MCLANE COMPANY, INC. WELFARE PLAN

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT AND LONG TERM DISABILITY BENEFITS

FOR SALARIED TEAMMATES

Summary Plan Description

January 1, 2021

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1. Introduction

If you are a Salaried Teammate, this summary describes the life and accidental death and dismemberment benefits ("Life and AD&D Benefits") and the long term disability benefits (the "LTD Benefits") offered to you under the Plan.

Many important details about the Life and AD&D Benefits and LTD 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 Life and AD&D Benefits and LTD Benefits offered to Salaried Teammates 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: If you are a Salaried Teammate, you are eligible to participate in Life and AD&D Benefits and LTD Benefits offered under the Plan as described in the Insurance Certificate. Please refer to the Insurance Certificate for detailed information regarding your eligibility to participate in these benefits.

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

Dependent Coverage: Your dependents, if any, may be eligible to participate in the optional Life and AD&D Benefits to the extent described in the Insurance Certificate. Dependents are not eligible to participate in basic Life and AD&D Benefits or LTD Benefits. 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 Salaried 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. Life and AD&D Benefits and LTD 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 Life and AD&D Benefits and LTD Benefits as described in the Insurance Certificate. The Plan may provide your eligible dependents, if any, with the opportunity to participate in these 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 Life and AD&D Benefits and LTD 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: Life and AD&D Benefits and LTD Benefits provided under the Plan pursuant to the Insurance Certificate, insurance contracts or pursuant to governing Plan documents adopted by the Company shall only be paid to the extent determined by the Insurance Company. 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 Life and AD&D Benefits and LTD 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 Life and AD&D Benefits and LTD 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 Life and AD&D Benefits and LTD 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 Life and AD&D Benefits and LTD 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 or your dependent(s), 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 for 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 may be filed in writing with the Claims Administrator and will generally be decided within 90 days (45 days in the case of a disability claim) after receipt by the Claims Administrator.

For claims other than disability claims, this time period may be extended for a period of up to 90 days if the Claims Administrator determines that an extension of time for processing is required, written notice of the extension is furnished to you prior to the termination of the initial 90-day period and the extension notice indicates the time and the date by which the Claims Administrator expects to render the benefit determination.

For disability claims, this time period may be extended twice for up to 30 days each time if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the extension. For the first 30-day extension the Claims Administrator must notify you of the extension before the end of the initial 45-day period of the circumstances requiring the extension and the date the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the

determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you prior to the end of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In each case, 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.

If additional information is needed, you will have at least 45 days within which to provide the specified information and the benefit determination period will be put on hold until the earlier of the date you respond with the information or the end of the 45-day period. Once you have provided the additional information or the 45-day period has ended, the benefit determination period shall recommence.

(b) **Notification of Adverse Determination**. Notice of the decision on such claim shall be furnished promptly to you. 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 you 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 your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

In addition to items (i) – (iv) above, the notice of the adverse benefit determination for disability claims shall include the following:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views you presented to the plan of health care professionals treating you and the vocational professionals who evaluated you;

- the views of medical or vocational experts whose advice was obtained by the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- your disability determination made by the Social Security Administration if you submitted such a determination to the Plan;

(ii) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

(iii) If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iv) Either the specific internal rules, guidelines, protocols, standards or other similar criteria ("Protocols") of the Plan relied upon in making the adverse determination or, alternatively, a statement that such Protocols do not exist.

For disability claims, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(c) **Right to Review**. You 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 (for disability claims, within 180 days) after you receive written notice of the decision. A failure to file a request for review within 60 days (for disability claims, within 180 days) will constitute a waiver of your right to request a review of the denial of the claim. Such written request for review should contain all additional information that you want the Claims Administrator to consider.

(d) **Review Procedures**. During the review process, the Claims Administrator will provide:

(i) You with the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits;

(ii) That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

(iii) For a review that takes into account all comments, documents, records, and other information submitted by you that relate to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

With respect to disability claims, in addition to the review process above, the review process shall also provide:

(i) For a review that does not afford deference to the initial adverse benefit determination and is conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(ii) To the extent any adverse benefit determination is based in whole or in part on a medical judgment, that the Claims Administrator shall consult with a health care 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;

(iii) For the identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iv) To you, free of charge and as soon as possible and sufficiently in advance of the date on which the adverse benefit determination is issued to give you a reasonable opportunity to respond prior to that date:

- any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination, and

- any new or additional rationale upon which the adverse benefit determination is based on.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to you within 60 days (for disability claims, within 45 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 you prior to the termination of the initial 60-day (for disability claims 45-day) period. In no event shall such extension exceed a period of 60 days (for disability claims, 45 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 you. 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 you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant your claim for benefits; and

(iv) A statement describing any voluntary appeal procedures, if any, offered by the Plan and your right to obtain additional information about those voluntary review procedures, if any, and a statement of your right to bring an action under Section 502(a) of ERISA.

For disability claims, in addition to the items in (i) through (iv) above, the adverse benefit determination notification will include the following:

(i) In the statement of your right to bring an action under Section 502(a) of ERISA, such statement shall also describe any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(ii) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you;

- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- your Social Security Administration disability determination that you present to the Plan.

(iii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of change upon request; and

(iv) either the specific Protocols relied upon in making the adverse determination or, alternatively, a statement that such Protocols do not exist.

In the case of an adverse benefit determination with respect to a disability claim, the notification will be provided in a culturally and linguistically appropriate manner. If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary in connection with a disability claim, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon your request, provide a notice in that non-English language; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

(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

As a participant in Life and AD&D Benefits and LTD 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 employee benefit 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 replaces the "Important Information About the Plan" subsections in the "Supplemental Information" sections of the Insurance Certificate that describes the Life and AD&D Benefits and LTD Benefits.

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 Life and AD&D Benefits and the LTD Benefits of the Plan that are applicable to Salaried Teammates.
Plan Year:	The calendar year
Plan Number:	502
Funding Medium & Administration	Life and AD&D Benefits and LTD Benefits are fully-insured by Lincoln Life Assurance Company of Boston. The following is the Insurance Company's address and telephone number: Lincoln Life Assurance Company of Boston 100 Liberty Way, Suite 100 Dover, NH 03820-4695 Telephone Number: 877-321-1139 The Insurance Company may change from time-to-time at the discretion of the Plan Administrator. Salaried Teammates may be required to pay all or part of the insurance premiums for Life and AD&D Benefits and LTD 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	Lincoln Life Assurance Company of Boston

and Insurance Company:	100 Liberty Way, Suite 100 Dover, NH 03820-4695 Telephone Number: 877-321-1139
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 Life and AD&D Benefits and LTD 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.

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 Life and AD&D Benefits and LTD 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(s) that describe the Life and AD&D Benefits and the LTD Benefits issued by Lincoln Life Assurance Company of

Boston available to Salaried Teammates, and shall include any and all summaries of material modifications, amendments, supplements, schedules, riders or replacement plans or documents, if any.

Insurance Company means Lincoln Life Assurance Company of Boston, and any successor.

Life and AD&D Benefits means the basic life insurance benefits, the optional life insurance benefits, the basic accidental death and dismemberment benefits and the optional accidental death and dismemberment benefits described in this SPD and the Insurance Certificate. Life and AD&D Benefits are fully insured by Lincoln Life Assurance Company of Boston pursuant to Policy Number No. SA3-890-LF0373-01, as may be amended.

LTD Benefits means the long term disability benefits described in this SPD and the Insurance Certificate. The LTD Benefits are fully insured by Lincoln Life Assurance Company of Boston pursuant to Policy Number No. GF3-890-LF0373-01, as may be amended.

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 Employer. Drivers are not Salaried Teammates.

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.