MCLANE COMPANY, INC.

McLane Company Welfare Plan

Vision Service Plan (VSP)
Core and Premium Options

Summary Plan Description

January 1, 2021

VISION SERVICE PROVIDER (VSP) OPTIONS

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VISION COVERAGE OVERVIEW

This summary describes your voluntary vision benefits offered under the McLane Company, Inc. Welfare Plan (the "Plan") sponsored by your employer, McLane Company, Inc. There are two vision options offered under the Plan – the standard core vision option (the "Core Option") and the enhanced buy-up vision option (the "Premium Option").

Many important details about these benefits are contained in the "Evidence of Coverage," a document provided by Vision Service Plan Insurance Company (or a future insurer). The Evidence of Coverage and this summary are meant to be read together to form the summary plan description (SPD) for these benefits.

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

This SPD is only a summary of the vision benefits under 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 vision benefits as they appear in the official Plan documents. In the event of a conflict between this SPD and the Plan documents, the Plan documents will control. You may obtain a copy of the Plan documents by requesting a copy from the Plan Administrator. You may be required to pay reasonable copying costs for the Plan documents.

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 for vision 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 vision 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 vision 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 vision 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 vision option that will become effective on the 60th Day of Active Service.

You must make the election for vision coverage 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 vision 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.

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

Vision benefits end on the last day of the pay period in which your employment ends (exception, see "COBRA Continuation Coverage" section).

Initial Deadline to Apply for Coverage

Salaried Teammates and Drivers must complete the enrollment process within 31 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 a Salaried Teammate or a Driver and you do not enroll in a vision 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 the Premium Option. The required monthly contribution amount for the Core Option and the Premium Option 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 vision 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 unless your rehire is in a new Plan Year.

If you are rehired and your rehire date is more than 90 days from your prior termination date or you area rehired in a subsequent Plan Year, you may re-enroll in the same vision option or a different option, provided that you re-enroll within the required timeframe set forth in the Flexible Benefit Plan. You will be considered a new Teammate, subject to a new eligibility Waiting Period (if applicable).

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 vision 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 vision 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 vision coverage and the Plan, 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 for vision benefits for yourself under one of the vision options will become covered for vision benefits under that vision option on the date of his or her birth, adoption, or Placement for Adoption if you elect Dependent vision benefits 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 dpendent audit process within 60 days from the time of birth, adoption or Placement for Adoption this child will not have vision coverage. No benefits for expenses incurred will be payable and you will be required to wait until the next Open Enrollment Period to elect vision 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 vision 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 vision 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 vision 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 vision coverage outside of the Plan and you lose this other vision coverage, you may be able to enroll yourself and your Dependents in one of the vision options offered under the Plan (even if the Open Enrollment Period has closed), if the following conditions are met:

- loss of 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 vision 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 vision 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 vision 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 vision 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 vision 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 vision options operate 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 the Plan 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 vision options under 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 vision coverage under the Plan.

Government or Educational Plan

The Plan may permit you to make an election to add vision 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.

Covered Services and Expenses

You will pay more if you participate in the Premium Option instead of the Core Option. The Premium Option provides the following enhanced benefits as more fully described in the Evidence of Coverage:

- An additional $20 allowance for Costco frames.
- An additional $30 allowance for frames + an additional $20 for feature frame brands.
- An additional $30 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts.
- Anti-reflective lenses are covered after a $20 copay.
- An additional $10 allowance towards contact lenses.

The following tables provides a comparison of the Core Option and the Premium Option using a VSP participating provider:

CORE OPTION	BENEFIT DESCRIPTION	COPAY
Well Vision Exam	• Focuses on your eyes and overall wellness • Every calendar year • KidsCare: Two every calendar year for dependent children	$10
Prescription Glasses		$15
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco frame allowance • Every other calendar year, • KidsCare: Every calendar year for dependent children	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year • KidsCare: One additional pair of lenses if needed, for dependent children. Minimum prescription change required.	Included in Prescription Glasses
Lens Enhance-ments	• Every calendar year • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • UV Protection • Average savings of 20.25% on other lens enhancements	$0 $95-$105 $150-$175 Covered in full
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60

Diabetic Eyecare Plus Program	• Retinal screening for members with diabetes • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$0 $20
Suncare	• $150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts • Every other calendar year	$15

PREMIUM OPTION	BENEFIT DESCRIPTION	COPAY
Well Vision Exam	• Focuses on your eyes and overall wellness • Every calendar year, • KidsCare: Two every calendar year for dependent children	$10
Prescription Glasses		$15
Frame	• $180 allowance for a wide selection of frames • $200 allowance for featured frame brands • 20% savings on the amount over your allowance • $100 Costco, Sam's Club, and Walmart frame allowance • Every other calendar year, • KidsCare:Every calendar year for dependent children	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year • KidsCare: One additional pair of lenses if needed, for dependent children. Minimum prescription change required.	Included in Prescription Glasses
Lens Enhance-ments	• Every calendar year • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Anti-reflective lenses • Average savings of 20.25% on other lens enhancements • UV Protection	$0 $95-$105 $150-$175 Covered after $20 Covered in full
Contacts (instead of glasses)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
Diabetic Eyecare Plus Program	• Retinal screening for members with diabetes • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD).Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$0 $20
Suncare	• $180 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts • Every other calendar year	$15

Please refer to the Evidence of Coverage for additional information on vision services, expenses and cost to you (i.e. copays) under the vision option that you participate in under this Plan.

Participating Providers

Please refer to the Evidence of Coverage for information on participating and out-of-network providers. Participating provider lists are furnished automatically in a separate document free of charge.

Exclusions and Limitations

Please refer to the Evidence of Coverage for information on excluded expenses, services and other limitations for vision benefits.

Amendment/Termination

The Company may amend or terminate all or any part of the vision coverage 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 vision coverage under the Plan that (1) do not significantly increase the costs of the Core Option or Premium 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 vision coverage under the Plan.

Qualified Medical Child Support Order

If you or the Plan receives a medical child support order requiring you to provide health 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 health 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 health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a 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 Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except that an order may require the Plan to comply with state laws regarding child health care coverage. If you need additional information concerning Qualified Medical Child Support Orders, please contact the Plan Administrator for a copy of the Plan's Qualified Medical Child Support Order procedures, which will be furnished to you free of charge.

Default coverage will be provided to alternate recipient(s) if the Qualified Medical Child Support Order does not specify the vision coverage for which such alternate recipient must be enrolled but specifies that such coverage must be provided. If you are enrolled in coverage, the default coverage will be the coverage you are currently enrolled in for vision coverage.

The child (and you, if you are not already enrolled) will be automatically enrolled in the applicable vision 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 Vision Benefits During Leave

Vision 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 vision 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 vision coverage pursuant to COBRA.

If you do not continue vision coverage or your vision 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 vision 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 vision coverage prospectively by resuming premium payments, and

    - May retroactively reactivate vision benefits for the period that you were out on an unpaid FMLA leave, as long as you timely pay all outstanding vision 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 coverage during your leave due to non-payment of insurance premiums, you may be reinstated in the Core Option or Premium Option that you previously participated in 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 to the extent that you had satisfied the Waiting Period, if applicable, prior to the start of such FMLA leave.

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 vision 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 vision coverage limitations will apply.

Medicaid

The vision options of this Plan will not take into account your eligibility or your Dependents' eligibility for health assistance or benefits payable under 42 U.S.C. §1396 et seq.

Plan Administration

The primary responsibility for the general administration of the vision benefits 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 vision coverage and benefits under the Plan. 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 vision benefits and to interpret the terms of the vision options 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 that you cease to be an eligible Teammate or cease to qualify for coverage.
- the last day of the pay period for which you have made all required contributions for the 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 vision benefits of the Plan terminate.

Termination of Coverage – Dependents

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

- the last day of the pay period for which your 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 for which all required contributions for the coverage have been made; or

- the last day of the pay period for 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 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 vision benefit option under this Plan offer you and your covered family members the opportunity to extend existing health coverage (COBRA) when your current Employer provided coverage ends due to a Qualifying Event. Read this notice carefully as you 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 vision coverage under the applicable vision benefit 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 a 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 vision 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 vision benefit 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 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 vision benefit 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 vision benefit options 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

Please refer to the "How to Use this Plan" section and the "Claim Payments and Denials" section of the Evidence of Coverage for information on filing claims and the claims review procedures. **The information below supplements the sections above in the Evidence of Coverage. This means that you should read this section together with the Evidence of Coverage for a complete understanding on filing claims and following claim review procedures.**

When you use a network provider, identify yourself as a member at the time of the services. You will pay your co-payment and any amounts for services and materials not covered by the vision option in which you participate. No paperwork or claim forms are required when you use a participating preferred provider.

If you select an out of network provider, you may be required to pay for services in full at the time they are rendered unless you have completed a valid assignment of benefits. If you pay for services when they are rendered, you will then have to seek reimbursement by mailing a completed claim form with a copy of your bill to:

Vision Service Provider (VSP)
PO Box 385018
Burmingham, AL 35328-5018

You should file your claim as soon as possible as claims must be submitted within 365 calendar days from the date services or materials are rendered.

Initial Determination: If VSP extends the time by no more than fifteen (15) days, it will do so only if VSP has both (i) determined that such extension is needed and beyond VSP's control and (ii) notifies you prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date VSP expects to render a decision.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to VSP within 45 days after receiving the notice. The determination period will be suspended on the date VSP sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination: If your claim is denied you will receive notice of the Adverse Benefit Determination. A notice of an Adverse Benefit Determination will be provided in writing and/or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific vision option Plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable, including a statement of your right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on appeal; (5) a description of any internal rule, guideline, protocol or other similar criterion (collectively "Protocols") that were relied upon in making the adverse determination regarding your claim, or a statement that a copy of such Protocols will be available, free of charge, upon your request; and (6) an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit applying the terms of the vision coverage of the Plan, as applicable to the your medical circumstances.

If you do not receive notice of the decision on the claim within the prescribed times periods, the claim is deemed denied. In that event you may proceed with the appeals procedure described below.

Claim Denial Appeals: You must file a written appeal with:

Vision Service Provider (VSP)
PO Box 385018
Burmingham, AL 35328-5018

The review of your appeal shall be reviewed without affording deference to the initial Adverse Benefit Determination and will not be conducted by the individual who made the initial review, nor a subordinate of such individual. Further, the Plan will provide you with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the benefit determination. If a health care professional is engaged for consultation in connection with the benefit determination, such individual shall not be the individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor a subordinate of such individual.

Notice of Benefit Determination on Appeal: A notice of a determination or appeal will be provided in writing and/or electronically by the determining party. If an adverse determination is rendered, it will include the following: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provision on which the determination is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information; (4) a statement that you have a right to bring an action under ERISA section 502(a); (5) a description of any Protocols that were relied upon in making the adverse determination regarding your appeal, or a statement that a copy of such Protocols will be available, free of charge, upon your request; and (6) an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

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 vision benefit. The Claims Administrator has full discretion and authority to finally grant or deny vision benefits under the appeals process of the Plan.

Written or Electronic Notifications

All notifications from the Claims Administrator will be either written or electronic. Electronic notification will comply with standards imposed by the Claims Administrator consistent with applicable guidance.

Statement of Rights under ERISA

As a Participant in this vision benefit 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 Vision Benefit Option 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 vision benefit option, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the vision benefit option of 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 vision benefit option of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the vision benefit option's annual financial report. The Plan Administrator is required by law to furnish each Participant under the vision benefit option with a copy of this summary financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the vision benefit option on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the vision benefit option, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for vision benefit option Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the vision benefit option, called "fiduciaries" of the vision benefit option, have a duty to do so prudently and in your interest and in the interest of other vision benefit option 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 vision benefit option documents or the latest annual report from the vision benefit option 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 vision benefit option's decisions or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. 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 vision benefit option fiduciaries misuse the vision benefit option'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 vision benefit option, 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 vision benefit options 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 vision benefits under the Plan, the vision 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:	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:	Vision Service Plan Insurance Company PO Box 385018 Burmingham, AL 35328-5018 800-877-7195 www.vsp.com
Company's Tax ID Number:	74-1478631
Plan Number:	502

Agent for Legal Process:	CT Corporation 1999 Bryan Street Suite 900 Dallas, TX, 75201
Type of Administration:	Both the Core Option and the Premium Option are fully-insured by VSP.
Plan Year:	The Plan Year is the calendar year.
Type of Plan:	The Plan is a welfare benefit plan which provides health benefits. This SPD describes the vision benefit options offered under the Plan.
Sources of Plan Contributions and Plan Costs:	The vision 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

Definitions

Active Service

You will be considered in Active 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."

Adverse Benefit Determination

Adverse Benefit Determination means any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigation or not medically necessary or appropriate. An Adverse Benefit Determination also includes a retroactive cancellation or discontinuance of coverage under the Plan.

CHIP

CHIP means a state children's health insurance program under Title XXI of the Social Security Act.

Claims Administrator

Claims Administrator means Vision Service Plan Insurance Company of its successor.

Company

Company means McLane Company, Inc. The Teammates of the Company and its eligible U.S. subsidiaries participate in this Plan.

Driver

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

Employer

The term Employer means the Company and all affiliated employers and subsidiaries who adopt the vision benefit option benefits of the Plan in the form and manner required by the Company.

Flexible Benefit Plan

Flexible Benefit Plan means the McLane Company, Inc. Flexible Benefit Plan which allows pre-tax contributions.

Hourly Teammate

Hourly Teammate means a Teammate who is compensated on an hourly basis and who is classified as an hourly Teammate by the Company.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Military Leave

The term Military Leave means the absence due to the performance of duty on a voluntary or involuntary basis under competent authority in (1) the Armed Forces, (2) the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, (3) the commissioned corps of the Public Health Service, and (4) other categories of persons designated by the President in time of war or emergency for a period of up to thirty (30) days during which a person who previously qualified as an eligible Teammate (excludes retirees) is not employed on a full-time basis solely because the person is engaged in active military service for the United States government.

Open Enrollment Period

The re-occurring annual time period normally held at designated dates during the fall preceding the Plan Year for which a Participant's annual election will be in effect.

Participant

The term Participant means you and any of your covered Dependents whose vision coverage has become effective under the Plan.

Placed for Adoption or Placement for Adoption

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

Plan Administrator

The term Plan Administrator means the Company.

Salaried Teammate

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

Spouse

The term Spouse means your legal Spouse, whether same-sex or opposite-sex, in a marriage validly entered into under the laws of a state of the 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

The term Teammate means an employee on the payroll of an Employer. The term does not include temporary employees or leased employees.

Waiting Period

Waiting Period means the period that must pass with respect to the individual before the individual is eligible to be covered for vision benefits under the terms of the vision option. Any period of time before a late enrollee enrolls under a Special Enrollment Period is not a Waiting Period.