highest level of benefits under the plan. Plus, you'll save money because the negotiated rates mean your portion of the expense is smaller. You can also use out-of-network providers at any time. However, if you decide to use out-of-network providers, you will most likely pay more because neither you nor SYSCO has access to network discounts.

How the Traditional Program Works

The Traditional Program offers an out-of-area solution for associates who do not have access to a PPO network due to geographic location. Under the Traditional Program, out-of-area associates may choose any doctor or healthcare provider and receive medical coverage on a fee-for-service basis. This means that you pay the doctor or healthcare provider at the time of service and submit a claim for reimbursement.

Looking for a doctor or hospital inside the network?

1. Visit https://myinfo.sysco.com
2. Under Provider Web sites on the right, choose "BCBSIL"
3. Click on "Provider Finder"

Or you may call 1-800-55-SYSCO (1-800-557-9726).

HMOs are Available at Some SYSCO Locations

Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMO do not cover the cost of services you receive from doctors or other providers outside of the HMO network. Under most plans, you must select a primary care physician to coordinate your care. Each HMO will have its own coverage specifications. HMO benefits are not covered in this benefits summary. To find out if your location participates in an HMO or for plan information, see your local benefits department.

Women's Health and Cancer Rights Act

The Healthcare Program, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services (even if the mastectomy was performed while you were covered under another plan) including 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 complications resulting from a mastectomy (including lymphedema). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Medical Plans.

Minimum Hospital Stays After Childbirth

The Healthcare Program, as required by federal law, does not 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 9 delivery by Cesarean section. Program may pay for a shorte attending provider, after cons with the mother, discharges t or newborn earlier.

For maternity care, you mu precertify your stay if it exte beyond 48 hours for a vagir or 96 hours for a birth by C section.

Medicare Part D

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. SYSCO has determined that the prescription drug coverage offered by the Group Benefit Plan Healthcare Program is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Individuals who enroll in the Healthcare Program and who are also eligible for Medicare can keep the coverage and not pay extra if they later decide to enroll in the Medicare prescription drug coverage, provided they enroll within 63 continuous days of losing their creditable coverage.

For more information, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). If you are eligible for Medicare and have further questions, you can also contact the Corporate Benefits Department at 281-584-1390.

Medical Options at a Glance

	Premium PPO Option		Value PPO Option		Traditional Program
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible					
Individual	$250	$750	$500	$1,500	$400
Family	$750	$1,500	$1,500	$3,000	$1,200
Out-of-Pocket Maximum					
Individual	$2,000	$3,000	$5,000	$6,000	$2,000
Family	$4,000	$6,000	$10,000	$12,000	$4,000
Lifetime Maximum* (The same $1,500,000 limit applies to cumulative benefits from all programs.)	**$1,500,000**				
Office/Hospital/Lab/Surgery					
Office Visits					
Primary care physician[1]	$20 copay	70% after deductible	$15 copay	65% after deductible	80% after deductible
Specialist	$35 copay	70% after deductible	$40 copay	65% after deductible	80% after deductible
Hospital Care					
Inpatient[2]	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Outpatient	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Physician Hospital Services	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Maternity Care	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Surgery	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Lab Fees/X-rays	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
MRIs, CT Scans & PET Scans	85% after deductible	70% after deductible	75% after deductible	65% after deductible	75% after deductible
Preventive Care					
Well-Child Care (includes immunizations; 6 visits first year; 2 visits from ages 1 to 2; 1 visit every calendar year from ages 2 to 7)	$15 copay	70% after deductible	$15 copay	65% after deductible	80% after deductible
Routine Physical Exam (once every 24 months age 7 and older but under age 65; once every calendar year age 65 and older)	$15 copay	70% after deductible	$15 copay	65% after deductible	80% after deductible
Gynecological Exam (includes pap smear and lab fees; once every calendar year)	$15 copay	70% after deductible	$15 copay	65% after deductible	80% after deductible
Wellness Mammogram (once every calendar year)	100%	100%	100%	100%	100%
Routine Hearing Exam (once every 24 months; exam only)	100% after office visit copay	70% after deductible	100% after office visit copay	65% after deductible	80% after deductible
Emergency Services					
Emergency Room (copay waived if admitted)	85% after $75 copay	85% after $75 copay	80% after $100 copay	80% after $100 copay	80% after $75 copay
Ambulance ($10,000 annual limit)	85% after deductible	85% after deductible	80% after deductible	80% after deductible	80% after deductible

* Includes medical (PPO and Traditional combined, in-network and out-of-network), prescription drugs and managed mental health.

Alternatives to Hospital Care	Premium PPO Option		Value PPO Option		Traditional Program
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Skilled Nursing Care[2] (up to 120 days per calendar year)	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Home Health Care[2] (up to 120 visits per calendar year)	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Private Duty Nursing[2] (up to 70 eight-hour shifts per calendar year)	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Hospice Care[2] Inpatient or Outpatient Care (6 month life expectancy)	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible
Short-Term Rehab (acute conditions only; up to 60 sessions total per calendar year)	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Outpatient Rehab Therapy (up to 60 visits per calendar year)	85% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Other Covered Services					
Allergy Testing	100% after Specialist Office Visit copay	70% after deductible	100% after Specialist Office Visit copay	65% after deductible	80% after deductible
Allergy Treatment/Allergy Serum	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Durable Medical Equipment	85% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Speech Therapy (25 visits per calendar year; other limitations)	85% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Family Planning	90% after deductible	70% after deductible	80% after deductible	65% after deductible	80% after deductible
Chiropractic Services	50% after deductible, up to $1,000 lifetime		50% after deductible, up to $2,000 lifetime		50% after deductible; up to $1,000 lifetime
Prescription Drug—Retail pharmacy (up to 30-day supply)					
	Participant Pays		Participant Pays		Participant Pays
Generic	$10 copay		$8 copay		$10 copay
Preferred (brand-name drugs when generic is not available, excludes non-preferred drugs)	30% (min $25; max $50)		50% (min $20; max $50)		30% (min $25; max $50)
Non-Preferred (brand-name drugs when generic is available, selected proton pump inhibitor [PPI] drugs)	40% (min $50; max $100)		50% (min $20; max $50)		40% (min $50; max $100)
Prescription Drug—Home Delivery (up to 90-day supply)					
	Participant Pays		Participant Pays		Participant Pays
Generic	$20 copay		$16 copay		$20 copay
Preferred (brand-name drugs when generic is not available, excludes non-preferred drugs)	30% (min $60; max $125)		50% (min $50; max $125)		30% (min $60; max $125)
Non-Preferred (brand-name drugs when generic is available, selected proton pump inhibitor [PPI] drugs)	40% (min $100; max $200)		50% (min $50; max $125)		40% (min $100; max $200)

NOTE: Non-Preferred PPI drugs include Nexium, Prevacid, Protonix, Aciphex and Prilosec

[1] General Practice, Family Practice, Internal Medicine, pediatrician and OB/GYN

[2] Pre-certification is required for inpatient hospitalization (and again for extended inpatient care), skilled nursing care, home health care, hospice care and private duty nursing. The penalty for failure to obtain pre-certification is $400 per occurance and this amount does not apply toward the out-of-pocket maximum.

Health Management Programs Offered by SYSCO Corporation

SYSCO's integrated Health Management Program provides you and your family with tools to improve your overall health and well-being and to assist you in making more informed decisions about your healthcare. A healthy lifestyle not only benefits you physically and mentally, but it also reduces overall health care costs for both you and SYSCO. The following programs are offered at no cost to PPO and Traditional Program participants:

Health Coach Line— Nurses available 24 hours a day/7 days a week via phone

Healthy Expectations Program— Nurses to guide and support a healthy pregnancy and delivery

Chronic Condition and Treatment Decision Support— Coaching services to help manage certain chronic health conditions such as diabetes, asthma and coronary artery disease

Care Advocate Program— Nurses to provide guidance and support during hospitalization and treatment for serious illness

Online Tools— www.bcbsil.com/sysco

Blue Access for Members

Blue Access for Members (BAM) is a secure and easy way to manage your healthcare. You can view your EOBs on this site, find a provider and do so much more. Start with BAM as the gateway to the Personal Health Manager, which includes many helpful features.

PERSONAL HEALTH MANAGER

Personal Health Manager—

Health Risk Assessment (HRA)— Take the HRA to help you identify health risks and receive recommendations to improve your health. Use information from this tool to present to your doctor when discussing your health and to track your progress.

Other features of the Personal Health Manager—

- **Questions/Feedback**— send a secure e-mail to a registered nurse, trainer, life coach or dietitian and receive a response within a day
- **Personal health record**— set up your own personal health record to keep track of and manage your family's health information
- **Health Encyclopedia**— view information on a variety of medical topics
- **Drug Index**— link to the National Library of Medicine "Medline" site to read about specific drugs
- **Blue Points incentives**— earn redeemable points each time you track a wellness activity

Free glucose meters available to members with diabetes (under "My Health" tab)

Blue Points™

Treatment Cost Advisor— determine costs for common health care services

Treatment Cost Advisor

BlueExtras Discount Program

You can find the discounts under the "My Coverage" tab

- Vision Discount Program - discounts on eye exams and eyewear, laser correction surgery and contact lenses at major retailers
- Hearing Aid Discount Program - Discounts on hearing aids for associates, their parents and their grandparents
- Weight Management Discount Program - discounts to certain weight management programs
- Alternative Medicine discounts - discounts on services such as massage therapy, chiropractic services, acupuncture, spas and fitness centers

Mental Health/Substance Abuse Benefits

SYSCO'S PPO and Traditional Programs include mental health/substance abuse coverage designed to provide benefits when long-term, inpatient or intensive treatment is recommended. The mental health program offers a network of certified professionals to assist in coordinating an effective method of treatment. You may choose an in-network facility to receive the in-network level of benefits, or you may decide to seek treatment at an out-of-network facility of your choice.

All mental health and substance abuse services or materials received, whether from an in-network or an out-of-network provider, must be pre-certified by United Behavioral Health (UBH) in order for benefits to be paid. Any expenses for services or materials that are not pre-certified will not be covered.

Please call UBH at 1-800-55 SYSCO or 1-800-622-7276 for pre-certification.

If you are enrolled in an HMO, you will need to contact your HMO provider or your local benefits department for mental health coverage information.

Mental Health/Substance Abuse Options at a Glance

Feature	In-Network Provider	Out-of-Network Provider
Deductible (does not apply toward medical plan deductible)	None	$250 Individual/$500 Family
Inpatient Treatment, Office Visit, Group Therapy (you may receive two substance abuse treatment courses per individual per lifetime.)	80%	50% after deductible
Lifetime Maximum (in or out-of-network and combined with medical and prescription drug)	$1,500,000	

Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential counseling and information service for all SYSCO associates administered by United Behavioral Health (UBH).

Pre-certification by UBH is required for all mental health treatment. If extended or long-term treatment is required, benefits may be paid by your mental health/substance abuse coverage. All associates and dependents will be referred to an in-network UBH provider.

EAP Program Highlights:

- The EAP is available to you and your dependents at no cost, regardless of whether you enroll in the PPO or Traditional program, HMO or waive healthcare coverage.
- The EAP serves as an outside source for associates and their dependents to call upon for consultation in dealing with personal problems or stress-related situations.
- Each individual may receive up to five free visits, per issue, per year, with an EAP professional.
- The EAP can assist with issues such as communicating effectively, managing stress, family conflict, child or elder care, overcoming anxiety, depression, financial planning, legal questions and much more.

The EAP should be your first step in receiving services for mental health/substance abuse issues. All contact with EAP professionals is strictly confidential. See the section on Mental Health/Substance Abuse for more information on mental health and substance abuse benefits.

All EAP services must be pre-certified through United Behavioral Health. You can call UBH for pre-certification on SYSCO's benefits hotline at 1800-55-SYSCO or 1-800-622-7276.

Decision 2: Dental Program

SYSCO offers you and your family the opportunity to receive valuable dental care benefits with these coverage options:

- Premium Option
- Basic Option
- Waive coverage

Dental program coverage is administered by MetLife. With this program, you have the freedom to choose any dentist at any time. However, you will receive discounted fees when you visit a participating dentist.

There are over 95,000 participating providers in the MetLife Preferred Dentist Program (PDP), offering discounted fees. For a directory of participating dentists in your area, call 1-800-55-SYSCO, or you may visit www.metlife.com/mybenefits.

This dental program does not issue ID cards. When making an appointment with a dentist, just identify yourself as a member of the MetLife Dental Program, and give them your Social Security number and the SYSCO Benefits Line number.

We Recommend

For services that cost over $300, have your dentist contact MetLife for a pre-determination. MetLife will identify what is covered and what you will need to pay.

Dental Options at a Glance

Feature	Premium Option	Basic Option
Annual Deductible		
Individual	$50 per person	$50 per person
Family	$100 per family	$100 per family
Calendar Year Maximum	$1,500 per person	$1,000 per person
Diagnostic & Preventive Services (exams, two cleanings per year, x-rays, topical fluoride treatments for children once each year to age 15, sealants once every 60 months to age 19)	The plan pays 100%	The plan pays 80%
Basic Services (extractions, fillings and oral surgery, peridontics and endodontics, repair or recementing of crowns, and relining of dentures once every 36 months)	After your annual deductible has been met, the plan pays 80%	After your annual deductible has been met, the plan pays 80%
Major Services (inlays, first installation of bridgework, dentures and crowns)	After your annual deductible has been met, the plan pays 50%	After your annual deductible has been met, the plan pays 50%
Orthodontia (Dependent children to age 19)	The plan pays 50%, up to a $1,500 lifetime maximum	Not covered

Decision 3: Vision Program

SYSCO offers you and your family great coverage for vision care, including exams, lenses, frames and contact lenses. Your vision options include:

- VSP Vision Care
- Waive coverage

Vision program coverage is administered through VSP and covers routine vision exams as well as prescription eyeglasses and contact lenses. How much the plan pays depends on the type of service or eyewear, and whether you choose a participating VSP provider. To receive a listing of VSP providers in your area, call 1-800-557-9726 or visit www.vsp.com.

This vision program does not issue ID cards. When making an appointment, just identify yourself as a member of VSP, and give them your Social Security number and the SYSCO Benefits Line number.

Discounts!

Laser vision correction discounts are available through an in-network provider.

The Member Contact Lens Program for soft contact lenses offers:

- Preferred pricing on annual supplies of leading manufacturers' most popular contact lenses
- Direct delivery to home or office
- Direct-from-manufacturer incentives such as rebates and coupons

Vision Options at a Glance

Feature	In-Network Provider	Out-of-Network Provider
Routine Exam (once every calendar year)	$10 copay	$50 allowance per year
Frames (one pair every other calendar year; if lenses and frames are purchased together, the combined copay is $25)	$25 copay	$42 allowance per two years
Standard Lenses (one set of lenses OR contacts every calendar year; polycarbonate lenses are covered)	$25 copay	Single—$36 Bifocal—$60 Trifocal—$84 Lenticular—$180 (allowance per year)
Contact Lenses (one set of lenses OR contacts every calendar year)		
Medically Required	$25 copay	$300 allowance per year
Cosmetic	$120 allowance per year (applied to fitting, evaluation and the contact lenses)	$120 allowance per year

SYSCO offers a variety of ways to protect your family with life insurance.

Basic Life Insurance

Once you are eligible, you are automatically enrolled for Basic life Insurance at no cost to you. Basic Life Insurance is equivalent to one-and-a-half times your previous year's eligible earnings, rounded up to the nearest $1,000, up to $225,000. Special calculations are applied if you have been with SYSCO less than one year.

Supplemental, Spouse and Child(ren) Life Insurance Options

You may elect Supplemental, Spouse and/or Child(ren) Life Insurance. Your options include:

- Supplemental Life Insurance coverage
- Spouse Life Insurance coverage
- Child(ren) Life Insurance coverage
- Waive additional coverage

You pay the cost of this optional coverage through payroll deductions (see rate chart).

Rates are based on the employee's age, the amount selected and your eligible earnings. The cost of spouse life insurance coverage is determined by the employee's birthday.

If you do not enroll in supplemental, spouse and/or child(ren) life insurance coverage when first eligible, you may add coverage during a subsequent enrollment period. However, evidence of insurability may be required.

If you purchase supplemental life insurance coverage when first eligible, you may increase your coverage during the next annual open enrollment period. At those times, or if you experience a qualified status change, you may increase the coverage by one times your previous year's earnings with no evidence of insurability required. Alternatively, if you want to increase your coverage by more than one times your earnings in a given year, you must submit an Evidence of Insurability Statement.

If you elect spouse coverage when first eligible, you may increase spouse life insurance coverage by one increment at annual open enrollment or if you experience a qualified status change without Evidence of Insurability. Evidence of Insurability is never needed for child(ren) life insurance coverage.

Supplemental Life Options at a Glance

Plan	Overview	Cost	
Supplemental Life Insurance	One, two, three, four or five times your previous year's eligible earnings rounded up to the nearest $1,000, up to $500,000	Age of Employee* Less than 35 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70 and over	Monthly Rate (per $1,000) $.065 $.098 $.153 $.207 $.338 $.730 $1.155 $1.918 $3.128
Spouse Life Insurance	From $10,000 to $50,000 (in $10,000 increments); cannot exceed 100% of associate's basic and supplemental life insurance combined	(Use Employee age and cost schedule as Spouse rates are based on the age of the employee.)	
Child(ren) Life Insurance	From $2,500 to $10,000 (in $2,500 increments)	Monthly Rate (per $1,000; this amount insures all eligible children) $.131	

* Rates will change on the employee's birthday when a new rate band is reached, for both supplemental life and spouse life.

Are your Beneficiaries Up to Date?

For Life Insurance benefits, make sure you have an up-to-date Beneficiary Form on file with your local benefits department. You are automatically the beneficiary for Spouse and Child(ren) Life Insurance benefits.

Decision 5: Seguro AD&D

The Accidental Death & Dismemberment (AD&D) Program provides insurance coverage in the event you lose your life or suffer dismemberment as a result of an accident. Benefit amounts may vary based on the type of loss.

Basic AD&D Insurance

Once you are eligible, you are automatically enrolled for Basic Accidental Death & Dismemberment (AD&D) Insurance coverage at no cost to you. AD&D Insurance benefits may be payable if you die or are seriously injured as the result of an accident. Your Basic AD&D Insurance coverage amount is equal to your previous year's eligible earnings, rounded up to the nearest $1,000, to a maximum coverage amount of $150,000.

Voluntary AD&D Options

You may elect Voluntary AD&D coverage for yourself only or for you and your family. Your options include:

- Voluntary AD&D Employee Only Plan
- Voluntary AD&D Family Plan
- Waive additional coverage

Voluntary AD&D Options at a Glance

Plan	Overview	Monthly Cost		
		Amount Selected	Employee Only	Family Plan
Voluntary AD&D Employee Only Plan	• You may purchase coverage from $10,000 to $500,000 (in increments of $10,000) • Coverage amounts in excess of $150,000 cannot exceed ten times your current basic annual salary	$10,000	$.14	$.20
		$20,000	$.28	$.40
		$30,000	$.42	$.60
		$40,000	$.56	$.80
		$50,000	$.70	$1.00
		$60,000	$.84	$1.20
		$70,000	$.98	$1.40
		$80,000	$1.12	$1.60
		$90,000	$1.26	$1.80
		$100,000	$1.40	$2.00
		$150,000	$2.10	$3.00
		$200,000	$2.80	$4.00
		$250,000	$3.50	$5.00
		$300,000	$4.20	$6.00
		$350,000	$4.90	$7.00
		$400,000	$5.60	$8.00
		$450,000	$6.30	$9.00
		$500,000	$7.00	$10.00
Voluntary AD&D Family Plan	• You may purchase coverage from $10,000 to $500,000 (in increments of $10,000) • If you have dependent children, your spouse is covered for 50% of your AD&D coverage (60%if you do not have dependent children) • If you are married, each child is covered for 15% of your AD&D coverage (20% if you are not married) • Maximum amount for any dependent child is $50,000			

Long-Term Disability Coverage

Long-term disability coverage is provided at no cost to associates by most SYSCO companies. Once eligible, enrollment is automatic, and coverage is generally equivalent to 60% of your basic pre-disability monthly eligible earnings, up to $5,000 per month. Benefits begin after 180 days of disability. Benefits may continue to be paid based on age and type of illness.

Please refer to the Summary Plan Description located at **https://myinfo.sysco.com** for eligibility requirements and more details on Long-term Disability, or contact your local benefits department.

Decision 6: Flexible Spending Accounts

SYSCO offers Flexible Spending Accounts (FSAs) to eligible associates. By allowing you to spend tax-free dollars on certain health and/or dependent day care expenses, FSAs lower your tax burden and increase your spendable income. Both accounts offer direct deposit of your reimbursement to your checking or savings account. Your FSA options include:

- Healthcare FSA
- Dependent Day Care FSA
- Waive participation in one or both FSAs

Healthcare FSAs

A Healthcare FSA allows you to set aside pretax dollars to pay for eligible out-of-pocket medical, dental and vision expenses, such as deductibles, coinsurance, copays and other unreimbursed medical expenses.

You can contribute between $100 and $5,000 to your Healthcare FSA each year. You must re-enroll in the Healthcare FSA each year in order to participate. For immediate access to FSA funds, you may use the Healthcare FSA debit card. The card can be used at most doctors' offices and pharmacies to pay for qualified expenses. You must save your receipts as proof that the expense is eligible. If you choose not to use the debit card, simply complete a claim form and submit it with proof-of-expense documentation to CONEXIS via fax or mail. You can check claim status, view account history and estimate actual expenses online at www.conexis.org.

Dependent Day Care FSAs

A Dependent Day Care FSA allows you to set aside pretax dollars to pay the costs of caring for your children under age 13, parents or disabled spouse while you work. To qualify for reimbursement, the care must be for an eligible dependent and must be necessary so that you can work. The dependent must live with you for more than half the year and be claimed as a dependent on your federal income taxes.

You can contribute between $100 and $5,000 to your Dependent Day Care FSA each year. There are some exceptions:

- If you are married and file separate returns, your maximum is $2,500.
- If either you or your spouse makes less than $5,000 in annual earned income, your maximum is the lesser of the two incomes.
- If your spouse has a dependent day care flexible spending account at work and you file a joint return, your combined total cannot exceed $5,000.

Think it Over Carefully!

The IRS sets the rules and guidelines for Flexible Spending Accounts. Here are some of the rules you should be aware of before deciding to participate in an FSA.

- You can't stop, start or change your FSA contributions mid-year unless you have a qualified change in status.
- You "use it or lose it." Any money left in your FSAs at the end of the year can't be carried over to the next year, nor can it be returned to you. However, you have until March 31 of the following year to claim reimbursement of expenses incurred during the calendar year in which you made contributions.
- If you have both a Healthcare and Dependent Day Care FSA, you can't transfer money between the two accounts.
- You can't claim an expense through an FSA if you will also use that expense as a deduction or credit on your federal income tax return. Carefully analyze whether the tax credit or the Dependent Day Care Spending Account provides you with the greater tax savings.

Examples of Eligible Expenses for Dependent Day Care FSAs

- Work-related child or elder care
- Tuition for nursery school and licensed day care centers that provide care while you are working
- Day care expenses (including elder care) for the care of disabled dependents while you are working, provided the center follows state and local laws
- Before-and after-school programs while you are working

Examples of Ineligible Expenses for Dependent Day Care FSAs

- Babysitting needed for social purposes
- Transportation to and from the care site
- Care provided by your spouse, your child under age 19 or by anyone you claim as a dependent for federal income tax purposes
- Educational expenses—kindergarten and above
- Expenses that you claim as a tax credit on your federal income tax return

Examples of Eligible Expenses for Healthcare FSAs

- Medical, prescription, dental or vision deductibles, copays and coinsurance
- Over-the-counter medications used for medical care (such as aspirin or Tylenol)
- Charges for eye exams, prescription eyeglasses, contact lenses or contact lens solution not covered by a vision plan
- Expenses that exceed the reasonable and customary limits for eligible services
- Laser eye surgery not covered by a vision or medical plan

Examples of Ineligible Expenses for Healthcare FSAs

- Premiums for insurance coverage, such as your contributions for the medical, dental and vision plans
- Marriage counseling
- Cosmetic surgery/cosmetic dentistry such as teeth whitening
- Vitamins, except pre-natal
- Non-prescription sunglasses
- Expenses that you claim as a deduction on your federal income tax return

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