MCLANE COMPANY, INC.

McLane Company Welfare Plan

Dental Care Plan

Summary Plan Description

January 1, 2021

DENTAL CARE PLAN

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DENTAL COVERAGE OVERVIEW

This Summary Plan Description ("SPD") describes your Dental Benefits offered under the McLane Company, Inc. Welfare Plan (the "Plan") sponsored by your employer, McLane Company, Inc. There are two dental options offered under the Plan – Dental Option I and Dental Option II. There are several differences between the two options, including different Deductible Amounts and the type of expenses covered. Please see the Schedule of Benefits below for more details.

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

This SPD is only a summary of the Dental Option of the Plan and does not list all of the details of these benefits. All statements made in this SPD are subject to and controlled by the terms of the Dental Option of the Plan as they appear in the official documents. In the event of a conflict between this document and the Plan document, the Plan document will control. You may obtain a copy of the Plan document by requesting a copy from the Plan Administrator. You may be required to pay reasonable copying costs for the Plan documents.

Teammate Eligibility for Coverage

If you are an eligible, full-time Teammate who normally works at least 30 hours per week, you will become eligible to elect dental coverage under the Plan after you complete the Waiting Period, if any, described below.

If you are a variable hour Teammate (such as a part-time Teammate) hired in 2019 and later, you may be eligible for dental coverage if you work an average of at least 30 hours per week during a 12 month measurement period. Please refer to the medical plan summary plan description ("PPO SPD") for other eligibility requirements applicable to variable hour Teammates. The PPO SPD also includes a number of examples that show how the 12 month measurement period is calculated to help you determine whether you are eligible to participate in dental benefits as a variable hour Teammate.

Teammate Waiting Period

If you are an eligible, full-time Salaried Teammate or Driver, you are eligible to elect a Dental Option that will become effective on the date of hire. If you are an eligible, full-time Hourly Teammate other than a Driver, you are eligible to elect a Dental Option that will become effective on the 60th Day of Active Service.

You must make the election for coverage under a Dental Option by the deadline discussed under the section entitled "Initial Deadline to Apply for Coverage" below.

If you are an eligible, full-time Teammate who was previously covered under a Dental Option 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.

Initial Deadline to Apply 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, you will have to wait until the next annual Open Enrollment Period to enroll (unless a special exception 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. If you are not Actively at Work on the date when your Dental Benefits would otherwise become effective, your Dental Benefits will become effective on the first day after you return to Active Work.

If you are a Salaried Teammate or a Driver and you do not enroll in a Dental Option within 30 days after the date you initially become eligible, or before the end of your Waiting Period if you are an Hourly Teammate other than a Driver, you will be required to wait until the next annual Open Enrollment Period to enroll (unless a special exception applies).

Costs of Coverage

You are required to pay a contribution toward the cost of your coverage. You will pay more if you elect to participate in Dental Option II. The required monthly contribution amount for Dental Option I and Dental Option II will be provided to you in your enrollment materials and will be presented as payroll contribution amounts. Required contributions will be withheld through payroll deductions each pay period on a pre-tax basis. You will be notified in advance of any change in your cost of coverage.

Rehire Policy

If you are rehired and your rehire date is within 90 days from your prior termination date and within the same Plan Year, you are automatically re-enrolled in the same Dental Option that you previously participated in under the Plan within the timeframe set forth in the Flexible Benefit Plan. You will not be subject to new eligibility Waiting Periods or new Plan Year provisions, such as Deductibles and Out-of-Pocket Maximum accumulations. Your required contribution for the applicable Dental Option 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 more than 90 days from your prior termination date, or if you are rehired in a subsequent Plan Year, you may re-enroll in the same Dental Option or a different option, provided that you re-enroll within the timeframe set forth in the Flexible Benefit Plan. You will be considered a new Teammate, subject to a new eligibility Waiting Period and Plan Year provisions, such as Deductibles and Out-of-Pocket Maximum.

Dependent Effective Date

Your Dependents will be covered on the same date that you become covered as long as you timely complete the Company's enrollment process and elect one of the "Teammate plus Dependent" coverage levels. Salaried Teammates and Drivers must enroll within 30 days of becoming eligible and Hourly Teammates other than Drivers must enroll before the end of their Waiting Period. All of your eligible Dependents will be included if they are included on your enrollment paperwork and you provide written documentation proving the eligibility of the Dependents within the timeframe communicated by the Plan Administrator.

Your Dependents may be covered only if you are covered. (Exception: Please see the Section entitled "COBRA Continuation Coverage" below.)

If you do not enroll your Dependents in your selected Dental Option within the applicable initial enrollment period when you become eligible, you will be required to wait until the next Open Enrollment Period, or Qualifying Life Event Change ("QLE") or other permitted election change to elect dental coverage for your Dependents. (See the section entitled "OLE's and Other Permitted Election Changes" for exceptions to this provision.)

Dependent Eligibility

Your eligible "Dependents" are:

- your legal Spouse;
- any Child who is:
    - less than 26 years old;
    - a Child of any age if the Child is permanently and totally disabled and incapable of self-sustaining employment by reason of a mental or physical disability. Proof of the child's condition and dependence must be submitted to the Claims Administrator within 31 days after the date the child ceases to qualify above. During the next two years the Plan Administrator may, from time to time, require proof of the continuation of such condition and dependence. After that, the Claims Administrator may require proof no more than once a year. Teammates should submit proof to the Claims Administrator.

The term "Child" includes your natural children, step-children legally adopted children, children Placed for Adoption, and foster children placed with you by an authorized placement agency or court order. It also includes (a) a child of whom you or your Spouse is the legal guardian, (b) a child who is related to you if the child resides in your household and depends on you for support and maintenance, or (c) for whom a Teammate has received a court order requiring the Teammate to have financial responsibility for providing coverage. Grandchildren are not eligible for coverage under the Plan unless the Teammate is the court-ordered legal guardian of the child. In the case of a Child with divorced parents where one or both parents have custody of the Child for more than half of the calendar year and where the parents together provide more than half of the

Child's support for the calendar year, the Child is treated as a Dependent of both parents. Once legal guardianship ends, the Dependent is no longer eligible to be covered under the Plan.

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

Dependent Audit Process

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, or divorce decree. If the audit reveals that any individual is not your Dependent as defined by the Dental Option, coverage will not become effective or will be terminated either on a go forward basis or, in the case of fraud or intentional misrepresentation, upon 30 days advance notice, as if no coverage was ever in force with respect to such individual. We 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.

Exception for Newborns, Children Adopted and Children Placed for Adoption

Any Dependent child born to, adopted by, or Placed for Adoption with you while you are covered under a Dental Option will become covered for dental benefits under that Dental Option on the date of his or her birth, adoption, or Placement for Adoption if you enroll the newborn child, adopted child or child Placed for Adoption under a Dental Option no later than 60 days after the child's birth, adoption or Placement for Adoption.

If you do not elect to cover your newborn child, adopted child or child Placed for Adoption with you by completing the Company's "Qualifying Event Change Form" and the Company's dependent audit process within 60 days from the time of birth, adoption or Placement for Adoption this child will not have coverage under the Dental Option. No benefits for Expenses Incurred will be payable and you will be required to wait until the next Open Enrollment Period to elect dental benefits for the Child (Coverage changes elected during the Open Enrollment Period go into effect at the beginning of the next Plan Year).

Enrollment after the Open Enrollment Period Has Closed

Generally, if you decline enrollment in dental coverage during the Open Enrollment Period, you must wait until the next annual Open Enrollment Period to enroll. However, special exceptions apply under the following circumstances:

- loss of eligibility for other health coverage;
- the acquisition of a new Dependent through marriage, birth, adoption or Placement for Adoption; or

- becoming eligible or ceasing to be eligible for state premium assistance subsidy.

You must enroll in dental coverage **within 60 days** of the event giving rise to the special enrollment opportunity.

In the case of loss of coverage or acquiring a new Dependent through marriage, birth, adoption, or Placement for Adoption, you must request enrollment in dental coverage under this Plan within 60 days (i) after your other coverage ends or (ii) after acquiring your new Dependent by completing a "Qualifying Event Change Form" and providing the necessary supporting documentation. You may obtain this form from your local Human Resources Department.

Special Enrollment – Loss of Eligibility for Other Coverage

If you declined enrollment for yourself or your eligible Dependents during the Open Enrollment Period because you had other dental coverage outside of the Plan and you lose this other dental coverage, you may be able to enroll yourself and your Dependents in one of the dental options offered under the Plan (even if the Open Enrollment Period has closed), if one of the following conditions are met:

- you lose eligibility for the prior coverage; or
- the employer ceased employer contributions for the prior coverage; or
- if such prior coverage was continuation coverage under COBRA, the continuation period has been exhausted.

However, you must enroll in a dental option **within 60 days** after losing or exhausting prior coverage in order to be eligible for this special enrollment.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after your other coverage ends, you will be required to wait until the next annual Open Enrollment Period to elect coverage (unless a special exception applies).

A loss of eligibility for coverage includes (but is not limited to) a loss due to:

- legal separation, divorce, annulment, death, termination of employment, reduction in number of hours of employment, the cessation of Dependent status (for example a Dependent child attains the other plan's limiting age), and any loss of eligibility after a period measured by reference to any of these events;
- an HMO or other arrangement provided in an individual market no longer provides benefits to an individual because the individual no longer resides, lives or works in the service area;
- an HMO or other arrangement provided in a group market no longer provides benefits to an individual because that individual no longer resides,

lives or works in the service area and there is no other benefit package available to the individual to transfer to in that group market; and

- the plan no longer offers any benefits to a class of similarly situated individuals.

Coverage timely elected in the case of a loss of coverage will be effective on the date the event occurred. Pre-tax premium deductions will begin at the end of the first full pay period following the event date. You will not be charged for retroactive coverage added in these instances.

Special Enrollment – Acquisition of New Dependent

If you acquire a new Dependent through marriage, birth, adoption or Placement for Adoption, you may enroll your eligible Dependent and yourself, if you are not already enrolled, within 60 days of such event. Only the eligible Teammate, eligible Spouse and newly eligible Dependent may enroll pursuant to a special enrollment right of a non-Spouse Dependent. This means that other non-Spouse Dependents who were previously eligible are not eligible to be covered under the dental benefit options as "tag-along" Dependents. For example, if a Teammate who is married with one Dependent child previously elected Teammate-only coverage, but during the Plan Year, the Teammate and Spouse adopt a second child, only the Spouse and the new second Dependent Child may be enrolled. The first Dependent Child who was previously eligible but was not covered may not be added to the Plan as a tag-along Dependent when the newly adopted Dependent Child is added.

You must enroll in a dental option **within 60 days** after acquiring a new Dependent through marriage, birth, adoption, or Placement for Adoption.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after acquiring a new Dependent through marriage, birth adoption or Placement for Adoption, you will be required to wait until the next annual Open Enrollment Period to elect coverage (unless a special exception applies).

Coverage timely elected related to the acquisition of a Dependent due to marriage, birth, adoption or Placement for Adoption will be effective on the date the event occurred. Pre-tax premium deductions for Teammates will begin at the end of the first full pay period following the event date. Teammates are not charged for retroactive coverage added in these instances.

Special Enrollment – Becoming Eligible for Premium Assistance

You may also be able to enroll yourself or your Dependents in one of the dental options under the Plan after the Open Enrollment Period has closed if you or your Dependents become eligible for premium assistance from the government or lose eligibility for coverage under Medicaid or CHIP. However, you must request coverage not later than 60 days after becoming eligible for premium assistance or the loss of coverage under Medicaid or CHIP.

If you or your Dependents gain eligibility for premium assistance from the government or lose eligibility for coverage under Medicaid or CHIP, you must request special enrollment in a dental

option under this Plan within 60 days after becoming eligible for premium assistance or losing eligibility for Medicaid or CHIP coverage by completing a "Qualifying Event Change Form" and providing the necessary supporting documentation. You may obtain this form from your local Human Resources Department.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after becoming eligible for premium assistance from the government or losing eligibility under Medicaid or CHIP, you will be required to wait until the next annual Open Enrollment Period to elect coverage (unless a special exception applies).

In the case of becoming eligible for premium assistance from the government or losing eligibility for coverage under Medicaid or CHIP, your coverage will be effective on the date the event occurred.

Changes in Elections - Qualifying Life Events

The elections that you make under the Plan generally must remain in place for the entire Plan Year, unless a special exception applies. The Dental Option operates in conjunction with the Flexible Benefit Plan, and the Flexible Benefit Plan rules limit your ability to make changes to the coverage you have selected.

You may only make changes in the coverage you elected (or declined) during the annual Open Enrollment Period, if you or your Dependents are eligible for Special Enrollment (as described above) or if you experience a Qualifying Life Event or other permitted election change as described in this Section.

If you do experience a Qualifying Life Event, you must request the election change in writing on a "Qualifying Event Change Form" within 60 days of the Qualifying Life Event or other permitted election change event.

The following are Qualifying Life Events:

- Change in legal marital status due to marriage, the death of a Spouse, divorce, annulment or legal separation;
    - Coverage for your Dependent who is your lawful Spouse *automatically* terminates upon divorce. In that event, please complete a "Qualifying Event Change Form" and refer to the Section entitled "COBRA Continuation Coverage" for more information.
- Change in number of Dependents due to birth, adoption, Placement for Adoption or death of a Dependent;
- Change in employment status of Teammate or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite;

- Changes in employment status of Teammate or Dependent resulting in eligibility or ineligibility for coverage;

- Change in residence or work location of a Teammate or Dependent (if that change results in the loss of or the gain of access of current coverage), including a change in residence that occurs when a Teammate and/or Dependent(s) residing in any country outside the United States return(s) to permanently reside in the United States; or

- Changes that cause a Dependent to become eligible or ineligible for coverage.

You are only permitted to make a Qualifying Life Event change if it is on account of and corresponds with that Qualifying Life Event, as determined by the Plan Administrator. This is referred to as the "consistency rule." For example, if one of your Dependents ceases to satisfy the eligibility requirements for coverage due to a Qualifying Life Event, you may only elect to drop coverage for that Dependent. Dropping coverage for any other Dependent will not "correspond" with the Qualifying Life Event so it will not meet the "consistency rule". Consistency rule information is available from your Human Resources Department.

Any election change made will be effective on the first day of the month after the Plan Administrator receives your completed Qualifying Event Change Form except in the case of marriage, birth, adoption, Placement for Adoption or divorce. In the case of marriage, birth, adoption, Placement for Adoption, or divorce, the election change will be effective retroactively back to the date that the election change event occurred. Pre-tax premium deductions for Teammates will begin at the end of the first full pay period following the event date. If notice is not timely provided due to divorce, no refunds will be provided absent unusual circumstances.

Other Permitted Election Changes

The following are other events that permit you to make an election change under a Dental Option during the Plan Year, if you request the election change in writing on a "Qualifying Event Change Form" within 60 days of the event and you provide documentation as required by the Plan Administrator to support the change:

Judgment, Decree or Order

You may change your election during the Plan Year if the change results from, and is consistent with, a judgment, decree or order pursuant to a divorce, legal separation, annulment or change in legal custody requiring health coverage for your child. You may only cancel your election for coverage for the child if health coverage is actually provided to the child by another person as required by a judgment, decree or order.

Medicare Eligibility/Entitlement

You may change your election to cancel or reduce coverage due to entitlement to Medicare, or to enroll or increase coverage due to loss of Medicare eligibility.

Another Employer Plan

The Plan may permit a prospective election change that is made on account of and corresponds with a change made under another employer plan if:

- The other employer plan permits participants to make election changes as provided by law; or
- The other employer plan permits participants to make elections for a period of coverage different from the period of coverage under the Dental Option.

Government or Educational Plan

The Plan may permit you to make an election to add coverage, prospectively, if you, your Spouse, or Dependent loses group health coverage sponsored by a governmental or educational institution including the following:

- A CHIP program;
- A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization;
- A state health benefits risk pool; or
- A Foreign government group health plan.

COBRA Exception

If your Spouse or your Dependent becomes eligible for COBRA under the Plan, you may elect to increase payments under the Flexible Benefit Plan to pay for COBRA coverage.

Cost or Coverage Changes

Election changes may also be permitted due to the cost or coverage changes listed below.

Automatic Cost Change

If your costs under one of the benefit options increases or decreases, and the Plan Administrator determines an election change is permitted by the Flexible Benefit Plan and the law, your election with respect to the cost will be adjusted to correspond to the changes. Your withholding election amount will be changed automatically to correspond with the cost change.

Significant Cost Decreases

If the cost of any benefit option under this Plan significantly decreases, the Plan Administrator may allow you to elect the benefit option which had a significant decrease in cost, even if you have elected another benefit option or have not previously participated in a benefit option under the Plan.

Significant Cost Increases

If the cost for a benefit option significantly increases, the Plan Administrator may allow you to make corresponding changes to your benefit option election, including revoking your election for the benefit option which significantly increased in cost. In such a case, you may either elect to receive on a prospective basis a new benefit option that provides similar coverage, or you may drop coverage if no other benefit option providing similar coverage is available.

Significant Coverage Change

If the coverage under a benefit option is changed significantly during a Plan Year, the Plan Administrator may allow you to make a corresponding election change.

Reduction in Coverage

If a benefit option has a significant reduction in coverage (other than a loss of coverage described in the paragraph below) such as a significant increase in the Deductible, the Copay, or out of pocket expenses, the Plan Administrator may allow you to revoke your election for that coverage and elect, on a prospective basis, to receive coverage under another benefit option providing similar coverage.

Loss of Coverage

If a benefit option has a "loss of coverage," the Plan Administrator may allow you to revoke your election for such benefit option and elect another benefit option providing similar coverage or drop coverage if no other benefit option providing similar coverage is available.

A "loss of coverage" means a complete loss of coverage under the benefit option including the elimination of a benefit option or an HMO ceasing to be available in the area an individual resides.

In addition, the Plan Administrator may treat the following as a loss of coverage:

- A substantial decrease in the health care providers available under the option;
- A reduction in the benefits for a specific type of health condition or treatment with respect to which the Teammate or Teammate's Spouse or Dependent is currently in a course of treatment; or
- Any other similar fundamental loss of coverage.

New or Improved Coverage

If a benefit option is added during a Plan Year, or if an existing benefit plan option is significantly improved, the Plan Administrator may allow you (whether or not you previously made an election under the Plan) to revoke your election under the Plan and make an election, prospectively, for coverage under the new or improved benefit package option.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after a Qualifying Life Event or other permitted change event, you will be required to wait until the next Open Enrollment Period to elect or change coverage (unless a special exception applies).

If you have questions about whether an event will permit an enrollment or change in election under the Flexible Benefit Plan, please ask the Plan Administrator.

Schedule of Benefits

The following benefits are provided subject to the provisions below.

DENTAL OPTION I

	In-Network	**Out-of-Network**
ANNUAL DEDUCTIBLE AMOUNT		
(Applies to Type B and Type C Expenses Combined)		
Individual	$50	$50
Family	$150	$150
COVERED PERCENTAGE		
Type A Expenses	100%	100%
Type B Expenses	80%	80%
Type C Expenses	50%	50%

MAXIMUM:

The Maximum Dental Benefit payable under Dental Option I for Covered Dental Expenses is $1,500 per Plan Year per Covered Person. Orthodontic Treatment is not covered under Dental Option I. Therefore, Orthodontic x-rays are not covered.

NOTE

If a dental bill is expected to be $300 or more, please see the Section entitled "Pre-Determination of Benefits" below.

The following benefits are provided subject to the provisions below.

DENTAL OPTION II

	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE AMOUNT		
(Applies to Type B and Type C Expenses Combined)		
Individual	$100	$100
Family	$300	$300
COVERED PERCENTAGE		
Type A Expenses	100%	100%
Type B Expenses	80%	80%
Type C Expenses	50%	50%
Type D Expenses	50%	50%

MAXIMUM:

The Maximum Dental Benefit payable under Dental Option II for Covered Dental Expenses that are not for Orthodontic Treatment is $2,000 per Plan Year per Covered Person.

The Lifetime Maximum Orthodontic Benefit payable under Dental Option II for Covered Dental Expenses that are for Orthodontic Treatment is $2,000 per Covered Person. Any services for Orthodontic Treatment received prior or related to the initial placement of an orthodontia appliance will be subject to this Lifetime Maximum Orthodontic Benefit.

NOTE

If a dental bill is expected to be $300 or more, please see the Section entitled "Pre-Determination of Benefits" below.

Determination of Dental Benefits

Once the Deductible Amount (if any) has been met, the Dental Option will pay a certain percentage of approved dental expenses incurred by you or your covered dependent. The percentage that will be covered (referred to as the "Covered Percentage") will vary depending on the type of approved dental expense (referred to as a "Covered Dental Expense") involved. The Covered Percentage is listed in the Schedule of Benefits, and the types of Covered Dental Expenses are listed in the section entitled "Types of Covered Dental Expenses" below.

The amount of Dental Benefits for Covered Dental Expenses (other than expenses for Orthodontic Treatment) incurred during the Plan Year is limited to the Maximum Dental Benefit, as set out in the Schedule of Benefits. This Maximum Dental Benefit is applied to each Covered Person. For example, if you cover yourself and your Spouse under Dental Option II, you may receive Dental Benefits of up to $2,000 for 2020, and your Spouse may receive Dental Benefits of up to $2,000 as well. An expense is "incurred" on the date that the dental service for which the charge is made is completed.

Please note that the amount of a Covered Dental Expense under a Dental Option may be less than the actual amount charged by your Dentist or other authorized provider for the dental services or supplies. For an Out-of-Network Benefit, the amount is generally based on the reasonable and customary charge for the service or supplies. For an In-Network Benefit, the approved amount is generally based on the amount the Participating Provider agreed to charge for the service. When dental care is given by Participating Providers, you or your covered Dependent will generally incur less out-of-pocket cost for the services rendered.

In order to determine the amounts payable for Covered Dental Expenses, the Claims Administrator may ask for X-rays and other diagnostic and evaluative materials. If such materials are not given to the Claims Administrator, the Claims Administrator will determine Covered Dental Expenses on the basis of the information which is available to the Claims Administrator. This may reduce the amount of benefits which otherwise would have been payable.

In-Network Benefits, Out-of-Network Benefits and Preferred Providers

Under the Dental Option, you are free to select your own Dentist. However, if you use a Participating Provider, you will generally incur less out-of-pocket cost for the services rendered. Services provided by a Preferred Provider are considered to be In-network Benefits. Services that are not provided by a Preferred Provider are considered to be Out-of-Network Benefits.

You can locate a Participating Provider by reviewing the Preferred Dentist Program Directory, a copy of which will be provided to you free of charge when you enroll in this Dental Option Plan.

You may also access the Preferred Dentist Program Directory on the internet at www.metlife.com or by calling MetLife Customer Service at 1-800-942-0854. The Preferred Dentist Program Directory will be periodically updated and will change without notice. It is your responsibility to verify that a dentist is a Preferred Dentist before services are rendered.

Types of Covered Dental Expenses

Type A Expenses

a. Two oral exams per calendar year.

b. One Full mouth X-ray or one Panoramic X-ray every 60 months.

c. Two Bitewing X-rays per calendar year for adults and Dependent Child.

d. Intraoral-periapical X-rays and other X-rays not specified above.

NOTE: Dental Option I participants may be eligible for the x-ray benefits listed above regardless of the place of service, if ordered by a Dentist, except for orthodontic x-rays and x-rays taken at an orthodontist's office. Dental Option II participants may be eligible for x-rays listed above regardless of the place of service, if ordered by a Dentist.

e. Two teeth cleanings (oral prophylaxis) per calendar year.

f. Pulp vitality tests, diagnostic casts, and bacteriological studies for determination of pathologic agents.

g. Two topical fluoride treatments per Plan Year.

h. Space maintainers, limited to non-orthodontic treatment.

i. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 2 times in a year less the number of regular teeth cleanings received during such year.

Type B Expenses

a. Initial placement of amalgam or composite fillings. Replacement of an existing amalgam or composite fillings.

b. Sedative fillings.

c. Prefabricated stainless steel crown or prefabricated resin crown, but not more than one in a 5 year period.

d. Repair or re-cementing of Cast Restorations.

e. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).

f. Pulp therapy and apexification/recalcification.

g. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36-month period.

h. Periodontal scaling and root planing but not more than once per quadrant in any 24 month period.

i. Oral surgery except as mentioned elsewhere.

j. Extractions of un-impacted teeth and removal of exposed roots.

k. Extractions of impacted teeth.

l. Root canal treatment but not more than once in a 24-month period for the same tooth.

m. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other covered services, including nitrous oxide, when the Dental

Option determines such anesthesia is necessary in accordance with generally accepted dental standards.

n. Two consultations per calendar year.

o. Injections of therapeutic drugs.

p. Local chemotherapeutic agents.

q. Repair of Dentures.

r. Relinings and rebasings of existing removable Dentures, if at least 6 months have passed since the installation of the existing removable Denture; and not more than once in any 36-month period.

s. Other removable prosthetic service not described elsewhere.

t. Other fixed Denture prosthetic service not described elsewhere.

u. Addition of teeth to a partial removable Denture.

v. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.

w. Emergency palliative treatment to relieve tooth pain.

x. One application of sealant material per each non-restored, non-decayed first and second molar of a Dependent child to age 14.

Type C Expenses

a. Initial installation of Cast Restorations.

b. Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth every five years.

c. Initial installation of full or removable dentures (i) when needed to replace congenital missing teeth; or (ii) when needed to replace natural teeth that are lost.

d. Crown buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a 5-year period.

e. Initial installation of implants for participants in Dental Option II only. Dental implants are bio-compatible substitutes for lost natural teeth. They are devices for attaching artificial replacement teeth firmly to the bone. Implants can be used to support a single crown or as anchors for fixed bridges or as support for removable partial or complete dentures.

i. Replacement of a non-serviceable denture if such denture was installed more than 5 years prior to replacement. (Implants only apply to Dental Option II participants.)

ii. Replacement of an immediate, temporary full denture with a permanent full denture if the immediate, temporary full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full denture.

Type D Expenses

Orthodontic Treatment, including appliance therapy (for Dental Option II participants only, adults and children).

Orthodontic Treatment is only covered under Dental Option II. It is NOT covered under Dental Option I.

Upon the initial placement of the appliance, which may include other services such as the initial workup, Dental Option II will pay an amount not to exceed 20% of the Lifetime Maximum Orthodontic Benefit. After the initial placement of the orthodontic appliance, the Dental Benefit payable under Dental Option II during the scheduled course of the Orthodontic Treatment (including periodic follow-up visits) will be the lower of:

a. the amount of the Covered Dental Expense times the Covered Percentage for Orthodontic Treatment; and

b. the remaining amount of the Lifetime Maximum Orthodontic Benefit.

Dental Option II payments can be made in a lump sum or in partial payments, depending on how the provider is paid by the Covered Person. If the Covered Person is paying installment or partial payments, the Dental Benefit payable for the course of the Orthodontic Treatment will be divided by the number of months in the scheduled course of the Orthodontic Treatment (but no more than 24 months and subject to the Lifetime Maximum Orthodontic Benefit). This amount will be multiplied by 3 to obtain the maximum Dental Benefit that will be paid under Dental Option II for each 3-month period during the scheduled course of the Orthodontic Treatment (subject to the Lifetime Maximum Orthodontic Benefit). Dental Option II will only reimburse Dental Benefits for Covered Dental Expenses for Orthodontic Treatment up to the amount the Covered Person has paid the provider (and subject to the Lifetime Maximum Orthodontic Benefit).

Benefits will only be payable during the scheduled course of the Orthodontic Treatment if:

a. the person receiving the orthodontic treatment is a Covered Person; and

b. proof is given to the Claims Administrator that the Orthodontic Treatment is continuing.

For minor Orthodontic Treatment services that are performed in one visit and do not require follow-up visits, Dental Option II will pay the amount of the Covered Dental Expense times the Covered Percentage for Orthodontic Treatment.

If the initial placement of the appliance was made prior to the date the individual was a Covered Person under Dental Option II, no benefits will be payable under Dental Option II for the initial placement of the appliance.

If periodic follow-up visits commenced prior to the date the individual was a Covered Person under Dental Option II:

a. the number of months for which benefits are payable based on the scheduled course of Orthodontic Treatment will be reduced by the number of months of Orthodontic Treatment performed before coverage under Dental Option II was in effect; and

b. the total amount of the benefit payable that Dental Option II would have normally provided for Orthodontic Treatment which was started while these Dental Benefits were in effect will be reduced proportionately.

Pre-Determination of Benefits

If a dental bill is expected to be $300 or more, before the Dentist starts the treatment, you are encouraged to find out what Dental Benefits will be paid under the Dental Option. To do this, you should send a claim form to the Claims Administrator in which the Dentist tells us the work to be done and the related cost.

The Claims Administrator will then tell you what Dental Benefits the Dental Option will pay. If you do not use this method to find out what Dental Benefits the Dental Option will pay, the Claims Administrator's decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Benefits the Dental Option will pay.

This method should not be used for:

a. emergency treatment; or

b. routine oral exams; or

c. X-rays, scaling and polishing, and fluoride treatments; or

d. dental services which cost less than $300.

Exclusions and Limitations

The following are not covered dental expenses:

a. Services or supplies received by a Covered Person before coverage for that person is effective under a Dental Option.

b. Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:

   i. scaling and polishing of teeth; or

   ii. fluoride treatments.

c. Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn Dependent child.

d. Replacement of a lost, missing or stolen crown, bridge or denture.

e. Services or supplies which are covered by any workers' compensation laws or occupational disease laws.

f. Services or supplies which are covered by any employers' liability laws.

g. Services or supplies which any employer is required by law to furnish in whole or in part.

h. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer.

i. Repair or replacement of an orthodontic appliance.

j. Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Benefits for that Covered Person.

k. Services or supplies for which a Covered Person is not required to pay.

l. Services or supplies which are deemed experimental in terms of generally accepted dental standards.

m. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Benefits for the Covered Person are in effect.

n. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.

o. Any duplicate appliance or prosthetic device.

p. Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.

q. Office visit charges for observation only or extraneous services (such as extra off-hours charges).

r. Instruction for oral care such as hygiene or diet.

s. Periodontal splinting.

t. Temporary or provisional restorations.

u. Temporary or provisional appliances.

v. Services or supplies to the extent that benefits are otherwise provided under the Dental Option or under any other plan which the Employer (or an affiliate) contributes to or sponsors.

w. Implantology (excluded under Dental Option I only).

x. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

y. Charges for broken or missed appointments.

z. Charges by the Dentist for completing dental forms.

aa. Sterilization supplies.

bb. Services or supplies furnished by a Family member.

cc. Treatment of temporomandibular joint disorders.

dd. Fixed and removable appliances for correction of harmful habits.

Amendment/Termination

The Company may amend or terminate all or any part of the Dental Option offered under the Plan at any time. The Company has delegated authority to the Director of Benefits, or any successor to this position, to make amendments to the Dental Option under the Plan that (1) do not significantly increase the costs of the Dental Option, or (2) are required to be made by law. No consent or advance notice to any participant is necessary to amend, change or terminate the Dental Option under the Plan.

Qualified Medical Child Support Order

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

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 dental benefit coverage to such child and relates to benefits under the group dental plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group dental benefits for which a Teammate 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 Dental Option to provide coverage for any type or form of benefit or option not otherwise provided under the Dental Option, except that an order may require the Dental Option 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 Dental Option's Qualified Medical Child Support Order procedures which will be furnished to you free of charge.

Dental Option I is the default dental coverage for the employee and the alternate recipient when there is a Qualified Medical Child Support Order that does not specify the coverage.

The child (and you, if you are not already enrolled) will be automatically enrolled in the applicable Dental Option 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 still should notify your local Human Resources Department of the order. Please contact your local Human Resources Department to get a "Qualifying Event Change Form," complete the form, attach a copy of the order and return it to your local Human Resources Department.

Continuation of Dental Coverage During Leave

Dental coverage may be maintained during an approved leave. Payments are required according to the Company's Leave of Absence Policies. If you fail to timely make required premium payments by the date communicated to you by the Plan Administrator for dental coverage while out on any unpaid leave of absence, including but not limited to, a FMLA leave, your coverage may be cancelled and, if cancelled, cannot be reinstated if you do not return to work. In addition, in this case, you may lose your right to continue your dental coverage pursuant to COBRA.

If you do not continue dental coverage or your dental coverage is otherwise lost due to your failure to make required premiums as provided above, but you do return to work from your unpaid leave:

- In leaves other than FMLA leaves (or if you come back to work after your FMLA leave has expired), you will be required to wait until the next Open Enrollment Period to reinstate your dental coverage; and

- If you timely return to work on or before the date your available FMLA leave expires, you:

    - Have a right to reinstate your dental coverage prospectively by resuming premium payments, and

    - May retroactively reactivate dental benefits for the period that you were out on an unpaid FMLA leave, as long as you timely pay all outstanding health premiums for the FMLA leave in the form and manner communicated to you by the Plan Administrator.

Reinstatement of Canceled Coverage Following Leave

If you return to Active Service from an approved FMLA leave where you had a lapse in dental coverage during your leave due to non-payment of dental premiums, you may be reinstated in the applicable Dental Option if requested within 31 days of your return. Any canceled coverage will be reinstated as of the date of your return, but subject to any changes in benefit levels that may have occurred during the leave that affected the entire work force.

You will not be required to satisfy any eligibility Waiting Period or the requirements of any Pre-existing Condition limitation to the extent that you satisfied these requirements prior to the start of such leave of absence.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. Coverage under the Plan may be continued in accordance with USERRA and Company policies for military leaves of absences.

For leaves of six months or more, you may continue coverage for yourself and your Dependent as follows:

> The Company is subject to federal continuation requirements called COBRA; therefore, you may continue benefits according to the federal continuation benefits shown in this SPD. You and your Dependents will be charged up to 102% of the total cost.
>
> The maximum period of Dental Option coverage available to you and your Dependents will not exceed the lesser of (1) 24 months or (2) the period ending on the day after the date upon which you fail to apply for a return to a position of employment under section 4312(a) of USERRA. The period of this coverage shall begin on the date on which your qualifying absence begins.

If your coverage ends during the leave because you do not elect COBRA or an available conversion plan at the expiration of COBRA and you are reemployed by the Company, coverage for you and your Dependents may be reinstated if: (a) you gave the Company advance written or verbal notice of your military service leave; and (b) the duration of all military leaves while you are employed with the Company does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Waiting Period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full Dental Option limitations will apply.

Medicaid

The Dental Option will not take into account your eligibility or your Dependents' eligibility for health assistance or benefits payable under 42 U.S.C. S1396 et seq.

Plan Administration

The primary responsibility for the general administration of the Dental Option is placed with the Plan Administrator. However, the Claims Administrator is responsible for processing and deciding all claims. The Claims Administrator has the exclusive right to make all determinations concerning eligibility for coverage and benefits under the Dental Option. 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 Dental Option under the Plan and to interpret the terms of the Dental Option under the Plan. Their good faith determinations and interpretations shall be binding and conclusive on all persons.

Termination of Coverage – Teammates

Your coverage will cease on the earliest date below:

- the last day of the pay period in which you cease to be an eligible Teammate or cease to qualify for coverage,
- the last day of the pay period prior to the date that you stopped making required contributions for coverage,
- the last day of the pay period after your Active Service ends, unless coverage is continued while you are on Military Leave or FMLA leave.
- the date the Dental Option that you participate in is terminated.

Termination of Coverage – Dependents

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

- the last day of the pay period for which your dental coverage ceases,
- the last day of the month in which your Dependent Child attains age 26 unless your Child is permanently and totally disabled, (see the "Dependent Eligibility" section above)
- the last day of the pay period prior to the date that you stopped making required contributions for coverage,
- the last day of the pay period for during which Dependent Coverage is cancelled.

Unless otherwise specified above, the coverage for any one of your Dependents will cease on the last day of the pay period in which that Dependent no longer qualifies as a Dependent.

COBRA Continuation Coverage

This communication is provided as part of a legal requirement to advise you of your COBRA Continuation 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, 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 Plan offers 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 or 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.

What Qualifying Events 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;
- Your divorce or legal separation;
- You become entitled to Medicare; or
- Dependent Child no longer qualifies as a Dependent.

What is COBRA Coverage?

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 any dental coverage under the Dental Option.** COBRA is subject to eligibility and the Administrator reserves the right to terminate COBRA coverage retroactively if you are found ineligible. This applies even if a COBRA payment has been accepted.

Can I Add a Newborn, Newly Adopted Child, Child Who has Been Placed for Adoption or a New Spouse to my COBRA Coverage?

You may add a newborn, newly adopted child, 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. . Although you may add your spouse to your COBRA coverage during the Open Enrollment Period or pursuant to a special enrollment right, your spouse is not considered a Qualified Beneficiary with independent COBRA election rights.

How should I Obtain COBRA Coverage?

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 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 dental 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 their 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;
- You become 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 coverage under the Dental Option 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 Teammate 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 Dependent child is disabled as determined by the Social Security Administration on one of the following:

- Your date of termination or reduction in hours; or
- 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 member 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.

What Happens if I become Entitled to Medicare?

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.*

What Happens if I become Entitled to Trade Assistance?

If you terminate employment from the Company and 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.

Who Pays for 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 and the 2% administration fee during the additional up-to-11-month coverage period.

How Does COBRA Help with 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, an employer's plan must allow such individuals to enroll in the plan within 30 days after exhausting their COBRA coverage.

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 the Dental Option 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.

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.

May I convert COBRA to an Individual Policy?

There is no conversion option for the Dental Option offered under the Plan.

Questions and Contact Information

You should provide written notice to the Company or the Plan Administrator of certain Qualifying Events as described 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**.

Claims Procedures

Procedures for Presenting Claims for Benefits

If you utilize an In-Network provider, you do not need to file a claim form. The provider will file your claim with the Claims Administrator.

If you utilize an Out-of-Network provider, in most cases, you will need to file the claim with Claims Administrator. Claim forms can be obtained from your Human Resources Department or on www.metlife.com. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The Plan Administrator has given the Claims Administrator the authority to establish or construe the terms and conditions of the Plan, the discretion to interpret and determine benefits and your eligibility for a benefit under the Plan. However, the Plan Administrator is responsible for determining whether any individual is eligible to participate in the Plan.

The completed claim form should be sent to the Claims Administrator at the address below:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
800-942-0854

When the claim has been processed, you will receive an Explanation of Benefits (EOB) which details the benefits paid. If any benefits have been denied, the reason for denial will be included on your Explanation of Benefits (EOB).

Claims must be filed within 12 months from the date of service. Claims submitted after the twelve-month period will not be processed for payment.

Concurrent Care Claims

A person or his duly authorized representative 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 Dental Option to be provided over a period of time or number of treatments.

Non-Urgent Care Claim. If there is any reduction or termination by the Dental Option of concurrent care (other than by Dental Option 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 you of such reduction or termination within a reasonable period of time not less than fifteen (15) days before any such reduction or termination.

Urgent Care Claim. If you make 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 Dental Option provided that any such claim must be made to the Dental Option at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

The Claims Administrator may notify you of its decision orally 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 you not later than three (3) days after the oral notification.

Post-Service Claims

If you believe you are being denied benefits under the Dental Option for a "post-service claim," you or your duly authorized representative may file a written claim with the Claims Administrator. "Post-service claim" means any claim for Dental Benefits under the Dental Option which is not a "pre-service claim." A "pre-service claim" means any claim for Dental Benefits under the Dental Option with respect to which the terms of the Dental Option condition receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining medical care.

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 you do not receive 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 you may request a review of your claim.

Extensions in the Case of Initial Determinations Post-Service Claims

For post-service claims, the claim review period may be extended once for up to fifteen (15) days, provided that the Claims Administrator both (i) determines that such extension is needed and is beyond the Claims Administrator's control and (ii) notifies you of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision prior to the expiration of the initial permissible response period of thirty (30) days. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension, shall specifically describe the required information, and you shall be afforded at least 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 you respond to the request for additional information, or (ii) the last day of the forty-five (45) day period. Once you have 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.

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

Notification Requirements for All Claims

If any claim is wholly or partially denied, the notification will be written in a way that is easy to understand and must contain: (i) the specific reason or reasons for the adverse determination, (ii) the specific reference to Dental Option provisions on which the determination is based, (iii) a description of any additional material or information necessary for the person to perfect his claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if you wish to submit a request for review, including applicable time limits and your right to bring a civil action under section 502(a) of ERISA. If the benefit determination was adverse, the notification must also contain any internal rule, guideline, protocol or other similar criterion (collectively "Protocols") that were relied upon in making the adverse determination and that a copy of such Protocols will be available to you, free of charge, upon your 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 Dental Option, as applicable, to your medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request. For all urgent claims for Dental Benefits, the notification must also contain a description of the expedited review process applicable to such claims.

Claims Review Procedures

Time Period for Review

Within one hundred and eighty (180) days after the date that you receive notice of a claim denial for Dental Benefits under the Dental Option, or if applicable, within one hundred and eighty (180) days after the date on which such denial is deemed to have occurred, you or your duly authorized representative may file a request that the Claims Administrator review your denied claim.

For concurrent claims, you or your duly authorized representative may file a written request with the Claims Administrator for a review of your denied claim on or before the date your benefits are reduced or terminated. Such request must be filed within a reasonable time but not later than five (5) days before a concurrent claim benefit is reduced or terminated.

You may request an expedited review of your urgent care claim by contacting the Claims Administrator orally or in writing if your urgent care claim has been wholly or partially denied. If you request an expedited review, all necessary information, including the Dental Option's benefit determination on review, shall be transmitted expeditiously between the Dental Option and you.

Review Standards

The Dental Option provides for two levels of appeal for all benefits. In order for you to pursue your rights as explained in the "Rights After Appeal" section below, you must first exhaust your appeal rights under the Dental Option.

You and/or your authorized representative may inspect or request, free of charge, relevant documents and submit written comments, documents, records, and other information to the Claims Administrator for review of his claim. Your appeal shall be reviewed without affording deference to the initial adverse benefit determination and will not be conducted by the individual who made the initial review, nor a subordinate of such individual, but shall be conducted by such individual(s) designated or appointed by the Claims Administrator. If the claim is denied upon review and notice of such denial upon review is provided to you as provided in these procedures, you may pursue your rights as set forth in the "Rights After Appeal" section described below.

Procedures Applicable to Appeal

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 you with such information regarding such health care professionals as the Claims Administrator determines is appropriate. You shall be provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Claims Administrator relied upon the expert's advice.

Notification of Decision on Review

The Claims Administrator will notify you of its decision. 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 written in a way that is easy to understand and will contain: (i) the specific reason or reasons for the denial, (ii) specific references to Dental Option 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 material and required information relevant to the claim for benefits, (iv) a statement describing any voluntary appeals offered by the Dental Option, including information concerning the procedures of the voluntary appeal that would allow you to make an informed decision about whether to appeal and such other information which the Claims Administrator determines is appropriate regarding alternative dispute resolution

options, (v) a statement of the your right to bring an action under section 502(a) of ERISA, (vi) a description of the Protocols, if any, used to make the decision and that a copy of the Protocols will be available free of charge upon request, and (vii) 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 Dental Option, as applicable, to your medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request.

Response Dates on Appeal

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

For a post-service claim, the decision on review will be made within thirty (30) days after the request for review is received by the Claims Administrator.

Level Two Appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. All second level mandatory appeals for post service and concurrent care claims will be handled by the Company. To initiate a level two appeal, you must notify the Benefits Manager at the Company in writing within 180 days of your receipt of the Claims Administrator's level one appeal denial.

All second level mandatory appeals for post service and concurrent care claims should be mailed to:

McLane Company, Inc.
Attn: BENEFITS MANAGER, DENTAL PLAN APPEAL
4747 McLane Parkway
Temple, Texas 76504

The Company will forward all requests for a second review to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by the Claims Administrator or any of its affiliates or by your Employer. A decision to use this level of appeal will not affect your rights to any other benefits under the Dental Option.

The Claims Administrator, to the extent reasonably requested by the Company will provide information that it has in its possession to assist the Independent Review Organization in making a second level determination.

For level two appeals, the Company will acknowledge in writing that your request has been received and that it has been forwarded to the Independent Review Organization.

When the Independent Review Organization reaches a decision, the Company will respond in writing to you and to the Claims Administrator with the decision within 15 calendar days after an appeal is received for a required Concurrent Care coverage determination, and within 30 calendar days after an appeal for a Post-Service coverage determination is received.

If more time or information is needed to make the determination, the Company will notify you in writing to request an extension of up to 15 calendar days and specify any additional information needed to complete the review.

There is no charge for you to initiate this second level appeal process. The Claims Administrator and your Employer will abide by the decision of the Independent Review Organization.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Doctor would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing hospital stay. When an appeal is expedited, the Company will respond orally with a decision within 72 hours, followed up in writing to you and to the Claims Administrator.

Rights After Appeal

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

Authority to Make Final Binding Decisions on Appeal

The Claims Administrator has the full discretion and authority to make final determinations of questions concerning the interpretation or administration of the Plan for internal appeals, including, without limitation, all questions relating to eligibility for any dental benefit. The Claims Administrator has full discretion and authority to finally grant or deny dental benefits under the appeals process of the Plan.

Written or Electronic Notifications

All notifications regarding claim decisions shall be either written or electronic, except as discussed in the Subsection entitled "Urgent Care Claim". Electronic notification will comply with standards imposed by the Claims Administrator consistent with applicable guidance.

This written or electronic notification can be included as part of the expedited method used as provided above (for example, if facsimile transmission is used).

Payment of Benefits

Dental Benefits will be paid:

a. to the Dentist, if you have assigned benefits directly to the Dentist; or

b. to you, in all other cases.

You will have 12 months from the date of service to submit a claim. The Claims Administrator will pay benefits when it receives satisfactory written proof of your claim.

Dental Expense Coverage After Benefits End

No benefits will be payable for Covered Dental Expenses incurred after coverage under a Dental Option ends. This will apply even if the Claims Administrator has pre-determined benefits for dental services. However, benefits for Covered Dental Expenses incurred for the following services will be paid after coverage under a Dental Option ends:

For a prosthetic device if:

a. the Dentist prepared the abutment teeth and made impressions while coverage under a Dental Option was in effect for the Covered Person; and

b. the device is installed within 31 days after the date the coverage ends.

For a crown if:

a. the Dentist prepared the tooth for the crown while coverage for the Covered Person was in effect; and

b. the crown is installed within 31 days after the date the coverage ends.

For root canal therapy if:

a. the Dentist opened the tooth while the coverage for the Covered Person was in effect; and

b. the treatment is finished within 31 days after the date the coverage ends.

Impact of Government Plans on Dental Benefits

To the extent that services or supplies, or benefits for them, are available to a Covered Person under a Government Plan, as defined below, they will not be considered for Dental Benefits under the Dental Option. This provision will apply whether or not the Covered Person is enrolled for all Government Plans for which that Covered Person is eligible.

This provision will not apply to a Government Plan if that Government Plan requires that Dental Benefits under the Dental Option be paid first.

A "Government Plan" is any plan, program or coverage, other than Medicare or Medicaid, which is established under the laws or the regulations of any government, or in which any government participates other than as an employer.

Participation After Becoming Eligible For Medicare

Unless you are eligible for Medicare and elect Medicare as your primary plan, the Dental Option will pay first for:

- You, if you are an active Teammate and are 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 (currently 30) as specified by regulation of the Centers for Medicare and Medicaid Services for treatment of end stage renal disease received by any Covered Person; unless the Covered Person rejects, in writing, coverage under the Dental Option.

Special rules apply when you are covered by the Dental Option of this Plan and by Medicare. Generally, the Dental Option under the Plan is the Primary Plan if you are an active Teammate, and Medicare is the Primary Plan if you are a retired Teammate. Refer to the "Medicare Generally is the Secondary Plan" subsection of the "Coordination of Benefits" section for more information about Medicare coordination of benefits rules.

Subrogation

The Dental Option maintains the right to recover expenses incurred under the Dental Option from a third party. For instance, if expenses were incurred as the result of a negligent act by another person, the Dental Option reserves the right to try to recover costs from the negligent party or their insurer.

Refund to the Dental Option for Overpayment of Benefits

If the Dental Option pays Dental Benefits for you or your Dependent, and it is found that the Dental Option paid more Dental Benefits than it should have paid because the relevant expenses were not paid for by you or your Dependent, or because you or your Dependent received payment for the expenses from another source (other than pursuant to an insurance policy issued to you or a Covered Person in your Family who ordinarily lives in your home), the Claim Administrator will have the right to seek a refund from you. However, at the Claim Administrator's option, the Dental Option may recover the excess amount by reducing or offsetting any future benefits payable to you or your Dependent by the amount of the overpayment.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Group Plan and determines how benefits payable from all such Group Plans will be coordinated. You should file all claims with each Group Plan.

The Dental Option under this Plan requires information regarding other group health insurance coverage for you and any of your eligible Dependents. The Company and/or the Claims Administrator will periodically request other insurance information from you. This request may or may not occur in connection with a submitted claim. If so, you will be advised that the other insurance information (including an explanation of benefits from the other insurance carrier) is required before the submitted claim will be processed for payment. If no response is received within 90 days, the claim will be denied. If the requested information is subsequently received by the Claims Administrator, the claim will be processed according to the Schedule of Benefits.

Definitions

Group Plan means a plan which provides benefits or services for, or by reason of, dental care and which is:

- a group insurance plan; or
- a group blanket plan, but not including school accident-type coverages covering students in:
  - a grammar school;
  - a high school; or
  - a college;
- for accident only (including athletic injuries) either on a 24 hour basis or on a "to and from school basis"; or
- a group practice plan; or
- a group service plan; or
- a group prepayment plan; or
- any other plan which covers people as a group; or
- a governmental program or coverage required or provided by any law, except Medicaid or a Qualified Health Plan, but including any motor vehicle No Fault coverage which is required by law.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Group Plan. Each part of such a Group Plan which reserves the right to take the benefits or services of other Group Plans into account to determine its benefits will be treated separately from those parts which do not.

Dental Option means only those parts of the Plan which provide benefits or services for dental care. The provisions of the Dental Option which limit benefits based on benefits or services provided under:

- Government Plans, except Medicaid; or
- Plans which the Employer (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

Primary Plan/Secondary Plan

When the Dental Option is a Primary Plan, it means that the Dental Option's benefits are determined:

- before those of the other Group Plan; and
- without considering the other Group Plan's benefits.

When the Dental Option is a Secondary Plan, it means that the Dental Option's benefits:

- are determined after those of the other Group Plan; and
- may be reduced because of the other Group Plan's benefits.

When there are more than two Group Plans covering the person, the Dental Option may be a Primary Plan as to one or more of those other Group Plans and may be a Secondary Plan as to a different Group Plan or Group Plans.

Allowable Expense means any reasonable and customary charge which meets all of the following tests:

- it is a charge for an item of necessary dental expense; and
- it is an expense which a Covered Person must pay; and
- it is an expense at least a part of which is covered under at least one of the Group Plans which covers the person for whom claim is made.

When a Group Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Group Plan will be deemed to be Allowable Expenses.

When a Group Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expenses do not include:

- expenses for services rendered because of:
    - an Occupational Sickness; or
    - an Occupational Injury.
- any amount of benefits reduced under a Primary Plan because the Covered Person does not comply with the Dental Option provisions. Examples of such provisions are those related to:

- second surgical opinions;
- precertification of admissions or services; and

- preferred provider arrangements.

Only benefit reductions based upon provisions similar in purpose to those described in the prior sentence and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision will not be used by a Secondary Plan to refuse to pay benefits because a Health Maintenance Organization member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obliged to pay for providing those services.

Claim Determination Period means a period which starts on any January 1 and ends on the next December 31. However, a Claim Determination Period for any Covered Person will not include periods of time during which that person is not covered under the Dental Option.

Custodial Parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Effect on Benefits

When there is a basis for a claim under the Dental Option and another Group Plan, the Dental Option is a Secondary Plan which has its benefits determined after those of the other Group Plan, unless:

- the other Group Plan has rules coordinating its benefits with those of the Dental Option; and

- both those rules and the Dental Option's rules in subsection 3 of this Section B require that the Dental Option's benefits be determined before those of the other Group Plan.

If the Dental Option is a Secondary Plan, when the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under the Dental Option without applying this Coordination of Benefits provision; and

- the benefits that would be payable under all other Group Plans without applying Coordination of Benefits or similar provisions;

The benefits described in item 2(a) of this Section B will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Group Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Group Plans include all benefits that would be payable if the proper claims had been given on time.

When the benefits of the Dental Option are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of the Dental Option.

When more than one Group Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

- Non-dependent/Dependent. The Group Plan which covers that person other than as a dependent (for example, as an Teammate, member, subscriber or retiree) determines its benefits before the Group Plan which covers that person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - Secondary to the Group Plan covering the person as a dependent; and
    - Primary to the Group Plan covering the person as other than a dependent (e.g., a retired person); then the benefits of the Group Plan covering the person as a dependent are determined before those of the Group Plan covering that person as other than a dependent.
- Child Covered under More than One Plan. When the Dental Option and another Group Plan cover the same child as a dependent of different persons, called "parents":
    - the Primary Plan is the Group Plan of the parent whose birthday is earlier in the year if:
        - the parents are married;
        - the parents are not separated (whether or not they ever have been married); or
        - a court decree awards joint custody without specifying that one party is responsible for providing health care coverage.

    For example, if one parent's birthday were January 8 and the other parent's birthday were March 3, then the Group Plan covering the parent with the January 8 birthday would determine its benefits before the Group Plan covering the parent with the March 3 birthday.
    - if both parents have the same date of birth (excluding year of birth), the Group Plan which covered the parent for the longer time determines its benefits before the Group Plan which covered the other parent for the shorter time.
    - if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Group Plan of that parent has actual knowledge of those terms, that Group Plan is Primary. This paragraph does not apply with respect to any

Claim Determination Period during which any benefits are actually paid or provided before that Group Plan has that actual knowledge of the terms of the court decree.

- if the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:
    - the Group Plan of the Custodial Parent;
    - the Group Plan of the Spouse of the Custodial Parent;
    - the Group Plan of the Non-Custodial Parent;
    - the Group Plan of the Spouse of the Non-Custodial Parent.

Active/Laid-off or Retired Teammate. The Group Plan which covers that person as an active Teammate (or as that Teammate's dependent) is Primary to a Group Plan which covers that person as a laid-off or retired Teammate (or as that Teammate's dependent). If the Group Plan which covers that person has not adopted this rule, and if, as a result, the Group Plans do not agree on the order of benefits, this rule shall not apply.

Continuation Coverage. The Group Plan which covers the person as an active Teammate, member or subscriber (or as that Teammate's dependent) is Primary to a Group Plan which covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Group Plan which covers that person has not adopted this rule, and if, as a result, the Group Plans do not agree on the order of benefits, this rule d. shall not apply.

Longer/Shorter Time Covered. If none of the above rules determines the order of benefits, the Group Plan which has covered the Teammate for the longer time determines its benefits before the Group Plan which covered that person for the shorter time.

Medicare Generally is the Secondary Plan

As indicated in the "Participation After Becoming Eligible for Medicare" section, in most instances, the Dental Option will be the Primary Plan and Medicare will be the Secondary Plan as explained in that section.

However, Medicare will be the Primary Plan:

- The 31st month after an individual under age 65 begins treatment for End Stage Renal Disease and services are rendered during the first 30 months of treatment, and
- The date the Eligible Teammate terminates group coverage, terminates employment, retires, or ceases to be in an eligible class for group coverage.

For purposes of the Dental Option, Medicare coverage will be assumed if you are eligible whether or not you have actually enrolled in Part A or Part B.

A person is eligible for Medicare if he/she:

- Is covered under it,
- Refused it,
- Dropped it, or
- Failed to make a proper request for it.

Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get facts from or give them to any other organization or person. The Claims Administrator need not tell, nor get the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each Group Plan which covers the person for whom Allowable Expenses were incurred. Each person claiming benefits under the Dental Option must give the Claims Administrator any facts it needs to pay the claim.

Facility of Payment

A payment made under another Group Plan may include an amount which should have been paid under the Dental Option. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the Dental Option. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Claims Administrator is more than the Claims Administrator should have paid under this Coordination of Benefits provision, the Claims Administrator may recover the excess from one or more of:

- the persons the Claims Administrator has paid or for whom the Claims Administrator has paid;
- insurance companies; or
- other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.

The fact that a Dentist may recommend that a Covered Person receive a dental service does not mean:

- that the dental service will be deemed to be necessary; or
- that benefits under the Dental Option will be paid for the expenses of the dental service.

Statement of Rights Under ERISA

As a participant in the Dental Option, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all 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 Dental Option, 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 Dental Option, including insurance contracts and collective-bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the annual financial report of the Dental Option offered under the Plan. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Option Insurance

Continue dental insurance for yourself, Spouse or Dependents if there is a loss of coverage under the Dental Option as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SP and the documents governing the Plan on the rules governing your federal continuation coverage rights.

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the 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.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the 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.

Important Plan Information

Plan Name:	McLane Company, Inc. Welfare Plan This SPD describes the Dental Option offered under the Plan.
Name, Address and Telephone Number of Company:	McLane Company, Inc. 4747 McLane Parkway P.O. Box 6115 Temple, Texas 76503-6115 (254) 771-7500 Although the Company is the most significant Employer maintaining the dental benefits under the Plan, the dental benefits under the Plan may be adopted by affiliated companies. Participants and covered dependents may, upon written request to the Plan Administrator, receive information as to whether a particular Employer is a sponsor and, if so, the address of that Employer.
Name, Address and Telephone Number of Plan Administrator and Agent for Service:	McLane Company, Inc. 4747 McLane Parkway P.O. Box 6115 Temple, Texas 76503-6115 (254) 771-7500
Name, Address and Telephone Number of Claims Administrator:	Metropolitan Life Insurance Company 177 South Commons Drive Aurora, Illinois 60504-4102 Tel: 800-942-0584
Company's Tax ID Number:	74-1478631
Plan Number:	502
Type of Administration:	The Dental Option of the Plan is self-funded by the Company, who is also the Plan Administrator. The Plan Administrator for the Dental Option has the full power to control and manage all aspects of the Dental

	Option in accordance with its terms and all applicable laws. The Plan Administrator may allocate or delegate its responsibilities for the administration of the Dental Option to others and employ others to carry out or give advice with respect to its responsibilities under the Dental Option. Various aspects of the Dental Option are administered by the Claims Administrator.
Plan Year:	The Plan Year is the calendar year.
Type of Plan:	The Plan is a welfare benefit plan providing a variety of welfare benefits. Only the Dental Option which provides dental benefits under the Plan, is described in this SPD.
Sources of Plan Contributions and Plan Costs:	The dental benefits under the Plan are funded by contributions made by participants and the Employer. Participants make their contributions on a pre-tax basis under the Flexible Benefits Plan.

No oral interpretations can change the Dental Option offered under this Plan. The Dental Option described is designed to provide Covered Persons with certain dental benefits.

Your coverage and your Dependent's coverage under the Dental Option will take effect when you have satisfied the eligibility requirements, including any applicable Waiting Period, and you enroll yourself and your Dependents in the coverage.

The Company intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Dental Option offered under the Plan at any time and for any reason. Changes in the Dental Option may occur in any or all parts of the Dental Option including benefit coverage, Deductibles, maximums, Copays, Coinsurance, exclusions, limitations, definitions, eligibility and the like. If the Dental Option under the Plan are terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Dental Expenses incurred before termination, amendment or elimination.

Failure to follow the eligibility or enrollment requirements of the Dental Option under the Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the applicable Dental Option, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections,

utilization review or other cost management requirements, lack of medical necessity, lack of pre-certification, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this SPD.

The Dental Option will pay benefits only for Covered Dental Expenses incurred while coverage under a Dental Option is in force. No benefits are payable for Covered Dental Expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or sickness that occurred, began or existed while coverage was in force. A Covered Dental Expense incurred for a service or supply is incurred on the date the service or supply is furnished.

Definitions

Actively at Work or **Active Service** means that you are actively in service:

- on any of the Company'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 Company's place of business or at some location to which you are required to travel for the Company's business.

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

- if your employment status in not "terminated."

Cast Restoration means an inlay, onlay, or crown.

Claims Administrator means Metropolitan Life Insurance Company. Claims Administrator may also mean any successor named by the Plan Administrator.

Company means McLane Company, Inc. and any successor.

Covered Dental Expense means:

For In-Network Benefits

The charges based on the Preferred Dentist Program Table of Maximum Allowed Charges for the Types of Covered Dental Expenses shown in Section D of the "How Does the Plan Work?" section. These services must be:

- performed or prescribed by a Dentist who is a Participating Provider; and

- necessary as determined by Claims Administrator in terms of generally accepted dental standards.

No more than the Maximum Allowed Charge for the types of dental services shown in Section C may be a Covered Dental Expense. The Maximum Allowed Charge is the lower of:

- the amount charged by the Participating Provider for the service or supply; and

- the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

For Out-of-Network Benefits

The charges for the types of dental services shown in Section C. These services must be:

- performed or prescribed by a Dentist who is not a Participating Provider; and

- necessary as determined by Claims Administrator in terms of generally accepted dental standards.

No more than the Reasonable and Customary Charge for the types of dental services shown in Section C may be a Covered Dental Expense.

Covered Percentage means the percentage or percentages of Covered Dental Expenses, as shown in the Schedule of Benefits, that is payable as a Dental Benefit under a Dental Option.

Covered Person means a Teammate or a Dependent whose coverage is effective under a Dental Option.

Deductible Amount means the amount shown in the Schedule of Benefits to be paid by you or your Dependent to the provider before specific benefits become payable by the Dental Option. The Deductible Amount is an annual amount.

The Deductible Amounts during any one Plan Year will not apply to Covered Dental Expenses for your Family after you incur Covered Dental Expenses for Covered Persons in your Family and those expenses equal the Family Deductible Amount.

Dental Benefits mean the benefits which are provided to you or your covered dependent under a Dental Option.

Dental Option means the Dental Benefits provided under Dental Option I or Dental Option II as set forth in the Schedule of Benefits. Both Dental Option I and Dental Option II provide Type A, Type B, and Type C Dental Benefits. Dental Option II also covers orthodontic benefits, which are Type D Dental Benefits.

Dentures mean fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

Dentist means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a Doctor will be considered for Dental Benefits as if it were performed or prescribed by a Dentist.

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

Doctor means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

- there is a law which applies to the Dental Option and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and

- the service performed by the practitioner is within the scope of his or her license.

Employer means the Company and its eligible U.S. subsidiaries that participate in the Dental Option.

Family means you and your Dependents.

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

In-Network Benefits means the Dental Benefits provided under a Dental Option for covered dental services that are provided by a Dentist who is a Participating Provider.

Lifetime Maximum Orthodontic Benefit means the maximum aggregate Dental Benefit that Dental Option II will pay for Covered Dental Benefits for Orthodontic Treatment incurred by a Covered Person. The Lifetime Maximum Orthodontic Benefit applies to all Dental Benefits for Orthodontic Treatment ever paid by Dental Option II for the relevant Covered Person, regardless of the Plan Year in which the expense was incurred.

Maximum Dental Benefit means the maximum Dental Benefit that a Dental Option will pay for Covered Dental Benefits incurred by the Covered Person during the relevant Plan Year. The Maximum Dental Benefit excludes expenses for Orthodontic Treatment.

Occupational Injury means an injury which happens in the course of any work performed by the Covered Person for wage or profit.

Occupational Sickness means a sickness which entitles the Covered Person to benefits under a worker's compensation or occupational disease law.

Orthodontic Treatment generally means the initial placement of an appliance and a specified number of periodic follow-up visits as initially requested by the Dentist. Orthodontic treatment also includes other services required for the orthodontic treatment such as transseptal fibrotomy and extractions of certain teeth.

Out-of-Network Benefits means the Dental Benefits provided under a Dental Option for covered dental services that are not provided by a Dentist who is a Participating Provider.

Participating Provider means a Dentist who has been selected by Claims Administrator for inclusion in the Preferred Dentist Program. These Participating Providers agree to accept the Claims Administrator's Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

Placed for Adoption or **Placement for Adoption** 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.

Preferred Dentist Program means the Claims Administrator's program to offer a Covered Person the opportunity to receive dental care from Dentists who are designated by the Claims Administrator as Participating Providers. When dental care is given by Participating Providers, the Covered Person will generally incur less out-of-pocket cost for the services rendered.

Preferred Dentist Program Directory means the list which consists of selected Dentists who:

1. are located in the Covered Person's area; and

2. have been selected by the Claims Administrator to be Participating Providers and part of the Preferred Dentist Program. These Participating Providers agree to accept the Claims Administrator's Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

You may access the Preferred Dentist Program Directory on the internet at www.metlife.com or by calling MetLife Customer Service at 1-800-942-0854. The Preferred Dentist Program Directory will be periodically updated and will change without notice. It is your responsibility to verify that a dentist is a Preferred Dentist before services are rendered.

Preferred Dentist Program Table of Maximum Allowed Charges means the Claims Administrator's fee agreement with a Participating Provider in which such Participating Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

Reasonable and Customary Charge means the lowest of:

a) the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or

b) the usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or

c) the actual charge for the services or supplies.

Salaried Teammate means a Teammate who is paid compensation on a salaried basis and who is classified as a salaried Teammate by the Employer.

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

Teammate means a person who works for the Company and who is currently in Active Service.