MCLANE COMPANY, INC. WELFARE PLAN

KAISER PERMANENTE HMO CORE AND PREMIUM MEDICAL BENEFITS FOR CALIFORNIA TEAMMATES

Summary Plan Description

January 1, 2021

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1. Introduction

This summary describes the core and premium medical benefits provided by Kaiser Foundation Health Plan, Inc. through health maintenance organizations (HMOs) offered by Kaiser Permanente under the McLane Company, Inc. Welfare Plan (the "Plan"). Core medical benefits may be elected under the Northern California Core Evidence of Coverage or the Southern California Core Evidence of Coverage, but only if you meet all eligibility requirements, including Service Area (defined in the applicable Evidence of Coverage) requirements. Premium medical benefits may be elected under the Northern California Premium Evidence of Coverage or the Southern California Premium Evidence of Coverage, but only if you meet all eligibility requirements, including Service Area (defined in the applicable Evidence of Coverage) requirements. However, you may only participate in one of these options at a time.

Many important details about the HMO core and premium medical benefits are contained in the applicable Evidence of Coverage. The applicable Evidence of Coverage 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 applicable Evidence of Coverage, 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 or in the applicable Evidence of Coverage.

This document is only a summary of the HMO core and premium medical benefits offered under the Plan to California Teammates. 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 applicable Evidence of Coverage). If the terms of this document conflict with the terms of such insurance or governing Plan documents, then the terms of the applicable Evidence of Coverage 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, Termination and Rehire Requirements

Eligibility: If you are an eligible, full-time Teammate, you are eligible to elect HMO core or premium medical coverage (subject to any applicable Waiting Period as defined below) and become a Subscriber (as defined in the applicable Evidence of Coverage) if you normally work at least 30 hours per week and meet the additional eligibility requirements set forth in the applicable Evidence of Coverage. If you desire to participate in core medical benefits, please refer to the Northern California Core Evidence of Coverage or the Southern California Core Evidence of Coverage for detailed information regarding additional eligibility requirements, including Service Area requirements. Likewise, if you desire to participate in premium medical benefits, please

refer to the Northern California Premium Evidence of Coverage or the Southern California Premium Evidence of Coverage for detailed information regarding additional eligibility requirements, including Service Area requirements.

As a Subscriber, you may choose to participate in core or premium medical benefits, but when you enroll, you are only eligible if you live or work in the Service Area described in the applicable Evidence of Coverage. For example, if you live or work in the Service Area for the Northern California Region, you may enroll in the core medical benefits described in the Northern California Core Evidence of Coverage or the premium medical benefits described in the Northern California Premium Evidence of Coverage, but you may not enroll in core benefits described in the Southern California Core Evidence of Coverage or in premium benefits described in the Southern California Premium Evidence of Coverage. The same rules apply when you enroll if you live or work in the Service Area for the Southern California Region.

After you enroll, in some circumstances you may be able to continue the coverage you elected even if you no longer live or work in the applicable Service Area for that region. Please refer to the applicable Evidence of Coverage for more information on when this might apply. You may not participate in more than one of these options at a time.

Variable hour Teammates (such as part-time Teammates) hired in 2019 and later must work an average of at least 30 hours per week during a 12- month measurement period in order to be eligible for coverage. If this requirement is met, the variable hour Teammate will be eligible for coverage for a 12-month period. The variable hour Teammate will need to continue to meet this 30-hour per week requirement in order to continue to be eligible for coverage. This determination is made every year, and if the Teammate does not meet the requirement, the Teammate will not be eligible for coverage for the following year.

The initial 12-month measurement period will be based on your date of hire. Each subsequent 12-month measurement period will begin October 15 and end the following October 14 (October to October Period).

The initial 12-month measurement period will start on the first day of the month on or after your date of hire and will end on the last day of the month on or after the one-year anniversary of your hire date. If you meet the 30 hour requirement during your first 12-month measurement period and you timely elect coverage, coverage will begin no later than the first day of the second calendar month on or after the first anniversary of your date of hire and will run for a period of 12 calendar months.

If you meet this requirement in an October to October Period and timely elect coverage, coverage will begin on the January 1 following the end of that October to October Period.

If your average weekly hours worked are less than 30 hours per week, you will not be eligible for coverage. However, you may be able to purchase coverage through the Marketplace.

Here are some examples of how these rules work. These examples assume the Teammate lives or works in the Service Area for the Northern California Region and meets all eligibility requirements to participate in either the core medical benefits described in the Northern California Core Evidence of Coverage or the premium medical benefits described in the Northern California Premium Evidence of Coverage. However, these examples also apply if a Teammate lives or works in the Service Area for the Southern California Region and meets all eligibility requirements to participate in either the core medical benefits described in the Southern California Core Evidence of Coverage or the premium medical benefits described in the Southern California Premium Evidence of Coverage.

Not Eligible during Initial Measurement Period, Becomes Eligible Based on First October to October Period:

- John is hired on June 15, 2019. John's initial measurement period will run from July 1, 2019 through June 30, 2020.

- John works less than 30 hours per week during his initial measurement (July 1, 2019 to June 30, 2020). He is not eligible for coverage.

- John works at least 30 hours per week on average during his first October to October Period (October 15, 2019, through October 14, 2020). He will be eligible to elect core medical coverage as described in the Northern California Core Evidence of Coverage or premium medical coverage as described in the Northern California Premium Evidence of Coverage for the period January 1, 2021 through December 31, 2021.

Eligible during Initial Measurement Period, Continues to Be Eligible Based on the October to October Period:

- John works at least 30 hours per week on average during his initial measurement period (July 1, 2019, through June 30, 2020). He is eligible to elect core medical benefits as described in the Northern California Core Evidence of Coverage or premium medical benefits as described in the Northern California Premium Evidence of Coverage for the twelve-month period starting on August 1, 2020 and ending July 31, 2021.

- John's first October to October Period will be October 15, 2019 through October 14, 2020. John works at least 30 hours per week on average during this period. He will be eligible to elect core medical coverage as described in the Northern California Core Evidence of Coverage or premium medical coverage as described in the Northern California Premium Evidence of Coverage for the period of August 1, 2021 (which begins when his coverage based on his initial measurement period ends) through December 31, 2021.

- John works at least 30 hours per week on average for the next October to October Period (October 15, 2020 through October 14, 2021). He will be eligible to elect core medical coverage as described in the Northern California

Core Evidence of Coverage or premium medical coverage as described in the Northern California Premium Evidence of Coverage for the period January 1, 2022 through December 31, 2022.

Eligible during Initial Measurement Period, Loses Eligibility Based on Subsequent October to October Period:

- John works at least 30 hours per week on average during his initial measurement period (July 1, 2019, through June 30, 2020). He is eligible to elect core medical coverage as described in the Northern California Core Evidence of Coverage or premium medical coverage as described in the Northern California Premium Evidence of Coverage for the twelve-month period starting on August 1, 2020 and ending July 31, 2021.

- John's first October to October Period will be October 15, 2019 through October 14, 2020. John does not work at least 30 hours per week on average during this period. He will not be eligible for medical coverage for the period of August 1, 2021 (which begins when his coverage based on his initial measurement period ends) through December 31, 2021.

- John's next October to October Period will be October 15, 2020 through October 14, 2021. John works at least 30 hours per week on average during this period. He will be eligible to elect core medical coverage as described in the Northern California Core Evidence of Coverage or premium medical coverage as described in the Northern California Premium Evidence of Coverage for the period of January 1, 2022 through December 31, 2022.

Participation and Enrollment: If you are an eligible, full-time Salaried Teammate or Driver, you are eligible to elect coverage on your date of hire if you meet the eligibility requirements, including Service Area requirements described in the applicable Evidence of Coverage for the coverage you are electing. If you are an eligible, full-time Hourly Teammate other than a Driver, you are eligible to elect coverage on the 60th day of Active Service (the 59 day period following your date of hire is known as the Waiting Period) if you meet the eligibility requirements, including Service Area requirements described in the applicable Evidence of Coverage for the coverage you are electing.

If you are an eligible, full-time Teammate who was previously covered under one of these medical options and your coverage ceased, or if your coverage ceased because you were no longer employed as an eligible Teammate, you are not required to satisfy any Waiting Period if you again become an eligible Teammate within 90 days after the date your coverage originally ceased.

Teammates residing in any country outside the United States who return to permanently reside in the United States immediately gain eligibility for coverage when the Teammate begins to reside in the HMO Service Area and is otherwise eligible for coverage.

Salaried Teammates and Drivers must complete the enrollment process within 30 days of becoming eligible. Hourly Teammates other than Drivers must complete the enrollment

process before the end of the Waiting Period. Otherwise, the Teammate will have to wait until the next annual Open Enrollment Period to enroll (unless a special enrollment event applies). Open Enrollment Period elections go into effect at the beginning of the next Plan Year. The enrollment process must be completed in the form and manner required by the Company. You will become covered on the first day that you are eligible following your election if you are in Active Service on that date. An exception to the Active Service requirement will be made if you are not in Active Service on that date due to a Health Status-Related Factor. However, no coverage will be offered until you complete one day of Active Service.

Please refer to the Northern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, the Southern California Core Evidence of Coverage or the Southern California Premium Evidence of Coverage, as applicable, for additional information regarding enrollment procedures.

Dependent Coverage: You may cover your Dependents (as defined in the applicable Evidence of Coverage) effective on the day you become eligible for coverage for yourself, or if later, the day you acquire a new Dependent. However, grandchildren and foster children are eligible for coverage if you or your spouse is the court-ordered legal guardian of the grandchild or foster child.

Dependent children are generally not required to live in the Service Area, but some Dependents may not be eligible for coverage if they do not live in or move out of the Service Area. Please refer to the applicable Evidence of Coverage for additional information regarding your ability to cover your Dependents under the applicable Evidence of Coverage.

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

Dependents residing in any country outside the United States who return to permanently reside in the United States immediately gain eligibility for coverage when the Dependent begins to reside in the applicable HMO Service Area and is otherwise eligible for coverage.

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 applicable Evidence of Coverage, 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.

Special Enrollment Events: Unless you intend to enroll in the Marketplace or Exchange coverage, your elections and coverage under the applicable Evidence of Coverage cannot be changed during the Plan Year unless the coverage or election change is permitted as a "special enrollment" event under the applicable Evidence of Coverage. However, if you intend to enroll in a qualified health plan through the Marketplace or Exchange, you may elect to drop coverage under the HMO core medical option or the HMO premium medical option, as applicable, if you are eligible to buy coverage in the Marketplace or Exchange. You (and any of your Dependents who were covered under the HMO core medical option or HMO premium medical option, as applicable, prior to the revocation of your election) must intend to enroll in coverage under a Marketplace or Exchange no later than the first day of the second month following the month that includes your revocation of coverage under the HMO core medical option or HMO premium medical option, as applicable.

Please refer to the applicable Evidence of Coverage for important information on "special enrollment" events, including how and when changes must be requested for "special enrollment" events.

Termination of Participation: Your participation and the participation of your Dependents covered under the applicable Evidence of Coverage 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 applicable Evidence of Coverage. HMO core medical benefits or HMO premium medical benefits, as applicable, will also cease upon termination of the Plan or upon termination of that particular benefit under the Plan in accordance with the applicable Evidence of Coverage. Please refer to the applicable Evidence of Coverage for other circumstances that can result in the termination, reduction, recovery, loss, or denial of benefits.

Rehired Teammates: If you are rehired and your rehire date is within 90 days from your prior termination date and within the same Plan Year, you will be automatically enrolled in the same plan option in which you previously elected, if any. You will not be subject to new eligibility waiting periods or new cost sharing provisions, such as deductibles and out-of-pocket maximum accumulations, if any. Your required contribution for the HMO medical coverage will be deducted from your pay on a pre-tax basis beginning with your first paycheck upon rehire.

If you are rehired and your rehire date is later than 90 days from your prior termination date or if you are rehired in a subsequent Plan Year, you may re-enroll, but you will be considered a new Teammate, subject to a new eligibility waiting period and subject to new cost sharing provisions, such as deductibles and out-of-pocket maximum accumulations, if applicable.

3. Summary of Benefits, Limitations, Costs and Coordination of Benefits

At your election, the Plan provides you with either (i) HMO core medical benefits under the Northern California Core Evidence of Coverage or the Southern California Core Evidence of Coverage, or (ii) HMO premium medical benefits under the Northern California Premium Evidence of Coverage or the Southern California Premium Evidence of Coverage, but only if you meet all eligibility requirements, including the Service Area requirements set forth in the applicable Evidence of Coverage. The Plan may provide your eligible Dependents, if any, with the opportunity to participate in HMO core or HMO premium medical benefits, but only as described in the applicable Evidence of Coverage.

As HMOs, these Plan options generally require that you obtain benefits from certain providers within a specified Service Area with some exceptions such as emergency services. Please be sure you refer to the applicable Evidence of Coverage for information on plan providers, the Service Area, benefits, limitations, exclusions, and coordination of benefits.

You may be required to pay all or part of the cost or premium for HMO core or premium medical benefits for you and your eligible Dependents, if any. Your Employer will determine and periodically communicate to you your share of the cost of these benefits. Your Employer will pay its contribution and your contributions to the Insurer. 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.

In addition to the premium costs described above, you may also be required to meet a deductible and other cost sharing requirements such as coinsurance and copayments before benefits are paid for certain services. Please refer to the applicable Evidence of Coverage to determine your additional cost sharing requirements and to determine your out-of-pocket maximum.

Important Note about Benefits: Benefits provided under the Plan pursuant to the applicable Evidence of Coverage or pursuant to governing Plan documents adopted by the Company shall only be paid to the extent determined by the 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 HMO core and premium medical 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 the applicable Evidence of Coverage. The Company will bear its costs of administering the Plan.

The HMO core and premium medical benefits are fully-insured by the Insurer who also serves as the Claims Administrator for these benefits. The Claims Administrator has the discretionary authority to interpret the terms of the applicable Evidence of Coverage 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 Northern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, the Southern California Core Evidence of Coverage or the Southern California Premium Evidence of Coverage 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 HMO core and premium medical 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 applicable Evidence of Coverage, 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 applicable Evidence of Coverage 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 Insurer may make such changes or modifications to the Northern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, the Southern California Core Evidence of Coverage and the Southern California Premium Evidence of Coverage consistent with its agreement with the Company or as required by law. No consent from any Subscriber is necessary to amend or change the benefits under the Plan.

6. COBRA Coverage

This communication is provided as part of a legal requirement to advise you of your COBRA coverage rights, in the event you or your covered Dependents should have the need for COBRA coverage in the future. No action is required at this time. However, you are responsible for keeping the Company aware of changes that occur such as addresses (for both you and your Dependents), divorce, your spouse's eligibility for Medicare, etc.

In accordance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), the HMO core and premium medical benefits under this Plan offer you and your covered family members the

opportunity to extend existing health coverage (COBRA) when your current Employer provided coverage ends due to a Qualifying Event. Read this notice carefully as you and your covered Dependents each have an independent right to elect or reject COBRA. For example, if you reject COBRA coverage, your spouse and/or Dependents may still elect COBRA for themselves. If your Dependents are minor children, either you or your spouse may elect or reject COBRA on their behalf.

Retain this notice in your permanent records. It is your responsibility to keep the Company informed of any address change in a timely manner in order to receive all information about COBRA prior to or after a COBRA election.

(a) **Qualifying Events that Entitle me to Elect COBRA Coverage**.

If you are a Teammate, you have a right to elect COBRA coverage beginning from the date coverage is lost due to:

- A reduction in hours; or
- Termination of employment.

Your spouse has the right to elect COBRA beginning from the date coverage is lost due to:

- Your death;
- Your termination of employment;
- Your reduction in hours;
- Divorce or legal separation; or
- You become entitled to Medicare.

Your Dependent Child has the right to elect COBRA beginning from the date coverage is lost due to:

- Your death;
- Your termination of employment;
- Your reduction in hours;
- Divorce or legal separation of Teammate;
- You become entitled to Medicare; or
- Dependent Child no longer qualifies as a Dependent.

(b) **COBRA Coverage Requirements.** COBRA coverage is coverage identical to coverage provided by the Company for similar Teammates or family members. In most cases, you will have the same coverage under COBRA as you did before a Qualifying Event occurred. You may continue medical coverage under the HMO core or premium medical benefit options. COBRA is subject to eligibility and the Plan Administrator reserves the right to terminate COBRA coverage retroactively if you are found ineligible. This applies even if a COBRA payment has been accepted.

(c) **Adding a Newborn, Newly Adopted Child, Child Who has Been Placed for Adoption to my COBRA Coverage**. You may add a newborn, newly adopted

child, or a child Placed for Adoption with you to your COBRA coverage within 60 days of the occurrence. If you enroll a newborn, adopted child, or child Placed for Adoption who later loses coverage as a result of a Qualifying Event, they are considered a "qualified beneficiary" with independent COBRA election rights.

(d) **COBRA Coverage Notice Requirements**. To obtain COBRA, you, your family members and the Company or the Plan Administrator must satisfy certain notification requirements. This means that you or your family members must notify the Company or the Plan Administrator at the address set forth below in **Section 6(m)** of certain Qualified Events described in this Section. Notice must be given within 60 days of the later of the Qualifying Event or the date coverage ends. If you fail to timely and properly provide this notice, you will lose the right to elect COBRA coverage and your right to continue medical coverage will end. You must provide notice to the Company or the Plan Administrator of these Qualifying Events:

- Your divorce or legal separation; or
- Your Dependent loses Dependent status.

The Company or the Plan Administrator will notify you and your covered qualified beneficiaries, as appropriate, of the right to continue coverage under COBRA within 44 days after the date coverage ends due to one of the Qualifying Events:

- Your death;
- Your termination of employment;
- Your reduction in hours;
- Your becoming entitled to Medicare; or
- Company's bankruptcy.

You have 60 days from the later of the date you lose coverage due to a Qualifying Event or the date the Company or the Plan Administrator informs you of your right to elect COBRA coverage. If you do not elect COBRA coverage within this 60-day period, your option to elect HMO core medical coverage or HMO premium medical coverage, as applicable, ends.

The duration of COBRA coverage depends on the reason coverage was lost. Once you elect COBRA, it is imperative that you make timely payments and comply with any other requirements set forth by the COBRA laws:

Qualifying Event	**Possible COBRA Period (Months)**
Termination of Employment	UP TO 18 months
Reduction in Hours	UP TO 18 months
Disability	UP TO 29 months
Divorce or Legal Separation	UP TO 36 months
Death	UP TO 36 months
Loss of Dependent Child Status	UP TO 36 months
Medicare Entitlement	UP TO 36 months

Special rules apply to extend COBRA coverage based on successive Qualifying Events as well as Social Security disability. If you are a spouse or Dependent of a Teammate, COBRA may be extended for up to a total of 36 months from the loss of coverage following the original date of the Teammate's termination or reduction in hours, if successive Qualifying Events occur. COBRA will not last beyond 36 months from the loss of coverage following the date of the original Qualifying Event that made the individual eligible for COBRA. A successive Qualifying Event is:

- Death of Teammate;
- Divorce or legal separation;
- Medicare entitlement; or
- Loss of Dependent status.

Successive Qualifying Events must occur within the original 18- month COBRA period and you must notify the Company or the Plan Administrator in writing within 60 days of a successive qualifying event. If you do not provide this notice timely, the right to extend coverage is lost.

COBRA may be extended for up to a total of 29 months if you, your spouse or your Dependent child is disabled as determined by the Social Security Administration on one of the following:

- Your date of termination or reduction in hours
- Within the first 60 days of the 18-month COBRA period.

You must notify the Company or the Plan Administrator of the Social Security Administration's determination within 60 days of receiving such determination and before the end of the original 18-month maximum COBRA period that applies to the Qualifying Event. You must also provide the Company or the Plan Administrator with a copy of the Notice of Award letter from the Social Security Administration. If this notice is not provided timely, the right to extend coverage for up to 29 months is lost.

Note: You or your family members must notify the Company or the Plan Administrator within 31 days of any final determination by the Social Security Administration indicating the individual is no longer disabled. If the individual is no longer disabled, COBRA ends at the end of the original 18-month period or the end of the current month, if the current month is after the original 18-month period.

(e) **COBRA and Medicare Entitlement**. If you become entitled to Medicare during the 18-month period prior to a termination of employment or reduction in hours, COBRA may be extended for your covered spouse and Dependents up to 36 months from the date of Medicare entitlement. For example, if you become entitled to Medicare and terminate employment 6 months later, your qualified beneficiaries are entitled to elect COBRA for up to 30 months from the date of termination.

(f) **COBRA and Trade Assistance Entitlement**. If you terminate employment from the Company and you fail to elect continuation benefits, and you later become eligible for trade assistance (as that term is defined in the Trade Act of 2002),

you may be eligible to re-elect continuation benefits. Please see the Company for more details if you think you may be affected.

(g) **Paying for COBRA Coverage**. You pay 100% of the monthly premium for COBRA coverage and the Company may charge a 2% administration fee unless you are eligible for the trade assistance subsidy explained in the Section above. If you or your family members are entitled to a continuation based on disability, the Company may charge you 150% of the monthly premium during the additional up-to-11-month coverage period.

(h) **COBRA and Special Enrollment Periods**. COBRA may allow you to take advantage of "Special Enrollment Periods" in your new employer's plan. Employer plans are required to have special enrollment periods for individuals who did not elect coverage when first eligible because they had COBRA coverage. Specifically, if certain requirements are met, an employer's Plan must allow such individuals to enroll in the plan within 30 days after exhausting COBRA coverage.

(i) **Election and Payment Deadlines.** You have 60 days to elect COBRA coverage from the later of the date you lose coverage due to a Qualifying Event or the date the Company or the Plan Administrator informs you of your right to elect COBRA coverage. If you do not elect COBRA coverage within this 60-day period, your option to elect coverage under an HMO medical benefit ends.

All retroactive payments are due within 45 days after your COBRA election is received and processed. COBRA coverage cannot be verified until the election form and the retroactive payment are received. Your initial payment must cover the entire period from the date of the Qualifying Event to the current date. For example, if you elect COBRA on the last day of the 60-day election period, your initial payment is for the first 2 months of COBRA coverage.

Generally, premiums are due on the 1st of the month and must be paid by personal or certified check. However, there is a 30-day grace period for payment. To qualify for the grace period, your payment must be postmarked or received by the Company or the Plan Administrator no later than 30 days after the due date.

(j) **COBRA Coverage can Terminate Early.** If you are a Teammate or spouse or Dependent of a Teammate, COBRA may end early for any of the following reasons:

- Employer no longer provides group health coverage;
- Premium is not paid on time;
- You become covered under another plan;
- You become entitled to Medicare; or
- Coverage was extended due to disability and there is a final determination by the Social Security Administration that you are no longer disabled.

(k) **Conversion to an Individual Policy**. Please refer to the applicable Evidence of Coverage for detailed information on what coverage, if any, can be converted.

(l) **Other Continuation of Coverage Options**. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. You may be eligible for Medicaid. Additionally, you may qualify for a special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You may also be eligible to continue coverage under a state continuation option. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistor in your area who you can talk to about the different options, visit www.HealthCare.gov. For more information on the availability of a state continuation option, please refer to the applicable Evidence of Coverage.

(m) **Questions and Contact Information.** You should provide written notice to the Company or the Plan Administrator of certain Qualifying Events as described in **Section 6(d)** above at the following address:

McLane Company
4747 McLane Parkway
P.O. Box 6115
Temple, TX 76503-6115

You may also contact the Plan Administrator at 1-254-771-7500 or 1-888-463-6089 if you have any questions concerning COBRA coverage. In addition, it is your responsibility to keep the Plan Administrator informed of any change of address for you or any of your covered Dependents since information concerning your COBRA rights will be sent to your last known address.

7. Leaves of Absence

The HMO core and premium medical benefits comply with the Family and Medical Leave Act of 1993 ("FMLA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). You should refer to the Company's leave of absence policies for information on continuing coverage during a FMLA or USERRA leave of absence.

8. Qualified Medical Child Support Orders

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

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to

a state domestic relations law, or a National Medical Support Order (as defined by section 609(a)(5)(C) of ERISA), which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states 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 Qualified Medical Child Support Order may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except that an order may require the Plan to comply with state laws regarding child health care coverage. If you need additional information concerning Qualified Medical Child Support Orders, please contact the Plan Administrator for a copy of the Plan's Qualified Medical Child Support Order procedures, which will be furnished to you free of charge.

The child (and you, if you are not already enrolled) will be automatically enrolled in the core medical benefits under either the Northern California Core Evidence of Coverage or the Southern California Core Evidence of Coverage depending upon the Service Area in which you live after the order has been determined to be a Qualified Medical Child Support Order. Although the Plan may receive the medical child support order from another party, you are still required to notify your local Human Resources Department of the order. Please contact your local Human Resources Department to get a "Qualifying Event Change Form," complete the form, attach a copy of the order and return it to your local Human Resources Department.

9. Nondiscrimination Requirements

Neither you nor your Dependents will be denied enrollment for HMO core or premium medical benefits due to a Health Status-Related Factor. Federal law and the HMO core and premium medical benefits offered under this Plan prohibit any discrimination in eligibility or cost of coverage because of one or more Health Status-Related Factors.

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

10. 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 HMO core or premium medical 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.

11. Claims Procedures

You, as the claimant, or your authorized representative, should follow the procedures in the applicable Evidence of Coverage and, if applicable, the additional procedures set forth below. The following supplements the claims procedures set forth in the Northern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, the Southern California Core Evidence of Coverage and the Southern California Premium Evidence of Coverage. To the extent there is a conflict between the provisions set forth below, and the Claims Provisions in the applicable Evidence of Coverage, the provisions of the applicable Evidence of Coverage shall prevail unless such provisions are contrary to applicable law.

(a) Claims Procedure for Health Benefits.

(1) Pre-Service Claims.

(i) *Urgent Care Claims*. If a person or his or her duly authorized representative files a "pre-service claim" which is an "urgent care claim" under the Plan, the Claims Administrator shall notify the claimant of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the claimant fails to provide sufficient information for the Plan to make a determination. A "pre-service claim" means any claim for health benefits under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An "urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain

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

If the information received by the Plan is insufficient for the Plan to make a determination, the Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. In such case, the claimant shall be afforded at least 48 hours to provide the specified information. The Claims Administrator shall notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of:

(A) the Plan's receipt of the specified information; or

(B) the end of the period afforded the claimant to provide the specified additional information.

The Claims Administrator may notify the claimant of its decision orally, in writing or electronically within the applicable 48 hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to the claimant not later than three (3) days after the oral notification.

(ii) *Non-Urgent Care Claims*. A person or his or her duly authorized representative, as determined by the Claims Administrator, may file a written claim with the Claims Administrator for a determination of benefits for a "pre-service claim" that is not an "urgent care claim."

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

(iii) *Failure to Follow Pre-Service Claims Procedures*. If a person or his or her duly authorized representative, as determined by the Claims Administrator, submits the claimant's name, specific medical condition, and specific treatment, service or product to a person or unit customarily responsible for handling Plan benefits matters, but fails to follow the Plan's procedures for pre-service claims, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an urgent care claim) following the failure. Notification may be oral unless written notification is requested by the claimant.

(2) Concurrent Care Claims. A person or his or her duly authorized representative, as determined by the Claims Administrator, may file a claim with the Claims Administrator for a determination of benefits for "concurrent care." "Concurrent care" means any ongoing course of treatment approved by the Plan to be provided over a period of time or number of treatments.

(i) *Non-Urgent Care Claim.* If there is any reduction or termination by the Plan of concurrent care (other than by Plan amendment or termination) before the end of such approved period of time or number of treatments which does not involve an urgent care claim, the Claims Administrator will notify the claimant of such reduction or termination within a reasonable period of time not less than such period communicated on a uniform and nondiscriminatory basis to the participants and designated by the Claims Administrator before any such reduction or termination; provided, however, that in the absence of any designation by the Claims Administrator, the Claims Administrator will notify the claimant not less than fifteen (15) days before any such reduction of termination.

(ii) *Urgent Care Claim.* If a claimant makes a request to extend the course of treatment beyond the period of time or number of treatments for an urgent care claim, the Claims Administrator shall make a claim determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim by the Plan provided that any such claim must be made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

The Claims Administrator may notify the claimant of its decision orally, in writing or electronically within the 24 hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to the claimant not later than three (3) days after the oral notification.

(3) Post-Service Claims. If any person believes that he is being denied any rights to benefits under the Plan for a "post-service claim," such person or his or her duly authorized representative may file a written claim with the Claims Administrator. "Post-service claim" means any claim for health benefits under the Plan which is not a "pre-service claim" as defined above.

Notification of a claim denial will be given within a reasonable time, but not later than thirty (30) days after the claim is received by the Claims Administrator. If the claimant does not receive written notice that the claim has been denied within the initial thirty (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 the claimant may request a review of his or her claim.

(b) **Extensions in the Case of Initial Determinations of Post-Service Claims and Non-Urgent Pre-Service Claims**.

For post-service claims and non-urgent pre-service claims, the claim denial time period may be extended once for up to fifteen (15) days, provided that the Claims Administrator both determined (i) that such extension is needed and beyond the Claims Administrator's control and (ii) notifies the claimant of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision prior to the expiration of (a) the initial permissible response period of forty-five (45) days (b) the initial permissible response period of fifteen (15) days for pre-service claims, or (c) the initial permissible response period of thirty (30) days for post-service claims. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (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 the claimant responds to the request for additional information, or (ii) the last day of the forty-five (45) day period. Once the claimant has provided the additional information or, if earlier, the forty-five (45) day period has ended, the benefit determination period shall recommence. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

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

(c) **Notification Requirements for All Claims**.

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

(i) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable,

(ii) the denial code and its corresponding meaning,

(iii) a description of the Plan's standard, if any, used to deny the claim,

(iv) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning,

(v) the specific reason or reasons for the adverse determination,

(vi) the specific reference to Plan provisions on which the determination is based,

(vii) a description of any additional material or information necessary for the person to perfect his or her claim and an explanation of why such material or information is necessary,

(viii) information as to the steps to be taken if the claimant wishes to submit a request for review, including applicable time limits,

(ix) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman, if any, established to assist individuals with claims, and

(x) the claimant's right to bring a civil action under section 502(a) of ERISA.

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

(d) **Review Procedures**.

(1) Time Period for Review. Within one hundred and eighty (180) days after the date that the claimant receives notice of a claim denial for benefits under the Plan, or if applicable, within one hundred and eighty (180) days after the date on which such denial is deemed to have occurred, the claimant or his or her duly authorized representative may file a request that the Claims Administrator review his or her denied claim.

For concurrent claims, the claimant or his or her duly authorized representative may file a written request with the Claims Administrator for a review of his or her denied claim on or before the date his or her benefits are reduced or terminated. Such request must be filed within a reasonable time but not later than such period communicated on a uniform and nondiscriminatory basis to the participants and designated by the Claims Administrator before a concurrent claim benefit is reduced or terminated; provided,

however, that in the absence of any designation by the Claims Administrator, such request must be filed not later than five (5) days before any such reduction of termination.

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

(2) Review Standards. This Plan provides for one level of internal appeal for all benefits. In order for a claimant to pursue his or her rights as explained in the "Legal Remedies" section below, he must first exhaust his or her appeal rights. The claimant and/or his or her authorized representative may inspect or request, free of charge, relevant documents and submit written comments, documents, records, and other information to the Claims Administrator for review of his or her claim. The review of the claimant's 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.

(3) Procedures Applicable to Appeals. If a decision is based in whole or part on a medical judgment, the appropriate person(s) determining the appeal 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 the claimant with such information regarding such health care professionals as the Claims Administrator determines is appropriate. Upon request, the claimant shall be provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Claims Administrator relied upon the expert's advice.

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

(i) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable),

(ii) the denial code and its corresponding meaning,

(iii) a description of the Plan's standard, if any, used to deny the claim and a discussion of the decision,

(iv) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning),

(v) the specific reason or reasons for the denial,

(vi) specific references to Plan provisions on which the benefit determination is based,

(vii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits,

(viii) a statement describing any voluntary appeals offered by the Plan, including information concerning the procedures of the voluntary appeal that would allow the claimant to make an informed decision about whether to appeal and such other information which the Claims Administrator determines is appropriate regarding alternative dispute resolution options,

(ix) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman, if any, established to assist individuals with claims,

(x) a statement of the claimant's right to bring an action under section 502(a) of ERISA,

(xi) a statement that the Protocols, if any, were relied upon in making the decision and that a copy of the Protocols will be available free of charge upon request, and

(xii) a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon request by the claimant.

(5) Response Dates on Appeal.

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

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

(iii) For concurrent claims, the decision on review will be made before the concurrent claim benefit is reduced or terminated.

(iv) For a post-service claim, the decision on review will be made within sixty (60) days after the request for review is received by the Claims Administrator. If the claimant does not receive notice of the decision within the sixty (60) day period, as may be extended, the claim shall be deemed to have been denied on review.

(e) **Written or Electronic Notifications**. All notifications from the Claims Administrator shall be either written or electronic. Electronic notification shall comply with standards imposed by the Claims Administrator consistent with applicable guidance. This written or electronic notification can be included as part of the expedited method used as provided above.

(f) **External Claims Review**. An external claims review may be available for certain medical claims under the applicable Evidence of Coverage. Claimants should refer to the external claims review procedures set forth in the applicable Evidence of Coverage for information regarding these procedures.

(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 applicable Evidence of Coverage, such later date.

12. ERISA Notices

The following are important notices that are in addition to the important ERISA Notices in the applicable Evidence of Coverage.

Medicaid

The HMO core and premium medical benefits of the Plan will not take into account your eligibility or your Dependents' eligibility for health assistance or benefits payable under 42 U.S.C. § 1396 et seq., except as necessary to comply with the special enrollment rights under Medicaid and CHIP.

Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008

The HMO core and premium medical benefits of the Plan will comply with the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 with respect to mental health and substance use benefits.

Medicare

Unless you elect Medicare as your primary plan, the HMO core or premium medical benefits, as applicable, under this Plan will pay first for:

- You, if you are an active Teammate who is age 65 and over; or
- Your Dependent spouse age 65 and over, if you are an active Teammate; or

- Your disabled Dependent under age 65, if you are an active Teammate; or

- the number of months as specified by regulation of the Centers for Medicare and Medicaid Services for treatment of end stage renal disease received by any participant; unless the participant rejects, in writing, HMO core or premium medical coverage under this Plan..

Special rules apply when you are covered by the HMO core and premium medical benefits under this Plan and by Medicare. Generally, the HMO core and premium medical benefits under the Plan is a primary plan if you are an active Teammate, and Medicare is a primary plan if you are a retired Teammate.

13. Statement of ERISA Rights

The following "Statement of ERISA Rights" is added to the Northern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, the Southern California Core Evidence of Coverage, and the Southern California Premium Evidence of Coverage.

As a participant in the HMO core or premium medical 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 Plan 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 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. 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.

14. General Information

The following “General Information” section regarding the Plan supplements the Northern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, the Southern California Core Evidence of Coverage, and the Southern California Premium Evidence of Coverage and replaces any provisions that are duplicative. All other provisions of the applicable Evidence of Coverage 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 HMO core and premium medical benefits offered under the Plan that are applicable to Teammates in California.
Plan Year:	The calendar year
Plan Number:	502
Funding Medium & Administration	The HMO core and premium medical benefits are fully-insured by the Insurer. The following is the Insurer's name, address, telephone number and website: Kaiser Foundation Health Plan, Inc. Claims Administration – SCAL P.O. Box 7004 Downey, CA 90242-7004 1-800-464-400 (TTU users call 711) Kaiser Permanente Claims Administration - NCAL P.O. Box 24010 Oakland, CA 94623-1010 Access website at kp.org The insurer of these benefits 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 HMO core and premium medical 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 Insurer:	Kaiser Foundation Health Plan, Inc.

	Claims Administration - SCAL P.O. Box 7004 Downey, CA 90242-7004 1-800-464-400 (TTU users call 711) Kaiser Permanente Claims Administration - NCAL P.O. Box 24010 Oakland, CA 94623-1010 Access website at kp.org Please also refer to the applicable Evidence of Coverage for additional information on HMO medical benefits.
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 HMO core and premium medical 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.

15. 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.

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

Employer means the Company and all affiliated employers and subsidiaries who adopt the HMO core and premium medical 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.

Evidence of Coverage means, collectively, the Northern California Core Evidence of Coverage, the Southern California Core Evidence of Coverage, the Northern California Premium Evidence of Coverage, and the Southern California Evidence of Coverage.

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

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Health Status - Related Factor means the following factors:

- health status,
- medical condition (include both physical and mental illnesses),
- claims experience,
- receipt of health care,
- medical history,
- Genetic Information,
- evidence of insurability (including conditions arising out of acts of domestic violence), and
- disability.

Insurer means Kaiser Foundation Health Plan, Inc., a California nonprofit corporation, which is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care, and any successor.

Kaiser Permanente means Insurer, Kaiser Foundation Hospitals, a California nonprofit corporation, and The Southern California Permanente Medical Group, a for-profit professional partnership.

Northern California Core Evidence of Coverage means the Evidence of Coverage for the Kaiser Permanente Traditional HMO Plan for the Northern California Region, together with the Group Agreement executed by Insurer and the Company that describes the HMO core medical benefits that are fully-insured by the Insurer and provided by Kaiser Permanente. The Northern California Core Evidence of Coverage shall include any and all summaries of material modifications, amendments, supplements, schedules, riders or replacement plans or documents, if any.

Northern California Premium Evidence of Coverage means the Evidence of Coverage for the Kaiser Permanente Deductible HMO Plan for the Northern California Region, together with the Group Agreement executed by Insurer and the Company that describes the HMO premium medical benefits that are fully-insured by the Insurer and provided by Kaiser Permanente. The Northern California Premium Evidence of Coverage shall include any and all summaries of material modifications, amendments, supplements, schedules, riders or replacement plans or documents, if any.

Open Enrollment Period means the recurring time period each year usually held during the fall when Teammates can enroll in medical benefits for the Plan Year immediately following the recurring time period.

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

Plan means the McLane Company, Inc. Welfare Plan.

Plan Administrator means the Company or its designee.

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

Southern California Core Evidence of Coverage means the Evidence of Coverage for the Kaiser Permanente Traditional HMO Plan for the Southern California Region, together with the Group Agreement executed by Insurer and the Company that describes the HMO core medical benefits that are fully-insured by the Insurer and provided by Kaiser Permanente. The Southern California Core Evidence of Coverage shall include any and all summaries of material modifications, amendments, supplements, schedules, riders or replacement plans or documents, if any.

Southern California Premium Evidence of Coverage means the Evidence of Coverage for the Kaiser Permanente Deductible HMO Plan for the Southern California Region, together with the Group Agreement executed by Insurer and the Company that describes the HMO premium medical benefits that are fully-insured by the Insurer and provided by Kaiser Permanente. The Southern California Premium Evidence of Coverage shall include any and all summaries of material modifications, amendments, supplements, schedules, riders or replacement plans or documents, if any.

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 applicable Evidence of Coverage. 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.