McLANE COMPANY, INC.

Health Care Expense Reimbursement Plan

Limited Purpose Reimbursement Plan

Dependent Day Care Assistance Plan

Summary Plan Description

January 1, 2021

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OVERVIEW OF THE PLANS

This Summary Plan Description (SPD) discusses three options available to you to set aside earnings on a pre-tax basis to pay for certain expenses:

- The Health Care Expense Reimbursement Plan allows you to set aside earnings to pay for eligible medical, dental and vision expenses. However, you cannot participate in the Health Care Expense Reimbursement Plan if you participate in a Health Savings Account (also referred to as an "HSA"). Please refer to the SPD plan description for the McLane Company Welfare Plan for more information on Health Savings Accounts.

- The Limited Purpose Reimbursement Plan is designed to be used in conjunction with coverage under the High Deductible Health option under the McLane Company Welfare Pan or another high deductible health plan option with a Health Savings Account. It allows you to set aside earnings to pay for eligible dental and vision expenses.

- The Dependent Day Care Assistance Plan (also known as the Dependent Care Assistance Plan) allows you to set aside earnings to pay for eligible dependent care expenses.

Each of the plans above may be referred to in this SPD as a "Plan," and all or a combination of the plans may be referred to collectively as "Plans," as indicated by the context. The Plans are sponsored by McLane Company, Inc. (the "Company"). The Company is also the Plan Administrator.

The McLane Company, Inc. Flexible Benefit Plan is the mechanism that allows earnings under the Plans to be set aside on a pre-tax basis.

You will find terms starting with capital letters throughout this SPD. This means that the term has a special meaning. These terms are defined in this SPD.

This document is only a summary of the Plans and does not list all of the details of the Plans. All statements made in this SPD are subject to and controlled by the terms of the Plans as they appear in the official documents. In the event of a conflict between this document and the Plan documents, the Plan documents will control since this document is considered only a summary of the features of the Plans. You may obtain a copy of the Plan documents by requesting a copy from your local Human Resources Department. You may be required to pay reasonable copying costs for the Plan documents.

HEALTH CARE EXPENSE REIMBURSEMENT PLAN (FOR TEAMMATES WITHOUT A HEALTH SAVINGS ACCOUNT)

How Does the Health Care Expense Reimbursement Plan Work?

Under the Health Care Expense Reimbursement Plan, contributions will be deducted from your paycheck on a pre-tax basis. You can use these amounts to receive reimbursement for eligible medical, dental and vision expenses incurred by you, your Spouse, your children and other qualified dependents.

Your election to have contributions deducted from your paycheck must generally remain in place for the entire calendar year. See the section below entitled "Eligibility, Time of Participation and Enrollment" for information on when you can make or change an election mid-year.

You cannot participate in the Health Care Expense Reimbursement Plan if you participate in a Health Savings Account.

How Can the Plan Save Me Money?

The Plan can save you money because the money that you set aside under the Plan is not taxed.

Assume that you earn $24,000 per year and your federal taxes in total (income tax and FICA) come to 30%.

You spend $2,000 each year in health care expenses.

	WITHOUT SETTING MONEY ASIDE	WITH CONTRIBUTIONS TO THE PLAN
GROSS ANNUAL SALARY	$24,000	$24,000
PRE-TAX CONTRIBUTIONS TO PLAN		-$2,000
TAXABLE INCOME	$24,000	$22,000
ASSUMED FEDERAL TAXES @ 30%	-$7,200	-$6,600
PAYMENT OF HEALTH CARE EXPENSES ON AFTER-TAX BASIS	-$2,000	
SPENDABLE INCOME	$14,800	$15,400

Because less tax was withheld, your spendable income increased $600 per year by participating in the Plan.

Please note that if you don't spend the money you have set aside on eligible expenses (and properly submit a claim for reimbursement), you will lose that money. Please see the section below entitled "What if I Don't Use All the Money By the Deadline?"

How Much Can I Contribute?

The minimum amount that may be contributed to the Health Care Expense Reimbursement Plan is $150. The maximum amount that can be contributed for 2020 is $2,750 (which is subject to adjustment in future years).

When Am I Eligible to Participate?

See the section below entitled "Eligibility, Time of Participation and Enrollment."

What Expenses Are Covered?

The following medical expenses may be reimbursed under the Plan. These expenses may be for you, your Spouse, your children and other qualified dependents.

- Out-of-pocket expenses, deductibles, co-insurance and co-payments that are not reimbursed by the health coverage under the McLane Company Welfare Plan or a Spouse's employer-sponsored plan;

- Health expenses that are not covered, or which exceed the amounts covered, by the McLane Company Welfare Plan or another a benefit plan;

- Charges for amounts that are not covered by a health plan, such as medical care for chronic conditions, weight loss treatment, orthodontia or private hospital rooms; and

- Other qualified health expenses which meet the requirements for reimbursable care set forth by the IRS, including over-the-counter nonprescription drugs and menstrual care products.

The following expenses are not eligible for reimbursement:

- Expenses reimbursed by any other benefit plan;

- Expenses not considered deductible for federal tax purposes, such as cosmetic surgery or cosmetic treatments, hair replacement, liposuction and electrolysis;

- Premiums for any type of health insurance (other than for COBRA Continuation coverage); and

- Expenses incurred while you are not participating in the Health Care Expense Reimbursement Plan.

Eligible expenses are determined by the IRS and are subject to change. For a more extensive list of Eligible/Ineligible Expenses, visit www.irs.gov.

The Plan Administrator has the discretion to limit the amounts of reimbursement that you may receive for certain categories of eligible expenses.

Does It Matter When the Expenses Were Incurred?

Your contributions to the Plan may only be used for medical expenses incurred in the calendar year in which the amounts were deducted from your paycheck or the 2 ½ month period after that calendar year (referred to as the "grace period"). So, for your contributions made in 2020, you can receive reimbursement for expenses incurred any time during 2020 and from January 1, 2021 through March 15, 2021. An expense is incurred when the service is provided, and not when you pay for the expense or when you are billed for it.

Special rules apply if you become eligible mid-year or if you terminate during the year. See the section below entitled "Eligibility, Time of Participation and Enrollment."

See the section below entitled "Receiving Reimbursement Under the Plans" for information on how to submit a claim for reimbursement.

As explained above, the grace period allows you to incur claims up until March 15 following the end of the relevant calendar year. All claims for a calendar year and its related grace period must be submitted no later than March 31. Once the claim has been timely submitted, the Plan allows you to provide supporting documentation for the claim as long as the documentation is provided no later than 90 days after the end of the relevant grace period (which is June 13). For example, for the 2021 plan year plus the grace period that will end March 15, 2022, all claims must be submitted by March 31, 2022. However, so long as a claim is filed by March 31, 2022, the Plan will permit you to submit supporting documentation for the claim up until June 13, 2022.

If you want to switch to a Health Savings account for future years, there are special rules that apply if you have any money left in your account due to the grace period. Feel free to call the benefits hotline at 888-403-6089 if you have any questions. You may also direct your questions to the Plan Administrator. The contact information for the Plan Administrator is listed at the end of this SPD.

What If I Don't Use All the Money by the Deadline?

If your eligible expenses submitted for the calendar year and the grace period for that year (the following January 1st through March 15th) are less than the money you set aside, you will lose whatever money is left in your account. Because this money is forfeited, it is important that you carefully estimate what you will spend for eligible expenses. Forfeited funds are used by the Plan for Plan expenses.

Can the Money in My Account be Used to Pay Expenses for My Spouse or Children?

You may receive reimbursements for qualified expenses incurred by the following individuals:

- You;
- Your legal Spouse;
- Your Children up to the end of the month in which they turn age 26;
- Your 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; and
- Anyone else you can claim as a dependent on your federal income tax return, such as your elderly or disabled parents or other dependents.

You may receive reimbursement for the qualified expenses of these eligible individuals even if you do not cover these individuals under a health plan.

See the section below entitled "Who is My Spouse and/or Child for Purposes of the Plan?" for the definitions of "Spouse" and "Child."

How Do I Receive Reimbursement for Expenses?

Please refer to the section below entitled "Receiving Reimbursement Under The Plans" for information on obtaining reimbursements under the Plan.

LIMITED PURPOSE REIMBURSEMENT PLAN (DESIGNED FOR TEAMMATES WHO HAVE A HEALH SAVINGS ACCOUNT)

How Does the Limited Purpose Reimbursement Plan Work?

The Limited Purpose Expense Reimbursement Plan is designed to be used in conjunction with a Health Savings Account. Because of this, the Limited Purpose Expense Reimbursement Plan can only be used to pay for eligible dental and vision expenses.

Contributions will be deducted from your paycheck on a pre-tax basis. You can use these amounts to receive reimbursement for certain eligible dental and vision expenses incurred by you, your Spouse, your Children and other qualified dependents.

Your election to have contributions deducted from your paycheck must generally remain in place for the entire calendar year. See the section below entitled "Eligibility, Time of Participation and Enrollment" for information on when you can make or change an election mid-year.

How Can the Plan Save Me Money?

The Plan can save you money because the money that you set aside under the Plan is not taxed.

Assume that you earn $24,000 per year and your federal taxes in total (income tax and FICA) come to 30%.

You spend $2,000 each year in dental and vision expenses.

	WITHOUT SETTING MONEY ASIDE	WITH CONTRIBUTIONS TO THE PLAN
GROSS ANNUAL SALARY	$24,000	$24,000
PRE-TAX CONTRIBUTIONS TO PLAN		-$2,000
TAXABLE INCOME	$24,000	$22,000
ASSUMED FEDERAL TAXES @ 30%	-$7,200	-$6,600
PAYMENT OF DENTAL AND VISION EXPENSES ON AFTER-TAX BASIS	-$2,000	
SPENDABLE INCOME	$14,800	$15,400

Because less tax was withheld, your spendable income increased $600 per year by participating in the Plan.

Please note that if you don't spend the money you have set aside on eligible expenses (and properly submit a claim for reimbursement), you will lose that money. Please see the section below entitled "What if I Don't Use All the Money By the Deadline?"

How Much Can I Contribute?

The minimum amount that may be contributed to the Limited Purpose Reimbursement Plan is $150. The maximum amount that can be contributed for 2020 is $2,750 (which is subject to adjustment in future years).

When Am I Eligible to Participate?

See the section below entitled "Eligibility, Time of Participation and Enrollment."

What Expenses Are Covered?

The following dental and vision expenses may be reimbursed under the Plan. These expenses may be for you, your Spouse, your Children and other qualified dependents.

- Out-of-pocket expenses, deductibles, co-insurance and co-payments for dental and vision care that are not reimbursed by the health coverage under the McLane Company Welfare Plan (other than reimbursements under the Limited Purpose Reimbursement Plan) or a Spouse's employer-sponsored plan;
- Expenses greater than a dental or vision plan's reasonable and customary limits; and
- Dental or vision expenses not covered, or which exceed the amounts covered by a health plan.

The following expenses are not eligible for reimbursement:

- Expenses reimbursed by any other benefit plan;
- Expenses not considered deductible for federal tax purposes, such as cosmetic treatments;
- Premiums for any type of insurance (other than for COBRA Continuation coverage); and
- Expenses incurred while you are not participating in the Limited Purpose Reimbursement Plan.

Eligible dental and visions expenses are determined by the IRS and are subject to change. For a more extensive list of Eligible/Ineligible Expenses, visit www.irs.gov.

The Plan Administrator has the discretion to limit the amounts of reimbursement that you may receive for certain categories of eligible expenses.

Does It Matter When the Expenses Were Incurred?

Your contributions to the Plan may only be used for dental and vision expenses incurred in the calendar year in which the amounts were deducted from your paycheck or the 2 ½ month period after that calendar year (referred to as the "grace period"). So, for your contributions made in 2020, you can receive reimbursement for expenses incurred any time during 2020 and from January 1, 2021 through March 15, 2021. An expense is incurred when the service is provided, and not when you pay for the expense or when you are billed for it.

Special rules apply if you become eligible mid-year or if you terminate during the year. See the section below entitled "Eligibility, Time of Participation and Enrollment."

See the section below entitled "Receiving Reimbursement Under the Plans" for information on how to submit a claim for reimbursement.

As explained above, the grace period allows you to incur claims up until March 15 following the end of the relevant calendar year. All claims for a calendar year and its related grace period must be submitted no later than March 31. Once the claim has been timely submitted, the Plan allows you to provide supporting documentation for the claim as long as the documentation is provided no later than 90 days after the end of the relevant grace period (which is June 13). For example, for the 2021 plan year plus the grace period that will end March 15, 2022, all claims must be submitted by March 31, 2022. However, so long as a claim is filed by March 31, 2022, the Plan will permit you to submit supporting documentation for the claim up until June 13, 2022.

What If I Don't Use All the Money by the Deadline?

If your eligible expenses submitted for the calendar year and the grace period for that year (the following January 1st through March 15th) are less than the money you set aside, you will lose whatever money is left in your account. Because this money is forfeited, it is important that you carefully estimate what you will spend for eligible expenses. Forfeited funds are used by the Plan for Plan expenses.

Can the Money in My Account be Used to Pay Expenses for My Spouse or Children?

You may receive reimbursements for qualified expenses incurred by the following individuals:

- You;
- Your legal Spouse;
- Your Children up to the end of the month in which they turn age 26;
- Your 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; and
- Anyone else you can claim as a dependent on your federal income tax return, such as your elderly or disabled parents or other dependents.

You may receive reimbursement for the qualified expenses of these eligible individuals even if you do not cover these individuals under a health plan.

See the section below entitled "Who is My Spouse and/or Child for Purposes of the Plan?" for the definitions of "Spouse" and "Child."

How Do I Receive Reimbursement for Expenses?

Please refer to the section below entitled "Receiving Reimbursement Under the Plans" for information on obtaining reimbursements under the Plan.

DEPENDENT CARE ASSISTANCE PLAN

How Does the Dependent Care Assistance Plan Work?

Under the Dependent Care Assistance Plan, contributions will be deducted from your paycheck on a pre-tax basis. These contributions will be accumulated in a "Dependent Care Account." You can use the amounts in your Dependent Care Account to receive reimbursement for eligible expenses to obtain care for your Eligible Dependents (defined below) while you (and your Spouse, if you are married) are working, attending school or are disabled. If you are married, in order to be eligible to participate in the Dependent Care Assistance Plan, your Spouse must also work, be a full-time student, or be disabled.

Who Are My Eligible Dependents?

Eligible Dependents include:

- Children under age 13 for whom you are entitled to a deduction under section 152(a)(1) of the Internal Revenue Code; and
- A person age 13 or over (including your Child or parent) if the person meets the following criteria:
    - Lives with you for more than one-half of the Plan Year and depends on you for more than half of his or her financial support;
    - Is physically or mentally incapable of self-care; and
    - Is claimed as a dependent on your federal income tax return.
- Your Spouse, if your Spouse is physically or mentally incapable of self-care and lives with you for more than one-half of the Plan Year.

What Expenses Are Covered?

You may be reimbursed for dependent care expenses for Eligible Dependents while you (and your Spouse, if you are married) are working, attending school or are disabled. Expenses paid to the

following providers may be reimbursed through your Dependent Care Account if you provide their Social Security or taxpayer identification number:

- A licensed child care center or adult day care center, including a church or non-profit center, where your Eligible Dependent receives care;

- A baby-sitter inside or outside your home who cares for your Eligible Dependent if the sitter does not care for more than six children at a time (not including the sitter's own dependents);

- A housekeeper whose duties include care for your Eligible Dependent;

- A relative who cares for your Eligible Dependents but is neither your Spouse, your Child, your dependent, nor the parent of your Eligible Dependent if the Eligible Dependent is under age 13;

- Someone who cares for an elderly or disabled Eligible Dependent inside or outside your home;

- An au pair (foreign visitors to the U.S. who perform day care and domestic services in exchange for living expenses) who cares for your Eligible Dependent, provided the au pair agency is a non-profit organization or the au pair obtains a U.S. Social Security number for tax identification purposes; or

- Costs for facilities away from home, provided your Eligible Dependent spends at least 8 hours per day at home.

How Much Can I Contribute to the Dependent Care Assistance Plan?

IRS rules limit the amount you may contribute to and the type of expenses that may be paid from your Dependent Care Account.

Your family and tax filing status determine the maximum amount you can contribute per calendar year:

- A single person may contribute up to $5,000, subject to the Earned Income limit explained below.

- A couple filing a joint income tax return, if both Spouses are employed, may contribute up to $5,000 or the Earned Income of the lower-paid Spouse (if it is less than $5,000). If you both participate in reimbursement accounts, your combined contributions may be up to $5,000 per year, subject to the Earned Income limit explained below.

- A couple filing separate income tax returns may each contribute up to $2,500, subject to the Earned Income limit explained below.

- The minimum amount that may be contributed to the Dependent Care Assistance Plan is $150.

If your Spouse has no Earned Income because he or she is a full-time student, is disabled and needs day care, or is unable to take care of your dependents because of a disability, you may still be able to contribute to a Dependent Care Account. You should consult your tax advisor regarding participation in the Dependent Care Assistance Plan when your Spouse is disabled or is a full-time student, or if you have questions concerning your marital status.

"Earned Income" is defined in section 32(c)(2) of the Internal Revenue Code, but does not include any amounts paid or expenses incurred by the Employer for your eligible dependent care expenses. If you have any questions concerning your Earned Income, please contact your tax advisor.

How Can the Plan Save Me Money?

The Plan can save you money because the money that you set aside under the Plan is not taxed.

Assume that you earn $24,000 per year and your federal taxes in total (income tax and FICA) come to 30%.

You spend $4,000 each year in dependent care expenses.

	WITHOUT SETTING MONEY ASIDE	WITH CONTRIBUTIONS TO THE PLAN
GROSS ANNUAL SALARY	$24,000	$24,000
PRE-TAX CONTRIBUTIONS TO PLAN		-$4,000
TAXABLE INCOME	$24,000	$20,000
ASSUMED FEDERAL TAXES @ 30%	-$7,200	-$6,000
PAYMENT OF DEPENDENT CARE EXPENSES ON AFTER-TAX BASIS	-$4,000	
SPENDABLE INCOME	$12,800	$14,000

Because less tax was withheld, your spendable income increased $1,200 per year by participating in the Plan.

Please note that if you don't spend the money you have set aside on eligible expenses (and properly submit a claim for reimbursement), you will lose that money. Please see the section below entitled "What if I Don't Use All the Money by the Deadline?"

When Am I Eligible to Participate?

See the section below entitled "Eligibility, Time of Participation and Enrollment."

Does It Matter When the Expenses Were Incurred?

Your contributions to the Plan may only be used for dependent care expenses incurred in the calendar year in which the amounts were deducted from your paycheck. (The "grace period" discussed above in connection with the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan is not applicable to the Dependent Care Assistance Plan.) An

expense is incurred when the service is provided, and not when you pay for the expense or when you are billed for it.

Special rules apply if you become eligible mid-year of if you terminate during the year. See the section below entitled "Eligibility, Time of Participation and Enrollment."

See the section below entitled "Receiving Reimbursement Under the Plans" for information on how to submit a claim for reimbursement.

You must submit all claims for a relevant year no later than 90 days after the end of that calendar year. This means that for the 2020 plan year, all claims must be incurred and paid by you by no later than December 31, 2020, and submitted for reimbursement by March 31, 2021.

What If I Don't Use All the Money by the Deadline?

If your eligible expenses submitted for the calendar year are less than the money you set aside, you will lose whatever money is left in your account. Because this money is forfeited, it is important that you carefully estimate what you will spend for eligible expenses. Forfeited funds are used by the Plan for Plan expenses.

How Do I Receive Reimbursement for Expenses?

Please refer to the section below entitled "Receiving Reimbursement Under the Plans" for information on obtaining reimbursements under the Plan. Eligible dependent care expenses incurred during the Plan Year will be reimbursed up to the amount remaining in your Account.

Dependent Care Assistance Plan vs. Federal Tax Credit

You should also be aware that Federal tax laws allow you to take a tax credit for eligible dependent care expenses. The tax credit is a percentage of your dependent care expenses. Although you may use the dependent care tax credit and participate in the Dependent Care Assistance Plan, expenses must be submitted either for a tax credit or under the Dependent Care Assistance Plan. This means that you may not submit the same expenses for a tax credit that you submit for reimbursement under the Dependent Care Assistance Plan. Amounts reimbursed under the Dependent Care Assistance Plan will be deducted from your tax credit. In some cases, using the Dependent Care Assistance Plan saves you more money. In other cases, you may save more by taking the credit on your tax return. However, because tax laws are complex and change from time to time, you should consult a tax advisor or obtain Publication 503 from www.irs.gov.

RECEIVING REIMBURSEMENT UNDER THE PLANS

How Are Eligible Expenses Reimbursed?

There are two ways in which to submit eligible expenses for reimbursement under the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan: you may use a Flexible Spending Account debit card ("FSA Card") or you may submit paper claims.

Dependent Care Assistance Plan expenses must be submitted in paper form. They cannot be reimbursed using the FSA Card.

How Does the FSA Card Work?

When you enroll in the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, an FSA Card will automatically be mailed to you at your home address (as shown on the Plan's records). You can then use the FSA Card to pay for eligible expenses incurred with providers who have implemented the FSA Card system. The card system will validate that your coverage is active and that you have available funds to pay for the expense. Your account balance under the Plan will be reduced by the amount of the expense paid.

If you want to use the FSA Card, you must agree to abide by the terms and conditions of the card as described in the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as applicable, and as described in the electronic payment card holder agreement. You must agree to all limitations applicable to the FSA Card and to the applicable Plan's right to withhold and offset amounts for ineligible claims. By using your FSA Card, you are also agreeing that you will (i) only use your card for eligible expenses, (ii) not use your card for any expense that has already been reimbursed, (iii) not seek reimbursement under any other plan for any expense paid for with the FSA Card, and (iv) acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the FSA Card.

You must read the back of your FSA Card and sign it.

Will I Need to Submit Documentation?

Yes, in some cases. Although there is no requirement for you to complete claim forms every time you use your FSA Card, additional documentation will be required in some cases in order to meet IRS guidelines. **Therefore, you must keep copies of all receipts and itemized statements (not just the FSA Card receipt) for each purchase for one year following the close of the Plan year in which the expense is incurred.** This includes itemized cash register receipts that list the merchant name, name of the item/product, date and amount, insurance plan Explanation of Benefit (EOB) statements, and itemized statements. For qualified prescription drugs purchased at a pharmacy, this would include the pharmacy receipt, or you can request a printout from your pharmacy. In some cases, you'll receive a letter from the Claims Administrator requesting the documentation and you will be required to submit this information to substantiate the expense.

What Happens if I Don't Provide the Requested Documentation or Accidentally Use the Card for Ineligible Expenses?

In the event that the proper documentation is not provided when requested or if you use the FSA Card to pay for an ineligible expense, your FSA Card will be deactivated and either you will be required to write a personal check to the Plan or the unsubstantiated transactions will be offset against future claims. If an offset is not possible, the amount may be withheld from your compensation or included in your gross income as taxable wages. Continued misuse of the FSA Card may result in disciplinary action, up to and including termination of employment.

Will I Receive a Statement or an Accounting of My FSA Card Transactions?

You can view detailed account information for each of the Plans, including FSA Card payments, on the website of the Claims Administrator.

How Do I Report a Lost or Stolen Card?

Lost or stolen cards should be reported as soon as possible by calling the Claims Administrator.

Can I Order a Card for My Dependents?

Yes. You can order additional FSA Cards for your Spouse or other dependents by contacting the Claims Administrator. Any additional card(s) will be issued in the name(s) of your dependent(s). By using the card, your dependent is agreeing to the same terms and conditions of the FSA Card that you must agree to. Any misuse of the FSA Card by your dependent will void your dependent's card as well as your card, and they will not be reactivated. Therefore, it is very important that your Spouse or dependent(s) fully understands that the FSA Card is to be used solely for appropriate uses, and that copies of documentation of each transaction must be retained.

Can I Continue to Use the FSA Card if I Terminate Employment?

No. The card is inactivated on your date of termination. If you have eligible expenses to submit after your termination of employment, you can file a paper claim.

If you are eligible for and elect COBRA coverage, you can continue coverage under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, but you will not be able to use your FSA Card. Instead, you will be required to submit paper claims.

How Do I File a Paper Claim?

You can submit a paper claim by uploading a copy of the receipt for the eligible expense to the Claims Administrator's website at www.connectyourcare.com/mclane. Or you can mail the applicable claim form with the receipt to the Claims Administrator via regular mail to: ConnectYourCare, 307 International Circle, Suite 200, Hunt Valley, MD 21030.

How Much Will I Receive as Reimbursement?

Reimbursement of eligible expenses under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as applicable, is available up to the dollar amount of coverage that you have elected for the relevant Plan Year (reduced by any prior reimbursements made during the applicable Plan Year and related grace period). The amount that you elected to contribute for the relevant Plan Year under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as applicable, less reimbursements will be available at all times during the Plan Year (and related grace period), regardless of the actual contributions that have been credited to your account on the date of payment.

You will be reimbursed up to the balance in your Dependent Care Account at the time you file your claim. If your account balance is less than the amount you request, your reimbursement will

only equal the amount in your account. Unreimbursed amounts will automatically be paid as additional deposits are made.

ELIGIBILITY, TIME OF PARTICIPATION AND ENROLLMENT

Am I Eligible to Participate?

You are eligible to participate in the Health Care Expense Reimbursement Plan, the Limited Purpose Reimbursement Plan and/or the Dependent Care Assistance Plan if you are a regular, full-time Teammate on the payroll records of the Company or one of its eligible U.S. subsidiaries (the "Employers"), are regularly scheduled to work at least 30 hours per week, and receive compensation from the Company or a participating Employer.

You are not eligible to participate in the Plans if you are:

- a self-employed individual as defined in section 401(c) of the Internal Revenue Code;
- an individual who is not treated as a regular, full-time Teammate on the payroll records of the Company or participating Employer, including a leased teammate; or
- not based in the United States.

Teammates residing in any country outside the United States who return to permanently reside in the United States immediately gain eligibility for coverage under all plans described in this SPD and are otherwise eligible for coverage under the Plans.

A "Teammate" means a person who works for the Company or participating Employer and who is currently in Active Service (defined below). Whenever the term "Teammate" is used in this SPD, it means a Teammate who is eligible to participate in the Plans, unless the context indicates otherwise.

When can I Begin Participating?

You are eligible to become a participant in the Health Care Expense Reimbursement Plan, Limited Purpose Reimbursement Plan and Dependent Care Assistance Plan as follows:

Each Hourly Teammate	Eligible after 59 days of Active Service (the "Waiting Period").
Each Salaried Teammate or Driver:	Eligible on the date of hire.

The term "Active Service" means that on any of the Company's scheduled work days, you are performing the regular duties of your work on a full-time basis on that day either at your Company's place of business or at some location to which you are required to travel for your Company's business. You will be considered to be in Active Service on a day which is not one of your Company's scheduled work days if you were in Active Service on the preceding scheduled work day and your employment status is not separated.

The term “Hourly Teammate” means a Teammate (other than a Driver) who is paid compensation on an hourly basis and who is classified as an Hourly Teammate by the Company or participating Employer.

The term “Salaried Teammate” means a Teammate who is paid compensation on a salaried basis and who is classified as a Salaried Teammate by the Company or participating Employer.

The term “Driver” means an Hourly Teammate who is hired by the Company or a participating Employer to drive a delivery vehicle who is responsible for the accurate and timely distribution of grocery/food staples, grocery/food specialty products and convenience store/restaurant supplies to various customer locations throughout the U.S. and who is classified as a Driver by the Company or participating Employer.

What If I Terminate Employment and Then I Am Rehired?

For the Health Care Expense Reimbursement Plan and the Dependent Care Assistance Plan, if you are rehired within 90 days from your prior termination date, and it is within the same Plan Year, you will resume participation in the Health Care Expense Reimbursement Plan and/or the Dependent Care Assistance Plan, as applicable. If you are rehired 91 days or more from your prior termination date, you will be treated as a new Teammate and must make new elections to participate in the relevant plan.

For the Limited Purpose Reimbursement Plan, if you are rehired within 90 days from your termination date and in the same Plan Year, you will resume participation in the Limited Purpose Reimbursement Plan, provided that you are enrolled in the High Deductible Health Plan option offered by the Company or another high deductible health plan option. If you are rehired 91 days or more from your prior termination date and you continued coverage in the High Deductible Health Plan option through COBRA, you may elect to be reinstated in the Limited Purpose Reimbursement Plan, provided that you continue coverage in the High Deductible Health Plan option. If you are rehired 91 days or more from your prior termination date and you did not continue coverage in the High Deductible Health Plan option through COBRA, you will be treated as a new Teammate, subject to a new eligibility Waiting Period, if applicable.

What is the Deadline to Enroll?

<u>Initial Election</u>

If you are a Driver or Salaried Teammate, you must make your elections within 31 days of your date of hire. If you are an Hourly Teammate (other than a Driver), you must make your elections before the end of your Waiting Period.

If you do not make an election within the time frames set out above, you will generally have to wait until the next annual Open Enrollment Period to enroll unless you have a Qualifying Life Event (“QLE”) or other permitted election change.

Elections after the Initial Election

You must make an election each year during open enrollment for coverage under the Health Care Expense Reimbursement Plan, the Limited Purpose Reimbursement Plan or the Dependent Care Assistance Plan. Your elections from the prior year do not carry over.

Who is My Spouse and/or Child for Purposes of the Plan?

Your "Spouse" is your legal spouse, whether same-sex or opposite-sex, in a marriage validly entered into under the laws of a United States or foreign jurisdiction having authority to sanction marriages. 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.

Your "Child" includes your natural children, stepchildren, 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 you have received a court order requiring you to have financial responsibility for providing coverage. Grandchildren are not eligible for coverage under the Plan unless you are 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.

In the case of a Child aged 26 or older who is permanently and totally disabled, you may receive reimbursement for the qualified expenses of the Child until the Child's condition and dependence no longer continues. Proof of the Child's condition and dependence must be submitted to the Claims Administrator within 31 days after the Child attains age 26. 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.

Please note that the Plan Administrator has the right to verify the dependents for whom you request reimbursement to ensure they meet the eligibility requirements. The Plan Administrator (or its designee) may audit the information and documentation you provide with respect to such individuals to determine if such individuals are dependents eligible to be covered under the Plan. In addition, the Plan Administrator 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 Plans 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 designee). Such additional 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 applicable Plan, coverage will not become effective or will be terminated either on a go forward basis or as if no coverage

was ever in force with respect to such individual. If you have made false statements, it may lead to disciplinary actions up to and including termination of employment.

What Happens If I Terminate Employment Mid-Year?

If your employment terminates, your participation in the Plan will end as of that date and you will not be able to make any more contributions to the Plan (unless you elect COBRA in connection with the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as discussed below). Any expenses incurred after your termination date will be ineligible for reimbursement. You may submit claims for eligible expenses incurred during the current Plan Year and prior to your termination within 90 days of the date of termination.

You can continue participation in the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan after your termination if you elect to continue your coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). This will allow you to continue to participate through the end of the Plan Year. When COBRA is elected, all contributions to your Health Care Expense Reimbursement Plan or Limited Purpose Reimbursement Plan after your employment terminates are made on an after-tax basis. Please see the section below entitled "What is COBRA?" for more information.

Can I Make Changes to My Elections Mid-Year?

Qualifying Life Event (QLE)

The elections that you make under the Plans generally must remain in place for the entire Plan Year. However, you may make changes to your elections (or make new elections) if you experience a Qualifying Life Event or other permitted election change as described in this section.

If you wish to change an election, you must request a change (in the form and manner required by the Plan Administrator) within 60 days of the date of the QLE. Any election change made will be effective as soon as administratively feasible after the Plan Administrator receives your election change request. No refunds will be issued.

A QLE includes the following events:

- Events that change your legal marital status such as marriage, the death of a Spouse, divorce, annulment, or legal separation;

- Events that change your, your Spouse's or your dependent's employment status, including (i) the termination or commencement of employment; (ii) commencement or return from an unpaid leave of absence by you, your Spouse or your dependent; (iii) a change in worksite; or (iv) a change in employment status for you, your Spouse or your dependent that causes a change in eligibility for benefits under the Plan or a similar plan of another employer; or

- Events that change your number of dependents, including the birth or death of a child, adoption or Placement for Adoption of a child with you, or the loss of dependency status of your dependents, for example, due to the dependent's attainment of age 26.

"Placement for Adoption" or "Placed for Adoption" means your assumption and retention of a legal obligation for the total or partial support of a child in anticipation that such child will be adopted before his or her 18th birthday. The Placement for Adoption status of the child is deemed to end on the date that such legal obligation ends.

Consistency Rules for QLEs

You may make a change in your election due to a QLE during a Plan Year only if the election is on account of and corresponds with the event that effects eligibility for coverage under the Plan ("Consistency Rule"). The Plan Administrator will determine whether the QLE satisfies the Consistency Rule in accordance with the Internal Revenue Code and other guidance issued by the Department of Treasury or the Internal Revenue Service ("IRS").

Other Permitted Election Changes

The following are other events that may permit you to make an election change under a Plan, as applicable, provided that you request the election change in writing on a "Qualifying Event Change Form" within 60 days of the event and you provide documentation in the form and manner required by the Plan Administrator.

COBRA Exception

If your Spouse or your dependent becomes eligible for continuation of health coverage under a Benefit Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you may be able to elect to increase contributions under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan to pay for COBRA coverage.

Judgment, Decree or Order

You may be able to change your election under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan if the change results from, and is consistent with, a judgment, decree or order pursuant to a divorce, legal separation, annulment or change in legal custody requiring health coverage for your child.

Entitlement to Medicare or Medicaid

You may be able to change your election under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan if you become entitled to or lose coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The same rule applies to dependents and Spouses.

Cost or Coverage Changes

If your costs or coverage under the Dependent Care Assistance Plan changes, you may be able to change your election if the Plan Administrator determines an election change is permitted by the

law. However, an election change is not permitted under the Dependent Care Assistance Plan due to cost changes if a dependent care provider who is your relative imposes the cost change.

Another Employer Plan

You may also be able to change your election under the Dependent Care Assistance Plan if the election change is made on account of and corresponds with a change made under another employer plan if: (i) the other employer plan permits participants to make election changes as provided by law; or (ii) the other employer plan permits participants to make elections for a period of coverage different from the period of coverage under the Dependent Care Assistance Plan.

Leave of Absence

If you intend to take a leave of absence from work, please refer to the Company's policies for leaves of absences including leaves under the Family and Medical Leave Act of 1993, as amended and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, or contact the Company for additional information about your rights to continued coverage.

If you take an unpaid FMLA leave, you may revoke coverage under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as applicable, or may continue coverage without being required to pay the premium for the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan during the FMLA leave.

Upon your return to work on or before the date the available FMLA leave expires, you may resume coverage for the rest of the Plan Year at either:

- The original level by making up the payments that were missed during the FMLA leave on a prospective basis; or

- A reduced level by disregarding any payments that would have otherwise been due during any period of FMLA leave.

What Is the Uniformed Services Employment and Reemployment Rights Act (USERRA) Of 1994?

If you are going into or returning from qualified military service, you may have special rights to continue health care coverage under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan. For more information or if you anticipate beginning qualified military service, please contact your Plan Administrator and refer to the Military Leave Policy.

When Does My Coverage End?

Your coverage will end under the applicable Plan on the earliest of the following to occur:

- the date you separate from service with the Company or a participating Employer or commence a leave of absence. With respect to the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan, you may be able to continue coverage

pursuant to COBRA or if you take a military or FMLA leave of absence and meet certain requirements;

- you no longer satisfy the requirements necessary to be classified as an eligible Teammate;
- you fail to enroll in the form and manner required by the Plan Administrator during an enrollment period; or
- the date the applicable Plan is terminated.

IMPORTANT INFORMATION ABOUT THE PLANS

What Are the Claims and Appeal Procedures?

The following claims and appeal procedures apply only to claims under the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan and do not apply to claims under the Dependent Care Assistance Plan. The Company reserves the right to choose a claims administrator.

You or your duly authorized representative may file a written claim with the Claims Administrator for the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as applicable.

Notification Requirements for Claims

If the claim is wholly or partially denied, the Claims Administrator will notify you of its decision in writing or electronically within a reasonable time, but not later than 30 days after the claim is received by the Claims Administrator. The notification will contain:

- the specific reason or reasons for the adverse determination,
- the specific reference to pertinent Plan provisions on which the determination is based,
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary,
- information as to the steps to be taken if you wish to submit a request for review, including applicable time limits and your right to bring a civil action under section 502(a) of ERISA,
- if the benefit determination was adverse, if any internal rule, guideline, protocol or other similar criterion (collectively "Protocols") were relied upon in making the adverse determination and a statement that a copy of such Protocols will be available to you, free of charge, upon your request, and
- if applicable, a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon your request.

Extensions for Claims

The 30 day time period in the "Notification Requirements for Claims" section above may be extended once for up to 15 days, provided that the Claims Administrator (i) determined that such extension is both needed and beyond the Claims Administrator's control, and (ii) notifies you prior to the expiration of the initial 30 day period of the circumstances requiring the extension of the time and the date the Claims Administrator expects to render a decision.

If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

The benefit determination period shall be put on hold from the date of the notice of extension until the earlier of (i) the date you respond to the request for additional information, or (ii) the last day of the 45 day period.

Once you have provided the additional information or, if earlier, the 45 day period has ended, the benefit determination period shall recommence. If you do not receive written notice that the claim has been denied within the initial 30 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 you may request a review of this claim.

Review Process For Appealing A Claim Denial

Within 180 days after the date that you receive written notice of a claim denial for benefits, or if applicable, within 180 days after the date on which such denial is deemed to have occurred, you or your duly authorized representative may file a written request with the Plan Administrator for a review of the denied claim.

Review Standards for Claims

You and/or your authorized representative may inspect or request, free of charge, relevant documents and submit written comments, documents, records, and other information to the Plan Administrator. The review of your appeal shall 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

If a decision is based in whole or part on a medical judgment, the appropriate named fiduciary shall 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 shall provide you with such information regarding such health care professionals as the Plan Administrator determines is appropriate. You shall be provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Plan Administrator relied upon the expert's advice.

Notification Requirements for Appeals

The Plan Administrator will notify you of its decision by written or electronic means. Such notification will be set forth in a manner calculated to be understood by you and will contain:

- the specific reason or reasons for the denial,
- the specific references to Plan provisions on which the benefit determination is based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits,
- a statement describing any voluntary appeals offered by this Plan, including information concerning the procedures of the voluntary appeal that would allow you to make an informed decision about whether to appeal and such other information which the Plan Administrator determines is appropriate regarding alternative dispute resolution options,
- a statement of your right to bring an action under section 502(a) of ERISA,
- 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
- if applicable, a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon your request.

Response Dates on Appeals of Benefit Claims

The decision on review will be made within 60 days after the request for review is received by the Plan Administrator. If you do not receive written or electronic notice of the decision within the 60 day period, the claim shall be deemed to have been denied on review as of the last day of such period.

Rights After Appeal and Exhaustion of Appeals Required

If you are dissatisfied with the Plan Administrator's review of the decision, you have the right to file suit in a federal or state court, which suit must be filed within 12 calendar months immediately following the date of such Plan Administrator's decision or deemed decision. No action may generally be brought for benefits provided by this Plan or to enforce any right hereunder until after a claim has been submitted to and determined by the Plan Administrator and all appeal rights under this Plan have been exhausted. Your beneficiary should follow the same claims procedure in the event of your death.

What Is COBRA?

If you are a participant in either the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan and would otherwise lose coverage, you may be able to temporarily continue your coverage under the relevant Plan pursuant to COBRA. If you choose not to

participate in COBRA, your benefits under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan will end.

COBRA coverage may be available under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan if you will lose coverage due to a reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct on your part) ("Qualifying Event") and the other requirements set forth below are met. It is your responsibility to notify your employer within 60 days of a Qualifying Event that a Qualifying Event has occurred.

Your Spouse and/or dependent child may also be able to elect COBRA coverage under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan in certain circumstances. Your Spouse may choose continuation coverage for himself or herself if he or she loses coverage for any of the following reasons:

(1) your death;
(2) your divorce or legal separation; or
(3) you become enrolled in Medicare

Your dependent children, including a child born to or Placed for Adoption with you during the period of COBRA coverage, may choose continuation coverage under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan for themselves if they lose coverage for any of the following reasons:

(1) your death;
(2) your divorce or legal separation;
(3) you become enrolled in Medicare; or
(4) your dependent ceases to be a dependent child under the Plan.

Generally, if you participated in either the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, you will be entitled to elect COBRA coverage only if you can receive some economic benefit from that election. COBRA coverage may only be elected under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan if, as of the date of the Qualifying Event, the maximum benefit available under the Plan for the remainder of the calendar year is more than the maximum amount that the Plan could require as payment to maintain coverage for the remainder of that calendar year.

For example, if you made an election to have $150 in compensation contributed to the Limited Purpose Reimbursement Plan and you have already been reimbursed that amount as of the date of the Qualifying Event, you will not have the right to make a COBRA election with respect to the Plan. (This example is also applicable for the Health Care Expense Reimbursement Plan.) In addition, you generally will not have COBRA rights under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan if the contributions you will pay for the remainder of the year under COBRA will exceed the amount you could be reimbursed under the applicable plan. Using the above example, if you had been paid $100 under the Limited Purpose Reimbursement Plan through your COBRA election date, you would still be entitled to a $50 reimbursement under the Limited Purpose Reimbursement Plan. If your COBRA

contributions for the remainder of the year will exceed $50, you will not be entitled to elect COBRA under the Plan. (This example is also applicable for the Health Care Expense Reimbursement Plan.)

If you are eligible and elect COBRA coverage, you are required to continue to make the same contributions that you were making before plus a 2 percent surcharge. These contributions will be made on an after-tax basis (unless taken from a final paycheck). There are certain circumstances, including non-timely payment of your COBRA premium, under which your COBRA coverage may be terminated.

COBRA coverage may not be elected for Plan Years which follow the year in which the Qualifying Event occurs, except in very unusual circumstances. You will be notified if you may elect COBRA under either the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan for later years. You may contact the Plan Administrator if you need additional information regarding eligibility for COBRA coverage.

Can the Plans Be Amended or Terminated?

The Company may amend or terminate all or any part of the Plans at any time. The Company has delegated to the Director of Benefits the authority to make amendments to the Plans that (1) do not significantly increase the costs of the Plans, or (2) are required to be made by law.

Who Administers the Plans?

The primary responsibility for the general administration of the Plans is placed with the Plan Administrator. However, the Claims Administrator is responsible for processing and deciding all claims under the Plans. The Claims Administrator has the exclusive right to make all determinations concerning eligibility for coverage and benefits under the Plans. 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 Plans and to interpret the terms of the Plans. The determinations and interpretations of the Plan Administrator and the Claims Administrator, as appropriate shall be binding and conclusive on all persons. The Plan Administrator or the Claims Administrator, as appropriate has the authority to interpret the provisions of the Plans and resolve any dispute as to eligibility, type or amount of benefits under the Plans in its sole and absolute discretion, and its decision shall be final and binding on all parties to the dispute.

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, the Uniformed Services Employment and Reemployment Rights Act, and any regulations or guidance issued thereunder.

What Are the Nondiscrimination Rules?

If the Plan Administrator determines during any Plan Year that any of the Plans may fail any nondiscrimination requirement imposed on the Plans by law or may exceed any limitation on benefits provided to highly compensated individuals or such other Teammates for whom benefits may not be discriminatory under the law, the Plan Administrator shall have the discretion and

authority to take such action as it deems necessary to assure compliance with such nondiscrimination requirement or limitation. Such action may include, without limitation, a modification or limit on elections by any individual for whom benefits may not be discriminatory under the Internal Revenue Code or regulations.

By executing an enrollment form, you are deemed to have expressly consented to any modifications or limitations to your election that are deemed necessary by the Plan Administrator in order to comply with applicable nondiscrimination or other qualification requirements. The Plan Administrator on a uniform and nondiscriminatory basis shall make any reduction of benefits that may be necessary to meet the nondiscrimination tests of applicable law.

Neither the Employer, Plan Administrator, nor their agents and representatives guarantee that the Plans, the benefits provided under the Plans, or contributions made to the Plans, are at any particular time nondiscriminatory, as determined in accordance with applicable provisions of the Internal Revenue Code and regulations or other authority issued by the appropriate governmental authority.

Any amount paid to a participant from the Plans during a particular Plan Year which is required to be included in income by reason of the Plans' being discriminatory under the Internal Revenue Code or regulations shall be treated as received by the participant during the Plan Year.

What Are Qualified Medical Child Support Orders?

In the event your Employer is required to provide benefits under either the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan in accordance with a "Qualified Medical Child Support Order" ("QMCSO"), the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, as applicable, shall provide benefits in accordance with such QMCSO. A QMCSO is a judgment, decree, order (including approval of a settlement agreement), administrative notice, or National Medical Support Notice (as defined in section 609(a) of ERISA) issued by a court of competent jurisdiction or state agency, which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any individual designated as a person entitled to receive health care coverage under the QMCSO (including a child of a participant). A QMCSO must satisfy each of the following requirements:

- it must clearly identify the person or persons responsible for providing benefits;
- it must specify the alternate recipient's name and last known address or must provide the name and address of any state official or political subdivision that will be substituted for that of the alternate recipient;
- it must provide a description of the coverage to be provided, or the manner in which the coverage is to be determined;
- it must state the period to which it applies; and

- 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 QMCSO may not require the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan to provide coverage for any type or form of benefit or option not otherwise provided under the applicable Plan. If you need additional information concerning QMCSOs, please contact the Plan Administrator for a copy of the QMCSO procedures, which will be furnished to you free of charge.

Default coverage will be provided to the alternate recipient(s) if the QMCSO does not specify the flexible spending account coverage for which such alternate recipient must be enrolled but specifies that such coverage must be provided. If you are enrolled in coverage, the default coverage will be the coverage in which you are currently enrolled. If you are not enrolled in any coverage, the default coverage will be the Health Care Expense Reimbursement Plan up to the dollar amount provided by the QMCSO. You and the alternate recipient will be required to enroll in such respective coverage. Otherwise, the alternate recipient (and you, if necessary) will be enrolled in the flexible spending account coverage (and to the extent) specified by the QMCSO.

In any event, you and the alternate recipient must be enrolled in any such coverage within 60 days after the QMCSO has been determined to be a "qualified medical child support order."

STATEMENT OF RIGHTS UNDER ERISA

The following statement of ERISA rights is required by Federal law and regulations to be included in this document:

As a participant in the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all participants in the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan are entitled to:

<u>Receive Information About Your Plan and Benefits</u>

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the applicable plan's annual financial report. The Plan Administrator is required by law to furnish each participant under the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan with a copy of the summary annual report for that Plan.

Continue Group Health Plan Coverage

You have the right to continued health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event, as described under COBRA. You or your dependents may have to pay for such coverage. Review this SPD plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan, called "fiduciaries" have a duty to do so prudently and in your interest and in the interest of other participants and beneficiaries.

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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 plan documents or the latest annual report from the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 Health Care Expense Reimbursement Plan's or the Limited Purpose Reimbursement Plan's decision 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 plan fiduciaries misuse the plans' 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about the Health Care Expense Reimbursement Plan or the Limited Purpose Reimbursement Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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.

PLAN OVERVIEW

Name of Plans	McLane Company, Inc. Flexible Benefit Plan
	McLane Company, Inc. Medical Expense Reimbursement Plan also known as the Health Care Expense Reimbursement Plan
	McLane Company, Inc. Limited Purpose Medical Expense Reimbursement Plan also known as the Limited Purpose Reimbursement Plan
	McLane Company, Inc. Dependent Day Care Assistance Plan also known as the Dependent Care Assistance Plan
Plan Sponsor, Plan Administrator and Agent for Legal Service:	The Company is the Plan Sponsor, Plan Administrator and Agent for Legal Service and may be contacted as follows:
	McLane Company, Inc. 4747 McLane Parkway Temple, Texas 76504 254-771-7500
Other Employers Participating in the Plans	Although the Company is the most significant Employer maintaining the Plans, the Plans provide for the possibility of adoption by affiliated companies. Plan participants and covered dependents may, upon written request to the Plan Administrator, receive information as to whether a particular Employer has adopted the plan, and is a sponsor and, if so, the address of that Employer.

Employer Identification	74-1478631
Plan Number	502 – Health Care Expense Reimbursement Plan 506 – Limited Purpose Reimbursement Plan
Plan Year	January 1 through December 31
Type of Administration	The Plans are administered for the Company by the Claims Administrator chosen by the Company.
Claims Administrator	ConnectYourCare 307 International Circle, Suite 200 Hunt Valley, MD 21030 Phone: 410-891-1000 www.connectyourcare.com (official site) www.connectyourcare.com/mclane| (McLane's direct micro-site)
Type of Plan	The Flexible Benefit Plan is a fringe benefit plan intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code that provides participants with the opportunity to select certain non-taxable statutory fringe benefits in lieu of cash. Both the Health Care Expense Reimbursement Plan and the Limited Purpose Reimbursement Plan are medical plans under Section 105 of the Internal Revenue Code. The Dependent Care Assistance Plan is a dependent care assistance plan under Section 129 of the Internal Revenue Code.
Contributions	Benefits are paid by participant salary reductions authorized by participants for pre-tax benefits that are taken solely from the general assets of the Company.