MCLANE COMPANY, INC.
WELFARE PLAN

OPTIONAL HOSPITALIZATION BENEFITS INCLUDING ANCILLARY ACCIDENT BENEFITS
PLAN 2

Summary Plan Description

January 1, 2021

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1. Introduction

This summary describes the optional hospitalization benefits which include ancillary accident benefits (Plan 2) offered under the McLane Company, Inc. Welfare Plan (the "Plan").

Many important details about the optional hospitalization benefits and the ancillary accident benefits are contained in the Insurance Certificate. The Insurance Certificate and this summary are meant to be read together to form the summary plan description (SPD) for these benefits. To the extent any greater legal rights are afforded to you by the Insurance Certificate, the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

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

This document is only a summary of the optional hospitalization and ancillary accident benefits offered under the Plan. All statements made in this summary are subject to and controlled by the terms of the Plan as they appear in the official documents (including without limitation the Insurance Certificate). If the terms of this document conflict with the terms of such insurance or governing Plan documents, then the terms of the insurance contract or governing Plan documents will control, rather than this document, unless otherwise required by law. 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.

2. Eligibility, Participation and Termination Requirements

Eligibility: Please refer to the Insurance Certificate for detailed information regarding eligibility to participate in the optional hospitalization benefit and ancillary accident benefit component of the Plan. If you elect to participate in these hospitalization benefits, you will automatically receive ancillary accident benefits.

Participation: Please refer to the Insurance Certificate for information regarding enrollment procedures, including when coverage begins and ends.

Dependent Coverage: Please refer to the Insurance Certificate for detailed information regarding your ability to cover your dependents under the Insurance Certificate.

The Plan Administrator has the right to verify the dependents you enroll (or request to enroll) to ensure they meet the eligibility requirements of the Plan. 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 Plan, and may require that you furnish additional information or documentation. 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 Insurance Certificate, coverage may not become effective or may be terminated as if no coverage was ever in force with respect to such individual. The Plan may also pursue recovery of any Plan benefits paid on behalf of your ineligible dependent, and, if you have made false statements, it may lead to disciplinary actions up to and including termination of employment.

Permitted Election Changes: Your elections and coverage under the Insurance Certificate cannot be changed during the Plan Year unless the coverage or election change is permitted under the Insurance Certificate.

Termination of Participation: Your participation and the participation of the individuals you cover under the Insurance Certificate will terminate on the date you terminate employment with the Employer or, if earlier, the date you are no longer an eligible Teammate. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you commit a fraud or intentional misrepresentation on the Plan (including the submission of a false claim), or for any other reason as set forth in the Insurance Certificate. Optional hospitalization benefits and ancillary accident benefits will also cease upon termination of the Plan or upon termination of that particular benefit under the Plan in accordance with the Insurance Certificate. Please refer to the Insurance Certificate for other circumstances that can result in the termination, reduction, recovery, loss, or denial of benefits.

3. Summary of Benefits, Limitations and Costs

The Plan provides you with optional hospitalization and ancillary accident benefits as described in the Insurance Certificate. The Plan may provide your eligible dependents, if any, with the opportunity to participate in the optional hospitalization and ancillary accident benefits, but only as described in the Insurance Certificate. Please refer to the Insurance Certificate for information on benefits and limitations.

You may be required to pay all or part of the cost for optional hospitalization benefits and ancillary accident benefits for you and your eligible dependents, if any.

The Employer will determine and periodically communicate to you your share of the cost of these benefits. The Employer will pay its contribution and your contributions to the Insurance Company. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Important Note about Benefits: Benefits provided under the Plan pursuant to insurance contracts or pursuant to governing Plan documents adopted by the Company shall only be paid to the extent determined by the applicable insurer. To the extent the Employer elects

to purchase insurance for any benefits under the Plan, any such benefits shall be the sole responsibility of the insurer, and the Employer shall have no responsibility for the payment of such benefits (except for refunding any participant contributions that were not remitted to an insurer). Nothing in this summary shall be construed or obligate the Company to self-insure any benefits under the Plan.

4. How the Plan is Administered

The primary responsibility for the general administration of the optional hospitalization with ancillary accident benefits is placed with the Plan Administrator. The administrative duties of the Plan Administrator include, but are not limited to, exercising its discretion to interpret the terms of the Plan, prescribing applicable procedures, and gathering information necessary for administering the Plan and for administering eligibility for coverage under the Plan and any Insurance Certificate. The Company will bear its costs of administering the Plan.

The optional hospitalization and ancillary accident benefits are fully insured by the Insurance Company who also serves as the Claims Administrator for these benefits. The Claims Administrator has the discretionary authority to interpret the terms of the Insurance Certificate in order to make benefit determinations concerning eligibility for coverage and benefits under the Plan. The Claims Administrator serves as the claims fiduciary responsible for processing and deciding all claims. No benefit will be payable under the Insurance Certificate unless the Claims Administrator determines the benefit is payable.

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 optional hospitalization and ancillary accident benefits under the Plan and to interpret the terms of these benefits under the Plan. Their determinations and interpretations shall be binding and conclusive on all persons.

If you have any questions regarding your eligibility for, or the amount of, any benefit payable under the Insurance Certificate, please contact the Plan Administrator or the Claims Administrator.

5. Amendment or Termination of the Plan

The Company may amend or terminate all or any part of these benefits offered under the Plan or the Insurance Certificate at any time. The Company has delegated authority to the Director of Benefits, or any successor to this position, to make amendments to these benefits under the Plan that (1) do not significantly increase the costs of the Plan, or (2) are required to be made by law. The Insurance Company may make such changes or modifications to the Insurance Certificate consistent with its agreement with the Company or as required by law. No consent or advance notice to any participant is necessary to amend or change the benefits under the Plan.

6. Continuation of Coverage

Please refer to the Insurance Certificate for detailed information on what coverage, if any, can be continued or converted. You should refer to the Company's leave of absence policies for information on continuing coverage during a leave of absence including a leave of absence taken in accordance with FMLA or USERRA.

7. Insurance Refunds or Rebates

You, any individuals you cover and any beneficiaries are not entitled to any refunds, rebates, discounts or other arrangements based on the actual cost of providing optional hospitalization and ancillary accident benefits. The Employer has complete discretion to apply any payments received from an insurer, including premium rebates based on experience, dividends, and proceeds from demutualization, to reduce its contributions to any welfare program offered under the Plan.

8. Claims Procedures

You, as the claimant, should follow the procedures in the Insurance Certificate and the additional procedures set forth below. The following supplements the procedures set forth in the Insurance Certificate by the Claims Administrator. To the extent there is a conflict between the provisions set forth below, and the Claims Provisions in the Insurance Certificate, the provisions of the Insurance Certificate shall prevail unless such provisions are contrary to applicable law.

(a) **Time for Decision on a Claim**. A claim shall be filed in writing with the Claims Administrator and decided within 90 days by the Claims Administrator unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the benefit determination.

(b) **Notification of Adverse Determination**. Notice of the decision on such claim shall be furnished promptly to the claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to

bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(c) **Right to Review**. A claimant may review all pertinent documents and may request a review by the Claims Administrator of such decision denying the claim. Any such request must be filed in writing with the Claims Administrator within 60 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 60 days will constitute a waiver of the claimant's right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Claims Administrator to consider.

(d) **Review Procedures**. During the review process, the Claims Administrator will provide: (i) the claimant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the claimant within 60 days unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice will describe the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

(f) **Notification of Determination on Review**. Notice of the decision on such claim shall be furnished promptly to the claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (iv) a statement describing any voluntary appeal procedures, if any, offered by the Plan and the claimant's right to obtain additional information about those voluntary review procedures, if any, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

(g) **Legal Remedies**. Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in the Insurance Certificate, such later date.

9. Statement of ERISA Rights

The following “Statement of ERISA Rights” replaces the “Statement of ERISA Rights” in the Insurance Certificate.

As a participant in optional hospitalization and ancillary accident benefits under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan 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 Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, 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 Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and 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 is frivolous.

Assistance with Your Questions

If you have any questions about your 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.

10. General Information

The following "General Information" section regarding the Plan supplements the "Summary Plan Description" section in the Insurance Certificate and replaces any provisions that are duplicative. All other provisions of the "Summary Plan Description" section of the Insurance Certificate shall prevail unless such provisions are contrary to applicable law.

Name of Plan:	McLane Company, Inc. Welfare Plan
Type of Plan:	The Plan is a welfare plan which provides various health and welfare benefit programs. This summary describes only the optional hospitalization benefits that include ancillary accident

	benefits under Plan 2 of the Plan that are applicable to Teammates.
Plan Year:	The calendar year
Plan Number:	502
Funding Medium & Administration	Optional hospitalization and ancillary accident benefits are fully-insured by The Lincoln National Life Insurance Company. The following is the Insurance Company's address, telephone number and website: The Lincoln National Life Insurance Company Group Insurance Service Office 8801 Indian Hills Drive Omaha, NE 68114-4066 Telephone Number: (800) 423-2765 www.LincolnFinancial.com The Insurance Company may change from time-to-time at the discretion of the Plan Administrator. Teammates may be required to pay all or part of the insurance premiums for optional hospitalization and ancillary accident benefits. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request.
Plan Sponsor/Plan Administrator:	McLane Company, Inc. 4747 McLane Parkway Temple TX 76504 (254) 771-7500
Plan Sponsor/Company Identification Number:	74-1478631
Claims Administrator and Insurance Company:	The Lincoln National Life Insurance Company Group Insurance Service Office 8801 Indian Hills Drive Omaha, NE 68114-4066

Telephone Number: (800) 423-2765
www.LincolnFinancial.com

Agent for Service of Legal Process: Same as Plan Administrator

Other Employers that Participate in the Plan: Although the Plan Sponsor or Company is the most significant Employer participating in the optional accident benefits and the optional hospitalization benefits under the Plan, the Plan provides for the possibility of adoption of these benefits by affiliated companies. Participants and covered dependents may, upon written request to the Plan Administrator, receive information as to whether a particular Employer is participating in the Plan and, if so, the address of that Employer.

11. Definitions

Capitalized terms used in this summary have the following meanings:

Actively at Work or 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 is not "terminated."

Company means McLane Company, Inc. or any successor.

Employer means the Company and all affiliated employers and subsidiaries who adopt the optional accident benefits and optional hospitalization benefits offered under the Plan in the form and manner required by the Company.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Insurance Certificate means the insurance certificate that describes the optional hospitalization and ancillary accident benefits that are fully-insured under Policy No.

ACC-0000001412 issued by The Lincoln National Life Insurance Company, and shall include any and all summaries of material modifications, amendments, supplements, schedules, riders or replacement plans or documents, if any.

Insurance Company means The Lincoln National Life Insurance Company, and any successor.

Plan means the McLane Company, Inc. Welfare Plan.

Plan Administrator means the Company or its designee.

Teammate means a person who works for an Employer on a full-time basis, who is currently in Active Service and who satisfies the eligibility provisions of the Insurance Certificate. The term does not include persons who are part-time, on call or temporary, or who normally work less than 30 hours per week for the Employer.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.