MCLANE COMPANY, INC.
WELFARE PLAN

EMPLOYEE ASSISTANCE PROGRAM

SUMMARY PLAN DESCRIPTION

January 1, 2021

EMPLOYEE ASSISTANCE PROGRAM

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EMPLOYEE ASSISTANCE PROGRAM OVERVIEW

The Employee Assistance Program ("EAP") is a voluntary, confidential program to provide you and your Dependents with support, resources and information for certain personal and work-life issues.

You will find terms starting with capital letters throughout this summary plan description ("SPD"). These terms are generally defined in the Definitions section at the end of this SPD, or they may be defined in the specific section where they are used.

This SPD is only a summary of the EAP Services offered under the Plan. All statements made in this SPD are subject to and controlled by the terms of the Plan as they appear in the official documents. In the event of a conflict between this document and the Plan document, the Plan document will control since this document is considered only a summary of the EAP Services. You may obtain a copy of the Plan documents by requesting a copy from the Plan Administrator. You may be required to pay reasonable copying costs for the Plan documents.

ELIGIBILITY AND AUTOMATIC ENROLLMENT

If you are an eligible, full-time Teammate who normally works at least 30 hours per week, you will become eligible to participate in the EAP on the day you complete the Waiting Period, if any, described below.

If you are an eligible, full-time Salaried Teammate or Driver, you are eligible to participate on your date of hire. If you are an eligible, full-time Hourly Teammate other than a Driver, you are eligible to participate on the 60th Day of Active Service.

You and your eligible Dependents will automatically begin participating in the EAP as soon as you are eligible.

Rehired Teammates

If you are an eligible, full-time Teammate who was previously covered under the EAP and your coverage ceased, or if your coverage ceased because you were no longer employed as an eligible Teammate, you are not required to satisfy any Waiting Period if you again become an eligible Teammate within 90 days after the date your coverage originally ceased. If you are rehired and your rehire date is later than 90 days from your prior termination date or if you are rehired in a subsequent Plan Year, you will be treated as a new Teammate.

Eligibility for Dependent Coverage

You and your eligible Dependents will automatically begin participating in the EAP as soon as you are eligible.

Dependent Audit Process

The Plan Administrator has the right to verify the Dependents you enroll to ensure they meet the eligibility requirements of the EAP. The Plan Administrator or its designee will audit the information and documentation you provide to determine if such individuals are Dependents eligible to be covered under the terms of the EAP, and may require that you furnish additional information or documentation to establish that any individuals whom you cover or request coverage for as a Dependent under the EAP are eligible for such coverage as a Dependent. All documentation and information requested must be provided within the timeframe communicated by the Plan Administrator (or its designee). Such information or documentation required may include, but is not limited to, a marriage license, birth certificate, tax return, and divorce decree. If the audit reveals that any individual is not your Dependent as defined by the EAP, coverage will be not become effective or will be terminated on a go forward basis.

In the case of fraud or intentional misrepresentation, coverage may be terminated immediately on a go forward basis or retroactively upon 30 days advance notice as if no coverage was ever in force. We may also pursue recovery of any Plan benefits paid on behalf of the ineligible individual. If you have made false statements, it may lead to disciplinary actions up to and including termination of employment.

HOW THE EAP WORKS

Your EAP Services are provided by ComPsych. You may access Services by calling ComPsych 24 hours a day, 7 days a week at its toll-free telephone number 1-800-327-2151 or TDD 1-800-697-0353. You may also connect directly with a GuidanceConsultant online by clicking on the following link: www.guidanceresources.com or by accessing the GuidanceResources® Now App downloaded on your smartphone. For access online or through your App, enter Web ID: MCLANE. When contacting the EAP, you will be greeted by an intake advocate known as a GuidanceConsultant who will answer your questions and, if needed, refer you to a counselor or other resource. Referrals may be for over-the-phone assistance or for a face-to-face consultation.

Participation in the EAP is voluntary and any information shared by you with the GuidanceConsultant or other counselors or through network referrals will not be made available to your Employer or any other party without written consent.

EAP SERVICES

The EAP provides the following EAP Services:

Confidential Emotional Support Clinicians will listen to your concerns and help you or your Dependents with issues such as:	• Anxiety, depression, stress • Grief, loss and life adjustments • Relationship/marital conflicts
Work-Life Solutions Specialists provide qualified referrals and resources for just about anything on your to-do list, such as:	• Finding child and elder care • Hiring movers or home repair contractors • Planning events, locating pet care

Legal Guidance
Attorneys provide practical assistance with your most pressing legal issues, including:
	• Divorce
	• Adoption
	• Family law
	• Wills
	• Bankruptcy
	• Personal injury
	  • Free 30-minute consultation
	  • Reduction in fees

Financial Resources Financial experts assist with a wide range of issues:	• • Budgeting • Debt consolidation • Managing credit • Other basic financial information
Online Support GuidanceResources® Online is your 24/7 link to vital information, tools and support:	• Articles, podcasts, videos, slideshows • On-demand trainings "Ask a GuidanceConsultant" personal responses to your questions

Confidential Emotional Support

You and your covered Dependents are each entitled to up to five face-to-face or telephonic sessions per calendar year. However, if you reside in California, you and your Dependents are entitled to up to a total of five face-to-face or telephonic sessions in a six-month period. You must pay for all other counseling sessions.

Upon your initial request, a GuidanceConsultant will assess the problem, provide short-term problem resolution and/or guide you to appropriate treatment resources. Subsequent

visits or phone conversations may be scheduled with you as necessary. If your concern cannot be addressed by the EAP Services, you may be referred for alternative services after assessment. The cost of these services rendered outside the EAP will be your responsibility.

ComPsych will respond to your call generally within two business days unless your request is urgent, in which case, ComPsych will generally respond within one business day. In the case of an emergency request, ComPsych will generally respond within two hours.

Work-Life Solutions Services

The EAP can assist you by providing information on child and/or elder care resources in your community. The EAP can also provide information on automobile purchases, relocation, pet services, apartment shopping, and mortgages. The decision as to whether or not to utilize a resource identified by ComPsych rests solely with you and you must decide whether or not to contract with or otherwise retain or employ the suggested resource. You should perform an independent review of any resource referral as ComPsych cannot guarantee that resources meet certain standards, quality, or competency requirements or that the resource is adequate for your situation.

Legal Guidance Services

The EAP can provide referrals to licensed attorneys, including an initial 30 minute consultation at no charge. You can receive information on topics ranging from bankruptcy to personal injury law. However, you cannot obtain information related to employment law or any issue related to a potential claim against your Employer. If you desire to retain the attorney after the initial assessment and referral, you are required to pay for such services, but the services will be provided at reduced rates (generally you are provided a 25% discount).

FinancialConnect Services

The EAP will assist you telephonically by providing you with information on your personal finances. You may receive information on topics such as spending habits, budgeting strategies, debt consolidation, managing credit, and other basic financial information.

GuidanceResources® Online Services

The EAP also provides online information, resources, tools and other features on topics such as health and wellness, law and regulations, family and relationships, work and education, money and investments, consumer and leisure, and home and automobile. Please go online at www.guidanceresources.com or access the GuidanceResources® Now App downloaded on your smartphone. For access online or through your App, enter Web ID: MCLANE.

Other Services

The EAP may also provide other services if requested by the Company. These services may include manager/supervisor training sessions, employee and manager orientations, wellness seminars and critical incident response in the cases of natural disasters or employee deaths that impact the entire organization. In addition, if you have been reported to the Federal Motor Carrier Safety Administration of the United States Department of Transportation ("DOT") for a safety violation that involves substance abuse, ComPsych, at the Company's request, may provide DOT services by referring you to a Substance Abuse Professional at DOT.

EXCLUSIONS

The EAP **does not** cover expenses for:

- conditions which are:
  - within the scope of usual medical practice; and
  - normally handled by non-mental health and substance abuse clinicians.
- charges in excess of the amount which the provider has agreed to accept for the service.
- services provided by a provider that is not approved by ComPsych.
- services provided by a provider who is a member of your family or your Dependent's family.
- physician or inpatient hospital treatment.
- counseling services beyond a total of five sessions per calendar year (or if you are a teammate residing in California, beyond a total of five sessions per six-month period) for each of you and your Dependents.
- charges for unnecessary care or treatment or in connection with experimental procedures or treatment methods.
- charges for custodial services, education or training.
- counseling required by law or paid for by any workers' compensation or similar law or by a public program other than Medicaid.
- services received before your participation in the EAP begins.
- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this EAP.
- treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.

- residential treatment.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs, even if combined with supportive therapy for age-related cognitive decline.
- acupuncture.
- bariatric surgery.
- chiropractic care.
- cosmetic surgery.
- dental care.
- diagnostic tests.
- durable medical equipment.
- emergency room services.
- emergency medical transportation.
- facility fees.
- habilitation services.
- hearing aids.
- home health care.
- hospice services.
- imaging.
- infertility treatment.
- long-term care.
- mental/behavioral inpatient services.
- non-emergency care when traveling outside the U.S.
- outpatient surgery.
- prenatal/postnatal/delivery/inpatient services for pregnancy.
- over the counter or prescription drugs.
- primary care services.
- private-duty nursing.
- rehabilitation services.
- eye care.
- foot care.
- skilled nursing care.
- specialist services.
- urgent care.
- weight loss program.

MILITARY LEAVE

EAP Services are available to active teammates who take Military Leaves of absence in accordance with the Uniformed Services Employment and Re-employment Rights Act.

FAMILY AND MEDICAL LEAVE ACT OF 1993

EAP Services are available to active teammates who take qualifying leaves of absence under the Family and Medical Leave Act of 1993 ("FMLA"). If you intend to take a leave of absence from work, please refer to the Company's policies for leaves of absences, including FMLA leaves, or contact the Company for additional information about your rights to continued EAP Services.

TERMINATION OF COVERAGE –TEAMMATES

Your coverage will cease on the earliest date below:

- the date you terminate employment with the Employer or cease to qualify for the coverage, unless COBRA coverage applies.
- the last day of the pay period in which your Active Service ends, unless coverage is continued while you are on Military Leave or FMLA leave.
- the date the EAP terminates.

TERMINATION OF COVERAGE – DEPENDENTS

Your coverage for all of your Dependents will cease on the earliest date below:

- the date your coverage ceases.
- the date you or your Dependent cease to be eligible for Dependent coverage, unless COBRA coverage applies.
- the date Dependent coverage is canceled.

MEDICAID

This EAP will not take into account your eligibility or your Dependents' eligibility for health assistance or benefits payable under 42 U.S.C. §1396 et seq.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Eligibility for Coverage under a Qualified Medical Child Support Order

If you or the Plan receives a medical child support order requiring you to provide health coverage for a child, you may be required to provide health coverage (including EAP Services) for that child if the Plan Administrator determines that the medical child support order is a Qualified Medical Child Support Order.

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law, or a National Medical Support Order (as defined by section

609(a)(5)(C) of ERISA), which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a Participant or beneficiary is eligible;

2. the order specifies your name and last known address, and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address;

3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

4. the order states the period to which it applies; and

5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The Qualified Medical Child Support Order may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except that an order may require the Plan to comply with state laws regarding child health care coverage. If you need additional information concerning Qualified Medical Child Support Orders, please contact the Plan Administrator for a copy of the Plan's Qualified Medical Child Support Order procedures, which will be furnished to you free of charge.

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The child (and you, if you are not already enrolled) will be automatically enrolled in the EAP after the order has been determined to be a Qualified Medical Child Support Order. Although the Plan may receive the medical child support order from another party, you are still required to notify your local Human Resources Department of the order. Please contact your local Human Resources Department to get a "Qualifying Event Change Form," complete the form, attach a copy of the order and return it to your local Human Resources Department.

CONTINUATION COVERAGE

If you or your covered Dependent would otherwise lose coverage for the health counseling services offered under the EAP, you or your Dependent may be able to temporarily continue the coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

If you or your Dependent elects COBRA coverage for the medical benefits offered under the McLane Company, Inc. Welfare Plan (other than vision and dental coverage), you or your Dependent will automatically receive COBRA continuation coverage for the health counseling services under the EAP. Please refer to the Summary Plan Description for the Medical Plan Options for information on how to elect COBRA continuation coverage.

NONDISCRIMINTATION REQUIREMENTS

Neither you nor your Dependents will be denied enrollment for EAP Services due to a Health Status-Related Factor. Federal law and the Plan prohibit any discrimination in eligibility or cost of coverage because of one or more Health Status-Related Factors.

The benefits described in this SPD shall be administered in accordance with the Americans With Disabilities Act of 1990, the Americans With Disabilities Act Amendments Act of 2008, and any regulations or guidance issued thereunder.

AMENDMENT/TERMINATION OF EAP

The Company may amend or terminate all or any part of the EAP at any time. The Company has delegated authority to the Director of Benefits, or any successor to this position, to make amendments to the EAP that (1) do not significantly increase the costs of the EAP, or (2) are required to be made by law. The EAP may be amended or changed at any time by the Company. The Company is not required to obtain your consent to amend or change the EAP.

PLAN ADMINISTRATION

The primary responsibility for the general administration of the EAP is placed with the Plan Administrator. However, the Claims Administrator is responsible for claims processing and deciding all claims. The Plan Administrator or the Claims Administrator, as appropriate, in its sole discretion, shall have the power to make reasonable rules and regulations, to make all determinations necessary for the administration of the EAP and to interpret the terms of the EAP. Their determinations and interpretations shall be binding and conclusive on all persons.

CLAIMS PROCEDURES

These claims procedures are only applicable to the health counseling portion of the EAP Services.

Pre-Service Claims

Urgent Care Claims. If a person or his duly authorized representative files a "pre-service claim" which is an "urgent care claim" under the EAP, the Claims Administrator, will notify the claimant of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information for the EAP to make a determination. A "pre-service claim" means any claim for medical benefits under the EAP with respect to which the terms of the EAP condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An "urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant

to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the information received by the EAP is insufficient for the EAP to make a determination, the Claims Administrator will notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. In such case, the claimant will be afforded at least 48 hours to provide the specified information. The Claims Administrator will notify the claimant of the EAP's determination as soon as possible, but in no case later than 48 hours after the earlier of: (a) the EAP's receipt of the specified information; or (b) the end of the period afforded the claimant to provide the specified additional information.

The Claims Administrator may notify the claimant of its decision orally, in writing or electronically within the applicable 48 hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator will provide written or electronic notification to the claimant not later than three days after the oral notification.

Non-Urgent Care Claims. A person or his duly authorized representative, in the Claims Administrator's sole discretion, may file a written claim with the Claims Administrator for a determination of medical benefits for a "pre-service claim" that is not an "urgent care claim."

The Claims Administrator will notify the claimant of its decision. Notification of a claim denial will be given within a reasonable time, but not later than 15 days after the claim is received by the Claims Administrator. If the claimant does not receive notice that the claim has been denied within the initial 15 day period, or prior to the expiration of an extension period, if applicable, the claim will be deemed to have been denied as of the last day of such period, and the claimant may request a review of his claim.

Failure to Follow Pre-Service Claims Procedures

If a person or his duly authorized representative, in the Claims Administrator's sole discretion, submits the claimant's name, specific medical condition, and specific treatment, service or product to a person or unit customarily responsible for handling benefits matters, but fails to follow the EAP's procedures for pre-service claims, the claimant will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification will be provided to the claimant as soon as possible, but not later than five days (24 hours in the case of a failure to file an urgent care claim) following the failure. Notification may be oral unless written notification is requested by the claimant.

Extensions in the Case of Initial Determinations of Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the claim denial time period may be extended once for up to 15 days provided that the Claims Administrator (i) determines that such extension is needed and beyond the Claims Administrator's control; and (ii) notifies the Claimant of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision.

If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information. The benefit determination period will be put on hold from the date of the notice of extension until the earlier of (i) the date the claimant responds to the request for additional information, or (ii) the last day of the 45 day period. Once the claimant has provided the additional information or, if earlier, the 45 day period has ended, the benefit determination period will recommence.

The claimant and the Claims Administrator may extend any claim filing deadline by mutual written consent.

Notification Requirements for Claims

If any claim is wholly or partially denied, the notification will be set forth in a manner calculated to be understood by the claimant and must contain:

- the specific reason or reasons for the adverse determination,
- the specific reference to EAP provisions on which the determination is based,
- a description of any additional material or information necessary for the person to perfect his claim and an explanation of why such material or information is necessary,
- information as to the steps to be taken if the claimant wishes to submit a request for review, including applicable time limits, and
- the claimant's right to bring a civil action under section 502(a) of ERISA.

The notification must also contain any internal rule, guideline, protocol or other similar criterion (collectively "Protocols") that were relied upon in making the adverse determination and that a copy of such Protocols will be available to the claimant, free of charge, upon his request. If the benefit determination is based on a medical necessity or Experimental Treatment or similar exclusion or limit, the notification must also contain either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the EAP, as applicable, to the claimant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request. For all urgent claims, the notification must also contain a description of the expedited review process applicable to such claims.

Review Process For Appealing An Adverse Benefit Determination

If you receive an Adverse Benefit Determination (as defined immediately below) and you believe the Claims Administrator incorrectly denied all or part of your benefits, you may have your denied claim reviewed. An 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;

- a denial, reduction, termination or failure to provide or make payment that is based on a determination of you or your beneficiary's eligibility to participate in the Plan;

- a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review; and

- a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigative or not medically necessary or appropriate.

For any "pre-service" claim which is an "urgent care claim" for which the claimant must be notified of the Adverse Benefit Determination within the 72 hour period, the claimant's medical provider is responsible for identifying and determining if the claim is an "urgent care claim." An Adverse Benefit Determination also includes a retroactive cancellation or discontinuance of coverage under the Plan, except where due to failure to timely pay required premiums or contributions.

An appeal must be filed with the Claims Administrator within 180 days after the date that the claimant receives notice of an Adverse Benefit Determination for medical benefits under the EAP, or if applicable, within 180 days after the date on which such denial is deemed to have occurred. The claimant or his duly authorized representative may file a request that the Claims Administrator review his denied claim.

The Claimant may request an expedited review of his urgent care claim by contacting the Claims Administrator orally or in writing if his urgent care claim has been wholly or partially denied. If the claimant requests an expedited review, all necessary information, including the EAP's benefit determination on review, will be transmitted expeditiously between the EAP and the claimant.

Review Standards for Claims

The claimant and/or his authorized representative may inspect or request, free of charge, relevant documents and submit written comments, documents, records, and other information to the Claims Administrator for review of his claim. The review of the claimant's appeal will be reviewed without affording deference to the initial adverse benefit determination and will not be conducted by the individual who made the initial review, nor a subordinate of such individual.

Procedures Applicable to Appeals of Claim Denials

The Claims Administrator will conduct a full and fair review of your appeal. If a decision is based in whole or part on a medical judgment, the appropriate person(s) determining the appeal will consult with a healthcare professional (not consulted in the initial claim that is being appealed nor a subordinate of such healthcare professional) who has appropriate

training and experience in the field of medicine involved in the medical judgment and will provide the claimant with such information regarding such health care professionals as the Claims Administrator determines is appropriate. Upon request, the claimant will be provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Claims Administrator relied upon the expert's advice.

Notification Requirements for Appeals

The Claims Administrator will notify the claimant of its decision upon the appeal. If an expedited method such as oral notification is used, it must be followed up with a transmission of the Claims Administrator's decision. Notifications will be set forth in a manner calculated to be understood by the claimant and will contain:

- the specific reason or reasons for the denial;
- specific references to EAP provisions on which the benefit determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits;
- a statement describing any voluntary appeals offered by the EAP, including information concerning the procedures of the voluntary appeal that would allow the claimant to make an informed decision about whether to appeal and such other information which the Claims Administrator determines is appropriate regarding alternative dispute resolution options;
- a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- any new or additional evidence or any new or additional rationale considered, relied upon or generated by the EAP or at its direction in connection with the claims, which new or additional evidence or new or additional rationale shall be required to be provided to the claimant as soon as possible and sufficiently in advance of the date that an Adverse Benefit Determination is required to be provided to allow you to respond prior to that date;
- a description of the Protocols, if any, used to make the decision and that a copy of the Protocols will be available free of charge upon request; and
- a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon request by the claimant.

Response Dates on Appeals of Benefit Claims

For an urgent, pre-service claim, the decision on review will be made as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review. If the claimant does not receive notice of the decision within the 72 hour period, the claim will be deemed to have been denied on review.

For a non-urgent, pre-service claim, the decision on review will be made within 30 days after the request for review is received by the Claims Administrator. If the claimant does not receive notice of the decision within the 30 day period, as may be extended, the claim will be deemed to have been denied on review.

Authority To Make Final Binding Decisions On Appeal

The Claims Administrator has the full discretion and authority to make final determinations of questions concerning the interpretation or administration of the Plan for appeals, including, without limitation, all questions relating to eligibility for EAP Services. The Claims Administrator has full discretion and authority to finally grant or deny benefits under the appeals process of the Plan. EAP Services will be paid only if the Claims Administrator decides in its sole discretion that the applicant is entitled to them. Unless you file a lawsuit under ERISA, the determination of the Claims Administrator on appeal will be final and binding. Once the appeal process has been exhausted or is deemed to be exhausted, you have one year from the date you are notified of a final Adverse Benefit Determination to file suit or initiate legal action against the Plan.

Written Or Electronic Notifications

All notifications from the Claims Administrator will be either written or electronic. Electronic notification will comply with standards imposed by the Claims Administrator consistent with applicable guidance. This written or electronic notification can be included as part of the expedited method used as provided above (for example, if facsimile transmission is used).

STATEMENT OF RIGHTS UNDER ERISA

As a Participant in this EAP, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all EAP Participants shall be entitled to:

Receive Information About Your EAP and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the EAP, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the EAP 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 EAP, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the EAP's annual financial report. The Plan Administrator is required by law to furnish each Participant under the EAP with a copy of this summary financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or Children 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 EAP on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for EAP Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the EAP, called "fiduciaries" of the EAP, have a duty to do so prudently and in your interest and in the interest of other EAP Participants and beneficiaries.

The law provides that no one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a welfare benefit or exercising your rights under ERISA.

The law provides that if your claim for a welfare 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 EAP documents or the latest annual report from the EAP and do not receive them within thirty (30) days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the EAP's decisions or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that EAP fiduciaries misuse the EAP'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 legal fees. If you are successful, the court may order the person you have sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your EAP, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 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.

IMPORTANT PLAN INFORMATION

Plan Name:	McLane Company, Inc. Welfare Plan This SPD describes the employee assistance program (EAP) benefits offered under the Plan.
Name, Address and Telephone Number of Plan Sponsor:	McLane Company, Inc. 4747 McLane Parkway P.O. Box 6115 Temple, Texas 76503-6115 Tel: 1-254-771-7500 A list of participating Employers who have adopted the Plan is available upon request.
Name, Address and Telephone Number of Plan Administrator:	McLane Company, Inc. 4747 McLane Parkway P. O. Box 6115 Temple, Texas 76503-6115 Tel: 1-254-771-7500
Name, Address and Telephone Number of Claims Administrator	ComPsych Corporation 455 N. Cityfront Plaza Drive Chicago, IL 60611-5322 Tel: 1-800-327-2151 www.guidanceresources.com
Company's Tax ID Number:	74-1478631
Plan Number:	502
Agent for Legal Process:	McLane Company, Inc. 4747 McLane Parkway P. O. Box 6115 Temple, Texas 76503-6115 1-254-771-7500
Type of Administration:	The EAP Services are fully-insured by ComPsych Corporation.
Plan Year:	The Plan Year is the calendar year.

Type of Plan:	The Plan is a welfare benefit plan which provides health benefits. This SPD describes the EAP Services offered under the Plan.
Sources of Plan Contributions and Plan Costs:	The EAP Services under the Plan are funded by contributions made by the Employer.

DEFINITIONS

Active Service - You will be considered in Active Service:

- on any of an Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at the Employer's place of business or at some location to which you are required to travel for the Employer's business.

- on a day which is not one of the Employer's scheduled work days if you were in Active Service on the preceding scheduled work day, or

- if your employment status in not "terminated."

Company means McLane Company, Inc. and any successor.

CompPsych means ComPsych Corporation.

Dependent means:

- your legal Spouse; and

- your Child who is:

    - less than 26 years old;

    - a Child of any age if the Child is permanently and totally disabled and incapable of self-sustaining employment by reason of a mental or physical disability. Proof of the child's condition and dependence must be submitted to the Claims Administrator within 31 days after the date the child ceases to qualify above. During the next two years the Plan Administrator may, from time to time, require proof of the continuation of such condition and dependence. After that, the Claims Administrator may require proof no more than once a year. Teammates should submit proof to the Claims Administrator.

The term "Child" includes your natural children, step-children, legally adopted children, children Placed for Adoption, and foster children placed with you by an authorized placement agency or court order. It also includes (a) a child of whom you or your Spouse

is the court-ordered legal guardian; (b) a child who is related to you if the child resides in your household and depends on you for support and maintenance, or (c) a child for whom a Teammate has received a court order requiring the Teammate to have financial responsibility for providing coverage. Grandchildren are not eligible for coverage under the Plan unless the Teammate is the court-ordered legal guardian of the child. In the case of a Child with divorced parents, where one or both parents have custody of the Child for more than half of the calendar year and where the parents together provide more than half of the Child's support for the calendar year, the Child is treated as a Dependent of both parents. Once legal guardianship ends, the Dependent is no longer eligible to be covered under the Plan.

Anyone who is covered as a Teammate will not be covered as a Dependent. No one may be covered as a Dependent of more than one Teammate.

Driver means a Teammate who is classified as a Driver by the Employer.

EAP means the employee assistance program described in this SPD and the underlying Plan documents.

EAP Services means services for the assessment, referral and/or short-term problem resolution counseling sessions to address concerns such as marital and relationship issues, stress, anxiety and depression, grief, loss, job pressures, alcoholism and drug abuse, as well as services related to work-life solutions, legal guidance, financial resources, online support and other service that may be requested by the Company.

Employer means the Company and all affiliated employers and subsidiaries who adopt the EAP Services of the Plan in the form and manner required by the Company.

Health Status-Related Factor means the following factors: health status; medical condition (includes both mental and physical illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); and disability.

Hourly Teammate means a Teammate who is compensated on an hourly basis and who is classified as an hourly Teammate by an Employer (not a Driver).

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Military Leave means the absence due to the performance of duty on a voluntary or involuntary basis under competent authority in (1) the Armed Forces, (2) 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, (3) the commissioned corps of the Public Health Service, and (4) other categories of persons designated by the President in time of war or emergency for a period of up to 30 days during which a person who previously qualified as an eligible Teammate (excludes retirees) is not employed on a full-time basis solely because the person is engaged in active military service for the United States government.

Participant means you and any of your covered Dependents.

Placed for Adoption means the assumption and retention by you of a legal obligation for total or partial support of a child in anticipation of adoption of such child prior to the date on which such individual attains age 18. The child's placement with such person terminates upon the termination of such legal obligation.

Plan means the McLane Company, Inc. Welfare Plan. The EAP Services are offered under the Plan.

Plan Administrator means the Company.

Salaried Teammate means a Teammate who is paid compensation on a salaried basis and who is classified as a salaried Teammate by an Employer. Drivers are not Salaried Teammates.

Spouse means your legal spouse, whether same-sex or opposite-sex, in a marriage validly entered into under the laws of a state of the United States or foreign jurisdiction having authority to sanction marriages. If your Spouse is covered, you may be asked to provide evidence of marriage, which may include a marriage certificate or other documentation satisfactory to the Pan Administrator. The Plan Administrator has the sole and absolute authority to determine an individual's status as your Spouse and any such determination is final, binding and conclusive on all parties covered under the Plan.

Teammate means a person who works for an Employer and who is currently in Active Service.

Waiting Period means the period that must pass before you are eligible for EAP Services.