2015
Health and group benefits summary plan description

CardinalHealth

cardinalhealth.com

Important information

This summary plan description (SPD) describes the benefit programs of the Cardinal Health Group Benefits Plan, effective January 1, 2015. It does not interpret, extend or change the terms of these benefit programs in any way. The full provisions of the benefit programs can only be determined precisely by consulting the applicable benefit program plan documents. In the event of any discrepancy between this SPD and the actual provisions of the plan documents, the plan documents will govern.

Cardinal Health retains the right to suspend, modify, amend or terminate the benefit programs described in this SPD at any time without notice. In addition, Cardinal Health as plan administrator is authorized to interpret the terms and provisions of the benefit programs and plan documents. Cardinal Health has the discretionary authority to determine who is eligible for the benefit programs under the plan and to construe and enforce the terms of the plan. In some cases, these powers may be exercised by insurance companies that have been given the authority to administer a particular benefit program on behalf of Cardinal Health.

Questions?

If you have questions about any of the information included in this SPD, or if you would like to learn about recent health and group benefits updates, you can get online information via the myHR website at **hr.cardinalhealth.com**. You also can call the myHR Service Center at **866.471.7867**. When you call, you will need your user ID and password.

You can log on wherever you have Internet access — from home, work or even a computer at the library, for example. When you log on, you will need your Enterprise ID and password. Then, once you have entered the site, follow the simple instructions to learn about your health and group benefits; to enroll; or to make changes during the year. If you do not have a password, call the myHR Service Center at **866.471.7867** between 9 a.m. and 8 p.m., Eastern time (ET), Monday through Friday. A temporary password is only good for 24 hours, so go online immediately to create a permanent one.

Non-Plan Benefits

For your convenience, following the SPD is general information about other benefits offered by Cardinal Health outside of the plan. The discussion of these benefits can be found in the “Other Benefits” section.

Contents

Overview

How to use this summary plan description

This SPD is designed to help you get the most value out of your health and group benefits program and the coverage you have selected.

The chart below shows what you will find in each section.

Section	What you will find
Overview	This section highlights the features that pertain to all or most of your health and group benefits options.
Medical	Here is where you will find details about your medical options, as well as your prescription drug benefits.
Dental	This section describes your dental care options.
Vision	This section describes your vision care benefits.
Life and accidental death and dismemberment insurance (AD&D)	Here you will learn about: • Basic employee life insurance; • Supplemental employee life insurance; • Dependent life insurance available for your spouse/domestic partner and your dependents/dependents of your domestic partner; • Basic employee AD&D insurance; • Supplemental AD&D insurance; and, • Business travel accident insurance.
Disability	This section focuses on income protection during periods of short-term and long-term disability. It also describes the supplemental short- and long-term disability coverage options.
Flexible spending accounts	This section explains how you can participate in the flexible spending accounts. It also explains how you can use your contributions to help pay many of your healthcare and dependent care expenses with tax-free dollars.
Employee assistance program/Work-Life Solutions	This section describes the employee assistance program.
Severance benefit	This section describes your benefits upon severance from employment.
Commuter benefit	This section explains how you can participate in the Commuter Benefit program. It also explains how you can enroll to help pay commuter cost expenses with tax-free dollars.
Wellness Center	This section describes the Wellness Center available on the Dublin campus.
Retiree medical	This section describes benefits available upon and after retirement.
Administering the plan	If you want to know how the health and group benefits program is administered or more about your legal rights as a plan participant, be sure to read this section.

What the health and group benefits program offers

The health and group benefits program includes basic coverage that is provided by Cardinal Health (at no cost to you), as well as supplemental coverage that you can elect (or decline) each year during the annual enrollment period. If you are eligible for the health and group benefits program, you can cover yourself only or you can cover yourself and your eligible family members — whichever makes the most sense for your personal situation. And, you can make changes to your coverage. This can be done annually during the enrollment period, or — if you experience a qualified life event — you may be able to make changes during the year as well.

Basic coverage

Cardinal Health provides the following coverage at no cost to you:

- Basic employee life insurance
- Basic employee AD&D insurance
- Basic employee short-term disability
- Basic employee long-term disability
- Business travel accident insurance
- Severance benefits
- Employee assistance program/Work-Life Solutions

Supplemental coverage

You also have the option to elect coverage in the following programs. You and Cardinal Health share the cost of your healthcare coverage. You pay the full cost (at group rates) for supplemental life, disability and AD&D insurance coverages. You also can decide whether to contribute to the flexible spending accounts. Your supplemental coverage choices include:

- Medical (includes prescription drug coverage)
- Dental
- Vision
- Healthcare flexible spending account
- Dependent care flexible spending account
- Supplemental short-term disability

- Supplemental long-term disability
- Supplemental employee life insurance
- Spouse life insurance (includes life insurance for domestic partners)
- Child life insurance (includes life insurance for domestic partner's children)
- Supplemental AD&D insurance

If you do not elect any supplemental coverage, you will automatically receive the basic coverage that is provided by Cardinal Health. Your basic coverage will remain in effect until the next annual enrollment period, when you will have another opportunity to elect supplemental coverage.

Notwithstanding the above, if you live in Hawaii, you will be provided medical coverage as required by the state.

If you work in a state that requires a state-defined disability plan, you also will be covered under the provisions of the laws and regulations of that state plan.

As an employee of Cardinal Health, you also have access to the Wellness Center at the Dublin campus. Although you are not required to make contributions in order to access the Wellness Center, you are required to pay for any services received there.

Your Cardinal Health short-term disability benefit will be reduced by the amount you are eligible to receive under the state disability program.

In addition, you will not be able to elect or change coverage until the next annual enrollment period, unless you experience a "qualified life event" or you satisfy the requirements for enrolling under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) special enrollment periods as described in this SPD.

Who is eligible

As an employee, you may participate in all of the health and group benefits programs, provided you are eligible. Your dependents are eligible for certain coverages as well. This section provides more information about eligibility rules.

Eligible employees

You are eligible to participate if you are on a U.S. payroll and you are a:

- Non-union employee of an eligible business unit who works an average of at least 30 hours per week, or who is scheduled to work fewer than 30 hours per week but averages at least 30 hours worked per week during your Initial Measurement Period or the Ongoing Measurement Period that immediately precedes the calendar year;
- Union employee who is covered by a collective bargaining agreement that provides for such participation; or,
- Employee in Hawaii who works 20 or more hours per week and is eligible for certain coverages under the Hawaii Prepaid Health Care Act.

If your scheduled number of hours changes in the middle of an Initial Measurement Period or Ongoing Measurement Period, your eligibility will be determined in accordance with the final regulations on employer shared responsibility in the sole and absolute discretion of Cardinal Health.

The medical plans do not exclude any otherwise-eligible employees or dependents for pre-existing conditions.

Spouse
The individual to whom you are legally married through a governmental or religious ceremony. Cardinal Health also recognizes a common-law spouse as a dependent, as long as you live in a state that recognizes common-law marriages.

Incapacitated dependent
An unmarried dependent child over age 19 who is considered disabled due to a physical handicap and/or mental retardation as defined by your health plan.

Dependent children
A dependent child (generally under age 26). Full-time student status is no longer a requirement.

Ongoing Measurement Period
October 15 – October 14 each year.

Initial Measurement Period
The 12-month period starting with an employee's hire date.

Initial Stability Period
The 12-month period starting with the first day of the second month following the end of the employee's Initial Measurement Period.

Employees who are not eligible

- If you are hired by Cardinal Health as a leased or contract employee, you are not eligible to participate in the plan. Additionally, if you are a nonresident alien, a self-employed individual or classified by Cardinal Health as an independent contractor, you are not eligible to participate.
- You are not eligible to participate in the plan if you are scheduled to work fewer than 30 hours per week and do not average at least 30 hours worked per week during either your Initial Measurement Period or an Ongoing Measurement Period.

Eligibility for the employee assistance program/Work-Life Solutions

Notwithstanding the above, all employees, regardless of number of hours worked per week, who otherwise meet the plan eligibility criteria, have access to Work-Life Solutions. If you are eligible for Work-Life Solutions benefits, you and your household members (those who share your residence) may begin accessing those benefits immediately after you are hired. You and your household members will continue to be eligible to access the benefits while you are employed and for up to 18 months (or 29 months if you would qualify for a disability extension under COBRA, as described in this SPD) following your termination from employment. Your household members may also continue to access the benefits for 36 months after your death, or after the household member ceases to be a household member (for example, after a divorce).

Eligibility for severance benefits

Generally

Notwithstanding the above, if you are a regular, active, benefit-eligible employee who works at least 20 hours per week for Cardinal Health immediately prior to your termination of employment, are eligible as described below, and do not fall into one of the ineligible categories described below, you will generally be eligible to participate in the Severance Benefit Program.

There are two ways you may become eligible for a severance benefit or benefits under the Severance Benefit Program (severance benefit):

- Due to a Reduction in Force (a RIF); or,
- If the plan administrator determines you are eligible for a severance benefit.

RIF severance benefit eligibility

To be eligible for a severance benefit due to a RIF (a RIF severance benefit), your employment must terminate because of a RIF and you must continue to work for Cardinal Health until the date it specifies. A RIF occurs when Cardinal Health:

- Eliminates two or more job positions at the same time, which leads to the termination of at least two employees of Cardinal Health; and,
- Designates in a written notice that such elimination of job positions and terminations is a RIF.

If you are part of a RIF and eligible to retire at the time your employment would have otherwise terminated in connection with the RIF, you are still eligible to receive a RIF severance benefit.

Discretionary severance benefit eligibility

The plan administrator has the discretion to determine whether you will receive a severance benefit on account of your termination of employment with Cardinal Health, regardless of whether such termination is due to a RIF (a discretionary severance benefit). If the plan administrator determines you are eligible for a discretionary severance benefit, you will receive a notice detailing your discretionary severance benefit.

Receipt of severance benefit not automatic

If you are otherwise eligible for a severance benefit, you may receive it only if:

- The plan administrator determines you were terminated by Cardinal Health for a reason other than "cause" (as defined below);
- You sign and deliver to Cardinal Health, within the amount of time specified by the plan administrator, a severance agreement and general release provided by Cardinal Health and satisfactory in form and substance to it (Severance Agreement); and,
- You do not revoke any part of the Severance Agreement.

Receipt of all or any portion of a severance benefit also may be conditioned on such other requirements as the plan administrator may specify. At the sole discretion of the plan administrator, your Severance Agreement may contain terms and provisions that are different from the Severance Agreements provided to other employees.

Release requirement

Under the Severance Agreement, you will be required to release any and all legal claims you have or may have against Cardinal Health and all related entities and persons through the date on which the Severance Agreement is signed. The release of claims will include, without limitation, any claims arising out of your employment with, or separation of employment from, Cardinal Health. The release of claims will not affect your eligibility for Workers' Compensation benefits or any vested rights you have under any company employee benefit plan. At the sole discretion of the plan administrator, your Severance Agreement may contain release terms that are different from the release terms provided in the Severance Agreement of other employees.

When you receive your severance benefit

The plan administrator will determine the date by which you must return your signed Severance Agreement, and the Severance Agreement will specify such date and the date on which your severance benefit will be paid and/or start. The date by which you must return your signed Severance Agreement will not be more than 90 days after your last day worked. Also, note if you are a "specified employee," generally defined as one of the top 50 officers by pay, the payment of some or all of your severance benefit may have to be delayed until six months after the date of your separation from service in certain circumstances in order to comply with Section 409A of the Code. If this required delay applies to you, it will be explained and included in the terms of your Severance Agreement.

Ineligible employees

Notwithstanding the information provided above, unless otherwise determined by the plan administrator, you will not be eligible to receive a severance benefit if you:

- Are not a regular, active employee of Cardinal Health in good standing on the date of your termination of employment;
- Are covered by a collective bargaining agreement;
- Voluntarily resign your employment with Cardinal Health;
- Are terminated from employment with Cardinal Health for "cause" (as defined below);
- Are on disability leave on the date when your employment with Cardinal Health terminates;
- Have an employment agreement with Cardinal Health that contains a severance pay or similar provision;
- Are offered comparable employment with Cardinal Health or one of its related companies, divisions or business units, or with a successor organization, with any affiliated company or with an unrelated third-party purchaser of all or substantially all of the assets of Cardinal Health or one of its related companies, divisions or business units; or,
- Do not timely sign and deliver the Severance Agreement, or revoke any part of, or breach any obligation under, the Severance Agreement.

For purposes of the Severance Benefit Program, "cause" means you engaged in one or more of the following:

- Neglect or misconduct in the performance of your employment duties and responsibilities;
- A material breach of fiduciary duty;
- Conduct that could injure the integrity, character or reputation of Cardinal Health; or,
- Unsatisfactory job performance.

The plan administrator, in its sole discretion, determines whether you are terminated for cause.

If, based on information received after your employment terminates, the plan administrator discovers that you could have been terminated for cause, you will be treated as having been terminated for cause for purposes of the Severance Benefit Program.

Eligible dependents

Your eligible dependents are your:

- **Legal spouse**, including a common-law spouse in states that recognize common-law marriages.
- **Domestic partner** (same sex or opposite sex).

- **Dependent children**, including:
  - Your natural children;
  - Children of your domestic partner;
  - Your legally adopted children;
  - Children placed with you for adoption;
  - Your stepchildren; and,
  - Any other children who live with you for whom you or your spouse are the legal guardian, or for whom your domestic partner is the legal guardian (including grandchildren, if you, your spouse or your domestic partner is the legal guardian).
- Coverage for eligible dependents continues as long as your own coverage continues. However, your dependent child's coverage ends at the end of the month in which he or she turns age 26 unless the child is an **incapacitated dependent** who is unmarried and disabled due to a mental or physical disability as defined by your health plan (and who is continuously covered under the plan) and who has the same principal place of abode as the employee for more than one half of the taxable year.

If your spouse/domestic partner or dependent works at Cardinal Health and is eligible for health and group benefits, you have some unique choices to make.

You both may choose "You only" for medical, dental or vision coverage. Or, you may share your coverage if one of you elects spouse/domestic partner or family coverage.

It is important to remember that you cannot enroll for dependent coverage on each other.

If one employee chooses to cover his or her spouse/domestic partner under his or her plan, the other spouse/domestic partner must elect "No coverage." In addition, children may only be covered as dependents under one parent.

With life and AD&D insurance, you may only be covered as an employee, and your child may only be covered as the dependent of one parent. You cannot be covered under both employee life insurance and dependent life insurance as a spouse/domestic partner.

When you enroll a dependent in the plan, you represent that the individual is eligible under the terms of the plan and you will provide proof that any dependents you cover are eligible dependents under the plan guidelines. Further, you understand that:

- The plan is relying on your representation of eligibility in accepting the enrollment of your dependent(s);
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and,
- Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date on which the individual became ineligible for plan coverage, as determined by the plan and subject to the plan's provisions on rescission of coverage.

Verification of marriage or domestic partnership

Domestic partner eligibility information

You can cover your same-sex or opposite-sex domestic partner, and any children of your domestic partner, under all Cardinal Health programs that allow domestic partner coverage. To qualify for coverage, you must meet the following requirements:

- You and your partner are age 18 or older;
- You share a committed, exclusive relationship;
- You share a residence;
- You are both unmarried;
- You are financially interdependent; and,
- You are not related in a way that would prevent marriage.

If you are adding a domestic partner or child of a domestic partner to your health and group benefits coverage, you may need to submit evidence that you meet these requirements.

Please note that Internal Revenue Service (IRS) regulations require employee premiums for domestic partner coverage to be paid on an after-tax basis. For administrative convenience, premiums are paid on a pre-tax basis and then are imputed into income. This amount will be added to your per-pay-period gross income as shown on your pay stub. IRS regulations also state that before-tax dollars contributed to the healthcare or dependent care flexible spending account cannot be used to reimburse expenses incurred by domestic partners and their dependents, unless the person receiving reimbursement qualifies as your IRS tax dependent.

Covering same-sex spouses

The IRS has ruled that legal same-sex marriages will be recognized for federal tax purposes as of September 16, 2013. Once you complete the verification process, you will no longer be charged imputed income for federal tax purposes on the value of the coverage that's provided, but you will continue to be charged for state and local purposes in jurisdictions where same-sex marriage is not recognized.

Spouse eligibility information

As noted above, your legal spouse through a governmental or religious ceremony is eligible for coverage. If you live in a state that recognizes common-law marriage, your common-law spouse is also eligible. If you are adding a legal spouse to your coverage, you will need to submit evidence that your spouse meets these requirements, or be registered as domestic partners under a state or local law.

Qualified Medical Child Support Order (QMCSO)

The health and group benefits plan also provides health coverage for your child due to the terms of a Qualified Medical Child Support Order (QMCSO). This coverage applies even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If Cardinal Health receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, Cardinal Health may withhold from your paycheck any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the company to cover a child under the program. Please provide such documentation to the Corporate Benefits Department immediately upon issuance. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. Cardinal Health follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the child support order qualification procedures, please contact Cardinal Health Corporate Benefits.

For additional information regarding enrolling a dependent due to a QMCSO, see "Enrollment Pursuant to a Qualified Medical Child Support Order (QMCSO)" below.

When coverage begins

If you meet the eligibility and enrollment requirements, your coverage begins on your date of hire or such other date as set forth in the "Who is eligible" section above. You must be actively at work for some benefits to begin.

Dependent coverages begin on the same day as your coverages begin, or the day your dependent first becomes eligible (whichever is later). Details regarding adding a dependent to coverage due to a qualified life event are provided herein.

Remember, you must enroll before medical, dental, vision, supplemental employee life, dependent life, supplemental AD&D, supplemental short-term disability and supplemental long-term disability coverages begin. You also must elect to participate in the flexible spending accounts before you can start contributing.

How to enroll

When you first become eligible, and each year during the annual enrollment period, you have the opportunity to select the benefit options you want.

When you first become eligible

Once you are eligible, you will receive an enrollment overview in the mail. You also will have access to the myHR website, which provides lots of information about your health and group benefits, as well as a way to enroll for your coverage online. You can access the myHR website at **hr.cardinalhealth.com**. You will need your Enterprise ID and password. Once on the website, you can access the **Benefits Center** link.

Plan year
January 1 – December 31

You'll pay less for medical coverage if you and your covered dependents do not use tobacco

You can receive a discount on your medical premiums — up to $600, which will be prorated based on your hire date — by signing a household tobacco-free pledge when you enroll or complete a tobacco cessation alternative program **within 180 days from your hire date**. You can conveniently take this pledge during the online enrollment process. Tobacco pledges can be changed during the plan year due to a qualified life event as long as the employee is enrolled in medical. In addition, if you quit smoking during the year, your election is updated.

Need help quitting? If you are not able to sign the tobacco pledge because one or more covered persons in your household use tobacco, you can still earn the tobacco credit by taking certain actions **within 180 days from your hire date**:

You must complete the tobacco-free pledge each year. If you are not able to sign the tobacco pledge because one or more covered persons in your household use tobacco, you can still earn the tobacco credit by taking certain actions:

- **Employees and spouses/domestic partners:** Employees and covered spouses/domestic partners can complete a free tobacco cessation program, which is available through our Healthy Lifestyles partner StayWell. There are three program delivery options available in addition to free nicotine replacement therapy. Employees and covered spouses/domestic partners can enroll in a phone, mail or online tobacco cessation program by calling StayWell at **866.280.9835**.
- **Dependents:** The StayWell tobacco cessation program is not available to tobacco-using dependents, so covered dependents are encouraged to call the Benefits Center at 866.471.7867 to arrange to meet one-on-one with their physician for a tobacco cessation consultation.

To earn the tobacco credit without making the tobacco-free pledge, each covered person who uses tobacco must complete the StayWell tobacco cessation program or, in the case of dependents, have their physician complete a form certifying that the dependent has had a tobacco cessation consultation. If all covered tobacco users complete these activities by June 30, 2015, you will earn the $600 tobacco credit toward your 2015 premiums.

Employees and spouses/domestic partners: Employees and covered spouses/domestic partners can complete a free tobacco cessation program, which is available through our Healthy Lifestyles partner, StayWell®.

There are two program delivery options available in addition to free nicotine replacement therapy. Employees and covered spouses/domestic partners can enroll in a phone- or mail-based tobacco cessation program by calling StayWell at **866.280.9835**.

Dependents: The StayWell tobacco cessation options are not available to tobacco-using dependents, so covered dependents are encouraged to call the Benefits Center at **866.471.7867** to arrange to meet one-on-one with their physician for a tobacco cessation consultation.

To earn the tobacco credit without making the tobacco-free pledge, each covered person who uses tobacco must complete the StayWell tobacco cessation program **within 180 days from your hire date** or, in the case of a dependent, have a physician complete a form certifying that the dependent has had a tobacco cessation consultation. If all covered tobacco users complete these activities **within 180 days from your hire date**, you will earn up to $600 toward your premiums, which will be prorated based on your hire date.

After you have reviewed your options and made your decisions about your benefit choices, you will have two ways to enroll — on the myHR website at **hr.cardinalhealth.com** or through the myHR Service Center at **866.471.7867**. The website is available 24 hours a day, seven days a week. Customer service representatives are available at the myHR Service Center from 9 a.m. to 8 p.m., Eastern time, Monday through Friday.

If you enroll online, you can print a confirmation statement of your benefit choices. If you make your elections with a myHR Service Center representative, you may request a confirmation statement be mailed to you. This coverage will continue through the remainder of the plan year unless you have a qualified life event (as defined herein) and decide to change your coverage. If you need to make any corrections to your benefit elections, please call the myHR Service Center to speak with a representative within the time period indicated on your confirmation of enrollment.

If you do not enroll within 31 days of your date of hire, you will automatically receive the basic Cardinal Health-provided coverages described above.

Annual enrollment period

Each fall, you may make changes to your benefits for the following plan year. You will receive information and updates about health and group benefits that can help you with your annual enrollment decisions. This information — available online and in the decision and enrollment guides — provides important tips on how to enroll. It describes enrollment procedures, the benefit options for which you are eligible and any changes that may have taken place since the last annual enrollment period.

Once you make your choices, you can enroll on the myHR website at **hr.cardinalhealth.com** or through the myHR Service Center at **866.471.7867**.

Enrollment pursuant to a Qualified Medical Child Support Order (QMCSO)

You, a custodial parent, a state agency or an alternate recipient may enroll a dependent child pursuant to the terms of a valid QMCSO. If you are not enrolled in the plan, you will be required to enroll in the same coverage as your dependent. A child who is eligible for coverage under a QMCSO may not enroll dependents for coverage under the health and group benefits plan.

Coverage under the program is subject to payment of the required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, a state agency makes the required contribution payment. Cardinal Health may withhold from your paycheck any required contributions for this coverage and send the contributions directly to the program.

Annual enrollment period

If you do not enroll within the annual enrollment period but you enrolled in the past, all of your current coverages, excluding your flexible spending account elections, remain in effect for the next plan year, if available. If an existing plan is being replaced and you do not enroll during annual enrollment, you will be assigned the default coverage for the eliminated plan. Each year, you will receive more information about the required enrollment process.

Special process for certain state disability claims

If you work in California, New Jersey, New York, Puerto Rico or Rhode Island, disability benefits are provided directly by the state or commonwealth. Please contact The Hartford to coordinate your state disability benefits.

Paying for your health and group benefits coverage

The amount you pay for your coverage depends on the options you select and whom you cover in each program. Each year during the annual enrollment period, you receive up-to-date cost information regarding your coverage. Your enrollment guide includes the employee contribution rates for the upcoming year so that you can make informed decisions regarding your coverage.

Before-tax vs. after-tax

You pay for certain coverages with before-tax dollars deducted from your paycheck each pay period. Using before-tax dollars reduces your taxable income for federal, Social Security and (in most cases) state income taxes. You pay for other coverages on an after-tax basis.

Refer to the table below for a list of benefits that are paid with before-tax dollars and those that are paid on an after-tax basis.

	Before-Tax	After-Tax
Medical	X*	
Dental	X*	
Vision	X*	
Healthcare flexible spending account	X	
Dependent care flexible spending account	X	
Supplemental short-term disability	X	
Supplemental long-term disability	X	
Supplemental employee life insurance		X
Spouse/domestic partner life insurance		X
Child/child of domestic partner life insurance		X
Supplemental AD&D insurance		X

*If you are covering a domestic partner, payment for those benefits must be made with after-tax dollars. As of 2014, employees with domestic partners can certify that their domestic partner is a tax dependent with an affidavit provided by the dependent verification team. If approved, domestic partner imputed income will be removed from the account.

Benefit pay

Benefit pay is used for determining your cost of benefits for all health and welfare benefits and is also used to calculate the amount of benefits you will receive upon making a claim for all health and welfare benefits except short-term disability, as separately described below.

Benefit pay — defined: Annual base pay calculated as follows:

Normal calculation

- For non-exempt employees, this equates to their base hourly rate times their standard weekly hours times 52 weeks.
- For exempt employees, this equates to their annual base salary in Workday.
- Benefit pay is recalculated annually using updated compensation data once the annual merit review process has been completed.

Exceptions:

- Sales Representatives hired after December 31 of the prior year:

If current annual base salary is greater than $50,000, then benefit pay is equal to the greater of current annual base salary or 75 percent of those gross earnings (base pay, draw and commissions).

If current annual base salary is less than $50,000, then benefit pay is equal to $50,000.

- Sales Representatives hired between July 1 and December 31 of the prior year:
  - If gross earnings paid (base pay, draw and commissions) for the prior fiscal year (July 1 through June 30) are less than $50,000, then benefit pay is equal to $50,000.
  - If gross earnings paid (base pay, draw and commissions) for the prior fiscal year (July 1 through June 30) are greater than $50,000 and commissions paid for the prior fiscal year are 25 percent or more of gross earnings, then benefit pay is the higher of the current annual base salary or 75 percent of those gross earnings paid.
  - If gross earnings paid (base pay, draw and commissions) for the prior fiscal year (July 1 through June 30) are greater than $50,000 and commissions paid for the prior fiscal year are less than 25 percent of gross earnings, then benefit pay is equal to current annual base salary.
- Sales Representatives hired before July 1 of the prior year:
  - If commissions paid for the prior fiscal year (July 1 through June 30) are 25 percent or more of gross earnings (base pay, draw and commissions), then benefit pay is the higher of current annual base salary or 75 percent of those gross earnings.
  - If commissions paid for the prior fiscal year (July 1 through June 30) are less than 25 percent of gross earnings (base pay, draw and commissions), then benefit pay is equal to current annual base salary.

Calculation for short-term disability pay

Benefits are calculated based on:

- Non-sales employees: earnings determined using scheduled hours worked
- Sales employees: prior 12 months earnings including commissions

Self-insured vs. fully insured

It is also important to know which of the Cardinal Health benefit programs are "self-insured" versus "fully insured." Self-insured means that Cardinal Health, together with employee contributions, pays all costs related to delivering benefits — such as claims for medical benefits and dental benefits — out of general assets.

Fully insured means Cardinal Health pays premiums to the administrator or insurance carrier for coverage, which includes employees' payroll deductions for the coverage. The administrator or insurance carrier then pays all benefit claims.

The following chart shows which benefits are self-insured by Cardinal Health and which are fully insured.

	Self-insured	**Fully insured**
Benefits	• Medical (includes prescription drug) – Anthem CDHP with Funded HRA – Anthem CDHP with Funded HSA – Anthem Basic CDHP with HSA – Anthem CDHP Out of Area with Funded HRA • Dental – Basic – Plus • Short-term disability – Basic short-term disability – Supplemental short-term disability • Severance benefits • Employee assistance program/ Work-Life Solutions • Wellness Center • Retiree medical	• Medical – Kaiser Permanente – Cigna Global Health Benefits • Vision • Life and AD&D – Basic employee life – Supplemental employee life – Dependent life (spouse/domestic partner) – Dependent life (child/child of domestic partner) – Basic employee AD&D – Supplemental AD&D – Business travel accident • Long-term disability – Basic long-term disability – Supplemental long-term disability

Changing your coverage

Because of the tax advantages associated with the plan, the IRS limits your ability to make changes to your coverage after the initial or annual enrollment period. These rules govern the types of changes that you may make during the plan year.

In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year. However, under certain circumstances, you may enroll for or change certain coverages during the year. For example, you may change your coverage if:

- You experience a "qualified life event" — described in this section — that affects your, your spouse's/domestic partner's or your dependent's eligibility for the program.
- You qualify for a special enrollment during the year under HIPAA.
- The plan receives a QMCSO or other court order, judgment or decree requiring you to enroll a dependent in the plan.
- You, your spouse/domestic partner or your dependent qualifies for or loses Medicare or Medicaid coverage.

CHIPRA (Children's Health Insurance Program Reauthorization Act) — HIPAA special enrollment rights also apply if (1) you or your dependent lose coverage under your state's Medicaid or CHIP program due to no longer being eligible for those benefits or (2) you or your dependent become eligible for a premium assistance subsidy provided by your state under CHIPRA. You must request special enrollment due to one of these reasons within 60 days of the event that entitles you or your dependent to the special enrollment period. Coverage will become effective no later than the first day of the first calendar month beginning after the date on which the plan receives your completed enrollment form.

Qualified life event information

You may change your benefit elections during the plan year if you meet the following three conditions:

- You have a qualified life event including the following:
  - You get divorced or legally separated, dissolve your domestic partnership or have your marriage legally annulled.
  - Your spouse/domestic partner or dependent dies.
  - Your dependent becomes ineligible or eligible for coverage (e.g., he or she reaches the program's eligibility age limit).
  - You get married or you enter into a domestic partnership.
  - You have a baby, adopt or have a child placed with you for adoption.
  - You, your spouse's/domestic partner's or your dependent's work schedule changes (a strike or lockout, the start or termination of an unpaid leave of absence, a change of work site or a change in employment) that leads to a loss or gain of eligibility for coverage.
  - You, your spouse's/domestic partner's or your dependent's work location or home address changes to outside the network service area.
- The qualified life event causes you, your spouse/domestic partner or your dependent to lose or gain eligibility for coverage under the plan (or under your spouse's/domestic partner's or dependent's plan).
- Your election change is consistent with the gain or loss of coverage.

If you have any questions regarding how life events may affect your benefit coverages, contact a representative from the myHR Service Center at **866.471.7867**.

Additional mid-year changes

You also may change your benefit elections during the plan year in the following circumstances:

Cost and coverage changes

You may be able to change your benefit elections if you, your spouse/domestic partner or your dependent experiences a significant change in the cost of coverage. Under this rule, for example, if you switch from part-time to full-time employment or vice versa, and as a result the cost of your benefits changes, you may be able to change your coverage. You also may be able to revoke your existing elections if your coverage is significantly curtailed (that is, if there is an overall reduction in coverage to all participants), or if a new benefit option is added or eliminated.

Changes to a dependent's plan

You may make a mid-year election change that is on account of, and corresponds to, changes made under the plan of your spouse's/domestic partner's, former spouse's/former domestic partner's or dependent's employer, or if the other plan has a different plan year, or if the enrollment period is different from the one under this plan.

Change in status

You may make a mid-year election change if you have a change in your employment status so that you will no longer reasonably be expected to average at least 30 hours per week (even if the reduction in hours does not affect your eligibility for coverage under the plan) and you intend to enroll yourself (and any dependents) in another plan providing minimum essential coverage effective no later than the first day of the second month following the month in which coverage under the plan is revoked.

Automatic changes

If the cost of your underlying coverage increases or decreases, the company may automatically change the amount of your premium contribution that is withheld. Likewise, the company may automatically change the amount of your deduction if it is required to do so by the terms of a QMCSO or by the terms of another judgment, decree or order that requires the plan to provide coverage for your dependents.

Special rules for rehired employees

If you terminate employment and are rehired as an eligible employee within 31 days of your termination date, the benefit elections that were in effect on the date of your termination will be automatically reinstated. If you are rehired as an eligible employee more than 31 days after the date of your termination, you will be allowed to make new benefit plan elections.

Procedure for mid-year changes

You must request a change in your benefit plan elections within 31 days of the date of the qualified life event. If a qualified life event has been experienced, you may alter your benefit plan options to, among other things, add or drop a dependent, or add or drop coverage for yourself or your spouse/domestic partner. Provided you notify the plan within the required time frames, any changes in your benefit plan options due to a permissible mid-year event will become effective:

- In the case of a dependent's birth, on the date of such birth;
- In the case of a dependent's adoption or placement for adoption, on the date of such adoption or placement for adoption; and,
- For all other events, no later than 31 days from the date of your qualified life event.

If you experience one of these qualified life events, you may change your medical, dental, vision, life insurance, AD&D, short-term disability and long-term disability coverages. The changes must be consistent with and correspond to the qualified life event. For example, in the case of birth, adoption or placement for adoption, you may generally **increase** coverage under your life insurance and enroll your new dependent for medical coverage, but you cannot drop your current coverage. In addition, you must be **actively at work** on the effective date of coverage or the effective date of the change in order to make changes to some benefit elections.

If you experience a qualified life event and need to change your coverage, you must make the change online or you must notify the myHR Service Center. Your change must be made within 31 days (which includes the day the event occurred) of the event that causes the change. If you do not make the change in time, you cannot make a coverage change until the next annual enrollment period, unless you once again meet one of the conditions for a mid-year change. If requested, you must provide proof of your qualified life event.

Depending on the reason for the qualified life event, you also may begin, increase, decrease or stop contributions to the healthcare and dependent care flexible spending accounts (if the change is consistent with the qualified life event).

Actively at work

For the following plans, you must be actively at work on the effective date of coverage or the effective date of the change in coverage:

- Basic short-term disability
- Supplemental short-term disability
- Basic long-term disability
- Supplemental long-term disability
- Basic employee life insurance
- Supplemental employee life insurance
- Spouse/domestic partner life insurance
- Child/child of domestic partner life insurance
- Basic AD&D insurance
- Supplemental AD&D insurance
- Business travel accident insurance
- Severance Benefit Program

If you are not actively at work, any coverage or change in coverage will not take effect until you return to active work. “Active work,” “actively at work” or “actively working” means you must be working at your employer’s usual place of business, or on an assignment for the purpose of furthering the employer’s business, and performing the material and substantial duties of your regular occupation on your normally scheduled basis. If you are on a residual disability, working in some capacity that is not your regular capacity, or if you are working reduced hours, you will not be considered actively at work. You are considered actively at work, however, if you are on an approved leave of absence (unless the leave is due to your own medical condition), a scheduled vacation or a holiday.

If you are not actively at work due to your own medical condition (including, but not limited to, a disability leave, a Family and Medical Leave Act (FMLA) leave, an excused unpaid leave of absence and/or a Workers’ Compensation leave), you are not considered actively at work for purposes of making or changing benefit elections.

For life insurance, the effective date of insurance will be delayed if your dependent, other than a newborn child, is disabled or confined to a hospital on the date his coverage would otherwise become effective. In such case, the dependent’s coverage will become effective on the later of:

- The date he completely recovers and resumes normal activities; or,
- If employed, the first day after he is performing the material and substantial duties of his regular occupation on a full-time basis.

If a dependent is a newborn child and you are currently enrolled in dependent child coverage, each succeeding child will automatically be covered for such life insurance on the date that child qualifies as a dependent.

- On the date dependent life insurance is scheduled to take effect, the dependent must not be:
  - confined at home under a physician's care;
  - receiving or applying to receive disability benefits from any source; or hospitalized.
- Life insurance for the dependent will take effect on the date that dependent is no longer:
  - confined;
  - receiving or applying to receive disability benefits from any source; or hospitalized.

Special enrollment rules under HIPAA

Special enrollment rules apply due to a loss of other coverage, a need to enroll because of a new dependent's eligibility or a gain of eligibility for certain subsidies.

Special enrollment due to loss of other coverage

You and your eligible dependents may enroll for medical coverage (subject to certain conditions) if you waived your initial coverage at the time it was first offered under this plan because you (or your spouse/domestic partner or dependent) were covered under another plan or insurance policy. You and your dependents may enroll provided your or your dependents' other coverage was:

- Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage that has since ended; or,
- Coverage (if not COBRA continuation coverage) that has since terminated due to a "loss of eligibility" or a loss of employer contributions.

Separate rules apply if you or your eligible dependents lose coverage under your state's Medicaid or CHIP program. See the "Special enrollment due to CHIPRA rights" section below.

- "Loss of eligibility" includes a loss of coverage due to:
  - Legal separation;
  - Dissolution of domestic partnership;
  - Divorce;
  - Death;
  - Termination of employment; or,
  - Reduction in the number of hours of employment.

It does not include loss of coverage due to failure to timely pay required contributions or premiums, or loss of coverage for cause (e.g., fraud or intentional misrepresentation). COBRA coverage also is not provided to any previously covered dependent(s) who are subsequently determined to be ineligible for coverage under the medical, dental or vision plans.

To be eligible for special enrollment, you and your dependents must meet certain other requirements as well.

- **Deadline for special enrollment:** You must request special enrollment in writing no later than 31 days from the day the other coverage was lost.
- **Effective date of coverage:** If you enroll within the 31-day period, coverage takes effect retroactive to the date coverage was lost.

Special enrollment due to new dependent eligibility

You and your eligible dependents may enroll in the plan (subject to certain conditions) if you acquire a dependent through marriage, domestic partnership, birth, adoption or placement for adoption. The conditions that apply are as follows:

- **Non-enrolled employee:** If you are eligible but have not yet enrolled, you may enroll upon your marriage/establishment of domestic partnership, or upon the birth, adoption or placement for adoption of your child.
- **Non-enrolled spouse/domestic partner:** If you are already enrolled, you may enroll your spouse/domestic partner at the time of his or her marriage to you/date you enter into the domestic partnership. You also may enroll your spouse/domestic partner if you acquire a child through birth, adoption or placement for adoption.
- **New dependents of an enrolled employee:** If you are already enrolled, you may enroll a child who becomes your eligible dependent as a result of marriage/domestic partnership, birth, adoption or placement for adoption.
- **New dependents/spouse/domestic partner of a non-enrolled employee:** If you are eligible but not enrolled, you may enroll an individual (spouse/domestic partner or your child/child of domestic partner) who becomes your eligible dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption. However, you (the non-enrolled employee) also must be eligible to enroll, and must actually enroll, at the same time.
- **Deadline for special enrollment:** You must request special enrollment in writing no later than 31 days from the date of the marriage, domestic partnership, birth, adoption or placement for adoption.
- **Effective date of coverage:** If you enroll within the 31-day period, coverage takes effect retroactive to the date of the gain of dependent eligibility.

Special enrollment due to CHIPRA rights

You and your eligible dependents may enroll in the plan if (1) you or your dependent lose coverage under your state's Medicaid or CHIP program due to no longer being eligible for those benefits or (2) you or your dependent become eligible for a premium assistance subsidy provided by your state under the Children's Health Insurance Program Reauthorization Act (CHIPRA).

- **Deadline for special enrollment:** You must request special enrollment in writing no later than 60 days after the date of the event that entitles you or your dependent to the special enrollment period.
- **Effective date of coverage:** If you enroll within the 60-day period, coverage takes effect on the first day of the first calendar month beginning after the date on which the plan receives your completed enrollment form.

You will have to provide verification documentation for any dependents that you enroll in the medical, dental or vision plans. Information will need to be provided approximately 30 days after you enroll your dependent(s) into coverage.

Coordination of benefits

If you or your dependents have coverage under another medical or dental plan, your Cardinal Health benefits will be coordinated with the other plan's benefits to help eliminate duplicate payments for the same services.

Coordinating plans

Certain types of plans normally coordinate benefits, including the following:

- Plans provided by an employer, union, trust or other similar sponsor.
- Other group healthcare plans that cover you or your dependents, including student coverage provided through a school above the high school level.
- Government benefit programs provided or required by law, including Medicare, Medicaid and no-fault automobile insurance.

These coordination provisions normally do not apply to individual or private insurance plans.

Any benefits to which you may be entitled are considered (even if you do not request payment from them).

How coordination works with other group plans

If you are covered by more than one group plan, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then — based on what the primary plan pays — the other plans may pay a benefit.

If your medical or dental coverages are primary, the plan pays benefits up to the limits described in this SPD. When your health and group benefits coverage is secondary, benefits are figured as if it was primary. Then, the benefit you receive from the primary plan is subtracted, and the health and group benefit equals the difference — up to the total amount Cardinal Health would have paid if it was the primary plan.

Determining the order of payment

When benefits coordinate, the plans determine which pays benefits first (the primary), second (the secondary), etc. Here are guidelines for determining which is primary:

- If one plan has no coordination-of-benefits provision, it automatically is primary.
- A program or plan required by law, such as Workers' Compensation, is automatically primary.
- A no-fault motor vehicle insurance or third-party liability policy is automatically primary.

- The plan covering the person as the employee, rather than as a dependent, is primary and pays benefits first.
- If both parents' plans cover a dependent, the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan does not follow the birthday rule, then the rules of that plan determine the order of benefits.
- In the case of a divorce or separation, the plan of the parent (who has not remarried) with custody of the dependent child usually pays benefits first. However, if there is a court order requiring a parent to take financial responsibility for healthcare coverage for the child, that parent's plan always is primary.
- If the parent with custody remarries, his or her plan pays benefits first, the stepparent's plan pays second and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for healthcare coverage for the child, that parent's plan always is primary.
- If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

How coordination works with Medicare

Under current law, you and your dependents generally become eligible for Medicare at age 65. If you become disabled, however, you may become eligible for Medicare before age 65.

Please notify the myHR Service Center at **866.471.7867** if you start Medicare benefits. The way medical coverage under the plan coordinates with Medicare depends on your age and whether you are an active or inactive employee.

If you are an active employee

If you are an active employee or covered by another active employer plan, and you or your spouse/domestic partner becomes Medicare-eligible, you or your spouse/domestic partner either has:

- Medical coverage under both the health and group benefits plan and Medicare (the health and group benefits plan is primary, it pays benefits as described in this SPD, and Medicare is secondary); or,
- Coverage under Medicare only.

You may decline coverage under the health and group benefits plan and elect Medicare as primary. However, in this case, by law, the plan cannot pay benefits secondary to Medicare. You and your spouse/domestic partner continue to be covered under this plan as primary unless you notify us that you do not want benefits under this plan or you otherwise cease to be eligible for benefits. Your spouse/domestic partner may make a Medicare election separate from yours if he or she is age 65 or older. Your spouse/domestic partner, however, may not elect coverage under the plan if you do not elect coverage.

If you file a medical claim with the plan, be sure to submit the Explanation of Benefits (EOB) you receive from Medicare. The combination of what Medicare pays and what the plan pays may not exceed what the plan alone would have paid.

Please note: If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, the plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payer of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

If you terminate employment

If you terminate employment (including retirement or disability), and you or your spouse/domestic partner is Medicare-eligible, Medicare is the primary payer regardless of your or your covered spouse's/domestic partner's age. You are responsible for notifying the myHR Service Center at **866.471.7867** if you or your spouse/domestic partner becomes Medicare-eligible.

Subrogation and reimbursement

In certain circumstances, you or your dependents (or your or your dependents' heirs, executors or beneficiaries) may have an obligation to reimburse the plan for payments made to or on behalf of you or your dependents. In particular, if you or your dependents are entitled to any benefits under the plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you (such as under a policy of insurance), then payments made by the plan are only made on the condition that the plan will be reimbursed by you or your dependents to the extent of any amounts received from such third party. It does not matter whether the amounts received from the third party are as a result of a judgment rendered in a lawsuit, as a settlement of a claim or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a recovery, it shall be subject to these provisions. The obligation to repay the plan for benefits paid in such a situation is not subject to any offset or reduction because you or your dependents had to pay legal fees or other expenses in securing the recovery from the third party. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan. In addition, the plan's right to be repaid is enforceable regardless of the purpose of the payment by the third party or how it is characterized in any agreement or judgments between you or your dependents and the third party.

By filing a claim for benefits, you or your dependents consent to the right of reimbursement and agree to cooperate with the plan administrator in any way necessary to enable the plan to be reimbursed. Before any claims of this sort are paid, you or your dependents must, if requested, enter into a written reimbursement or subrogation agreement with the plan, confirming the plan's right to be reimbursed to the extent of any payments made or to be made under the plan. Further, the plan shall have a lien against any right you or your dependents may have to recover any payments made by the plan from any other party. The plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries. To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the plan's subrogation claim and any claim held by you, the plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs. You and your legal representative must hold in trust for the plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the recovery.

If you or your dependents do not pursue recovery from the liable third party, the plan is subrogated to the rights of you or your dependents and may pursue claims of more than $500 on your or your dependents' behalf. In addition, you or your dependents may not do anything that would prejudice the rights of the plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your dependents may be delayed, withheld or denied unless you or your dependents cooperate fully and enter into the requested reimbursement or subrogation agreement. In the event that you fail to disclose the amount of your settlement to the

plan, the plan shall be entitled to deduct the amount of the plan's lien from any future benefit under the plan. In essence, it is your duty to enter into the requested reimbursement or subrogation agreement.

The plan's complete subrogation and reimbursement rights may be found in the plan's governing documents.

How long coverage continues

Generally, your health and group benefits coverage continues while you are still employed by Cardinal Health.

Please Note: Once eligible, eligibility is retained for the entire plan year while you are still employed, regardless of full-time or part-time status.

When coverage ends

Your coverage in your health program ends at the end of the pay period in which your final benefit deduction is taken from your pay, when any one of the following events occurs:

- Your employment ends;
- You are on a leave of absence for more than six months;
- The end of either your Initial Stability Period or any Ongoing Stability Period, if you do not average at least 30 hours per week during the most recent Ongoing Measurement Period;
- You are a non-union employee, transfer and become a union employee (except if you become part of a collective bargaining unit that provides for participation in the plan);
- For coverage provided through an insurance policy, the date the policy is terminated (unless replaced by similar coverage);
- You stop making the necessary contributions; or,
- You are no longer eligible to participate.

Your coverage in all other group benefit programs ends on the day on which any of the above events occur.

Your dependents' coverage ends on the day yours ends, the day you stop making contributions, the end of the month in which your dependent reaches age 26 (medical, dental, vision and child dependent life insurance coverage) or the end of the month in which your dependent no longer meets the eligibility requirements (whichever occurs first).

In addition, the plan administrator may terminate coverage for you and/or your dependents if you and/or your dependents commit an act of fraud or intentional misrepresentation of a fact that is material to your eligibility for coverage or benefits under the plan. The plan administrator may, in its sole discretion, determine whether such an act has been committed and, if so, whether and when coverage will be terminated.

Continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA)

Cardinal Health continues your health and group benefits coverage under the plan during your period of FMLA leave just as if you were still employed. Continued coverage ends once you:

- Terminate employment;
- Exhaust your approved period of FMLA leave; or,
- Do not return from your leave.

If your employment does not terminate during your leave, but you do not return to work once your leave ends, you can elect to continue health coverage under the COBRA continuation rules. Your COBRA continuation period begins on the last day of your FMLA leave.

If you do not return to covered employment after your leave, Cardinal Health may recover the value of benefits or premiums paid to maintain your health coverage during your FMLA period of leave. (This does not apply if your failure to return to work is due to a continuation, recurrence or onset of a serious health condition that affects you or a family member and for which you would normally qualify for a leave under the FMLA.)

Continuation of coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you may elect to continue health coverage for yourself and your eligible dependents under the provisions of USERRA. The period of coverage for you and your eligible dependents ends on the earlier of:

- The end of the 24-month USERRA continuation period starting on the day after the first 26 weeks your military leave of absence began; or,
- The day after the day on which you are required but fail to apply for or return to work (e.g., for periods of military service of more than 180 days, you are generally required to return to work within 90 days of your discharge).

You may be required to pay all or a portion of the cost of your coverage:

- **If your military service is 26 weeks or less:** You are required to pay no more than your usual share of the cost for this period of coverage. At the end of 26 weeks, your benefits terminate.
- **If your military service is more than 26 weeks:** You may continue through USERRA certain medical benefits for which you were enrolled for up to an additional 24-month period in accordance with USERRA. You pay the active employee rate less any tobacco, health assessment and biometric screening credits received for the first 26 weeks. At the end of the 26 weeks, you are required to pay the full cost of benefits during the remaining 18-month period, plus a 2 percent administrative fee. If you fail to pay required premiums during your military leave, your group health plan coverage may be cancelled.
- You also must notify the myHR Service Center that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions.

Taking coverage with you (portability)

Portability allows you to continue your supplemental and dependent life insurance under a new term life policy if your employment ends or you are no longer eligible for coverage. This type of policy is for a specified period of time. The premiums are offered at a special group rate. However, no cash value is built up from which you can take loans or receive a cash refund if you surrender the policy. You have 31 days from the date your insurance terminates to elect portability. At the end of your portability period, you may convert your supplemental employee or dependent life insurance. See the next section, "Converting coverages," for details.

Converting coverages

When certain group coverages end, you or your covered dependents may obtain individual insurance coverage with the same insurance company without undergoing a medical examination. This is called a "conversion right."

Conversion applies to the following coverages:	**Conversion does not apply to the following coverages:**
• Basic employee life • Supplemental employee life • Dependent life (spouse/domestic partner and/or your child/child of domestic partner)	• Medical • Dental • Vision • Flexible spending accounts • Short-term disability • Long-term disability • Accidental death and dismemberment (AD&D) • Business travel accident insurance

To convert to an individual policy, you or your dependent must apply and pay for the conversion coverage at the conversion rate within 31 days after the group coverage ends. Since this is an individual policy, you will no longer have the advantage of group rates, and the coverage level may not be the same that you had while covered under the Cardinal Health plan.

If your term life insurance coverage ends and you die during the 31-day conversion period, your beneficiary receives the benefit that would have been payable had you converted to an individual policy. This is true regardless of whether or not you actually applied for conversion.

When life insurance ends for you or your dependents, MetLife will mail you and your dependents a form and instructions for electing conversion or portability, as appropriate.

Continuation of benefits (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires the plan to offer you and your dependents the opportunity to pay for a temporary extension of health coverage in certain situations where your active employee coverage is lost. This section highlights your COBRA coverage.

COBRA coverage is a temporary continuation of health coverage when it otherwise would end because of a life event, known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each "qualified COBRA beneficiary." You, your spouse and your dependent children could become qualified COBRA beneficiaries if coverage under the health plans is lost because of the qualifying event. Qualified COBRA beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

If you were covering a dependent who is subsequently determined to be ineligible for coverage under the medical, dental or vision plans, he or she will be **ineligible** for COBRA coverage.

When you and/or your dependents elect COBRA

COBRA allows you and your dependents to continue the health coverage that was in effect on the day that your active employee coverage ended. In other words, if you did not have active coverage, you cannot elect COBRA. If health and group benefits coverage changes while you are on COBRA, your COBRA coverage also will change. In addition, you will have the same annual enrollment benefit choices as health and group benefits participants.

If you elect COBRA coverage, it takes effect on the date your health and group benefits coverage ends, and continues for up to 18 or 36 months (depending on your situation).

Snapshot of COBRA coverage continuation

Here is a snapshot of who is eligible for COBRA continuation coverage and under what circumstances and how long COBRA continuation coverage lasts.

If:	Qualifying event	Who is eligible for COBRA coverage	Duration of COBRA coverage*
You	Become laid off	You and your dependents	18 months
	Have a reduction in hours	You and your dependents	18 months
	Terminate employment (other than by reason of gross misconduct)	You and your dependents	18 months
	Do not return from a leave of absence after six months	You and your dependents	18 months
	Become disabled within the first 60 days of COBRA continuation coverage	You and your dependents	29 months
	Die	Your dependents	29 months
	Become divorced or legally separated	Your dependents (including your spouse or former spouse)	36 months
	Become laid off, have a reduction in hours or terminate employment within 18 months of becoming entitled to Medicare**	Your dependents	Up to 36 months
Your dependent	Is no longer an eligible dependent (due to age limit, divorce or legal separation)	Your dependent	36 months
	Is no longer an eligible dependent because of your death	Your dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your dependent	29 months

*Duration of coverage is from the date of the first qualifying event.
**The 36-month coverage begins on the day you become enrolled in Medicare.

COBRA continuation benefits for domestic partners

Your designated domestic partner and, if applicable, the dependents of your domestic partner qualify for continuing coverage under the Cardinal Health plan comparable to COBRA upon the occurrence of any of the following events:

- You die.
- You terminate employment (other than by reason of gross misconduct).
- You become entitled to benefits under Title XVIII of the Social Security Act.
- Your dependent child or your domestic partner's dependent child is no longer an eligible dependent.

However, your domestic partner and your domestic partner's children do not qualify for COBRA coverage if eligibility is lost due to you and your domestic partner severing your relationship.

If you lose medical, dental or vision plan coverage

If you lose coverage because of a layoff, reduction in hours or termination of employment (other than by reason of gross misconduct), COBRA continuation coverage is available to you and your dependents for up to 18 months from the date of the qualifying event. COBRA administration is managed by Aon Hewitt.

Aon Hewitt will notify you and your dependents of your right to continue coverage when you experience a qualifying event. Aon Hewitt provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event. Such an event makes continuation of coverage available. You must then notify Aon Hewitt (within 60 days of the date the notice is sent or the date coverage is lost, whichever is later) of your decision to continue coverage.

An election of COBRA continuation coverage under the Anthem CDHP with Funded HRA options applies to both the health fund account and the employee responsibility.

An election of COBRA continuation coverage under the Anthem CDHP with HSA options applies only to the employee responsibility.

If you elect COBRA coverage within the 60-day period and pay the required premium, your coverage is retroactively reinstated. If you do not elect COBRA within the initial enrollment period, or if you do not pay the required premium in full, your coverage ends, and you will not be able to re-enroll in the future.

Even if you decline COBRA, each of your eligible dependents has an independent right to elect or reject COBRA coverage. A parent or legal guardian can elect COBRA on behalf of a minor child.

If you or your covered dependent are disabled (as defined by Social Security) during the first 60 days of COBRA continuation coverage, the disabled beneficiary and each non-disabled COBRA beneficiary may extend the 18-month continuation period an additional 11 months, up to 29 months.

For the 29-month continuation coverage period to apply, you must notify Aon Hewitt of the disability directly at **866.866.8525** within the initial 18-month continuation coverage period.

If, during the initial 18-month period, the Social Security Administration determines that you are no longer disabled, the 11-month extension does not apply. If your disability ends during the 11-month extension period, your COBRA coverage ends the first day of the month after 30 days have passed since the Social Security Administration's determination (provided the COBRA period does not exceed 29 months).

If you lose healthcare flexible spending account coverage

You may continue your current contributions to the healthcare flexible spending account through COBRA for the remainder of the plan year in which your active coverage ends. (Please see "Flexible spending account continuation" below for further details.) Keep in mind that you will lose the before-tax benefit of the plan by continuing coverage through COBRA. However, you will be able to continue to submit eligible claims to the plan during your COBRA continuation period.

Flexible spending account continuation

You may elect to continue coverage under your healthcare flexible spending account through COBRA until the end of the plan year only if your remaining contributions for the plan year would be less than the remaining benefits available to you for the plan year.

Example: You elect to contribute $1,200 ($100 per month) for the plan year to your healthcare flexible spending account. You have a qualifying event on October 31. You have been reimbursed $300, leaving a $900 balance in your flexible spending account. The premium to continue coverage under COBRA would be $816 (102 percent COBRA rate x $100 per month × 8 months remaining in the plan year). Because the COBRA premium of $816 is less than the $900 remaining balance in your flexible spending account, you can elect to continue coverage under COBRA.

COBRA coverage does not have to be offered for a healthcare flexible spending account if, as of the qualifying event date, the remaining benefits available to you under your healthcare flexible spending account are less than the contributions the plan could require to maintain your healthcare flexible spending account coverage for the remainder of the plan year.

Employee assistance program/Work-Life Solutions continuation

As previously described, eligibility for benefits under the Work-Life Solutions program will automatically continue for you and your eligible dependents during the COBRA continuation period. Therefore, you and your eligible dependents do not have to elect or pay for COBRA continuation to remain eligible for Work-Life Solutions.

If your dependent loses medical, dental or vision plan coverage

Your covered dependent has the right to continue his or her coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You and your spouse become divorced or legally separated;
- He or she is no longer eligible for coverage under the program (e.g., reaches the age limit);
- You become entitled to benefits under Medicare; or,
- You die.

If you divorce or become legally separated, or if your child ceases to be eligible for coverage, you or your dependents must notify Aon Hewitt at 866.866.8525 within 60 days of the event. Failure to provide this notification results in the loss of COBRA rights. Aon Hewitt, in turn, notifies your dependent of his or her COBRA enrollment options. Your dependent must elect to continue coverages by notifying Aon Hewitt within 60 days of the later of the date the notification is received or the date benefits terminate due to the qualifying event.

If you are eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA) and did not elect COBRA continuation coverage during the COBRA election period that applied to your loss of healthcare coverage due to your separation from employment, then you may have an additional COBRA election period. You may elect COBRA continuation coverage during the 60-day period that starts on the first day of the month that you become a TAA- or ATAA-eligible individual. Your election for COBRA continuation coverage must not be made later than six months after the date of the TAA- or ATAA-related loss of coverage (the date that you lost healthcare coverage due to your separation from employment that gives rise to you being a TAA- or ATAA-eligible individual).

Newborn or adopted children

If, during your COBRA continuation period, you have or adopt a child, you may elect COBRA coverage for that child. Coverage for the newborn or adopted child continues for the remainder of your 18-month (or 29-month) continuation period, as a qualified COBRA beneficiary. You must notify Aon Hewitt at **866.866.8525** within 31 days after the birth, adoption or placement for adoption of the child.

Cost of COBRA coverage

You do not have to provide medical evidence that you are insurable to choose COBRA coverage. If you elect COBRA continuation, you are responsible for paying the required premium. The cost is 102 percent (a 2 percent administrative cost is added to the actual cost of the coverage) of the total premium rate. These costs are reviewed annually and are subject to change. For benefits that are self-insured, the premium rate is based on actuarial data. If you are entitled to the 11-month extended coverage period as a result of a disability, you are required to pay 50 percent of the premium for any coverage during that extended period of coverage. Employee assistance program/Work-Life Solutions benefits are provided free of charge to you and your eligible dependents for the duration of the COBRA period.

You or your dependents will be billed monthly for the coverage(s) you or your dependents elect. Payment is due by the first of the month for which you are buying coverage. If payment is not received within 30 days of that date, the coverage will be cancelled. The first premium payable when you or a dependent initially elects COBRA coverage, however, is due within 45 days of the coverage election.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment for 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Service Center toll-free at **866.365.6822**. More information about the Trade Act is also available at **doleta.gov/tradeact**.

How to enroll in COBRA

To enroll in COBRA, contact Aon Hewitt at **866.866.8525**.

If your or your dependents' home address changes while on COBRA, you or your dependents must call Aon Hewitt at **866.866.8525** to report that change.

When COBRA coverage ends

COBRA continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period.
- The date Cardinal Health no longer provides health coverage to any of its employees.
- The date a required premium for continuation of group coverage is due and not paid within the required time.
- The date you or your dependents become covered under another group health plan.
- The date you or your dependents become entitled to Medicare.

Special continuation periods apply to retired participants and their dependents in the event of bankruptcy under Title 11 of the United States Code if the retired participant and his or her dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Retired participants may continue their coverage until their death. For a spouse, surviving spouse or dependent child of the retired participant, coverage ends at the earlier of the qualified COBRA beneficiary's death or 36 months past the date of the death of the retired participant.

Other coverage options besides COBRA continuation coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your dependents through the Health Insurance Marketplace, Medicaid or other group health plan coverage options. You may qualify for lower costs on your monthly premiums and lower out-of-pocket costs by enrolling in coverage through the Marketplace. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. As noted, some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

If you have questions

For more information about your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **dol.gov/ebsa**.

Addresses and telephone numbers of Regional and District EBSA offices are available through EBSA's website.

Claims and appeals procedures under the plan

Claims procedures

If your claim for a benefit is wholly or partially denied, you will receive a written notice of the decision that will contain:

- Specific reasons for the claim's denial;
- Specific references to pertinent plan provisions;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and,
- Information about what to do if you wish to submit a request for review.

In addition to the information above, if your claim is a healthcare benefits or disability claim, the notice also will contain any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination and, if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement indicating that this information will be provided upon written request at no charge.

For more information on Anthem and Kaiser medical plan claims, CVS Caremark pharmacy claims, EyeMed vision plan claims, as well as the appeals process for those claims, refer to the Appendix at the end of this document.

Advocacy Services can help with benefit issues

If you need help when it comes to resolving benefit plan issues, you can use the confidential Advocacy Services through the myHR Service Center, where Advocate team members are trained to assist you and address concerns you may have about medical, dental, vision or healthcare flexible spending account providers.

Advocacy Services may be reached by calling the myHR Service Center at **866.471.7867** and pressing "3" to access Health and Group Benefits. Once you are transferred to Aon Hewitt, a representative will take the information and notify Advocacy Services. An Advocate will contact you within two business days. Advocates are available between 9 a.m. and 7 p.m., Eastern time, Monday through Friday.

Advocacy Services are available to employees and retirees enrolled in medical, dental, vision or healthcare flexible spending account plans.

The written notice will be given within the following time frames, depending on the type of claim:

- **Urgent care claims:** Within 72 hours after receipt of your claim, unless you do not provide enough information for the plan to determine what benefits are payable under the plan. If this occurs, you will be notified of the deficiency within 72 hours of receiving your claim. You will have a reasonable amount of time, not less than 72 hours, to provide the additional necessary information. You will then be notified of the plan's determination as soon as possible, but no later than 72 hours after the earlier of:

  - The plan's receipt of the additional information; or,
  - The end of the time period given to you to provide additional information.

  An **urgent care claim** is a claim for medical care or treatment where a delay in making a determination could jeopardize the life or health of you or your dependent, could jeopardize the ability of you or your dependent to regain maximum function, or — in the opinion of your or your dependent's physician — would subject you or your dependent to severe pain that cannot be adequately managed without the requested treatment.

- **Pre-service claims:** Within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the plan, but only if the plan notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the plan expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of:

  - The day you respond to the notice; or,
  - At least 45 days from receipt of the notice requesting additional information.

  A **pre-service claim** is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include pre-authorization for hospital stays, second surgical opinions, etc.

- **Post-service claims:** Within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the plan's control if the plan notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the plan expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of:

  - The day you respond to the notice; or,
  - At least 45 days from receipt of the notice requesting additional information.

  A **post-service claim** is any claim for healthcare benefits that is not a pre-service claim. "Healthcare benefits" include medical, prescription drug, dental, vision, healthcare flexible spending account, employee assistance program benefits and access to the Wellness Center.

- **Ongoing treatment:** If you are receiving ongoing treatments (i.e., treatment over a period of time or a specified number of treatments) that have been previously approved by the plan, any reduction or termination of ongoing treatments is an adverse benefit determination (including rescissions of coverage under healthcare reform). The plan must notify you within a reasonable time prior to the reduction or termination of services. If you request to extend urgent care beyond the approved period of time or number of treatments, the plan will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed on the previous page) will apply. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

- **Disability claims:** Within a reasonable time, but no later than 45 days after receipt of your claim. The review period may be extended for an additional 30 days due to matters beyond the plan's control if the plan notifies you before the end of the 45-day period of the circumstances requiring the extension and the date by which the plan expects to make a decision. If, prior to the end of the first 30-day extension, the plan determines that a decision cannot be made within the 30-day extension, the period for making a decision may be extended another 30 days, as long as the plan notifies you of the reasons requiring the extension and the date by which the plan expects to make a decision. Any notice of extension will contain an explanation of the standards on which entitlement to the disability benefit is based, a description of the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues.

- **Other claims:** The plan will notify you within 90 days. An extension of an additional 90 days is available if written notice is given to you before the initial 90-day period ends. The notice of extension will describe the special circumstances requiring the extension and provide the date the determination is expected.

If notice of a benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period.

Please Note: The plan will not cancel or discontinue your or your dependent's medical coverage retroactively except in the case of fraud or intentional misrepresentation of a material fact. In the event of fraud or an intentional misrepresentation of a material fact, the plan will provide at least 30 days' notice to you or your dependent before medical coverage is rescinded. This 30-day period is in place to provide you and the plan with an opportunity to explore your rights to contest the rescission or look for alternative coverage, as appropriate.

Appeals procedures

If your claim is denied and you wish to have the claim reconsidered, you or your properly authorized representative on your behalf may appeal and request a review of your claim. Your appeal must be received by the plan administrator within the following time frames:

- Medical benefit claims (including urgent care, pre-service, post-service and ongoing treatments) — **180 days** after the adverse benefit determination

- Disability claims — **180 days** after the adverse benefit determination

- Pharmacy claims – **180 days** after the adverse benefit determination
- Dental claims — **180 days** after the adverse benefit determination
- Vision claims — **180 days** after the adverse benefit determination
- Healthcare flexible spending account claims — **180 days** after the adverse benefit determination
- Employee assistance program claims — **180 days** after the adverse benefit determination
- Wellness Center access claims — **180 days** after the adverse benefit determination
- All other claims — **60 days** after the adverse benefit determination

You may submit additional comments, records and documents related to your claim. You also may review, upon request and at no charge, copies of the documents and information relevant to your claim.

The appeal will be conducted by a claims administrator who did not make the initial adverse benefit determination and who is not a subordinate of the party who made the initial decision. This second-level fiduciary (or "appeals fiduciary") will not defer to the initial benefit determination and will consider all comments, documents, records and other information you submit for the claim, even if the information was not submitted or considered in the initial benefit determination. If the adverse benefit determination was based on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appeals fiduciary will consult with a healthcare professional who has appropriate training and experience in the medical field. This healthcare professional will not be an individual who was consulted in connection with the initial benefit determination or the subordinate of any such individual. The appeals fiduciary will identify any medical or vocational experts whose advice was sought in making the adverse benefit determination.

Appeal notification

If your appeal is received by the appropriate deadline, the plan administrator will independently review your appeal and any additional information that you submit. The plan will notify you of its decision regarding your appeal within the following time frames:

- **Urgent care claims:** As soon as possible, but no later than 72 hours after receipt of your appeal.
- **Pre-service claims:** Within a reasonable period, but no later than 30 days after receipt of your appeal.
- **Post-service claims:** Within a reasonable period, but no later than 60 days after receipt of your appeal.

- **Disability claims:** Within a reasonable time, but no later than 45 days after receipt of your appeal. If special circumstances require, the time period may be extended for 45 days. The plan will notify you of the necessary extension before the initial 45-day period ends. The notice will describe the special circumstances that require an extension of time and will include the date by which the decision will be made.
- **Other claims:** Within a reasonable time, but no later than 60 days after receipt of your appeal. If special circumstances require, the time period may be extended for 60 days. The plan will notify you of the necessary extension before the first 60-day period ends.

Summary of time limits

	Type of healthcare claim		
	Urgent care claim	**Pre-service claim**	**Post-service claim**
To make initial claim determination	24 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days
Extension (if proper notice is given and delay is beyond the claims administrator's control)	None	15 days	15 days
To request missing information from claimant	72 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days
For claimant to request appeal	180 days	180 days	180 days
To make determination on appeal	72 hours (depending on circumstances)	30 days	60 days

If your appeal is denied, the plan will send you a statement containing:

- Specific reasons for the denial;
- Specific references to pertinent plan provisions;
- A statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim; and,
- A statement describing any voluntary appeal procedures offered by the plan, including your right to bring an action in federal court under Section 502(a) of ERISA.

In addition to the previous information, if your claim is a healthcare benefits or disability claim, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial, as well as the opportunity to request any applicable diagnosis and treatment codes. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge. Administrative processes and safeguards are in place so that claim determinations are made in accordance with the governing plan documents and, where appropriate, provisions are applied consistently in similar situations.

Filing a civil suit

If you choose to file a civil action against the plan, including under Section 502(a) of ERISA, it must be brought no later than one year from the date of completion of the plan's claims appeal process, or if earlier, three years from the time proof of loss of the benefit is required and must be brought in the United States District Court for the Southern District of Ohio. If a proof of loss time frame is not set forth in the governing plan documents, the proof of loss time frame will be within 90 days following the date you experience an event entitling you to the benefit under the plan.

Additional claims information

Enrollment and eligibility claims

In order to file an enrollment or eligibility claim under Section 502(a) of ERISA, you must complete a Claim Initiation Form, which is available through the Benefits Center at **866.866.8525.** You should submit a claim form, including the reason(s) for your request and any information, documents or arguments you want considered to:

Claims and Appeals Management
Post Office Box 1407
Lincolnshire, IL 60069-1407

Medical claims

Fully insured medical options may have additional review and appeal processes available, including arbitration. Check with your medical option carrier to see if these options are available. Review the Appendix at the end of this document for additional information on the claims and appeals procedure applicable to Anthem and Kaiser claims.

Pharmacy claims

All appeals should be sent to:

CVS Caremark
Prescription Claim Appeals
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

Appeals may also be faxed to **866.443.1172**.

Requesting an external review

You or your authorized representative may request an external review of the denied claim within four months after receiving notice of the final adverse benefit determination. The request should be made in writing and include your name, contact information (including mailing address and daytime phone number), CVS Caremark identification number and a copy of the coverage denial.

Your request for external review and supporting documentation may be mailed to:

CVS Caremark
External Review Appeals Department
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

You may also fax your request to **866.689.3092**.

Review the Appendix at the end of this document for additional information on pharmacy appeals.

Dental claims

MetLife PPOs

To appeal a denied dental claim, you must submit your request for review in writing to the Group Claims Review at the MetLife office that processed your claim.

Vision claims

To appeal a denied vision claim, you must submit your request in writing to EyeMed Vision Care and include the applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable. Also include the item of your vision coverage that you feel was misinterpreted or inaccurately applied. Include additional information from your eye care provider that will assist EyeMed Vision Care in completing its review of your appeal, such as documents, records, questions or comments. The appeal should be mailed or faxed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: **513.492.3259**

Review the Appendix at the end of this document for additional information about vision appeals.

Flexible spending account claims

To appeal a denied flexible spending account claim, you must send your request in writing to WageWorks®. Appeals of claims from the healthcare flexible spending account are handled as for "medical" claims. Appeals of claims from the dependent care flexible spending account are processed as "other" claims.

Life insurance or AD&D claims

To appeal a denied life insurance or AD&D claim, you must send your request in writing to MetLife. Life insurance and AD&D claims are processed as "other" claims.

Employee assistance program/Work-Life Solutions claims

If you believe that you are entitled to receive benefits under the employee assistance program/Work-Life Solutions that you have not otherwise been provided, you may make a claim for such benefits to the plan administrator.

Wellness Center access claims

If you believe you are eligible to use the Dublin Wellness Center but have been denied access, you may appeal that denial by sending a written request to:

Total Rewards — Benefits
Location 1A3819
7000 Cardinal Place
Dublin, OH 43017

Disability claims

To appeal a denied disability claim, you must send your request in writing to The Hartford. The Hartford disability claims are processed as stated in the "Appeals procedures" section.

Severance Benefit Program

If you believe that you are entitled to receive benefits under the Severance Benefit Program and have not otherwise been provided with a Severance Agreement, you may make a claim for such benefits to the plan administrator.

Medical

How your medical benefits work

The health and group benefits plan offers up to four medical options:

- Anthem CDHP with Funded HRA, Anthem CDHP with Funded HSA, Anthem Basic CDHP with HSA
- Kaiser Permanente (in certain locations)

The options available to you depend on your home zip code. The three Anthem medical options are offered in almost all Cardinal Health locations. The Kaiser Permanente options are available in certain locations. If the standard Anthem medical plans are not available in your area, you will have the opportunity to select the Anthem CDHP Out of Area with Funded HRA.

All of the options are designed to help you pay for the cost of medical care. The options cover doctor's office visits, hospital expenses, tests and X-rays, etc. The options differ, however, in the way you share costs for covered expenses. Employees living in Hawaii have access to the Kaiser option only because of state law.

Pay less for medical coverage if you pledge not to use tobacco products
You will pay less for medical coverage if you do not use tobacco products. When you are enrolling for medical coverage, you will have the option to pledge not to use tobacco. If you make the pledge that you and your covered dependents do not and will not use tobacco, you will save $600 annually in premiums.

Please note: You and your eligible family members must take the pledge not to use tobacco products if you want to pay less for medical coverage.

Pay less for medical coverage in the Anthem medical plans if you complete both a biometric screening and health assessment annually (if you join Cardinal Health on or after September 1, you will automatically receive a $300 Healthy Lifestyles Kickstart Incentive).

Receive a $300 credit on your medical premiums if you take a biometric screening and health assessment. You can also receive an additional $150 if you complete a healthy activity. If your covered spouse/domestic partner takes the health assessment as well, you can receive an additional $150.

Cigna Global Health Benefits (coverage for expats only)

Cardinal Health provides a special medical plan for employees on international assignment. This is the only health plan available to expatriates, which are employees who are on international assignment outside of their home country for at least six months out of any 12-month period. On your return to the U.S., you will again be eligible for the domestic medical, dental and vision plans that are described in this SPD. For additional information, see the "International medical coverage" section.

A snapshot of your medical options

The chart below summarizes each type of coverage.

Type of coverage	Summary
Anthem CDHP with Funded HRA	The Anthem CDHP with Funded HRA is a consumer-driven health plan that provides you with access to both in-network and out-of-network providers, as well as a health reimbursement account (HRA) funded by Cardinal Health. In this way, the plan allows you to manage the cost of routine medical services while at the same time providing you with financial protection against catastrophic medical expenses. You use the money in your HRA fund to meet covered "first dollar" healthcare expenses during the year. When your HRA fund is depleted, you meet any deductible remaining, then the plan pays 80 percent of your covered expenses up to the annual out-of-pocket maximum. Once the out-of-pocket maximum is reached, the plan pays eligible expenses at 100 percent. If you do not use all of the money in your HRA fund by the end of the year, any unused amounts can be rolled over to the following year (up to a maximum cap), provided you re-enroll in the plan.
	Here is how the Anthem CDHP with Funded HRA works: • Cardinal Health puts money into a health fund account in your name. The amount you receive depends on whether you elect coverage for yourself or yourself and your family members. The amount also depends on your annual income — you will receive more money in your health fund account if you earn less than $35,000. • The full cost of your eligible healthcare expenses — including prescription drugs — is covered by money from your health fund account first. • If you go to a healthcare provider in the Anthem National BlueCard PPO network, you will pay less than if you went outside the network and you do not need to submit claim forms. That is because Anthem has negotiated discounts with those providers, and it handles all the paperwork. Or, you can go to another provider — it is up to you. • If you use all the money in your health fund account, you pay for additional expenses up to your annual deductible, which is part of your "employee responsibility" amount. • Once you meet your deductible, the plan pays 80 percent of covered charges (60 percent for out-of-network providers) until you reach your annual out-of-pocket maximum. The co-insurance you pay is another portion of your employee responsibility amount. • If you have family coverage, no individual can contribute more than his or her individual deductible and/or out-of-pocket maximum amount in order to help satisfy the family deductible and/or out-of-pocket maximum. This feature is known as an "embedded deductible." • Once your expenses reach the out-of-pocket maximum amount, Cardinal Health pays 100 percent of eligible expenses, as long as you receive care from a network provider. If you go out-of-network for care, Cardinal Health pays 60 percent of eligible expenses. • To help you stay healthy, preventive care is covered at 100 percent — this means that preventive care is not charged against your health fund account and does not count toward your employee responsibility. Preventive care is paid at 100 percent for in-network services only. Out-of-network preventive care is paid at the applicable plan co-insurance. • If you do not use all the money in your health fund account by the end of the plan year, the remaining balance rolls over into your health fund account for the next plan year, provided you re-enroll in the plan (and up to the applicable cap). • Your health fund account is capped at one and one-half times the plan's out-of-pocket maximum. Any amounts above this cap are placed into a Healthy Future Fund that you can access if you leave or retire from Cardinal Health at age 55 with at least 10 years of service and have continually been enrolled in the CDHP with Funded HRA.
	This plan encourages you to understand and manage how your healthcare dollars are being spent. If you choose this option, you can track the actual cost of healthcare services and prescription drugs through personal websites (**anthem.com and caremark.com**) and you will receive quarterly statements. You will need to know where your healthcare dollars are being spent — and about how much healthcare actually costs so you can budget for expenses. **Need to find a participating provider?** If you are enrolled in the Anthem CDHP with Funded HRA, you can access providers through the Anthem National BlueCard PPO network. Copies of the participating provider directory are available by contacting Anthem directly at **844.256.4818**, or you can search the online provider directory on the website at **anthem.com**.

Type of coverage	Summary
Anthem CDHP with Funded HSA	The Anthem CDHP with Funded HSA combines traditional medical and pharmacy coverage with a tax-free health savings account (HSA). It couples a consumer-driven health plan (CDHP) with an HSA that Cardinal Health funds and to which you can contribute before-tax dollars up to a combined IRS annual maximum of $3,350 for single coverage and up to $6,650 for family coverage. The plan allows you to manage the cost of your medical services while at the same time providing you with financial protection against catastrophic medical expenses. You can elect to use the money in your HSA to cover your deductible and any co-insurance expenses during the year. Once your deductible is satisfied, the plan pays 80 percent of eligible expenses up to the annual out-of-pocket maximum. Once the out-of-pocket maximum is reached, the plan pays eligible expenses at 100 percent for the balance of the year for you and your family. If you do not use all of the money in your HSA by the end of the year, any unused amounts can be rolled over to the following year and earn tax-free interest. In addition, since you decide how and when to use these funds, you can either use them to pay for your healthcare expenses today or save them for future healthcare needs. Unlike the CDHP with Funded HRA, the HSA is portable and you can take the money with you if you retire or leave Cardinal Health. This means that the account can be used in the future to help pay for your retiree medical needs. It is a powerful tool to help you save for your future healthcare needs, as well as providing coverage for you and your family today while you are working. • Here is how the Anthem CDHP with Funded HSA works: Anthem partners with HealthEquity to provide a comprehensive health plan that combines health coverage with a health savings account. • Cardinal Health will contribute dollars to your HSA. The amount you receive depends on whether you elect coverage for yourself or yourself and your family members. The amount also depends on your annual income — you will receive more money in your health fund account if you earn less than $35,000. Contributions from Cardinal Health will be deposited on a quarterly basis at the beginning of each quarter. • You also can contribute before-tax dollars to your account through payroll deductions up to the IRS federal limits of $3,350 individual/$6,650 family in 2015, which includes the contribution from Cardinal Health. Once you turn age 55 or older, you also can make an additional catch-up contribution of up to $1,000. Since your contributions are before-tax, they are reducing your taxable income today — another advantage that the plan offers. • The cost of your eligible healthcare expenses — including prescription drugs — can be covered by money from your HSA. However, you decide whether to use the funds to pay for your healthcare expenses or save them for future healthcare needs. • If you go to a healthcare provider in the Anthem National BlueCard PPO network, you will pay less, and you do not need to submit claim forms. That is because Anthem has negotiated discounts with those providers, and handles all the paperwork. Or, you can go to an out-of-network provider — it is up to you — but costs are greater if you elect not to use the network. • If you use all the money in your HSA, you pay for additional expenses up to your annual deductible, which is part of your "employee responsibility" amount. Please note that the deductible is collective rather than individual. This means that if you elect family coverage, the family deductible must be satisfied before there can be any co-insurance payments. • Once you meet your deductible, the plan pays 80 percent of covered charges (60 percent for out-of-network providers) until you reach your annual out-of-pocket maximum. The co-insurance you pay is another portion of your employee responsibility amount. • Once your expenses reach the out-of-pocket maximum amount, Cardinal Health pays 100 percent of eligible expenses for the balance of the year. • To help you stay healthy, preventive care is covered at 100 percent — this means that preventive care is not charged against your HSA and does not count toward your employee responsibility. Preventive care is paid at 100 percent for in-network services only. Out-of-network preventive care is paid at 60 percent. The IRS imposes some unique requirements on plans with HSAs. In order to be eligible to contribute to the HSA plan an employee: • Must be enrolled in a High Deductible Health plan • Cannot be claimed as a dependent on someone else's tax return. • Cannot be enrolled in Medicare, Tricare or someone else's non-high deductible health plan. • Cannot be enrolled in or covered under a general purpose healthcare flexible spending account.

Type of coverage	Summary
Anthem CDHP with Funded HSA (cont'd)	• If you do not use all the money in your HSA by the end of the plan year, the remaining balance stays in your HSA for use in the next plan year or any future year. There is no limit to the amount that you can roll over each year in your HSA. Unlike the HRA, monies in your HSA earn interest, which is posted monthly to your account. • Both the Cardinal Health and your contributions are placed in a cash account that earns interest at a nominal rate of return. Once your account balance reaches $1,000, you have the option to invest your money in several funds that are offered through HealthEquity. A listing of funds is available through the myHR website. **Need to find a participating provider?** If you are enrolled in the Anthem CDHP with Funded HSA, you can access providers through the Anthem National BlueCard PPO network. Copies of the participating provider directory are available by contacting Anthem directly at **844.256.4818**, or you can search the online provider directory on the website at **anthem.com**.
Anthem Basic CDHP with HSA	The Anthem Basic CDHP with HSA combines traditional medical and pharmacy coverage with a tax-free health savings account (HSA). It couples a consumer-driven health plan (CDHP) with an HSA, and you can contribute before-tax dollars up to the IRS annual maximum of $3,350 for single coverage and up to $6,650 for family coverage in 2015. **Please Note: Under this plan, you receive no company contributions from Cardinal Health.** You can elect to use the money in your HSA to cover your deductible and any co-insurance expenses during the year. Once your deductible is satisfied, the plan pays 80 percent of eligible expenses up to the annual out-of-pocket maximum. Once the out-of-pocket maximum is reached, the plan pays eligible expenses at 100 percent for the balance of the year for you and your family. If you do not use all of the money in your HSA by the end of the year, any unused amounts can be rolled over to the following year and earn tax-free interest. In addition, since you decide how and when to use these funds, you can either use them to pay for your healthcare expenses today or save them for future healthcare needs. Unlike the CDHP with Funded HRA, the HSA is portable and you can take the money with you if you retire or leave Cardinal Health. This means that the account can be used in the future to help pay for your retiree medical needs. It is a tool to help you save for your future healthcare needs, as well as providing coverage for you and your family today while you are working. • Here is how the Anthem Basic CDHP with HSA works: Anthem partners with HealthEquity to provide a comprehensive health plan that combines health coverage with a health savings account. • You can contribute before-tax dollars into your account through payroll deductions up to the IRS federal limits of $3,350 individual/$6,650 family in 2015. Once you turn age 55 or older, you also can make an additional annual catch-up contribution of up to $1,000. Since your contributions are before-tax, they are reducing your taxable income today — another advantage that the plan offers. • The cost of your eligible healthcare expenses — including prescription drugs — can be covered by money from your HSA. However, you decide whether to use the funds to pay for your healthcare expenses or save them for future healthcare needs. • If you go to a healthcare provider in the Anthem National BlueCard PPO network, you will pay less, and you do not need to submit claim forms. That is because Anthem has negotiated discounts with those providers, and handles all the paperwork. Or, you can go to an out-of-network provider — it is up to you — but costs are greater if you elect not to use the network. The IRS imposes some unique requirements on plans with HSAs. In order to be eligible to contribute to the HSA, an employee: • Must be enrolled in a High Deductible Health Plan • Cannot be claimed as a dependent on someone else's tax return. • Cannot be enrolled in Medicare, TRICARE or someone else's non-high deductible health plan. • Cannot be enrolled in or covered under a general purpose healthcare flexible spending account.

Type of coverage	Summary
Anthem Basic CDHP with HSA (cont'd)	If you use all the money in your HSA, you pay for additional expenses up to your annual deductible, which is part of your "employee responsibility" amount. Please note that the deductible is **collective** rather than individual. This means that if you elect family coverage, the family deductible must be satisfied before there can be any co-insurance payments. Once you meet your deductible, the plan pays 80 percent of covered charges (60 percent for out-of-network providers) until you reach your annual out-of-pocket maximum. The co-insurance you pay is another portion of your employee responsibility amount. • Once your expenses reach the out-of-pocket maximum amount, Cardinal Health pays 100 percent of eligible expenses for the balance of the year. • To help you stay healthy, preventive care is covered at 100 percent — this means that preventive care is not charged against your HSA and does not count toward your employee responsibility. Preventive care is paid at 100 percent for in-network services only. Out-of-network preventive care is paid at 60 percent. • If you do not use all the money in your HSA by the end of the plan year, the remaining balance stays in your HSA for use in the next plan year or any future year. There is no limit to the amount that you can roll over each year in your HSA. Unlike the HRA, monies in your HSA earn interest, which is posted monthly to your account. • Your contributions are placed in a cash account that earns interest at a nominal rate of return. Once your account balance reaches $1,000, you have the option to invest your money in several funds that are offered through Health Equity. A listing of funds is available through the myHR website. **Need to find a participating provider?** If you are enrolled in the Anthem CDHP with Funded HSA, you can access providers through the Anthem National BlueCard PPO network. Copies of the participating provider directory are available by contacting Anthem directly at **844.256.4818**, or you can search the online provider directory on the website at **anthem.com**.
Anthem CDHP Out of Area with Funded HRA	The Anthem CDHP Out of Area with Funded HRA is a consumer-driven health plan that provides you with access to both in-network and out-of-network providers, as well as a health reimbursement account (HRA) funded by Cardinal Health. In this way, the plan allows you to manage the cost of routine medical services while at the same time providing you with financial protection against catastrophic medical expenses. You use the money in your HRA to meet covered "first dollar" healthcare expenses during the year. When your HRA fund is depleted, you meet any deductible remaining, then the plan pays 80 percent of your covered expenses up to the annual out-of-pocket maximum. Once the out-of-pocket maximum is reached, the plan pays eligible expenses at 100 percent. If you do not use all of the money in your HRA fund by the end of the year, any unused amounts can be rolled over to the following year (up to a maximum cap), provided you re-enroll in the plan. Here is how the Anthem CDHP Out of Area with Funded HRA works: • Cardinal Health puts money into a health fund account in your name. The amount you receive depends on whether you elect coverage for yourself or yourself and your family members. The amount also depends on your annual income — you will receive more money in your health fund account if you earn less than $35,000. • The full cost of your eligible healthcare expenses — including prescription drugs — is covered by money from your health fund account first. • If you go to a healthcare provider in the Anthem National BlueCard PPO network, you will pay less than if you went outside the network and you do not need to submit claim forms. That is because Anthem has negotiated discounts with those providers, and it handles all the paperwork. Or, you can go to another provider — it is up to you. • If you use all the money in your health fund account, you pay for additional expenses up to your annual deductible, which is part of your "employee responsibility" amount. • Once you meet your deductible, the plan pays 80 percent of covered charges (60 percent for out-of-network providers) until you reach your annual out-of-pocket maximum. The co-insurance you pay is another portion of your employee responsibility amount. • If you have family coverage, no individual can contribute more than his or her individual deductible and/or out-of-pocket maximum amount in order to help satisfy the family deductible and/or out-of-pocket maximum. This feature is known as an "embedded deductible."

Type of coverage	Summary
Anthem CDHP Out of Area with Funded HRA (cont'd)	• Once your expenses reach the out-of-pocket maximum amount, Cardinal Health pays 100 percent of eligible expenses, as long as you receive care from a network provider. If you go out-of-network for care, Cardinal Health pays 60 percent of eligible expenses. • To help you stay healthy, preventive care is covered at 100 percent — this means that preventive care is not charged against your health fund account and does not count toward your employee responsibility. Preventive care is paid at 100 percent for in-network services only. Out-of-network preventive care is paid at the applicable plan co-insurance. • If you do not use all the money in your health fund account by the end of the plan year, the remaining balance rolls over into your health fund account for the next plan year, provided you re-enroll in the plan (and up to the applicable cap). • Your health fund account is capped at one and one-half times the plan's out-of-pocket maximum. Any amounts above this cap are placed into a Healthy Future Fund that you can access if you leave or retire from Cardinal Health at age 55 with at least 10 years of service and have continually been enrolled in the CDHP Out of Area with Funded HRA. This plan encourages you to understand and manage how your healthcare dollars are being spent. If you choose this option, you can track the actual cost of healthcare services and prescription drugs through personal websites (**anthem.com** and **caremark.com**) and you will receive quarterly statements. You will need to know where your healthcare dollars are being spent — and about how much healthcare actually costs so you can budget for expenses. **Need to find a participating provider?** If you are enrolled in the Anthem CDHP Out of Area with Funded HRA, you can access providers through the Anthem National BlueCard PPO network. Copies of the participating provider directory are available by contacting Anthem directly at **844.256.4818**, or you can search the online provider directory on the website at **anthem.com**.
Kaiser Permanente Plan	Kaiser Permanente is a network of doctors and hospitals who agree to charge negotiated rates for healthcare services. When you receive care from a Kaiser provider, preventive care is covered at 100 percent. For other types of care, you must pay all the costs up to the deductible amount before the plan begins to pay for covered services. There are certain eligible expenses and services for which you pay co-insurance and the plan covers the remaining amount. If you use non-network providers, you generally do not receive benefits. This means you must use in-network providers for all medical services to receive benefits, except for emergency care. The Kaiser plans require that you select a primary care physician (PCP) to provide or coordinate your care. If this is the case, when you need care you must first go to your PCP. He or she will treat you or refer you to a specialist within the Kaiser network. You do not typically need a referral for an OB/GYN provider. You do not need to file a claim. In general, the plan will not pay benefits if your PCP does not coordinate your care, or if you use a doctor or other service provider that is not in the Kaiser network. If a Kaiser plan is available where you live, it is listed on the myHR website and in the enrollment overview you receive when you first become eligible or during the annual enrollment period. **Please Note:** Kaiser participants automatically receive the biometric screening and health assessment premium credits in 2015. However, bear in mind that you will need to take the biometric screening and health assessment in 2015 to receive credits for your premiums in 2016. Although this SPD provides a brief Benefit Summary for Kaiser coverage, it is important that you reference your separate Kaiser materials for details. These materials provide an in-depth look at how your particular Kaiser plan pays benefits. However, please note: • The "Patient protection disclosure" section of this SPD supplements the Kaiser materials and will apply to the Kaiser coverage. • The Appendix that describes the Anthem and Kaiser claims and appeals procedures supplements the Kaiser materials and will apply to the Kaiser coverage. • Even if not specifically described in the Kaiser materials, the Kaiser coverage complies with the requirements of the Affordable Care Act regarding pre-existing condition limitations, annual and lifetime dollar limits, coverage of preventive health services, internal and external claims and appeals procedures, emergency services, out-of-pocket maximums and clinical trials.

Choosing whom to cover

In addition to selecting a coverage option, you need to decide whom to cover. You can choose from four levels of coverage.

Choose a coverage category

- You only
- You + spouse or domestic partner
- You + child(ren)
- You + family

Please see "Who is eligible" in the "Overview" section for a complete description of which family members are eligible.

How the medical plan pays benefits

Depending on the coverage option you select, a deductible, co-payment (where applicable), co-insurance, annual out-of-pocket maximum or employee responsibility may apply. Here is a brief description of each feature.

Deductibles

The deductible is the fixed dollar amount that you must pay out of your pocket each plan year before Cardinal Health pays benefits. You can refer to the Benefit Summary for your coverage option and for more details about deductibles. The summary is in the "How the medical options pay benefits" section.

The individual deductible applies separately to each covered individual, and the family deductible applies collectively to all covered persons in the same family. Once you meet the family deductible, your remaining covered family members do not have to meet their individual deductible amounts for the rest of the plan year. If you are enrolled in one of the Anthem CDHP HRA plans, an embedded deductible applies. This means that once any covered individual reaches that plan's individual deductible, co-insurance would apply. In the Anthem CDHP HSA options, a collective deductible applies.

Co-payments

A "co-payment" is the fixed dollar amount that you pay for certain services. You can refer to the Benefit Summary for your coverage option and for more details about co-payments. The summary is in the "How the medical options pay benefits" section.

Co-insurance

Your "co-insurance" is the percentage of eligible expenses you are responsible for paying. Percentages apply after you meet any applicable deductible. The amount you pay (your co-insurance) depends on:

- The coverage option you select; and,
- Whether you receive in-network or out-of-network care.

You can refer to the Benefit Summary for your coverage option for more details about co-insurance. The summary is in the "How the medical options pay benefits" section.

Out-of-pocket maximums

The "out-of-pocket maximum" is the most you have to pay in deductibles and co-insurance for eligible expenses in one plan year. You can refer to the Benefit Summary for your coverage option and for more details about out-of-pocket maximums. The summary is in the "How the medical options pay benefits" section.

Under the Anthem CDHP HRA options, once you reach your individual out-of-pocket maximum, Cardinal Health pays 100 percent of your additional eligible expenses for the remainder of that plan year. The family out-of-pocket maximum applies collectively to all covered family members under the Anthem CDHP HSA options. Once you meet the family out-of-pocket maximum, Cardinal Health pays 100 percent of eligible expenses for any covered family member for the remainder of that plan year.

If you are enrolled in one of the Anthem CDHP medical options, your in-network and out-of-network out-of-pocket maximums will cross-accumulate, which means if you use out-of-network providers, your medical expenses will apply toward your in-network, out-of-pocket maximum. The same applies if you use an in-network provider: the in-network out-of-pocket maximum will apply toward your out-of-network, out-of-pocket maximum. Certain charges do not apply toward your medical out-of-pocket maximum. As a result, the medical plan does not pay for the following expenses:

- Co-payments (where applicable);
- Any additional charges you pay for not following pre-certification requirements; and,
- Any charges not covered by the plan or exceeding reasonable and customary plan limits.

What's considered "medically necessary and appropriate"?
Services and supplies provided by a hospital, facility or professional provider are considered medically necessary and appropriate if the plan determines they are:

- Appropriate for the symptoms and diagnosis or treatment of a medical condition, illness, disease or injury;
- Provided for the diagnosis or the direct care and treatment of a medical condition, illness, disease or injury;
- Provided according to good medical practice standards and consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or healthcare coverage organizations or governmental agencies accepted by the plan; and,
- Not provided only as a convenience, such as custodial services. See page 99 for a definition of custodial services.

The plan reserves the right to determine in its sole judgment whether a service is medically necessary and appropriate. Benefits are not provided unless the plan determines that the service or supply is medically necessary and appropriate.

Lifetime maximums

The individual "lifetime maximum" is the maximum amount Cardinal Health pays for eligible expenses during the life of a covered individual. Under healthcare reform, lifetime maximums can no longer be applied to benefits that are considered "essential health benefits" under the Affordable Care Act. As a result, the plan does not apply any lifetime maximums to the total amount of benefits that you can receive under the plans. However, the plans may impose individual lifetime maximums on benefits that are not considered "essential health benefits" under the Affordable Care Act. The lifetime maximums are listed in the Benefit Summaries in this SPD.

Health fund account or HRA

A "health fund account" is an account funded by Cardinal Health to pay for expenses under the Anthem CDHP HRA options.

Health savings account or HSA

A "health savings account" is an account funded by Cardinal Health and you to pay for expenses under the Anthem CDHP with Funded HSA. The Basic CDHP with HSA also allows you to fund an HSA, but there is no funding provided by Cardinal Health.

Employee responsibility

The "employee responsibility" is your portion of the plan year deductible that you must pay out-of-pocket on covered expenses after you deplete the benefit dollars in your health fund account or health savings account, and before the health coverage component kicks in. Your employee responsibility will be less if you roll over health fund account or health savings account benefit dollars from the previous plan year or apply funds from your flexible spending account. However, the employee responsibility could increase, up to the amount of your deductible, if you choose to spend your health fund account benefit dollars on "extra" non-traditional covered expenses — refer to "More details about the healthcare flexible spending account" for a listing of such expenses.

Pre-admission certification (PAC)

"Pre-admission certification" is the process used to certify the medical necessity and length of any hospital stay as a registered bed patient. You or your dependent are responsible for pre-certification whether services are provided by an in- network provider or out-of-network/ non-participating provider. **Failure to pre-certify your inpatient hospital stay will result in a $300 penalty applied to inpatient charges for failing to contact Anthem.** You should start the pre-admission certification process by calling the number listed on your ID card, or in the case of an emergency admission, within 48 hours. **Please note: The $300 penalty for failing to pre-certify does not apply toward your out-of-pocket maximum.**

Release of medical information — HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the medical, dental, prescription drug, vision, mental health, employee assistance program and healthcare flexible spending account portions of the plan are subject to HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, healthcare operations, plan administration or as required or permitted by law. A description of the plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the plan's Notice of Privacy Practices, which is furnished to all plan participants and is available on **hr.cardinalhealth.com**. The plan will provide you with a copy of the most recent version of this notice at any time upon your written request sent to the Privacy Officer. In addition, for any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint with the plan, please contact the Privacy Officer.

Any inquiry to the Privacy Officer should be directed to:

Privacy Officer
c/o Cardinal Health, Inc. Group Benefit Plan
7000 Cardinal Place
Dublin, OH 43017

The plan and its business associates will take appropriate steps to ensure that protected health information is secure and will comply with HIPAA's breach notification requirements if a breach of unsecured protected health information occurs.

Protection of genetic information — GINA

The plan may not request, use or disclose your genetic information except as required by law, with your written permission, or as otherwise permitted by the Genetic Information Nondiscrimination Act of 2008.

How the medical options pay benefits

Here is how each coverage option pays benefits for medically necessary eligible expenses.

Anthem CDHP with Funded HRA

The following Benefit Summary shows how the Anthem CDHP with Funded HRA pays for your eligible medical expenses. Remember, your expenses are first paid out of your health fund account. Then, you pay your employee responsibility until you meet the annual deductible.

Once the annual deductible is met, you pay 20 percent co-insurance — Cardinal Health pays 80 percent — until you reach the out-of-pocket maximum. Once you have met the out-of-pocket maximum, Cardinal Health pays 100 percent of your eligible medical expenses, as long as you use network providers. Keep in mind that under the Anthem CDHP with Funded HRA, you pay the actual cost of services and prescription drugs (there is no co-payment).

Your health fund account, employee responsibility and out-of-pocket expenses depend on your salary and whether you have coverage for yourself only or for you and your family.

Benefit Summary — Anthem CDHP with Funded HRA

Annual salary less than $35,000

Plan design	In-network		Out-of-network	
Coverage tier	Employee only	Employee + family	Employee only	Employee + family
Your health fund account (Cardinal Health funds)*	$1,000	$2,000	$1,000	$2,000
Annual deductible	$2,500	$5,000	$5,000	$10,000
Annual out-of-pocket maximum	$3,000	$6,000	$6,000	$12,000
Cardinal Health pays after employee reaches the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

* Your health fund account will be prorated based on your hire date with Cardinal Health.

Annual salary $35,000 or greater

Plan design	In-network		Out-of-network	
Coverage tier	Employee only	Employee + family	Employee only	Employee + family
Your health fund account (Cardinal Health funds)*	$750	$1,500	$750	$1,500
Annual deductible	$2,500	$5,000	$5,000	$10,000
Annual out-of-pocket maximum	$3,000	$6,000	$6,000	$12,000
Cardinal Health pays after employee reaches the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

The Anthem CDHP with Funded HRA covers preventive care at 100 percent when received from a participating in-network Anthem healthcare provider. That means there is no cost to you, no cost to your HRA and no plan deductible to meet. All other services are subject to the annual deductible and annual out-of-pocket maximum. Of course, you can use your health fund account for first dollar coverage.

Anthem CDHP with Funded HSA

The following Benefit Summary shows how the Anthem CDHP with Funded HSA pays for your eligible medical expenses. Your expenses can be paid out of your health savings account. Once the annual deductible is met, you pay 20 percent co-insurance — Cardinal Health pays 80 percent — until you reach the out-of-pocket maximum. Once you have met the out-of-pocket maximum, Cardinal Health pays 100 percent of your eligible medical expenses, as long as you use network providers. Keep in mind that under the Anthem CDHP with Funded HSA, you pay the actual cost of services and prescription drugs (there is no co-payment).

When you enroll in the Anthem CDHP with Funded HSA, Cardinal Health will make payroll contributions to your account on your behalf. The amount you receive in your HSA depends on your salary and whether you elect coverage for yourself or yourself and your family members.

Your health savings account, employee responsibility and out-of-pocket expenses depend on your salary and whether you have coverage for yourself only or for you and your family.

* Your health fund account will be prorated based on your hire date with Cardinal Health.

Benefit summary — Anthem CDHP with Funded HSA

Annual salary less than $35,000

Plan design	In-network		Out-of-network	
Coverage tier	Employee only	Employee + family	Employee only	Employee + family
Your health savings account contribution by Cardinal Health*	$500	$1,000	$500	$1,000
Annual deductible	$1,500	$3,000	$3,000	$6,000
Annual out-of-pocket maximum	$2,500	$5,000	$5,000	$10,000
Cardinal Health pays after employee has reached the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

Annual salary greater than $35,000

Plan design	In-network		Out-of-network	
Coverage tier	Employee only	Employee + family	Employee only	Employee + family
Your health savings account contribution by Cardinal Health*	$250	$500	$250	$500
Annual deductible	$1,500	$3,000	$3,000	$6,000
Annual out-of-pocket maximum	$2,500	$5,000	$5,000	$10,000
Cardinal Health pays after employee has reached the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

The Anthem CDHP with Funded HSA covers preventive care at 100 percent when you receive it from a participating in-network Anthem healthcare provider. That means there is no cost to you, no cost to your HSA and no plan deductible to meet. All other services are subject to the annual deductible and annual out-of-pocket maximum. Of course, you can use your HSA for first dollar coverage or choose to pay for healthcare services yourself — the choice is yours.

Anthem Basic CDHP with HSA

The following Benefit Summary shows how the Anthem Basic CDHP with HSA pays for your eligible medical expenses. Your expenses can be paid out of your health savings account. Once the annual deductible is met, you pay 20 percent co-insurance — Cardinal Health pays 80 percent — until you reach the out-of-pocket maximum. Once you have met the out-of-pocket maximum, Cardinal Health pays 100 percent of your eligible medical expenses, as long as you use network providers. Keep in mind that under the Anthem Basic CDHP with HSA, you pay the actual cost of services and prescription drugs (there is no co-payment). The Anthem Basic CDHP with HSA offers the tax-saving advantages of an HSA and lower premiums, but provides much less coverage and significantly higher deductibles and out-of-pocket maximums than the other plans.

* Your health fund account will be prorated based on your hire date with Cardinal Health.

Benefit summary — Anthem Basic CDHP with HSA

Plan design	In-network		Out-of-network	
Coverage tier	Employee only	Employee + family	Employee only	Employee + family
Your health savings account contribution by Cardinal Health*	N/A	N/A	N/A	N/A
Annual deductible	$4,000	$8,000	$8,000	$16,000
Annual out-of-pocket maximum	$5,000	$10,000	$10,000	$20,000
Cardinal Health pays after employee has reached the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

Anthem CDHP Out of Area with Funded HRA

The following Benefit Summary shows how the Anthem CDHP Out of Area with Funded HRA pays for your eligible medical expenses. Remember, your expenses are first paid out of your health fund account. Then, you pay your employee responsibility until you meet the annual deductible.

Once the annual deductible is met, you pay 20 percent co-insurance — Cardinal Health pays 80 percent — until you reach the out-of-pocket maximum. Once you have met the out-of-pocket maximum, Cardinal Health pays 100 percent of your eligible medical expenses, as long as you use network providers. Keep in mind that under the Anthem CDHP Out of Area with Funded HRA, you pay the actual cost of services and prescription drugs (there is no co-payment).

For a more detailed description of each covered service, see the “Covered services” section. In order to comply with the requirements of Hawaii, the covered benefits differ slightly in that state. In no case are the benefits in Hawaii less than those described here.

Your health fund account, employee responsibility and out-of-pocket expenses depend on your salary and whether you have coverage for yourself only or for you and your family.

Benefit summary — Out-of-Area option

Annual salary less than $35,000

Plan design	In-network		Out-of-network	
Coverage tier	**Employee only**	**Employee + family**	**Employee only**	**Employee + family**
Your health fund account (Cardinal Health funds)*	$1,000	$2,000	$1,000	$2,000
Annual deductible	$2,500	$5,000	$5,000	$10,000
Annual out-of-pocket maximum	$3,000	$6,000	$6,000	$12,000
Cardinal Health pays after employee reaches the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

Annual salary $35,000 or greater

Plan design	In-network		Out-of-network	
Coverage tier	**Employee only**	**Employee + family**	**Employee only**	**Employee + family**
Your health fund account (Cardinal Health funds)*	$750	$1,500	$750	$1,500
Annual deductible	$2,500	$5,000	$5,000	$10,000
Annual out-of-pocket maximum	$3,000	$6,000	$6,000	$12,000
Cardinal Health pays after employee reaches the out-of-pocket maximum	100 percent	100 percent	100 percent	100 percent

* Your health fund account will be prorated based on your hire date with Cardinal Health.

Covered services for all the CDHPs are described on the following pages.

Outpatient medical care services

Plan feature	Anthem CDHPs*
	Cardinal Health pays
Outpatient doctor's office visits — for injury or illness	80 percent after deductible
Outpatient doctor's office visits — allergy injections	80 percent after deductible
Outpatient doctor's office visits — allergy serums/antigens	80 percent after deductible
Outpatient pre-admission testing (office visit or outpatient facility)	80 percent after deductible

Preventive care services

To help you stay healthy, all in-network preventive care services (e.g., annual physical exams, Pap smears, cholesterol screenings and mammograms) as well as additional in-network preventive healthcare services for women (e.g., screening and counseling for HIV and domestic violence, counseling for sexually transmitted infections, and certain contraceptives) are covered at 100 percent with no deductible to meet.

Plan feature	Anthem CDHPs
	Cardinal Health pays
Preventive care (routine preventive care for children through age 2 — including immunizations)	100 percent
Preventive care (annual routine exam for ages 3 and up — including immunizations — includes school physical as an annual exam)	100 percent
Well-woman exam (includes Pap smear)	100 percent
Routine mammogram	100 percent
Well-man exam (includes PSA and colorectal screening)	100 percent

Maternity services

(Coverage applies to employees and all eligible dependents)

Plan feature	Anthem CDHPs*
	Cardinal Health pays
Maternity (initial visit to determine pregnancy)	80 percent after deductible
Maternity (all subsequent prenatal and postnatal visits, combined with the delivery charge)	80 percent after deductible
Maternity (hospital or birthing center)	80 percent after deductible

*Subject to maximum reimbursable charge.

Family planning services

(Coverage applies to employees and all covered eligible dependents)

Plan feature	Anthem CDHPs* Cardinal Health pays
Family planning (office visits, including tests/ counseling, surgical sterilization procedures for vasectomy/tubal ligations, and certain contraceptive devices, implants and injectables — excludes reversals)	80 percent after deductible
Family planning (inpatient/outpatient facility and physician's services)	80 percent after deductible

*Subject to maximum reimbursable charge.

Infertility treatment

(Coverage applies to employees and all covered eligible dependents)

Infertility treatment includes procedures to induce pregnancy, such as, but not limited to:

- In vitro fertilization; and,
- Artificial insemination — includes gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

A $10,000 lifetime maximum applies to infertility treatment. Prescription drugs used to treat infertility have a separate $10,000 lifetime maximum, for a $20,000 total lifetime maximum. Infertility drugs are covered by CVS Caremark.

Plan feature	Anthem CDHPs* Cardinal Health pays
Office visits	80 percent after deductible
Inpatient/outpatient facilities and physician's services	80 percent after deductible

Inpatient hospital medical care services

Plan feature	Anthem CDHPs* Cardinal Health pays
Hospital room and board**	80 percent after deductible
Inpatient hospital provider visits/consultations	80 percent after deductible
Skilled nursing facility (up to a maximum of 60 days per plan year; no prior hospitalization required)	80 percent after deductible
Inpatient hospital professional services • Surgeon • Radiologist • Pathologist • Anesthesiologist	80 percent after deductible
Organ transplants (includes all medically appropriate, non-experimental transplants) Use of Blue Distinction Centers of Excellence also provides coverage of companion travel and expenses ($10,000 maximum)	100 percent at Blue Distinction Centers of Excellence; otherwise 80 percent after deductible
Multiple surgery reduction	Multiple surgeries performed during one operating session result in payment reduction of 50 percent of the surgery of the lesser charge. The most expensive procedure is paid as any other surgery.

*Subject to maximum reimbursable charge.
**Limited to semi-private room negotiated rate.

Outpatient hospital medical care services

Plan feature	Anthem CDHPs* Cardinal Health pays
Outpatient surgical facility services	80 percent after deductible
Outpatient professional services • Surgeon • Radiologist • Pathologist • Anesthesiologist	80 percent after deductible
Second opinions for surgery — voluntary	80 percent after deductible
Outpatient short-term rehabilitation (up to a maximum of 60 visits per plan year for each therapy not combined) • Physical therapy • Speech therapy • Occupational therapy • Cardiac therapy • Pulmonary rehab • Cognitive therapy	80 percent after deductible

Emergency services

Plan feature	Anthem CDHPs* Cardinal Health pays
Emergency care — doctor's office	80 percent after deductible
Hospital emergency room	80 percent after deductible
Urgent care facility	80 percent after deductible
Ambulance	80 percent after deductible

Laboratory services

Plan feature	Anthem CDHPs* Cardinal Health pays
Lab and X-ray services (inpatient, hospital outpatient, lab and X-ray facility, doctor's office)	80 percent after deductible

*Subject to maximum reimbursable charge.

Mental health, alcohol and drug abuse rehabilitation

(Work-Life Solutions to provide up to eight visits)

Plan feature	Anthem CDHPs* Cardinal Health pays
Inpatient	80 percent after deductible
Outpatient	80 percent after deductible

Mental health, alcohol and drug abuse rehabilitation — all medical plans

Mental health parity — In accordance with the Mental Health Parity Act changes effective January 1, 2010, mental health/substance abuse benefits are now paid comparably to any other medical condition. As a result, there are no visit or day limits for these types of services.

Dental care

(Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth)

See dental plan coverage details.

Plan feature	Anthem CDHPs* Cardinal Health pays
Doctor's office visits	80 percent after deductible
Inpatient facility, outpatient surgical facility and physician's services	80 percent after deductible
Oral surgical procedures (limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth (see dental plan coverage details)	Not covered
TMJ treatment — surgical and non-surgical (excludes appliances and orthodontic treatment)	80 percent after deductible

*Subject to maximum reimbursable charge.

Other services

Plan feature	Anthem CDHPs* Cardinal Health pays
Chiropractic therapy (includes chiropractors — up to 20 visits per plan year)	80 percent after deductible
Abortion (coverage applies for employees and all eligible dependents for non-elective procedures)	80 percent after deductible; only if medically necessary
Inpatient facility, outpatient surgical facility, physician's services	80 percent after deductible
Durable medical equipment	80 percent after deductible
External prosthetic appliance	80 percent after deductible
Miscellaneous items (ostomy supplies, injectable drugs dispensed and billed from a physician's office, drawing and storage of blood donated by self or other for use by covered individual for scheduled service for up to 90 days)	80 percent after deductible
Routine hearing exam (annual exam in office)	100 percent
Hearing aids (up to $3,000 per ear every three calendar years)	80 percent after deductible
Acupuncture (used in lieu of other types of anesthesia and administered by an M.D. or when used for treatment of chronic pain only for the following conditions: arthritis, back or cervical pain syndromes, Bell's palsy, bursitis, headaches, herpes zoster [shingles], lumbago, sciatica, dysmenorrhea, pinched nerve, post laminectomy-intractable pain, rheumatism, sinusitis, invertebral disc displacement, spastic colon, stroke (pain, paralysis, etc.), tendonitis, tennis elbow and trigeminal neuralgia [tic douloureux]) Up to 15 visits per condition; additional visits for same condition when treatment is separated by a period of six months	80 percent after deductible
Home healthcare (up to a maximum of 120 visits per plan year)	80 percent after deductible
Hospice (inpatient or outpatient facility)	80 percent after deductible
Hospice (bereavement counseling within the hospice; otherwise, may be covered under Work-Life Solutions if billed by a separate provider)	80 percent after deductible
Bariatric Surgery **Treatment of clinically severe obesity as defined by the body mass index (BMI) is only covered when performed at one of Anthem's approved Blue Distinction Centers of Excellence.**	80 percent after deductible

*Subject to maximum reimbursable charge.

Kaiser Permanente Plans

The following Benefit Summary shows how the Kaiser plans generally pay benefits. This is a very brief snapshot of that coverage. For details on how your particular Kaiser plan pays benefits for covered services, see your separate Kaiser materials.

Kaiser Permanente Plans Benefit summary

Plan feature	
Annual deductibles • Individual • Family	$600/$1,200
Co-insurance (plan pays/you pay after deductible) • In-network • Out-of-network	80 percent/20 percent 0 percent/100 percent
Doctor's office visit	20 percent after deductible
Annual out-of-pocket maximums • Individual • Family	$2,500/$5,000
Lifetime maximum	None

Please Note: Generally, if a primary care physician (PCP) does not coordinate care, the HMO does not pay benefits.

Cigna Global Health Benefits medical coverage

Cardinal Health provides a special medical plan for Global Assignees through an arrangement with Cigna Global Health Benefits. This is the only health plan available to you while working as an expat overseas. On your return to the United States, you will again be eligible for the domestic medical plan that is described in this SPD. Your Cigna Global Health benefits are available to you 24 hours a day, seven days a week anywhere you travel in the world, including any trips home. For additional information on covered/not covered services, log on to **cignaenvoy.com** or contact a member services representative at the number listed on your ID card.

Benefit summary — Cigna Global Health Benefits

Plan feature	Cigna Global Health Benefits option
Plan year deductibles • Individual • Family	$0 $0
Co-insurance (Cardinal Health pays/you pay)	80 percent/20 percent
Annual out-of-pocket maximums • Individual • Family	$2,500 $5,000
Lifetime maximum	None

Group medical benefits

Plan feature	Cigna Global Health Benefits option
Room and board	Hospital's average semi-private charge per day of confinement.
Bariatric surgery/obesity	Covered at 80 percent to a lifetime maximum of $10,000, subject to medical necessity and clinical guidelines and certain other limitations.
Maternity expense	Treated the same as any other condition for employee and eligible dependents.
Infertility	Procedures directly related to diagnosis are covered. Treatment and prescription drugs are covered to a lifetime maximum of $5,000.
Routine nursery	Covered as any other treatment, including room and board, physician charges and circumcision for males prior to discharge.
Private duty nursing	Covered as any other treatment.
Prescription drugs (including oral contraceptives)	Covered at 80 percent, subject to deductible, included in out-of-pocket expenses. Expenses for prenatal vitamins and smoking cessation products are excluded.
Cigna pharmacy management	A service provided through Cigna Pharmacy Management, which offers a managed pharmacy benefit plan for prescription drugs purchased in the U.S. at participating retail pharmacies. Mail order drugs also are available via Tel-Drug, but cannot be shipped overseas. Some limitations may apply.
Adult routine physicals	Covered at 100 percent. Services covered include (tests are those related to the annual physical): Routine tests, such as chest X-rays, urinalysis, blood tests, EKG. Adult immunizations not covered. Travel immunizations covered at 80 percent.
Child preventive care	Covered at 100 percent for dependent children from birth through age 18. Includes health history, physical exam, development assessment and immunizations.
Mental illness and alcohol or drug abuse treatment (mental illness and alcohol or drug abuse expenses do not count toward your out-of-pocket maximum [excluding biologically based mental illness expenses])	Inpatient treatment – Covered at 80 percent Outpatient treatment – Covered at 80 percent
Skilled nursing facility	Covered as any other treatment up to a 60-day limit in a calendar year.
Home healthcare	Covered as any other treatment, up to a 120-day limit in a calendar year.
Chiropractic services	Covered as any other treatment, up to a 20-day limit in a calendar year.
Hospice care services	Covered at 80 percent
Temporomandibular Joint Disorder (TMJ)	Covered as any other treatment with a lifetime maximum of $1,000.
Pap test*	Covered at 100 percent; one test per calendar year for all eligible females.

Plan feature	Cigna Global Health Benefits option
Prostate cancer screening*	Covered at 100 percent; one test per calendar year for males ages 50 and over.
Mammograms*	Covered at 100 percent per the following schedule: • Ages 35 – 39: one baseline exam. • Ages 40 – 49: one exam every one or two years for asymptomatic women, but no sooner than two years after a woman's baseline. • Age 50 and older: one exam annually • Any age: Whenever prescribed by a physician.
Lead poisoning screening test*	Covered at 100 percent for children at or around 12 months old and children under age 6 who are considered to be at high risk.
Colorectal cancer screening*	Covered at 100 percent for persons age 50 and older or for any person deemed at high risk of colon cancer because of family history or ethnic or lifestyle background.
Immunizations*	Covered at 100 percent for children from birth through age 18 for immunization against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, Haemophilus influenzae B and hepatitis A.
Contraceptives*	Covered as any other treatment for FDA-approved prescription contraceptive drug/devices and for outpatient contraceptive services, including consultations, exams, procedures and medical services related to the use of contraceptives.
Diabetes equipment and supplies*	Covered as any other treatment for the following equipment and supplies, if recommended in writing or prescribed by a physician: insulin pumps; blood glucose meters and strips; urine testing strips; insulin; syringes; lancets; alcohol swabs and pharmacological agents for controlling blood sugar.
Dental care	Coverage limited to accidental injury of sound, natural teeth sustained while covered under the plan.
Pre-admission certification and continued stay review (PAC/CSR)	Will apply with penalties for non-compliance for **U.S.** confinements. Penalties: $300 penalty applied to hospital inpatient charges for failure to pre-certify admission. Benefits are reduced 50 percent for any admission not certified or additional days not deemed medically necessary.
Case Management	A service provided through Intracorp, a Cigna company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or as an inpatient in a hospital or specialized facility. This service works with the patient, his or her family and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. Case managers will help coordinate the treatment program and arrange for necessary resources.

* Delaware state mandate.

Covered services

If you select coverage under the Anthem CDHP plans, you receive benefits — up to the maximum allowable amount or negotiated fee — **for medically necessary eligible expenses**. (Refer to the description of Maximum Allowable Amount below.) The Benefit Summary for your coverage explains how Cardinal Health pays benefits for each covered service. The Benefit Summary also includes any benefit limit or co-payment requirement that may apply for each service.

Remember, if you are a Kaiser Permanente participant, the materials provided by Kaiser will give you additional details about covered services.

Under the Anthem CDHP HSA options, the following is a list of covered expenses payable only under your health savings account and will not count toward satisfaction of your plan year deductible:

- Amounts in excess of any health coverage limits.
- Amounts over usual and customary.

The IRS has specific guidelines that must be followed for many of these items. For more information about a specific benefit, please call **HealthEquity** at **877.713.7712**.

For the Anthem CDHP medical options, the following is a list of covered expenses payable under your health fund account or health savings account, and the health coverage that will count toward satisfaction of your annual deductible.

Cardinal Health pays benefits for the following services and supplies:

- Hospital room and board, up to the semi-private room rate.
- Licensed ambulance service to or from the nearest hospital for needed medical care and treatment.
- Outpatient medical care and treatment.

What types of care are considered "emergency care"?
Any care that you receive after a sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain. Your care must be such that the absence of immediate medical attention for the condition could result in:

- Serious jeopardy to your (or with respect to a pregnant woman, the unborn child's) health;
- Serious impairment to bodily function; or,
- Serious dysfunction to any organ or body part.

Out-of-network emergency services are generally paid the same as in-network emergency services.

What is "urgent care"?
Care that is not an emergency. The delay of this type of care until care is available from an in-network provider can significantly jeopardize a patient's health or life.

What is "durable medical equipment"?
Medical equipment that can withstand repeated use and is not disposable. This type of medical equipment is used for a medical purpose, is not generally useful to a person in the absence of an illness or injury, does not serve as a comfort or convenience item and is appropriate for use in the home.

- Medical care and treatment in a freestanding surgical facility.
- Outpatient medical care and treatment in a hospital emergency room or an urgent care center.
- Medical care and treatment in a skilled nursing facility (up to a maximum of 60 days per plan year).
- Outpatient care and treatment of mental illness.
- Outpatient alcohol and drug abuse treatment.
- Medical services provided by a physician or psychiatrist.
- Medical services provided by a nurse.
- Medically necessary hospital ancillary services and supplies, including:
  - Anesthesia and oxygen services;
  - Diagnostic X-ray and laboratory examinations;
  - X-ray, radium and radioactive isotope treatment;
  - Chemotherapy;
  - Blood transfusions and blood not donated or replaced;
  - Rental or purchase of durable medical equipment;
  - Prosthetic appliances;
  - Prostheses following a mastectomy;
  - Dressings; and,
  - Drugs and medications prescribed by a physician during the hospital stay (vitamins are excluded).

Save money!
You can use your healthcare flexible spending account to pay yourself back for eligible healthcare expenses that your medical plan did not cover.

- Obstetrical services, including hospital services and surgical/medical services provided for a mother's maternity care and nursery care of the newborn.
- Prenatal care.
- Postnatal care.
- Hospital services and surgical/medical services associated with complications of pregnancy and childbirth.
- Consistent with the Newborns' and Mothers' Health Protection Act, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

- Approved organ transplant services, including:
  - Immunosuppressive medication;
  - Organ procurement costs; and,
  - Donor's medical costs. The amount payable for the donor's medical costs is reduced by the amount payable for those costs from any other plan. Certain transplants are not covered. Contact Anthem before incurring any such costs.
- Preventive care services for:
  - Well-child care;
  - An annual routine physical examination;
  - A well-woman examination;
  - A well-man examination (includes PSA and colorectal screening);
  - An annual mammogram;
  - Routine Pap smears;
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and,
  - With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Diagnosis and treatment of toenails (including removal of nail matrix or root, or services furnished in connection with treatment of a metabolic or peripheral vascular disease or of a neurological condition).
- Outpatient rehabilitation by a licensed physical, occupational or speech therapist.
- Voluntary family planning services, including:
  - Medical history;
  - Physical examination;
  - Related laboratory tests;
  - Medical supervision in accordance with generally accepted medical practices;
  - Information and counseling on contraception;
  - Oral contraceptives and contraceptive devices (excluding injectable/implantable contraceptives and morning after pill); and,
  - Medical services connected with surgical therapies, such as vasectomies and tubal ligations (excluding reversals).

- Infertility treatment (including procedures to induce pregnancy, such as, but not limited to, in vitro fertilization, artificial insemination, GIFT, ZIFT, etc.) up to a $10,000 lifetime maximum. Prescription drug therapy to treat infertility has a separate $10,000 lifetime maximum.
- Hyperalimentation or Total Parenteral Nutrition (TPN) charges for persons recovering from or preparing for surgery; however, benefits are not paid for a period lasting longer than three months.
- Acupuncture treatment for specific conditions and subject to limits.
- Diabetes self-education and management.
- Reconstructive breast surgery following a medically necessary mastectomy. Consistent with the Women's Health and Cancer Rights Act, if you have a mastectomy and elect reconstructive surgery in connection with the mastectomy, coverage will be provided for:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
  - Prosthesis and physical complications for all stages of the mastectomy, including lymphedemas.
- Medical services and supplies provided by a home healthcare agency for:
  - Part-time or intermittent nursing care by or under the supervision of a registered graduate nurse;
  - Part-time or intermittent services of a home health aide, agency or hospital program;
  - Physical, occupational or speech therapy; and
  - Medical supplies, drugs, medications and laboratory services, but only to the extent that such charges would have been considered covered expenses had a person required confinement in the hospital as a registered bed patient or confinement in a skilled nursing facility.
- Hospice care services provided under a hospice care program for:
  - Room and board;
  - Outpatient services;
  - A physician's professional services;
  - Individual and family counseling provided by a psychologist, social worker, family counselor or ordained minister (including bereavement counseling within one year after a person's death);
  - Pain relief treatment (including drugs, medicines and medical supplies);

What is "home healthcare"?
Care that is provided in a patient's home through a home healthcare agency or hospital program.

What is "hospice care"?
A special type of care for terminally ill patients and their families. This type of care is provided in an inpatient hospice facility or in the patient's home.

  - Part-time or intermittent nursing care by or under the supervision of a nurse from a home healthcare agency;
  - Part-time or intermittent services of a home health aide from a home healthcare agency;
  - Physical, occupational and speech therapy;
  - Medical supplies, drugs, medications and laboratory services, but only to the extent that such charges would have been payable under the policy if the person had remained or been confined in a hospital or hospice facility.

- Chiropractic care services, subject to limitations, including:
  - The management of disability of the spine, neck and muscular ligamentous attachments of that organ system;
  - Office examinations (patient history, physical examination, spinal X-rays, laboratory tests and neuromuscular treatment and manipulation);
  - Lab work;
  - Medically necessary care provided in an office setting; and,
  - Acute conditions only.
- Cardiac rehabilitation:
  - Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when medically necessary. Phase II is a hospital-based outpatient program following an inpatient hospital discharge. The Phase II program must be physician-directed with active treatment and EKG monitoring.
  - Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phase I and Phase II. Phase IV is an advancement of Phase III that includes more active participation and weight training.

- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided that:
  - The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement;
  - The orthognathic surgery is medically necessary as a result of tumor, trauma or disease; or,
  - The orthognathic surgery is performed prior to age 19 and is required as a result of a severe congenital facial deformity or congenital condition.

- Repeat or subsequent orthognathic surgeries for the same condition are covered only when:
  - The previous orthognathic surgery met the above requirements; and,
  - There is a high probability of significant additional improvement as determined by Anthem.

- Clinical trials. Routine patient services associated with clinical trials approved and sponsored by the federal government and conducted in relation to the prevention, detection or treatment of cancer or other life-threatening diseases or conditions, meaning any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. In addition, the following criteria must be met:
  - The clinical trial is approved or funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services, a cooperative group or center of any of these entities or the Department of Defense or the Department of Veterans Affairs, or a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
  - The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or,
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- Routine patient services do not include, and reimbursement will not be provided for:
  - The investigational item, device or service, itself;
  - Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
  - Services or supplies listed in the "Medical expenses not covered" section below; or,
  - Services or supplies that, in the absence of private healthcare coverage, are provided by a clinical trial sponsor or other party (e.g., a device, drug, item or service supplied by a manufacturer and not yet FDA-approved) without charge to the trial participant.
- Gender reassignment surgery is considered medically necessary and is covered when ALL of the following criteria are met:
  - The individual is 18 years of age or older.
  - The individual is diagnosed as having a gender identity disorder (GID), including a diagnosis of true transsexualism that includes ALL of the following criteria:
    - The individual has demonstrated the desire to live and be accepted as a member of the opposite sex, in addition to a desire to make his or her body as congruent as possible with the preferred sex through surgery and hormone replacement;
    - The transsexual identity has been present consistently for at least two years; and,
    - The disorder is not due to another mental disorder or chromosome abnormality.
  - The individual is an active participant in a recognized gender identity treatment program and demonstrates ALL of the following conditions:
    - The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real-life experience) without returning to the original gender;

  - One qualified health professional recommends initiation of hormonal therapy or breast surgery with written documentation submitted to the physician who will be responsible for the medical treatment;
  - The individual has received at least 12 months of continuous hormonal sex reassignment therapy, unless medically contraindicated (may be simultaneous with real-life experience);

- Two qualified mental health professionals recommend sex reassignment surgery with written documentation submitted to the physician performing the genital surgery. (At least one letter should be an extensive report. Two separate letters or one letter with two signatures is acceptable. One letter from a master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.); and,
- The individual has undergone evaluation by the physician performing the genital surgery.

For more detail regarding how services are paid under each of the Anthem CDHP medical options, log on to **anthem.com** or contact Anthem Customer Service at **844.256.4818**.

Anthem's Health & Wellness Programs

Quick Care Options

Quick Care Options helps to raise your awareness about appropriate alternatives to hospital emergency rooms (ERs). When you need care right away, retail health clinics and urgent care centers can offer appropriate care for less cost — and leave the ER available for actual emergencies. Quick Care Options educates you on the availability of ER alternatives for non-urgent diagnoses and offers a provider finder website to support searches for ER alternatives.

ComplexCare

The ComplexCare program reaches out to you if you are at risk for frequent and high levels of medical care in order to offer support and assistance in managing your healthcare needs. ComplexCare empowers you for self-care of your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with you and your physician to offer:

- Personalized attention, goal planning, and health and lifestyle coaching;
- Strategies to promote self-management skills and medication adherence;
- Resources to answer health-related questions for specific treatments;
- Access to other essential healthcare management programs; and,
- Coordination of care between multiple providers and services.

The program helps you effectively manage your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches, supported by pharmacists, registered dietitians, social workers and medical directors. You'll get:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions;
- *Your Pregnancy Week by Week*, a book to show you what changes you can expect for yourself and your baby over the next nine months; and,
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks.

24/7 NurseLine

You may have emergencies or questions for nurses around the clock. The 24/7 NurseLine provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, you can make more informed decisions about the most appropriate and cost-effective use of healthcare services. A staff of experienced nurses is trained to address common healthcare concerns such as medical triage, education, access to healthcare, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team — RN license (BSN preferred) — that helps members access systems, understand medical conditions, receive the right care in the right setting and find programs and tools appropriate to their condition;
- Bilingual RNs, language line and hearing impaired services;
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics;
- Proactive callbacks within 24 to 48 hours for members referred to 911 emergency services or poison control and for pediatric dependents with needs identified as either emergent or urgent; and,
- Referrals to relevant community resources.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier. Here's how it works: Anthem reviews your incoming health claims to see if we can save you any money. Anthem can check to see what medications you're taking and alert your doctor if we spot a potential drug interaction. Anthem also keeps track of your routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Notes. MyHealth Notes summarizes your recent claims. From time to time, Anthem offers tips to save you money on prescription drugs and other healthcare supplies.

AIM Imaging Cost and Quality Program

Cardinal Health has selected this innovative Imaging Cost and Quality Program for Anthem Blue Cross Blue Shield members through AIM Specialty Health. This program provides you with access to important information about imaging services you might need. The program is not a benefit under your healthcare plan.

If you need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where you go to receive the service. Sometimes the differences are significant — anywhere from $300 to $3,000 — but a higher price does not necessarily guarantee higher quality. If you are required to pay a portion of this cost (like a deductible or co-insurance) where you go can make a very big difference to your wallet.

That's where the AIM Imaging Cost and Quality Program comes in — AIM does the research for you and helps you find the *right* location for your MRI or CT scan. Here's how the program works:

- Your doctor refers you to a radiology provider for an MRI or CT scan;
- AIM works with your doctor to help make sure that you are receiving the right test, using evidence-based guidelines;
- AIM also reviews the referral to see if there are other providers in your area that are high quality but have a lower price than the one you were referred to;
- If AIM finds another provider that meets the quality and price criteria, AIM will give you a call to let you know; and,
- **You have the choice** — you can see the radiology provider your doctor suggested OR you can choose to see a provider that AIM tells you about. AIM will even help you schedule an appointment with the new provider.

The AIM Imaging Cost and Quality Program gives you the opportunity to reduce your healthcare expenses (and those of your employer) by selecting high-quality, lower-cost providers or locations. No matter which provider you choose, there is no effect on your healthcare benefits. This program gives you information that helps you make informed choices about where to go when you need care.

Health plan individual case management

Anthem's health plan case management program (Case Management) helps coordinate services for members with healthcare needs due to serious, complex and/or chronic health conditions. Anthem's program coordinates benefits and educates members who agree to take part in Case Management to help meet their health-related needs.

Case Management is confidential and voluntary and made available at no extra cost to you. The program is provided by, or on behalf of and at the request of, your health plan case management staff. Case Management is separate from any other covered services you are receiving.

If you meet program criteria and agree to take part, Case Management will help you meet your identified healthcare needs. This is handled through contact and teamwork with you and/or your authorized representative, treating doctor(s) and other providers.

In addition, Case Management may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the plan may provide benefits for alternative care that is not listed as a covered service through the Case Management program. The Plan may also extend covered services beyond the benefit maximums of this plan. Anthem will make any recommendation of alternative or extended benefits to the plan on a case-by-case basis, if in Anthem's discretion the alternative or extended benefit is in the best interest of the member and the plan. A decision to provide extended benefits or approve alternative care in one case does not obligate the plan to provide the same benefits again to you or to any other member. The plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternative care. In such cases, Anthem will notify you or your authorized representative in writing.

Medical expenses not covered

Your coverage pays benefits for many types of expenses, provided they are medically necessary and appropriate to properly treat a medical condition. However, limits and exclusions do apply. The plan does not pay benefits for the following services or products:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in the plan document. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the health plan medical director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an institutional review board for the proposed use.

What is considered "experimental" or "investigational"?

A drug, device, procedure or treatment is experimental or investigational if:

- There is insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- Approval has not been granted for marketing by the FDA; or,
- A recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational or for research purposes.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

- The following services are excluded from coverage regardless of clinical indications. Please refer to your plan booklet or contact Anthem Member Services at the 800 number provided on your ID card for verification of benefits. massage therapy, cosmetic surgery and therapies; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; Rolfing; prolotherapy; non-medical counseling or ancillary services; assistance in the activities of daily living; cosmetics; personal or comfort items; dietary supplements; health and beauty aids; aids or devices that assist with non-verbal communications; dental implants for any condition; telephone consultations; email and Internet consultations; telemedicine; health club membership fees; weight loss program fees; smoking cessation program fees; reversal of male and female voluntary sterilization procedures; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound, natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50 percent bony support and are functional in the arch.

- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.

- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia and premature ejaculation.

- Court ordered treatment or hospitalization, unless such treatment is being sought by a participating physician or otherwise covered under "Covered services and supplies."

- Medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under the plan. Non-medical counseling or ancillary services, including, but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation, including ABA (applied behavioral analysis) therapy.

What are "custodial services"?
Custodial services are non-health-related services, such as daily living assistance, or health-related services that do not seek to cure a patient. This care is generally provided during periods when a patient's medical condition is not changing, or during a period when the condition does not require the continued care of a trained medical person.

- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient hospital services," "Outpatient facility services," "Home health services" or "Breast reconstruction and breast prostheses" sections of "Covered services and supplies."
- Private hospital rooms and/or private duty nursing except as provided in the "Home health services" section of "Covered services and supplies."
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered services and supplies."
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the health plan medical director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.

- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Any drugs over the counter that do not require a prescription by federal or state law, and any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
- Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the Pharmacy and Therapeutics (P&T) Committee.
- Injectable drugs that require physician supervision and are not typically considered self-administered drugs. The following are examples of physician supervised injectable drugs: injectable used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectable, and endocrine and metabolic agents.
- Any drugs that are experimental or investigational, within the meaning set forth in the plan.
- FDA-approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal.
- Implantable contraceptive products, except as covered in the plan.
- Any prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products.
- Drugs used for cosmetic purposes, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products.
- Immunization agents, biological products for allergy immunizations, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription drugs and related supplies due to loss or theft.
- Drugs which are to be taken by or administered to a member while the member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the original date of issue.
- Any dental medication, except as needed for pain or inflammation.

- Medical and surgical services intended primarily for the treatment or control of obesity.
  - **However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI), is covered only at approved centers** if the services are demonstrated through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without co-morbidities, or 35-39 with co-morbidities.
  - **The following are specifically excluded:** medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.

For additional information regarding covered/not covered services under the Anthem medical plans, log on to anthem.com or contact Anthem Member Services at 844.256.4818.

Prescription drug coverage

If you elect coverage in an Anthem CDHP medical option, you will receive prescription drug coverage through CVS Caremark. CVS Caremark offers both retail and mail order options. In addition, discounts for some lifestyle drugs — for example, cosmetic drugs, fertility drugs, hair growth agents and impotence agents — are available through the prescription drug program.

To locate a participating pharmacy or determine coverage of a prescription, please visit **caremark.com**, or contact customer service at **855.559.1389**.

For participants in an Anthem CDHP:

- There are no co-payments under these plans — the negotiated discounted cost for each prescription is paid from your health fund account or health savings account until depleted.*
- Once these funds are used, you are responsible for the cost of your prescription drugs until you have reached your deductible.
- Once you meet the annual deductible, you are responsible for co-insurance charges up to your out-of-pocket maximum.
- Once the out-of-pocket maximum is reached, prescriptions are covered at 100 percent.

Retail prescription program

When you or a family member needs a prescription, simply take it to a pharmacy that participates in the CVS Caremark network. You will need to show your CVS Caremark ID card the first time a pharmacy fills a prescription for you. To find out which pharmacies participate in the CVS Caremark network, you can reach CVS Caremark in two ways:

- Log on to **caremark.com**; or,
- Call Caremark customer service at **855.559.1389**.

Mail order prescription program

If you have prescriptions you take on a regular basis — such as a medication for asthma or high blood pressure — you also can take advantage of the mail order component of the program. You can order up to a 90-day supply of medication through the mail.

*You can choose whether or not to use your health savings account to pay for eligible healthcare expenses. If you are enrolled in the Anthem CDHP with Funded HRA, eligible healthcare expenses are automatically deducted from your HRA until the funds are depleted.

Prior authorization

Most prescription drugs are covered under the program. However, some prescriptions require prior authorization. If the prescription your doctor has written requires prior authorization, your pharmacist will notify you and the physician. Your physician is responsible for submitting to CVS Caremark the necessary documentation needed for the prior authorization. For more information contact Customer Care at **855.559.1389.**

Generic medications – step therapy

The Generic Step Therapy Plan (GSTP) requires the use of cost-effective generic alternatives, within the same therapeutic class, as first line therapy before targeted brands are covered.

Some preventive generic drugs are covered

Some of your preventive generic drugs are not subject to the deductible. That means you only have to pay 20 percent co-insurance for eligible in-network preventive drugs, even if you have not met your medical plan deductible. If your preventive medication is a generic drug designated by the Affordable Care Act (ACA) as fully covered, you pay nothing. Go to myHR at **hr.cardinalhealth.com** for the list maintained by CVS Caremark of preventive therapy generic drugs not subject to the deductible and to see which generic drugs qualify for full coverage through the ACA. You can then contact CVS Caremark for more information at **855.559.1389**.

Why generics?
Generic drugs are less expensive for you. They are less expensive for Cardinal Health, too. That's why your prescription will be automatically filled with a generic drug — unless your doctor specifically indicates that a brand name be used. (This is called "dispense as written.") Of course, if you want a brand-name prescription, you can request it — but you will pay the generic co-payment plus the difference in cost between the brand name and the generic.

Generic drugs include the same ingredients as brand names, and have been proven to be just as safe and effective as their brand-name counterparts. And, since they cost considerably less than brand-name drugs, they help keep our medical plan affordable.

If you have any questions about generics versus brand names, be sure to talk to your doctor or pharmacist.

Prescription drug benefits

Covered expenses

If you or any one of your dependents, while insured for prescription drug benefits, incurs expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician, CVS Caremark will provide coverage for those expenses as shown in the schedule. Coverage also includes medically necessary prescription drugs and related supplies dispensed for a prescription issued to you or your dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a dependent is issued a prescription for medically necessary prescription drugs or related supplies as part of the rendering of emergency services and that prescription cannot reasonably be filled by a participating pharmacy, the prescription will be covered by CVS Caremark, as if filled by a participating pharmacy.

Limitations

Each prescription order or refill shall be limited as follows:

- Up to a consecutive 30-day supply, excluding specialty medications, at a retail pharmacy, unless limited by the drug manufacturer's packaging;
- Up to a consecutive 90-day supply at a mail order participating pharmacy, unless limited by the drug manufacturer's packaging; or,
- To a dosage and/or dispensing limit as determined by the Pharmacy and Therapeutics (P&T) Committee.

Coverage for prescription drugs and related supplies provided by a participating pharmacy is limited to those prescription drugs and related supplies that appear on the Prescription Drug List.

In the event that you insist on: (a) a more expensive brand-name drug where a generic drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the brand-name drug exceeds the cost of the generic drug, plus the required co-payment identified in the schedule; or (b) a non-Prescription Drug List drug, you will be financially responsible for the full cost of the non-Prescription Drug List drug.

Coverage for certain prescription drugs and related supplies requires your physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your physician believes non-Prescription Drug List prescription drugs or related supplies are necessary, or wishes to request coverage for prescription drugs or related supplies for which prior authorization is required, your physician may call or complete the appropriate prior authorization form and fax it to CVS Caremark to request a Prescription Drug List exception or prior authorization for coverage of the prescription drugs or related supplies. Your physician should make this request before writing the prescription.

If the request is approved, your physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those prescription drugs or related supplies. The length of the authorization will depend on the diagnosis and prescription drugs or related supplies. When your physician advises you that coverage for the prescription drugs or related supplies has been approved, you should contact the pharmacy to fill the prescription(s).

If the request is denied, your physician and you will be notified that coverage for the prescription drugs or related supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the prescription drugs or related supplies should be covered.

If you have questions about a specific Prescription Drug List exception or prior authorization request, you should call Member Services at the toll-free number on your ID card.

All drugs newly approved by the FDA are designated as non-Prescription Drug List drugs until the P&T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.

Prescription drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a prescription drug.

Your payments

Coverage for prescription drugs and related supplies purchased at a pharmacy is subject to the co-payment or co-insurance shown in the schedule, after you have satisfied your prescription drug deductible, if applicable. Please refer to the schedule for any required co-payments, co-insurance, deductibles or maximums if applicable.

When a treatment regimen contains more than one type of prescription drug which are packaged together for your or your dependent's convenience, a co-payment will apply to each prescription drug.

In no event will the co-payment for the prescription drug or related supply exceed the amount paid by the plan to the pharmacy, or the pharmacy's usual and customary (U&C) charge. U&C means the established pharmacy retail cash price, less all applicable customer discounts that pharmacy usually applies to its customers regardless of the customer's payment source.

Exclusions

No payment will be made for the following expenses:

- Drugs available over the counter that do not require a prescription by federal or state law;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- FDA-approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than related supplies;
- Implantable contraceptive products;
- Prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products;
- Drugs used for cosmetic purposes, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;

- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis; immunizations required to be covered by the Affordable Care Act are covered by the plan at no cost to you;
- Replacement of prescription drugs and related supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to you while you are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals; and,
- Prescriptions more than one year from the original date of issue.

Reimbursement/filing a claim

When you or your dependents purchase your prescription drugs or related supplies through a retail participating pharmacy, you pay any applicable co-payment, co-insurance or deductible shown in the schedule at the time of purchase. You do not need to file a claim form.

If you or your dependents purchase your prescription drugs or related supplies through a non-participating pharmacy, you pay the full cost. Purchases made through a non-participating pharmacy are not covered and will not be reimbursed.

To purchase prescription drugs or related supplies from a mail order participating pharmacy, see your mail order drug introductory kit for details, or contact member services for assistance at the toll-free number on the ID card.

CVS Caremark's Prescription Drug List is developed and updated on a regular basis in accordance with clinical recommendations of the CVS Caremark Pharmacy and Therapeutics Committee, a panel of participating physicians and pharmacists. Only those medications that have successfully passed federally required clinical testing and evaluation and have been proven effective are included in the list. To help ensure the objectivity of the Committee's decisions, 15 of the 20 Committee members are from the external medical community and do not work for CVS Caremark.

To find out which prescriptions are covered under the prescription drug program, please contact CVS Caremark at **caremark.com** or at **855.559.1389**.

OncoSourceRx specialty pharmacy

Specialty prescription benefits are provided through OncoSourceRx. OncoSourceRx provides enhanced services to members with complex chronic or genetic conditions while keeping costs as low as possible.

To find out which prescriptions are covered through OncoSourceRx, please contact them at **888.662.6779** to speak with a pharmacy technician.

Kaiser Permanente prescription drug coverage

Kaiser provides its own prescription drug coverage. Contact your Kaiser plan to learn about how the plan covers prescription drugs.

Cigna Global Health Benefits prescription drug coverage

The Cigna Global Health Benefits plan provides prescription drug coverage. For additional information, see the “Cigna Global Health Benefits medical coverage” section on page 81.

Applying for benefits

Depending on the coverage option you select, you may or may not have to file a claim before the plan pays benefits.

Do you need to file a claim?

The chart below shows who needs to file claims for benefits.

If you are…	Do you need to file a claim?
A participant in the Anthem CDHP Out of Area with Funded HRA	Yes**
Anthem CDHP HRA or HSA participant who receives care from an in-network provider	No*
Anthem CDHP HRA or HSA participant who receives care from an out-of-network provider	Yes**
A participant in a Kaiser Permanente plan	No*
A participant in the Cigna Global Health Benefits plan	Yes**

*Your in-network provider deals directly with the plan regarding your claims. You receive notification that benefits have been considered, as well as any amounts (if any) that you owe.
**Unless your provider submits the claim on your behalf.

How to file claims

If you are an Anthem CDHP participant and you receive care outside the network, or you have Out of Area coverage, you may be required to pay your provider at the time you receive care. You then must file a claim for benefits. To obtain claim forms, you can download a claim form from the myHR website at **hr.cardinalhealth.com**, or you can contact the myHR Service Center at **866.471.7867**. Mail your completed claim (along with supporting documentation as noted on the form) to:

Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

The BlueCard Program

Anthem participates in a program called "BlueCard." This program lets you get covered services at the network cost share when you are traveling out of state and need healthcare, as long as you use a BlueCard provider. All you have to do is show your ID card to a participating Blue Cross and Blue Shield provider, and they will send your claims to Anthem.

If you are out of state and an emergency or urgent situation arises, you should get care right away.

In a non-emergency situation, you can find the nearest contracted provider by visiting the BlueCard Doctor and Hospital Finder website (**BCBS.com**) or call the number on the back of your ID card.

You can also access doctors and hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Please refer to "Inter-Plan Programs" in the "Claims payment" section for more information about BlueCard.

Care outside of the United States — BlueCard® Worldwide

Prior to travel outside the United States, call Customer Service at the number on your ID card. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Customer Service number on your ID card for coverage details.
- Always carry your current ID card.
- In an emergency, go directly to the nearest hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at 800.810.BLUE (2583). An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- You need to find a physician or hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.
- You need to be hospitalized or need inpatient care. After calling the Service Center, you must also call Anthem to obtain approval for benefits at the phone number on your ID card. **Please Note:** This number is different than the phone numbers listed above for BlueCard Worldwide.

Payment information

- **Participating BlueCard Worldwide hospitals.** In most cases, when you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay up front for inpatient care at participating BlueCard Worldwide hospitals except for out-of-pocket costs (non-covered services, deductible and co-insurance) you normally pay. The hospital should submit your claim on your behalf.

- **Doctors and/or non-participating hospitals.** You will need to pay up front for outpatient services, care received from a doctor and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim filing

- The hospital will file your claim if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for out-of-pocket costs you normally pay.
- You must file the claim for outpatient and physician care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the provider and subsequently send an international claim form with the original bills to Anthem.

Claim forms

International claim forms are available from Anthem, the BlueCard Worldwide Service Center or online at **bcbs.com/bluecardworldwide**. The address for submitting claims is on the form.

Claims payment

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore, if the BlueCard® PPO network hospitals, physicians and ancillary providers are used, claims for their services will generally not have to be filed by the member. In addition, many out-of-network hospitals and physicians will also file claims if the information on the Blue Cross and Blue Shield ID card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by visiting **anthem.com**.

Please Note: You may be required to complete an authorization form in order to have your claims and other personal information sent to Anthem when you receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending your claims and other personal information to Anthem.

How to file claims

Under normal conditions, Anthem should receive the proper claim form within 12 months after the service was provided.

Each person enrolled through the plan receives an ID card. In order to receive full benefits, you must receive treatment from a network provider. When admitted to a network hospital, present your ID card. Upon discharge, you will be billed only for those charges not covered by the plan.

When you receive covered services from a network physician or other network licensed healthcare provider, ask him or her to complete a claim form. Payment for covered services will be made directly to the provider.

For healthcare expenses other than those billed by a network provider, use a claim form to report your expenses. You may obtain these from Anthem. Claims should include your name, plan and group numbers exactly as they appear on your ID card. Attach all bills to the claim form and file directly with Anthem. Be sure to keep a copy of all forms and bills for your records. The address is on the claim form.

Save all bills and statements related to your illness or injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum allowed amount

General

This section describes how Anthem determines the amount of reimbursement for covered services. Reimbursement for services rendered by network and out-of-network providers is based on the plan's maximum allowed amount for the covered service that you receive. Please see the "Inter-Plan Programs" section for additional information.

The maximum allowed amount for this plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- That meet Anthem's definition of covered services, to the extent such services and supplies are covered under the plan and are not excluded;
- That are medically necessary; and,
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the plan.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your deductible or have a co-payment or co-insurance. In addition, when you receive covered services from an out-of-network provider, you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant.

When you receive covered services from a provider, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Anthem's determination of the maximum allowed amount. Anthem's application of these rules does not mean that the covered services you received were not medically necessary. It means Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the plan may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100 percent of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider network status

The maximum allowed amount may vary depending upon whether the provider is a network provider or an out-of-network provider.

A network provider is a provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with Anthem. For covered services performed by a network provider, the maximum allowed amount for this plan is the rate the provider has agreed with Anthem to accept as reimbursement for the covered services. Because network providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your deductible or co-insurance. Please call Customer Service for help in finding a network provider or visit **anthem.com**.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are considered out-of-network providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For covered services you receive from an out-of-network provider, the maximum allowed amount for this plan will be one of the following as determined by Anthem:

1. An amount based on Anthem's out-of-network provider fee schedule/rate, which Anthem has established in its discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare & Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or,
2. An amount based on reimbursement or cost information from the Centers for Medicare & Medicaid Services ("CMS"). When basing the maximum allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or,
3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) the level of skill and experience required for the treatment; or (3) the comparable providers' fees and costs to deliver care; or,
4. An amount negotiated by Anthem or a third-party vendor that has been agreed to by the provider. This may include rates for services coordinated through Case Management; or,
5. An amount based on or derived from the total charges billed by the out-of-network provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered out-of-network. For this plan, the maximum allowed amount for services from these providers will be one of the five methods shown above unless the contract between Anthem and that provider specifies a different amount.

For benefits related to out-of-network emergency services, the maximum allowed amount for this plan will be one of the following as determined by Anthem:

1. The amount negotiated with in-network providers for the emergency service furnished (or the median of such negotiated amounts), excluding any in-network co-payment or co-insurance imposed with respect to the patient;
2. The amount of the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services, excluding any in-network co-payment or co-insurance imposed with respect to the patient; or,
3. The amount that would be paid under Medicare for the emergency service, excluding any in-network co-payment or co-insurance imposed with respect to the patient.

Unlike network providers, out-of-network providers may send you a bill and collect for the amount of the provider's charge that exceeds the plan's maximum allowed amount. You are responsible for paying the difference between the maximum allowed amount and the amount the provider charges. This amount can be significant. Choosing a network provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a network provider or visit Anthem's website at **anthem.com**.

Customer Service is also available to assist you in determining the plan's maximum allowed amount for a particular service from an out-of-network provider. In order for Anthem to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final maximum allowed amount for your claim will be based on the actual claim submitted by the provider.

Member cost share

For certain covered services and depending on your plan design, you may be required to pay a part of the maximum allowed amount as your cost share amount (for example, deductible and/or co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from a network or out-of-network provider. Specifically, you may be required to pay higher cost share amounts or may have limits on your benefits when using out-of-network providers. Please see the Schedule of Benefits in this SPD for your cost share responsibilities and limitations, or call Customer Service to learn how the plan's benefits or cost share amounts may vary by the type of provider you use.

The plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a network or out-of-network provider. Non-covered services include services specifically excluded from coverage by the terms of this SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower network cost share amount when you use an out-of-network provider. For example, if you go to a network hospital or provider facility and receive covered services from an out-of-network provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a network hospital or facility, you will pay the network cost share amounts for those covered services. However, you also may be liable for the difference between the maximum allowed amount and the out-of-network provider's charge.

Authorized services

In some circumstances, such as where there is no network provider available for the covered service, the plan may authorize the network cost share amounts (deductible and/or co-insurance) to apply to a claim for a covered service you receive from an out-of-network provider. In such circumstance, you must contact Anthem in advance of obtaining the covered service. The plan also may authorize the network cost share amounts to apply to a claim for covered services if you receive emergency services from an out-of-network provider and are not able to contact Anthem until after the covered service is rendered. If the plan authorizes a network cost share amount to apply to a covered service received from an out-of-network provider, you also may still be liable for the difference between the maximum allowed amount and the out-of-network provider's charge. Please contact Customer Service for authorized services information or to request authorization.

Services performed during same session

The plan may combine the reimbursement of covered services when more than one service is performed during the same session. Reimbursement is limited to the plan's maximum allowed amount. If services are performed by out-of-network providers, then you are responsible for any amounts charged in excess of the plan's maximum allowed amount with or without a referral or regardless if allowed as an authorized service. Contact Anthem for more information.

Processing your claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a hospital or physician. Always make certain you have your ID card with you. Be sure the hospital or physician's office personnel copy your name and identification numbers (including the three-letter prefix) accurately when completing forms relating to your coverage.

Timeliness of filing for member-submitted claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by you within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, Anthem will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary information

In order to process your claim, Anthem may need information from the provider of the service. As a member, you agree to authorize the physician, hospital or other provider to release necessary information. Anthem will consider such information confidential. However, the plan and Anthem have the right to use this information to defend or explain a denied claim.

Claims review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from out-of-network providers could be balance billed by the out-of-network provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

Claim Recap/Explanation of Benefits

After you receive medical care, you will generally receive a Claim Recap/Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement sent by Anthem to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any); and,
- General information about your appeals rights and, for ERISA plans, information regarding the right to bring an action after the appeals process is completed.

Inter-Plan Programs

Out-of-area services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside Anthem's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield licensees.

Typically, when accessing care outside Anthem's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or,
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct over- or under-estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Anthem serves, if this SPD covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them, which are specifically excluded from, or in excess of the limits of, coverage provided by this plan.

Non-participating healthcare providers outside Anthem's service area

Member liability calculation

When covered healthcare services are provided outside of Anthem's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment Anthem would make if the healthcare services had been obtained within Anthem's service area, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount Anthem will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's service(s) will be considered out-of-network care, and you may be billed the difference between the charge and the maximum allowable amount. You may call the Customer Service number on your ID card or go to **anthem.com** for more information about such arrangements.

Unauthorized use of ID card

If you permit your ID card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the member's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

Cigna Global Health Benefits participants

If you are a Cigna Global Health Benefits participant, you may be required to pay your provider at the time you receive care. You then must file a claim for benefits. To obtain claim forms, you can download a claim form from **cignaenvoy.com**. Mail your completed claim (along with supporting documentation as noted on the form) to:

Cigna Global Health Benefits Expatriate Benefits
P.O. Box 15050
Wilmington, DE 19850-5050
USA

If a claim is denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. See the "Overview" section for details regarding the appeals process.

Dental

An introduction to your dental benefits

Dental care is an integral part of your overall wellness. That is why Cardinal Health offers a dental program for eligible employees and family members. See the "Overview" section for more details regarding who is eligible.

Dental coverage

The health and group benefits program offers you the following dental coverage. You can receive dental coverage through a MetLife Preferred Provider Organization (PPO). With this dental coverage, you have a choice of the:

- Basic option; or,
- Plus option.

The chart below summarizes each type of coverage.

If you have any questions after reading this section, you can obtain online information via the myHR website at **hr.cardinalhealth.com**, or you can contact the myHR Service Center at **866.471.7867**.

Dental Preferred Provider Organization (PPO) options	
The dental PPO options (Basic and Plus) are offered through MetLife. A dental PPO works much like a medical PPO when it comes to receiving care. You have access to a network of dental providers, and you can visit a dentist in or outside the network. See "More about the MetLife Preferred Dentist Program (PDP)" section for details regarding the network. With the dental PPO options, the plan pays benefits at the same level whether you see an in-network or out-of-network provider. However, your out-of-pocket costs are reduced if you receive care from a provider within the PPO network. The difference between the Basic and Plus PPO options is the amount you pay out-of-pocket. The Plus option pays more benefits when you receive care — in other words, it has lower deductibles and co-insurance. Because it pays more benefits, the Plus option costs you more in premiums than the Basic option.	• **Basic:** This option covers preventive services (with no deductible), basic services (fillings) and major services (bridges and crowns). This option does not pay for orthodontia services. See the "Snapshot" chart below for the percentages and maximums the plan pays. • **Plus:** This option covers preventive services (with no deductible), basic services and major services. Children under age 19 are eligible for orthodontia benefits, up to a lifetime maximum. For new hires or added dependents after the effective date of coverage, the total benefit payable under the plan will be determined based on the orthodontia lifetime maximum under the plan minus the benefits paid for services rendered prior to the effective date of coverage. The remaining benefit will be considered over the course of treatment, and will apply to services rendered on and after the dependent's effective date of coverage under this plan. Repetitive orthodontia payments for appliance adjustment visits are paid at the end of a quarter (three-month period). See the "Snapshot" chart below for the percentages and maximums the plan pays.

How the dental plan works

This section provides a snapshot of your dental options and a brief overview of the coverages they provide and describes how the features of your dental coverage work.

Snapshot of the dental options

Here is a snapshot of each option's coverage, with additional information provided below.

Dental Options	Basic	Plus
Deductible		
• Individual/Family	$100/$200**	$50/$100**
• Co-Payment	N/A	N/A
Co-insurance *(Preventive, Basic, Major, Orthodontia)*		
• In-network (plan pays)	100 percent*** 70 percent*** 50 percent*** N/A	100 percent*** 80 percent*** 50 percent*** 50 percent***
• Out-of-network*(plan pays)	100 percent 70 percent 50 percent N/A	100 percent 80 percent 50 percent 50 percent
Annual maximum	$1,000	$2,000
Lifetime orthodontia maximum	N/A	$1,500
Eligibility for orthodontia	N/A	Children under age 19

*Subject to reasonable and customary charges.

**Deductible applies to basic and major expenses only.

***Co-insurance is based on the Preferred Dentist Program (PDP) fee.

Choosing whom to cover

In addition to selecting a coverage option, you need to decide whom to cover. You can choose from four levels of coverage.

Choose a coverage category

- You only
- You + spouse or domestic partner
- You + child(ren)
- You + family

Please see "Who is eligible" under the "Overview" section for a complete description of which family members are eligible for coverage.

How the dental plan pays benefits

Depending on the coverage option you select, a deductible, co-insurance or annual and lifetime maximums may apply. Here is a brief description of each feature.

Deductible

Your deductible is the fixed-dollar amount that you may pay out of your pocket each plan year before the plan pays benefits. The individual deductible applies separately to each covered individual, and the family deductible applies collectively to all covered persons in the same family. Once you meet the family deductible, your remaining covered family members do not have to meet their individual deductible amounts for the rest of the plan year.

Co-insurance

Your co-insurance is the percentage of eligible expenses you are responsible for paying. Percentages apply after any applicable deductibles or co-payment amounts.

PDP fees

PDP fees refer to the fees that participating Preferred Dentist Program (PDP) dentists have agreed to accept as payment in full.

Annual maximums

Benefits are limited for each covered person during each plan year. Orthodontia expenses are not included in this limit. A separate lifetime limit does apply to orthodontia services for each person eligible for these benefits.

Orthodontia lifetime maximum

The individual lifetime maximum is the maximum amount paid for orthodontia expenses during the life of a covered individual. For new hires or added dependents after the effective date of coverage, the total benefit payable under the plan will be determined based on the orthodontia lifetime maximum under the plan minus the benefits paid for service rendered prior to the effective date of coverage. The remaining benefit will be considered over the course of treatment and will apply to services rendered on and after the dependent's effective date of coverage under this plan.

Repetitive orthodontia payments for appliance adjustment visits are paid at the end of a quarter (three-month period).

Eligible expenses

All references to eligible expenses throughout this section assume that charges are for reasonable and customary charges for covered services. In most cases, the plan pays benefits directly to the provider. If necessary, benefits are paid to you once you have had the expense and submit a claim. MetLife determines the reasonable and customary charge for a particular treatment or service.

Reasonable and customary charges

A "reasonable and customary charge" is the:

- Fee that is most frequently charged to the majority of a dentist's patients for the same or similar service or procedure; and,
- Prevailing range of fees charged by most dentists of similar training and experience within a geographic area for the same or similar services or procedures.

Reasonable and customary charges are based on the 90th percentile. MetLife also takes into consideration any unusual circumstances or dental complications that require additional time, skill or experience.

Alternate benefits

The dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative.

Here is an example:

If a removable denture will serve as well as fixed bridgework, plan benefits will be based on the less costly removable denture.

Need to find a participating provider in the MetLife PDP?

A complete list of participating providers automatically will be furnished to you as a separate document free of charge.

Copies of the participating provider directory also are available by calling the PDP automated Computer Voice Response Line toll-free at **800.942.0854**. The Voice Response Line is available 24 hours a day, seven days a week. You also may speak with a customer service representative Monday through Friday, 8 a.m. to 11 p.m., Eastern time.

When you call, the system prompts you to enter your Social Security number and a home or work zip code. You then receive a list of participating providers in the requested zip code area. You also may conduct a provider search online at MetLife's dental website at **metlife.com/mybenefits**.

If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you are responsible for any additional payment. To avoid any misunderstandings, you should discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high-cost services such as crowns, bridges or dentures.

You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services and your out-of-pocket expense. Actual payments may vary from the pre-treatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at the time of payment.

More about the MetLife Preferred Dentist Program (PDP)

If you elect the Basic or Plus option, you have access to more than 250,000 participating PDP dentists nationwide, including more than 65,000 specialists. All network participating dentists agree to provide services at fees that are typically 15 – 45 percent less than the average charge in their communities.

If you participate in the Basic or Plus option, you receive benefits for eligible expenses whether or not you or your dependents visit a participating provider. However, you will generally pay less if you receive care when a participating provider is chosen.

Pre-determination of benefits

You are not obligated to receive a pre-determination of benefits. However, if you want to find out what the dental plan will pay before you receive services, it is a good idea to file a pre-treatment estimate before any procedure that exceeds $300. To do so, have your dentist complete the regular dental claim form, indicating the type of work planned and the cost. MetLife will send you and your dentist a statement showing the estimate of benefits payable.

Cigna Global Health Benefits dental coverage

Cardinal Health provides a special dental plan for global assignees through an arrangement with Cigna Global Health Benefits. This is the only dental plan available to you while you are working as an expat overseas. On your return to the United States, you will again be eligible for the domestic dental plan that is described in this SPD. Your Cigna Global Health Benefits are available to you 24 hours a day, seven days a week anywhere you travel in the world, including any trips home. For additional information on covered/not covered services, log on to **cignaenvoy.com** or contact a member services representative at the number listed on your ID card.

Cigna Global Health Benefits group dental benefits

Calendar year maximum (Classes I, II, III combined)		$1,500
Calendar year deductible (waived for Class I)		$0
Class IV lifetime maximum		$1,500
Individual deductible		$0
Aggregate family maximum deductible		$0
Benefits		**Co-insurance percentage**
Class I:	**Preventive care**	
	Not subject to deductible, up to two visits per year	100 percent
	Diagnostic — general	
	Preventive	
Class II:	**Basic restorative**	80 percent
	Restorative (basic)	
	Endodontics	
	Periodontics	
	Prosthodontics — removable (maintenance)	
	Prosthodontics — fixed bridge (maintenance)	
	Oral surgery	
Class III:	**Major restorative**	50 percent
	Restorative (major)	
	Prosthodontics — removable (installation)	
	Prosthodontics — fixed bridge (installation)	
Class IV:	Orthodontia Class IV orthodontia applies only to a dependent child less than 19 years of age.	50 percent

Covered services

If you select the dental Basic or Plus option, you receive benefits — up to the negotiated fee or the reasonable and customary charge — for **eligible expenses that are necessary in terms of generally accepted dental standards**. A detailed schedule of benefits is available upon request.

The following are benefits under the MetLife plan:

Preventive

The plan pays benefits for the following preventive services:

- Oral examinations (but not more than two in a plan year).
- Prophylaxis (cleaning and scaling of teeth) (but not more than twice in a plan year).
- X-rays, including:
  - Full-mouth X-rays (once every 36 months); and,
  - Bitewing X-rays (but not more than once for adults and twice for children in a plan year).
- Topical fluoride applications for children under age 19 (but not more than once in a plan year).
- Space maintainers, fixed unilateral, limited to non-orthodontic treatment.
- Sealants for children under age 19 (one application every five years for each non-restored molar only).
- Emergency palliative treatment necessary to relieve pain or necessary to avoid serious deterioration or risk of permanent damage to your health.

Basic

The plan pays benefits for the following basic services:

- Fillings (amalgam and composite resin). Extractions.
- Root canal treatment.
- Treatment of periodontal disease and other diseases of the gums and tissues of the mouth, four per plan year including routine cleanings.
- Oral surgery.
- Administration of general anesthesia, when medically necessary in connection with oral surgery, extractions or other covered dental services.

- Injections of antibiotic drugs.
- Relinings and rebasings of existing removable dentures.
- Repair or recementing of crowns, inlays, onlays, dentures or bridgework.

Major

The plan pays benefits for the following major services:

- Installation of fixed bridgework or partial or full removable dentures done for the first time.
- Replacement of existing removable dentures or fixed bridgework due to the loss of one or more natural teeth after the existing dentures or bridgework was installed, and existing dentures or bridgework was installed at least five years prior to its replacement.
- Replacement of existing removable dentures or fixed bridgework that can no longer be used and was installed at least five years prior to its replacement.
- Replacement by a new, permanent, full denture of an existing temporary full denture when the existing denture cannot be made permanent (if installed within 12 months after the existing denture was installed).
- Adding teeth to an existing partial removable denture or to bridgework when necessary to replace one or more natural teeth removed after the existing denture or bridgework was installed.
- Restorations of inlays, onlays and crowns (not more than one to the same tooth surface within five years of a prior restoration).
- Implantology.

Orthodontia

Basic option

The plan does not pay benefits under this option.

Plus option

The plan pays benefits for orthodontia services, including appliance therapy, for a dependent child under age 19, up to a lifetime per person maximum benefit of $1,500.

What happens if your plan coverage ends before a dental treatment is completed?

No benefits are payable for covered dental expenses incurred by you or your covered dependents after your dental plan coverage ends. This applies even if you have a pre-determination of benefits completed.

However, benefits for covered dental expenses for the following services will be paid after your dental plan coverage ends:

- For a prosthetic device, if the dentist prepared the abutment teeth and made impressions while dental benefits were in effect, and the device is installed within 90 days after the date the dental benefits end.
- For a crown, if the dentist prepared the tooth for the crown while the dental benefits were in effect, and the crown is installed within 90 days after the date the dental benefits end.
- For root canal therapy, if the dentist opened the tooth while the dental benefits were in effect, and the treatment is finished within 90 days after the date the dental benefits end.

Dental expenses not covered

You receive benefits for many dental expenses, provided they are necessary in terms of generally accepted dental standards. In addition, the service must be appropriate to properly treat a dental condition. However, some limits and exclusions do apply. You do **not** receive benefits for certain services or products — including:

- Services or supplies that are:
  - Covered by Workers' Compensation, occupational disease or employers' liability laws;
  - Required by law to be furnished (in whole or in part) by an employer;
  - Received through a medical department or similar facility maintained by Cardinal Health, a labor union, a mutual benefit association or a VA hospital;
  - Free to the patient;
  - Experimental in terms of generally accepted dental standards; or,
  - Furnished by a family member.
- Services or supplies received before your or your dependents' coverage takes effect.
- Services not provided by a dentist, except for the cleaning and scaling of teeth or fluoride treatments by a licensed dental hygienist under a dentist's supervision.
- Cosmetic surgery or supplies, unless they are a required covered expense:
  - For reconstructive surgery that results from a trauma, an infection or another disease; or,
  - Because of a congenital disease or anomaly that — for a dependent child — results in a functional defect.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Repair or replacement of an orthodontic appliance.
- Any duplicate appliance or prosthetic device.
- Use of materials (other than fluorides and sealant materials as described herein) to prevent decay.
- Instruction for oral care, such as hygiene or diet.

- Periodontal splinting.
- Myofunctional therapy or correction of harmful habits.
- Treatment of temporomandibular joint disorders (TMJ).
- Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan that Cardinal Health (or an affiliate) contributes to or sponsors.
- Charges associated with missed dental appointments.
- Charges to complete or file claim forms.
- Sterilization supplies.
- Appliances or treatment of bruxism (grinding teeth), including, but not limited to, occlusal guards and night guards.
- Services or appliances that restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- The following, when charged by the dentist on a separate basis:
  - Local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
  - Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food. However, this exclusion will not apply if this injury is due to a medical condition or domestic violence;
  - Caries susceptibility tests;
  - Modification of removable prosthodontic and other removable prosthetic services;
  - Adjustment of a denture made within six months after installation by the same dentist who installed it; or,
  - Intra- and extra-oral photographic images.

Applying for benefits

Depending on the coverage option you select, you may or may not have to file a claim before the plan pays benefits.

Do you need to file a claim?

The chart below shows who needs to file claims for benefits.

If you are…	Do you need to file a dental claim?
A dental PPO participant who receives care from an in-network provider	No. The provider will submit the claim.
A dental PPO participant who receives care from an out-of-network provider	You complete and sign the employee portion of the form. Your dentist completes and sends in the form.
A Cigna Global Health Benefits International participant	Yes.*

*Unless your provider submits the claim on your behalf.

How to file out-of-network claims

As a participant of one of the dental PPO options (Basic or Plus), you can receive claim forms by contacting MetLife at **800.942.0854**. Or, you can download and print out forms from MetLife's dental website at **metlife.com/mybenefits**. Remember to take a form with you to your appointment.

Complete the employee portion of the claim form, and make sure to sign it. Your dentist will complete the rest.

Claim forms should be submitted (within one year after the calendar year in which the claim was incurred) to:

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

MetLife will mail you a concise Explanation of Benefits (EOB) showing charges and payments. However, MetLife will no longer automatically mail EOBs to participants if all dental services on a particular visit are covered in full (i.e., you have no financial responsibility) and payment is being made directly to your dentist. This typically occurs for routine visits for preventive care, such as exams and cleanings covered at 100 percent when payment is being made to your dentist. Benefits will be paid to you, unless you assign payment to your dentist. If you have a claim inquiry or a benefits-related question, call MetLife's Dental Customer Service Department toll-free at **800.942.0854**.

How to file a Cigna Global Health Benefits claim

If you are a Cigna Global Health Benefits participant, you may be required to pay your provider at the time you receive care. You then must file a claim for benefits. To obtain claim forms, you can download a claim form from **cignaenvoy.com**. Mail your completed claim (along with supporting documentation as noted on the form) to:

Cigna Global Health Benefits
Expatriate Benefits
P.O. Box 15050
Wilmington, DE 19850-5050
USA

If a claim is denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a plan decision. See the “Overview” section for details regarding the appeals process.

Vision

An introduction to your vision benefits

All benefits-eligible Cardinal Health employees and their eligible family members have the option to elect vision care coverage through the health and group benefits program.

Vision coverage is provided through EyeMed Vision Care. EyeMed is a leading vision care provider delivering vision care benefits to more than 140 million people nationwide. All EyeMed vision care programs are offered through a national network of more than 64,000 providers.

If you have any questions after reading this section, you can obtain online information via the myHR website at **hr.cardinalhealth.com** or you can contact the myHR Service Center at **866.471.7867**.

About your vision coverage

If you select vision coverage, you can see any vision care provider you choose and the plan reimburses a portion of your cost. However, since EyeMed negotiates discounted rates with doctors and centers in the network, you save money if you use in-network doctors. There is no deductible for either an in- or out-of-network service.

If you elect vision care coverage, EyeMed sends you an informational package following enrollment. Contact EyeMed to find out which vision care providers participate in the network. You can reach EyeMed in two ways.

1. Log on to their website at **eyemedvisioncare.com** for your needs. The website allows you to find a provider, print a replacement ID card, check online claim status and print an Explanation of Benefits and also includes enhanced help tools such as frequently asked questions and expanded vision wellness content; or,
2. EyeMed also has a member mobile app available for iPhones. Get the information you need when you need it:
   - Find a network provider near your current location or enter a zip code, then map it and get driving directions.
   - View current benefits eligibility and in-network benefit details.
   - View your member ID card (and store it in the app for future use).
   - Get answers to commonly asked questions.
   - Contact EyeMed.

Once you log on to the app, just shake your phone to view your ID card. The app is available for iPhone®, iPad® and iPod Touch® users right now. Note that the app requires iOS 6.1 or later and is optimized for iPhone 5. Go the Apple® iTunes® store and search "EyeMed Members" to download the free app.

Please Note: You will be prompted through a brief registration process to use the "View Benefits" feature on the app if you have not already established a member login through the main **eyemedvisioncare.com** member website.

You can also call the myHR Service Center at **866.471.7867** to reach EyeMed.

How the vision plan works

This section provides a snapshot of your vision care benefits and a brief overview of the coverage, and it describes how the features of your vision coverage work.

Snapshot of your vision coverage

Here is a snapshot of your vision coverage.

Service	In-network coverage You pay	Out-of-network coverage Plan reimburses
Exam (once every calendar year)	$10 co-payment	Up to $35
Single lenses	$10 co-payment	Up to $35
Bifocal lenses	$10 co-payment	Up to $50
Trifocal lenses	$10 co-payment	Up to $60
Lenticular lenses	$10 co-payment	Up to $60
Standard progressive lenses	$75	Up to $50
Frames (once every 12 months from calendar year)	$0 co-payment, $150 allowance; 20 percent off balance over $150	Up to $55
Contact lenses (Either lenses or contacts — but not both — are covered once every 12 month period.)	**Conventional:** $10 co-payment; $120 allowance, 15 percent off balance over $120 **Disposable:** $10 co-payment; $120 allowance, plus balance over $120 **Medically necessary:** $0 co-payment, paid in full	$90 $90 $200
Retinal imaging	Up to $39	Not covered
Laser vision correction (LASIK)	15 percent off retail price OR 5 percent off promotional pricing	Not covered

Choosing whom to cover

You need to decide whom to cover by selecting a coverage level. You can choose from four levels of coverage.

Choose a coverage category

- You only
- You + spouse or domestic partner
- You + child(ren)
- You + family

Please see "Who is eligible" under the "Overview" section for a complete description of which family members are eligible for coverage.

Terms to know

Co-payments

If you receive services from an in-network provider, you must meet a co-payment requirement before the plan pays benefits. See the "Snapshot" chart for the co-payment that applies for each type of service.

Schedule of benefits

If you receive care from an out-of-network provider, you pay the provider's fee in full and then submit a claim form. See the "Snapshot" chart for the scheduled amount the plan pays for each type of covered service.

Please Note: There is no guarantee that the scheduled amount the plan pays will cover the entire cost of your exam, glasses or contact lenses.

Maximum benefits

If you receive care from an in-network provider, the plan limits the benefits you can receive, as shown in the chart below.

Service	**Plan limits benefits to…**
Eye exams	One exam every 12 months
Lenses	One pair every 12 months
Frames	One pair every 12 months
Elective contact lenses (in lieu of spectacle lenses)	$10 co-payment, $120 allowance every 12 months

In-network and out-of-network providers

You can receive services from an in-network or an out-of-network provider.

- **In-network providers** — Network providers offer the convenience of "one-stop shopping" and can provide everything you need (eye exams, routine eye care, eyeglasses and contacts). You generally pay a co-payment when you receive care and materials from an in-network provider. See the "Snapshot" chart for details.

- **Out-of-network providers** — If you prefer, you can go to an optometrist, ophthalmologist or dispensing optician who is outside the network. If you do, you pay the provider's regular charge in full. You receive reimbursement once EyeMed receives an itemized paid receipt and claim form. See below for how to submit a vision claim and for the scheduled amount the plan pays.

How to use in-network providers

Here is what you need to do, and what happens when you use an in-network provider.

To find a provider near you, call **866.723.0514** or visit **eyemedvisioncare.com** and choose the Select network.

- Schedule an appointment with your EyeMed provider, identifying yourself as an EyeMed member.

- Present your EyeMed card for easy access to your benefits at your EyeMed provider. No paperwork is involved — you simply pay your co-payment and any expenses that are not covered.

The benefits under this plan are provided through an insurance policy. The terms of the policy cannot be modified by oral or written statements. If there is a conflict between the policy and this SPD, the provisions of the policy control. This SPD does not change, expand or otherwise interpret the terms of the policy.

Cigna Global Health Benefits vision coverage

Cardinal Health provides a special vision plan for global assignees through an arrangement with Cigna Global Health Benefits. This is the only vision plan available to you while you are working as an expat overseas. On your return to the United States, you will again be eligible for the domestic vision plan that is described in this SPD. Your Cigna Global Health Benefits are available to you 24 hours a day, seven days a week anywhere you travel in the world and including any trips home. For additional information on covered/not covered services, log on to **cignaenvoy.com** or contact a member services representative at the number listed on your ID card.

Cigna Global Health Benefits group vision benefits	
Calendar year maximum	$200 per calendar year for exams, frames and lenses
Eye exams	90 percent coverage for one exam per year
Eyeglass frames	90 percent coverage; one set per calendar year
Lenses	90 percent coverage; one set per calendar year

Covered services

The plan covers the following vision care services. See the "Snapshot" chart to see how the plan pays benefits for each covered service, as well as any limits that may apply.

- Eye exams.
- Lenses.
- Frames.
- Medically necessary contact lenses:
  - Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses and the professional provider attests to visual improvement in either eye;
  - High ametropia exceeding –10 D or +10 D (spherical equivalent) in either eye;
  - Anisometropia of 3 D in spherical equivalent or more; or,
  - Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best standard spectacle lenses correction.
- Elective contact lenses.
- Discounts on laser vision correction.

Vision expenses not covered

While you receive benefits for many vision expenses, some limits and exclusions do apply. You do **not** receive benefits for certain services or products, including:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Services provided as a result of any Workers' Compensation law or similar legislation or required by any governmental agency or program whether federal, state or subsidized.
- Plano non-prescription lenses and non-prescription sunglasses (except for a 20 percent discount).
- Two pairs of glasses in lieu of bifocals.
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to, Bulgari, Cartier, Chanel, Gold & Wood, Maui Jim and Pro Design. Discounts on non-covered services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Save money!

Remember, you can use the healthcare flexible spending account to pay yourself back for eligible vision care expenses that are not covered by the plan.

Benefits may not be combined with any discount, promotional offering or other group benefit plans. Allowances are one-time use benefits; no remaining balance may be used for additional pairs. Lost or broken materials are not covered.

Applying for benefits

Depending on the coverage option you select, you may or may not have to file a claim before the plan pays benefits.

How to file claims

If you receive care from an **in-network provider**, you do not have to file a claim for benefits. You simply present your EyeMed membership card to the EyeMed provider and you will receive fast, paperless authorization of benefits with EyeMed's automated system. If you do not have your card, the provider can identify you in other ways, e.g., address, date of birth. Once you meet the necessary co-payment requirement, the plan automatically pays the full cost of your covered service.

If you receive care from an **out-of-network provider**, you pay the provider's fee in full, and the plan reimburses you up to the scheduled benefit amount. To receive your reimbursement, submit an itemized, paid receipt and claim form to EyeMed. You may submit your out-of-network claim to First American Administrators "FAA." FAA is a wholly owned subsidiary of EyeMed. You may submit your out-of-network claim to FAA/EyeMed at:

FAA/EyeMed Vision Care
PO Box 8504
Mason, OH 45040
Email: oonclaims@eyemedvisioncare.com

If you are a Cigna Global Health Benefits participant, you pay the provider's fee in full, and the plan reimburses you up to the scheduled benefit amount. You then must file a claim for benefits. To obtain claim forms, you can download a claim form from **cignaenvoy.com**. Mail your completed claim (along with supporting documentation as noted on the form) to:

Cigna Global Health Benefits
Expatriate Benefits
P.O. Box 15050
Wilmington, DE 19850-5050
USA

If a claim is denied

If disagreements arise regarding your benefits, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a plan decision. See the "Overview" section for details regarding the appeals process.

Life and accidental death and dismemberment insurance

An introduction to your life and AD&D benefits

While you are working, you and your dependents rely on your paycheck to meet day-to-day expenses. If you die or are seriously injured in an accident, your dependents' financial security could be seriously affected.

Cardinal Health provides eligible employees with life and accidental death and dismemberment (AD&D) insurance coverages to assist you during these difficult times. See the "Overview" section for more details regarding who is eligible.

If you have any questions after reading this section, you can obtain online information via the myHR website at **hr.cardinalhealth.com**, or you can contact the myHR Service Center at **866.471.7867**.

The health and group benefits program offers both basic and supplemental life and accident insurance, including:

- Basic employee life
- Supplemental employee life
- Dependent life (spouse/domestic partner and/or child[ren]/child[ren] of domestic partner)
- Basic employee AD&D
- Supplemental AD&D
- Business travel accident

How your life and AD&D insurance coverage works

This section provides a snapshot of your life and AD&D options, gives a brief overview of the coverages and describes how the features of your life and AD&D coverages work.

Snapshot of your life and AD&D options

Coverage	Coverage levels*	Payment method
Basic employee life**	One and one-half times your benefit pay	Cardinal Health pays the full cost of coverage.
Supplemental employee life**	One to five times your benefit pay	You pay the cost of coverage with after-tax payroll deductions.
Dependent life • Spouse/domestic partner*** • Your child(ren)/child(ren) of domestic partner	• $25,000 • $50,000 • $75,000 • $100,000 • $5,000 per child • $10,000 per child	You pay the cost of coverage with after-tax payroll deductions.
Basic employee AD&D	One and one-half times your benefit pay (up to $2 million)	Cardinal Health pays the full cost of coverage.

*All coverage levels are rounded to the next higher $1,000 if not already an even $1,000 increment.

**Your total coverage (basic and supplemental life) cannot exceed $2 million.

***Spouse/domestic partner life insurance in an amount equal to the lesser of: (i) $100,000; and (ii) the combined amount of your basic and supplemental life insurance benefits.

Coverage	Coverage levels*	Payment method
Supplemental AD&D	One to five times your benefit pay (up to $1 million); yourself only or family coverage. If you elect family coverage, your dependents are covered at a percentage of your benefit. • **Spouse/domestic partner only** — Coverage equals 50 percent of supplemental AD&D coverage amount (up to $500,000) • **Your child(ren)/child(ren) of domestic partner only** — Coverage (per child) equals 15 percent of supplemental AD&D coverage amount (up to $150,000) • **Spouse/domestic partner + your child(ren)/child(ren) of domestic partner** — Coverage for spouse/domestic partner equals 40 percent of supplemental AD&D coverage amount (up to $400,000). Coverage (per child) equals 10 percent of supplemental AD&D coverage amount (up to $100,000)	You pay the cost of coverage with after-tax payroll deductions.
Business travel accident	Four times your benefit pay subject to the following maximums: $1 million coverage maximum; $5 million aggregate maximum per accident excluding aircraft; and $8.4 million aggregate maximum per accident for aircraft)	Cardinal Health pays the full cost of coverage.

*All coverage levels are rounded to the next higher $1,000 if not already an even $1,000 increment.

Naming a beneficiary

A "beneficiary" is a person or entity that receives benefits in the event of your or your covered dependent's death.

When you enroll (either online or over the phone) you must name a beneficiary. If you purchase dependent life insurance for your spouse/domestic partner and/or your children/children of domestic partner, you are automatically the beneficiary if your covered spouse/domestic partner or dependent dies. If you reside in a community-property state, your spouse will need to provide written consent to name a beneficiary other than your spouse.

You can name one or more beneficiaries. If you name more than one beneficiary, you need to designate what portion of the entire benefit should be paid to each. You also need to indicate the beneficiaries' relationship to you. For example, Pam Smith, spouse — 50 percent; Peggy Smith, child — 25 percent; Colby Smith, child — 25 percent. If you fail to name a percentage when naming multiple beneficiaries, the benefit is paid in equal shares to the designated beneficiaries.

Changing your beneficiary

Because family situations can change, you may want to review your beneficiary designations from time to time. You may change your beneficiary at any time by going online or calling a myHR Service Center representative. Your new designation takes effect on the date the beneficiary designation change is made.

If you do not name a beneficiary

If you do not name a beneficiary or if your beneficiary dies before you do, the benefit is paid in one lump sum to those below in the following successive order:

- Your surviving legal spouse; or if none,
- Your surviving child(ren) (in equal shares); or if none,
- Your surviving parent(s) (in equal shares); or if none,
- Your surviving sibling(s) (in equal shares); or if none,
- Your estate (unless otherwise provided via a beneficiary assignment as explained in the "Assigning your benefits" section below).

If you desire that the proceeds of your insurance coverage be paid to your designated domestic partner, you should complete and file an effective beneficiary designation form naming your domestic partner as the beneficiary of such proceeds. If you do not designate your domestic partner as your beneficiary, your domestic partner will not be entitled to your life insurance benefit.

Assigning your benefits

You may make an absolute assignment of your life and AD&D benefits. By making an absolute assignment, you are assigning your life insurance ownership over to some person or entity. Once you make an absolute assignment, you cannot change your coverage options, convert your coverage to an individual policy or change the beneficiaries because your assignee now owns the policy.

If you want to make an absolute assignment, please contact a representative from the myHR Service Center at **866.471.7867**.

Evidence of insurability

When you choose certain amounts of supplemental life insurance, evidence of good health or "evidence of insurability" (EOI/Statement of Health) must be provided.

EOI is required if:

- Your basic and supplemental employee life insurance combined exceeds 4.5x your pay (employer-paid basic life plus an election of supplemental employee life of at least 3x pay) whether at initial enrollment as a new hire or based on an election completed during annual enrollment.
- You increase your coverage level after the initial election (either during annual enrollment or as a result of a qualified life event).
- You seek more than $25,000 in spouse or domestic partner coverage.

Evidence of insurability

You may be required to submit answers to a health statement questionnaire and take a physical exam. This questionnaire seeks medical information about you or your dependents and must be completed by you and/or your physician. When required, coverage does not take effect until the evidence is approved by the carrier.

If you are denied requested coverage that required EOI, you will receive the highest coverage available to you that did not require EOI.

Child life, AD&D and business travel accident insurance do not require EOI.

If you become disabled

If you become totally disabled (as defined by MetLife) you may qualify for a waiver of premium. The waiver of premium provision allows you to continue your life insurance without paying a premium. If you qualify for this benefit, your dependent's coverage also will be extended without a premium payment.

The amount of life insurance continued will be the amount of life insurance and dependent life insurance in effect on the last day of your active employment.

To qualify for this benefit, you must become totally disabled before you reach age 60, and you must remain totally disabled for a period of six months. At the end of six months, the waiver may be approved and will continue until you reach age 65, as long as you continue to be disabled and provide proof of your total disability.

Premiums will not be waived if your total disability results from intentionally self-inflicted injuries, while sane or insane.

Imputed income

Under current tax laws, you are required to pay income taxes on the "value" of your Cardinal Health-provided basic life insurance coverage over $50,000. The "value" is determined by your age and according to a schedule established by the IRS. This tax liability is called "imputed income" and is included on each paycheck and your W-2 form at the end of the calendar year.

The chart below shows the rates used by the IRS to determine annual imputed income. These rates are subject to change, but do not necessarily change annually.

Age bracket (12/31 of the calendar year)	**Annual imputed income (per $1,000 of coverage above $50,000)**
Under 25	$0.60
25 to 29	$0.72
30 to 34	$0.96
35 to 39	$1.08
40 to 44	$1.20
45 to 49	$1.80
50 to 54	$2.76
55 to 59	$5.16
60 to 64	$7.92
65 to 69	$15.24
70 and above	$24.72

To show how this works, let us assume you are age 45 and have $90,000 of basic employee life insurance coverage. Since you have over $50,000 of coverage, your annual imputed income is $72 ($40,000 [the amount of coverage over $50,000] of coverage × $1.80 per $1,000).

More details about your life insurance coverages

You automatically receive basic life insurance coverage as an eligible employee. For additional protection, you may purchase supplemental life insurance coverage for yourself. You also may purchase dependent life insurance for your spouse/domestic partner and/or your dependent children/children of domestic partner.

Basic employee life insurance coverage

Cardinal Health provides you with basic employee life insurance coverage equal to one and one-half times your benefit pay at no cost.

Supplemental employee life insurance for you

If you want additional coverage beyond the Cardinal Health-provided basic employee life insurance coverage, you may purchase supplemental employee life insurance for yourself from the following options. Your total coverage (basic and supplemental) cannot *exceed* $2 million.

Supplemental employee life insurance options

- One times benefit pay
- Two times benefit pay
- Three times benefit pay
- Four times benefit pay
- Five times benefit pay

Pay less for life insurance if you do not use tobacco

Your prices for supplemental employee and spouse/domestic partner life insurance are based on the amount of coverage selected, your age and whether or not you or your spouse/domestic partner uses tobacco. Cardinal Health offers lower rates if you and your spouse/domestic partner are not tobacco users. That is because experience shows that tobacco users are more expensive to insure.

To enroll for or increase supplemental employee life insurance coverage, you may be required to provide evidence of insurability. For information regarding evidence of insurability rules, see "Evidence of insurability."

Dependent life insurance for your spouse/domestic partner

You may want to purchase dependent life insurance for your spouse/domestic partner. This coverage pays a benefit to you in the event of your spouse's/domestic partner's death.

If you elect life insurance for your spouse/domestic partner, coverage is available in the following increments:

Spouse/domestic partner life insurance coverage options

$25,000
$50,000
$75,000
$100,000

Evidence of insurability (EOI) is required for any spouse or domestic partner coverage over $25,000.

Spouse/domestic partner life insurance may not exceed the lesser of: (i) $100,000; and (ii) the combined amount of your basic and supplemental life insurance benefits.

To enroll for or increase supplemental life insurance coverage for your spouse/domestic partner, your spouse/domestic partner may be required to provide evidence of insurability. For information regarding evidence of insurability rules, see "Evidence of insurability."

Dependent life insurance for your child(ren)/child(ren) of domestic partner

You may want to purchase life insurance for your eligible dependent children. If you elect life insurance for your child(ren)/child(ren) of domestic partner, coverage is available in the following increments:

Child life insurance coverage options

- $5,000
- $10,000

When you elect life insurance for your children/children of domestic partner, the amount chosen applies to all of your eligible dependent children. For example, if you elect the $5,000 option and have three children, each of the three children has coverage of $5,000. Also, your after-tax payroll deduction to pay for this coverage is the same regardless of how many children you cover.

More details about your AD&D coverages

If you want additional coverage beyond the Cardinal Health-provided basic AD&D coverage, you may purchase supplemental AD&D insurance for yourself and your dependents (including your domestic partner and your domestic partner's children). This provides additional protection to ease the financial strain in the event of a covered accident.

Basic employee AD&D insurance coverage

Your basic employee AD&D coverage equals one and one-half times your benefit pay to a maximum of $2 million. If you die as a result of an accident, your beneficiary receives this basic AD&D benefit in addition to the basic (and supplemental life, if applicable) employee life insurance benefit.

In the event of an accidental dismemberment (you lose your sight, a hand or a foot, or you experience another covered loss), you receive a portion of your basic employee AD&D benefit, as shown in the "Covered AD&D losses" section.

If you are seriously injured in an accident that results in the loss of a limb or your sight, you need to submit the following information to MetLife (see page 223 for the carrier's address):

- A completed claim form;
- A police report (if applicable);
- The accident report;
- Any hospital records pertaining to the injury;
- Any newspaper articles (if applicable); and,
- Any other additional information that may help in the proper evaluation of the claim.

Dismemberment

A dismemberment may be a:

- Severance of a thumb (actual severance through or above the second joint from the tip of the thumb).
- Severance of an index finger (actual severance through or above the third joint from the tip of the index finger).
- Severance of a hand or foot (through or above the wrist or ankle joint).
- Complete loss of sight that cannot be recovered or corrected.
- Complete and irrevocable loss of speech or hearing following a covered injury.

Supplemental AD&D insurance for you

You can purchase supplemental AD&D insurance coverage equal to one, two, three, four or five times your benefit pay to a maximum of $1 million. You do not need to provide evidence of insurability if you elect this coverage.

In the event of an accidental death, your beneficiary receives the full amount of your supplemental AD&D coverage. This is in addition to the basic life (and supplemental life, if applicable) and basic AD&D benefits.

In the event of an accidental dismemberment (you lose your limb, sight, hearing or speech), you receive a portion of your supplemental AD&D benefit as shown in the "Schedule of covered AD&D losses." This is in addition to any basic AD&D benefits you may receive.

Supplemental AD&D insurance for your family

If you elect supplemental AD&D insurance coverage for your whole family, you will elect coverage for yourself in increments of one to five times your benefit pay. All your family members are covered as well. Here is how this supplemental AD&D insurance works:

- If you are married or have a domestic partner, but do not have children and elect family coverage, your spouse's/domestic partner's coverage equals 50 percent of your supplemental coverage.
- If you do not have a spouse/domestic partner, but do have children and elect family AD&D coverage, each child's coverage equals 15 percent of your supplemental coverage.
- If you have a spouse/domestic partner and children/children of domestic partner and elect family coverage, your spouse's/domestic partner's coverage equals 40 percent of your supplemental coverage, and each child's coverage equals 10 percent of your supplemental coverage.

Covered AD&D losses

AD&D benefits for loss of life and dismemberment are shown in the chart below.

Schedule of covered AD&D losses

Loss…	Percentage of coverage amounts payable…
Life	100 percent to your beneficiary
Dismemberment	
• Entire sight in both eyes	100 percent to you
• Both hands or both feet	100 percent to you
• Both arms or both legs	100 percent to you
• Paralysis of both arms and both legs	100 percent to you
• Brain damage	100 percent to you
• One arm or one leg	70 percent to you
• Paralysis of both legs	50 percent to you
• Paralysis of the arm and leg on either side of the body	50 percent to you
• One hand or one foot	50 percent to you
• Entire sight in one eye	50 percent to you
• Speech	50 percent to you
• Hearing in both ears	50 percent to you
• Paralysis of one arm or leg	25 percent to you
• Thumb and index finger on the same hand	25 percent to you
• Coma	1 percent monthly (after seventh day of coma for 60 months)

A covered loss must have happened within 365 days of the accident.

In the event of multiple losses from one accident, you cannot receive more than the full amount of coverage. No benefits are paid for a loss that is not shown on this schedule.

Special benefits under basic employee AD&D insurance coverage

An "**automobile**" is defined as a validly registered four-wheel vehicle, sport utility vehicle, pickup truck or minivan. It does not include any commercially licensed car, any private car being used for commercial purposes or any vehicle used for recreation or professional racing.

A "**seat belt**" is any restraint device that meets published United States government safety standards, has been installed by the car manufacturer, and has not been altered after installation.

An "**air bag**," also known as a supplemental restraint system, is a passive restraint device in a vehicle. This device inflates upon collision to protect individuals in the car from injury and death.

Seat belt benefit

Your beneficiary receives an additional 10 percent of your AD&D coverage amount (or $25,000, whichever is less) if you or a covered dependent die as a result of an accident in a private automobile and you were wearing a properly fastened seat belt (subject to police verification). Your beneficiary is not eligible for this benefit if you were:

- Not wearing a seat belt for any reason;
- Sharing a seat belt;
- Driving under the influence of alcohol or drugs;
- Driving or riding in any vehicle used in a race, speed or endurance test, or for acrobatic or stunt driving; or,
- Breaking any traffic laws when the accident occurred.

Air bag benefit

Air bag means an inflatable restraint device that meets published United States government safety standards, is properly installed by the car manufacturer and is not altered after installation. If benefits are payable under the seat belt benefit, and if your automobile is equipped with a factory-installed air bag, your beneficiary receives an additional 5 percent of your AD&D coverage amount (or $10,000, whichever is less) if the deceased person:

- Was in an accident while driving or riding as a passenger in a passenger car equipped with an air bag(s).
- Was riding in a seat protected by an air bag;
- Was wearing a seat belt which was properly fastened at the time of the accident; and
- Died as a result of the injuries sustained in the accident.

Your beneficiary is not eligible for this benefit if you were:

- Not wearing a seat belt for any reason;
- Sharing a seat belt;
- Driving under the influence of alcohol or drugs;
- Driving or riding in any vehicle used in a race, speed or endurance test, or for acrobatic or stunt driving; or
- Breaking any traffic laws when the accident occurred.

Special benefits under supplemental AD&D insurance coverage

Seat belt benefit

Your or your dependents' beneficiary receives an additional 10 percent of the AD&D coverage amount if you or your dependents die as a result of an accident in a private automobile and you or your dependents were wearing a properly fastened seat belt (subject to police verification). The exclusions listed under basic coverage also apply to this supplemental coverage.

Air bag benefit

If benefits are payable under the seat belt benefit, and if the automobile is equipped with a factory-installed air bag, your or your dependents' beneficiary receives an additional 5 percent of the AD&D coverage amount if:

- You or your dependents were sitting in a seat designed to be protected by an air bag; and,
- A police report or other evidence establishes that the air bag inflated properly upon impact.

The maximum amount payable under supplemental AD&D insurance coverage is $50,000 for the seat belt and air bag benefit combined.

Additional benefit: childcare

If you or your spouse dies as a result of an accidental injury, MetLife will pay this additional childcare benefit if:

1. MetLife pays a benefit for loss of life under the accidental death and dismemberment insurance section;
2. This benefit is in effect on the date of the injury; and,
3. MetLife receives proof that:
   - On the date of your death a child was enrolled in a childcare center; or,
   - Within 12 months after the date of your death a child was enrolled in a childcare center.

Childcare center means a facility that:

- Is operated and licensed according to the law of the jurisdiction where it is located; and,
- Provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

Benefit amount

For each child who qualifies for this benefit, MetLife will pay an amount equal to the childcare center charges incurred for a period of up to four consecutive years, not to exceed:

- An annual maximum of $5,000; and
- An overall maximum of 10 percent of the full amount shown in the schedule of benefits.

In the event that both you and your spouse die such that each death would cause a payment to be made for a child under this additional benefit, the following rules apply:

- The annual maximum will be two times the amount stated above;
- The overall maximum will be equal to the stated percentage applied to the sum of the full amounts shown in the schedule of benefits for both you and your spouse; and,
- In no event will the amount paid under all childcare benefits exceed the amount of childcare charges incurred.

MetLife will not pay for childcare center charges incurred after the date a child attains age 12 and may require proof of the child's continued enrollment in a childcare center during the period for which a benefit is claimed.

Benefit payment

MetLife will pay this benefit quarterly when they receive proof that childcare center charges have been paid. Payment will be made to the person who pays such charges on behalf of the child. If this benefit is in effect on the date you die and there is no child who could qualify for it, we will pay $1,000 to your beneficiary in one sum.

Additional benefit: child education

If you or your spouse dies as a result of an accidental injury, MetLife will pay this additional child education benefit if:

1. MetLife pays a benefit for loss of life under the accidental death and dismemberment insurance section;
2. This benefit is in effect on the date of the injury; and,
3. MetLife receives proof that on the date of your death a child was:
   - Enrolled as a full-time student in an accredited college, university or vocational school above the 12th-grade level; or,
   - At the 12th-grade level and, within one year after the date of your death, enrolls as a full-time student in an accredited college, university or vocational school.

Benefit amount

For each child who qualifies for this benefit, MetLife will pay an amount equal to the tuition charges incurred for a period of up to four consecutive academic years, not to exceed:

- An academic year maximum of $10,000; and,
- An overall maximum of 10 percent of the full amount shown in the schedule of benefits.

- In the event that both you and your spouse die such that each death would cause a payment to be made for a child under this additional benefit, the following rules apply:
  - The academic year maximum will be two times the amount stated above;
  - The overall maximum will be equal to the stated percentage applied to the sum of the full amounts shown in the schedule of benefits for both you and your spouse; and,
  - In no event will the amount paid under all child education benefits exceed the amount of tuition incurred.

MetLife may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit payment

MetLife will pay this benefit semi-annually when we receive proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Additional benefit: spouse education

If you die as a result of an accidental injury, MetLife will pay this additional spouse education benefit if:

1. MetLife pays a benefit for loss of life under the accidental death and dismemberment insurance section;
2. This benefit is in effect on the date of the injury; and,
3. MetLife receives proof that:
   - On the date of your death, your spouse was enrolled as a full-time student in an accredited school; or,
   - Within 12 months after the date of your death, your spouse enrolls as a full-time student in an accredited school.

Benefit amount

MetLife will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed:

- An academic year maximum of $5,000; and,
- An overall maximum of 3 percent of the full amount shown in the schedule of benefits.

MetLife may require proof of the spouse's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit payment

MetLife will pay this benefit semi-annually when we receive proof that tuition charges have been paid. Payment will be made to the spouse. If this benefit is in effect on the date you die and there is no spouse who could qualify for it, we will pay $1,000 to your beneficiary in one sum.

Additional benefit: hospital confinement

Subject to the provisions of the accidental death and dismemberment insurance, MetLife will pay this additional benefit if:

1. MetLife receives proof that you or a dependent are confined in a hospital as a result of an accidental injury which is the direct result of such confinement independent of other causes; and,

2. This benefit is in effect on the date of the injury.

Benefit amount

MetLife will pay an amount for each full month of hospital confinement equal to the lesser of:

- 1 percent of the full amount shown in the schedule of benefits; and,
- $2,500

MetLife will pay this benefit on a monthly basis beginning on the fifth day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement. We will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Benefit payment

Benefit payments will be made monthly. Payment will be made to you.

Additional benefit: common carrier

If you or a dependent dies as a result of an accidental injury, MetLife will pay this additional benefit if:

1. MetLife pays a benefit for loss of life under the accidental death and dismemberment insurance section;

2. This benefit is in effect on the date of the injury; and,

3. MetLife receives proof that the injury resulting in the deceased's death occurred while traveling in a common carrier.

Benefit amount

The common carrier benefit is an amount equal to the full amount shown in the schedule of benefits.

Benefit payment

For loss of your life, MetLife will pay benefits to your beneficiary. For a loss of a dependent's life, they will pay benefits to you.

Business travel accident insurance

This plan provides death, dismemberment and paralysis benefits for losses that occur in a covered accident while on a company-authorized business trip.

How the plan works

Business travel accident insurance offers financial protection in the event that an accident or death occurs while you are on company-authorized business.

If you die as a result of an accident, the designated beneficiary will receive business travel accident insurance benefits in addition to other life insurance you are enrolled in.

If an accident results in paralysis or the loss of a hand, foot, sight, speech or hearing, you will receive business travel accident benefits.

You or your beneficiary will need to file a claim to receive benefits. To file a claim, you or your beneficiary must speak to a representative by calling the myHR Service Center at **866.471.7867**.

Cost of coverage

The company pays the full cost of the business travel accident insurance.

Your coverage amount

All active regular U.S. employees of Cardinal Health (including named corporate pilots kept on file with Cardinal Health) are covered for four times their benefit pay, rounded to the next $1,000, to a maximum of $1 million.

All guests of Cardinal Health (not otherwise covered under the plan) traveling on the specific request of Cardinal Health are covered for $250,000.

If you are piloting a private aircraft with the consent of Cardinal Health, you are covered for one times your benefit pay, rounded to the nearest $1,000, to a maximum of $100,000.

If your spouse/domestic partner is traveling with you on a trip for purposes of relocation, your spouse/domestic partner is covered for $25,000.

If your dependent children/children of domestic partner are traveling with you on a trip for purposes of relocation, your children/children of domestic partner are covered for $5,000.

Depending on your loss, you will receive a percentage of your total coverage amount. The percentage you receive is based on the schedule of benefits listed below.

The most you can receive as the result of one accident is 100 percent of your coverage amount.

Schedule of benefits

The business travel accident insurance plan has predetermined coverage amounts. Depending on the nature of the injury, you or your beneficiary will receive a percentage of the total coverage amount. For benefits to be payable:

- The loss suffered must be the direct result of the accidental injury and from no other cause.
- The loss must occur within 365 days of the accidental loss.

The plan does not cover certain exclusions or any accidental losses not listed. You or your beneficiary will receive a percentage of your total benefit for the following types of loss:

Schedule of covered losses

Loss…	Percentage of coverage amount payable…
Life	100 percent to your beneficiary
Dismemberment	
• Entire sight in both eyes	100 percent to you
• Both hands or both feet	100 percent to you
• Speech and hearing	100 percent to you
• Either hand or foot and sight of one eye	100 percent to you
• One hand or one foot	50 percent to you
• Entire sight in one eye	50 percent to you
• Speech	50 percent to you
• Hearing in both ears	25 percent to you
• Thumb and index finger on either hand	25 percent to you

Paralysis benefit

If you become paralyzed (if you sustain paraplegia or quadriplegia) because of a covered injury to the spinal cord within 365 days after the date of the accident, you will receive 1 percent of the stated percentage shown in the schedule on page 158. This benefit is payable on a monthly basis beginning with the 13th month of such paralysis for a maximum of 100 successive months, provided such paralysis continues. However, the maximum benefit payable will not exceed the coverage amount percentage.

Paralysis benefit schedule

Type of paralysis…	Percentage of coverage amount payable…
Quadriplegia (total paralysis of all four limbs)	100 percent
Paraplegia (total paralysis of both lower limbs)	75 percent
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50 percent

If you die during a period for which benefits are payable and before an amount equal to the coverage amount has been paid, the remaining unpaid benefit is paid in one lump sum. In no event will the paralysis benefit plus any AD&D benefit exceed your coverage amount due to the same accident.

Paralysis must be determined by a competent medical authority to be permanent, complete and irreversible. Proof of total paralysis may be required on a periodic basis.

Exclusions

Life and AD&D benefits are not payable if your death or injury results from the following situations.

Basic employee life insurance

- Your coverage terminates when you enter the armed forces of any country. Membership in the reserves or a call to active duty for 26 weeks or less is not considered entry into the armed forces.

Supplemental employee life and dependent life insurance

- Your coverage terminates when you enter the armed forces of any country. Membership in the reserves or a call to active duty for 26 weeks or less is not considered entry into the armed forces.
- If you or your dependent dies as the result of suicide or any attempt at suicide, while sane or insane, within two years of the effective date of coverage, you will receive a refund of the premiums actually paid. The refund of premiums is in lieu of any death benefit that would have been payable. For any increase in the amount of insurance, the two-year period will begin as of the effective date of the increase.

Basic employee AD&D insurance

- Your coverage terminates when you enter the armed forces of any country. Membership in the reserves or a call to active duty for 26 weeks or less is not considered entry into the armed forces;
- Riding in or boarding or deplaning from an aircraft that is not owned, chartered or leased by or on behalf of Cardinal Health;
- Riding in or boarding or deplaning as a pilot or crew member from any vehicle or device for aerial navigation that is not owned or leased by or on behalf of Cardinal Health;
- Declared or undeclared war or an act of either;
- Suicide, a suicide attempt, self-destruction or an attempt to self-destroy while sane or insane;
- Intentionally self-inflicted injury while sane or insane;
- Medical or surgical treatment of a sickness or disease;
- Intoxication, or being under the influence of drugs, unless taken as prescribed by a doctor. Intoxication means that which is defined and determined by the laws of the jurisdiction where the loss or cause of loss was incurred;

- Intentionally placing yourself in a condition of peril where the outcome is foreseeable;
- Driving or riding in any vehicle used in a race, speed or endurance test or for acrobatic or stunt driving;
- Participation in an illegal occupation or attempt to commit a felony; or,
- Sickness or disease, except infections that result from an accidental injury, or infections that result from accidental, involuntary or unintentional ingestion of a contaminated substance.

Supplemental AD&D insurance

Life insurance will not pay benefits if you, your spouse, your domestic partner or your children are disabled when you elect coverage. An employee must be actively at work and dependents not be disabled or in the hospital before any coverage increases become effective.

- Your coverage terminates when you enter the armed forces of any country. Membership in the reserves or a call to active duty for 26 weeks or less is not considered entry into the armed forces;
- Riding in or boarding or deplaning from an aircraft that is not owned, chartered or leased by or on behalf of Cardinal Health;
- Riding in or boarding or deplaning as a pilot or crew member from any vehicle or device for aerial navigation that is not owned or leased by or on behalf of Cardinal Health;
- Declared or undeclared war or an act of either;
- Suicide, a suicide attempt, self-destruction or an attempt to self-destroy while sane or insane;
- Intentionally self-inflicted injury while sane or insane;
- Medical or surgical treatment of a sickness or disease;
- Intoxication, or being under the influence of drugs, unless taken as prescribed by a doctor. Intoxication means that which is defined and determined by the laws of jurisdiction where the loss or cause of loss was incurred;
- Intentionally placing yourself in a condition of peril where the outcome is foreseeable;
- Driving or riding in any vehicle used in a race, speed or endurance test or for acrobatic or stunt driving;
- Participation in an illegal occupation or attempt to commit a felony; or,
- Sickness or disease, except infections which result from an accidental injury, or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance.

Business travel accident insurance

- Your coverage terminates when you enter the armed forces of any country. Membership in the reserves or a call to active duty for 26 weeks or less is not considered entry into the armed forces;
- Suicide or attempted suicide while sane, or self-destruction or attempted self-destruction while insane;
- Declared or undeclared war or an act of either within the United States, Canada or the insured's country of permanent residence;
- Riding as a pilot or crew member in any vehicle or device for aerial navigation unless a specific written agreement has been obtained to provide such coverage;
- Any accident occurring while the aircraft covered under the policy is carrying passengers or goods for hire; or,
- Sickness or disease, except pyogenic infections that occur through an accidental cut or wound.

Receiving benefits

How and when benefits are paid

Benefits are paid based on the coverage in effect:

- On the date of death for life and AD&D insurance.
- On the date of the accident for AD&D insurance, even if a death or dismemberment occurs after the accident date.

If the proceeds payable are $5,000 or more, a total control account (TCA) will be opened in the beneficiary's name, giving him or her complete control of and immediate access to the insurance proceeds. A TCA is an interest bearing account with unlimited draft writing privileges. Accountholders can withdraw all or part of their TCA balance immediately or at any time without penalty and there are no transaction fees or charges for draft reorders.

You or your beneficiary also may elect to have all or part of your insurance proceeds paid in a fixed number of monthly installments.

Accelerated death benefit

For you

If you have a life expectancy of 12 months or less, you can request an accelerated death benefit from the basic and supplemental employee life insurance plans.

You will receive up to 80 percent of your life insurance coverage benefit up to a maximum of $500,000. Once you receive the accelerated death benefit, your total benefit is reduced by the amount you receive.

For your covered spouse/domestic partner

If your covered spouse has a life expectancy of 12 months or less, and is covered under spouse life insurance, you can request an accelerated death benefit from the spouse life plan.

You will receive up to 80 percent of the spouse life insurance coverage benefit up to a maximum of $80,000. Once you receive the accelerated death benefit, your total benefit is reduced by the amount you receive.

When you die, your beneficiary will receive the remaining balance of the life insurance benefit.

For more information about the accelerated death benefit, contact a representative from the myHR Service Center at **866.471.7867**.

Taking your coverage with you

Portability and Conversion

Portability

Portability allows you to continue your supplemental and dependent life insurance under a new group term life policy if your employment ends or you are no longer eligible for coverage. You have 31 days from the date your insurance terminates to elect portability. The amounts you can port are listed below:

Portability eligible life insurance for you

Minimum portability eligible life insurance amount	$10,000
Maximum portability eligible life insurance amount	The lesser of your total life insurance in effect on the date you elect to port or $2,000,000

Portability eligible dependent spouse life insurance

When porting dependent spouse life insurance along with insurance for you:

Minimum portability eligible dependent spouse life insurance amount	$2,500
Maximum portability eligible dependent spouse life insurance amount	The lesser of your total dependent spouse life insurance in effect on the date you elect to port or $250,000

When porting dependent spouse life insurance alone

Minimum portability eligible dependent spouse life insurance amount	$10,000
Maximum portability eligible dependent spouse life insurance amount	The lesser of your total dependent spouse life insurance in effect on the date you elect to port or $250,000

Portability eligible dependent child life insurance

Minimum portability eligible dependent child life insurance amount	$1,000 maximum portability eligible
Dependent child life insurance amount	The lesser of your total dependent child life insurance in effect on the date you elect to port or $25,000

Request period

For you or a former dependent to port, MetLife must receive a completed request form within the request period as described below. If written notice of the option to port is given within 15 days before or after the date such insurance ends, the request period:

- Begins on the date the insurance ends; and,
- Expires 31 days after the date.

If written notice of the option to port is given more than 15 days after but within 91 days of the date such insurance ends, the request period:

- Begins on the date the insurance ends, and expires 45 days after the date of the notice.

If written notice of the option to port is not given within 91 days of the date such insurance ends, the request period:

- Begins on the date the insurance ends; and,
- Expires at the end of such 91-day period.

The portability options are applicable to supplemental employee life insurance only. You may only apply for portability options because of employment termination. Portability is not available if benefit termination is because of disability or retirement.

Basic employee AD&D and supplemental AD&D benefits are not portable or convertible.

Conversion

Conversion allows you to continue your group term life benefits as an individual permanent policy. Conversion is applicable to basic life, spouse/domestic partner life and child/child of domestic partner life insurance coverages.

Conversion is available to you if your supplemental employee life insurance is terminated due to disability or retirement.

You can convert life insurance coverage up to the amount of the coverage you lost. If you convert coverage, you will pay the insurance company's usual rate for that coverage.

When you lose coverage, you will receive a conversion notice in the mail with information on how to convert your coverage. You will have 31 days from the date you lost coverage to make the conversion.

When you convert coverage, you will receive a new policy from the insurance company.

Please direct any questions about converting or continuing your coverage to the myHR Service Center at **866.471.7867**.

Applying for benefits

If you or a covered dependent dies or is seriously injured in an accident, you or your beneficiary should immediately call the myHR Service Center at **866.471.7867**.

How to file claims

You or your beneficiary should contact the myHR Service Center as soon as possible regarding the death or accident of a covered individual. A myHR Service Center representative will obtain the necessary information from you or your beneficiary, and then the representative will contact MetLife, who in turn will provide you or your beneficiary with the information he or she needs to receive life or AD&D benefits.

Remember, you are the beneficiary for any dependent life insurance coverage for your spouse/domestic partner or dependent children/children of domestic partner. If your spouse/domestic partner or child/child of domestic partner dies, contact the myHR Service Center as soon as possible to obtain the necessary information.

If a claim is denied

If disagreements arise regarding your or your beneficiary's claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you (or your beneficiary) may appeal a decision. See the "Overview" section for details regarding the appeals process.

Estate Resolution Services

MetLife's Estate Resolution Services provide a value-added benefit for the representative of the employee or the spouse's/domestic partner's estate that assists him or her in distributing the employee's assets. It provides probate services to beneficiaries, who are also executors or administrators of a deceased employee's estate. Probate is the legal process of distributing an employee's assets.

The following Estate Resolution Services are provided at no additional cost to individuals insured for supplemental life insurance coverage as described below. *It is a value-added benefit for the representative of the employee's estate that assists him or her in distributing the employee's assets*. If you are eligible to receive these Estate Resolution Services and you or your spouse (for the will preparation service) or you or a beneficiary (for the probate service) would like to speak with a representative from Hyatt Legal Plans or get the name of a plan attorney that you can speak with about these services, please call **800.821.6400**.

Will preparation service

If you elect supplemental life insurance coverage, a will preparation service (the "service") will be made available to you, through a MetLife affiliate (the "affiliate"), while your supplemental life insurance coverage is in effect. This service will be made available at no cost to you. It is a living benefit that can be used by the employee as part of the estate planning process. It includes in-person consultation(s) with a Hyatt lawyer who will prepare a new will, or update an existing will for the employee, spouse and/or domestic partner, free of charge by attorneys designated by the affiliate. If you have a will prepared by an attorney not designated by the affiliate, you must pay for the attorney's services directly. Upon proof of such payment, you will be reimbursed for the attorney's services in an amount equal to the lesser of the amount you paid for the attorney's services and the amount customarily reimbursed for such services by the affiliate.

Probate service

If you become insured for supplemental life insurance coverage and die while such group supplemental life insurance coverage is in effect, a probate benefit (the "benefit") will be made available to your estate, through a MetLife affiliate ("affiliate"). The benefit provides for certain probate services to be made available upon your death, free of charge by attorneys designated by the affiliate. If probate services are provided by an attorney not designated by the affiliate, your estate must pay for those attorney's services directly. Upon proof of such payment, your estate will be reimbursed for the attorney's services in an amount equal to the lesser of the amount your estate paid for the attorney's services and the amount customarily reimbursed for such services by the affiliate. This benefit will be provided at no cost to you and will end on the date your supplemental life insurance coverage ends.

Disability

An introduction to your disability benefits

Your disability coverage is designed to help protect your income if you are unable to work because of an illness or injury. Please see "Who is eligible" under the "Overview" section for a complete description of who is eligible.

Disability coverages include:

- **Basic short-term disability.** This coverage is provided to all eligible employees of Cardinal Health at no cost to you.
- **Basic long-term disability.** This coverage is provided to all eligible employees of Cardinal Health at no cost to you.
- **Supplemental short-term disability.** You can purchase this coverage to supplement the basic coverage you receive from Cardinal Health.
- **Supplemental long-term disability.** You can purchase this coverage to supplement the basic coverage you receive from Cardinal Health.

If you have any questions after reading this section, you can obtain online information via the myHR website, or you can contact the myHR Service Center at **866.471.7867**.

If you work in a state that requires a state-defined disability plan, you also are covered under the provisions of the laws and regulations of that state plan. If you work in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island, state disability benefits are provided directly by the state. Please contact a leave specialist in the myHR Service Center at **866.471.7867** to coordinate your state disability benefits.

Your Cardinal Health short- and long-term disability benefits will be reduced by the amount you are eligible to receive under the state disability program.

How your short-term disability coverage works

If you become disabled and are eligible for short-term disability benefits, you continue to receive a percentage of your base pay. This section describes how the features of your short-term disability coverage work.

When you become eligible

If you meet the eligibility and enrollment requirements, your coverage begins on your date of hire.

When benefits start

If approved by The Hartford, your short-term disability benefits begin on the eighth day following a seven-calendar-day waiting period that you are out of work due to an illness or injury. If you return to work for three days or less during the waiting period, but again become disabled due to the same or related condition, you do not have to satisfy another waiting period. The days you worked are applied to the waiting period. If you become disabled and return to work on a part-time basis because you are unable to work your full schedule, the short-term disability plan will apply any partial days toward your waiting period. You will be required to use five days of PTO, if available, to cover the five business days within the seven-calendar-day waiting period; or if eligible, you may use paid parental leave for the five days within the seven-calendar-day waiting period.

How is "disability" defined?

A disability can prevent you from doing your current job at Cardinal Health. To be considered disabled because of an illness or injury, you must:

- Be continuously unable to perform the substantial and material duties of your own job;
- Not be gainfully employed in any occupation for which you are qualified by education, training or experience; and
- Be under the regular care of a licensed physician (other than yourself, if you are a physician).

How short-term disability benefits are paid

The timing of your disability pay is dependent upon approval by The Hartford. No benefits can be paid until your leave specialist receives notification from The Hartford that your disability leave has been approved.

Your short-term disability benefit equals 70 percent of your current plan year base pay. For most employees, this is your regular base pay excluding items such as bonuses, overtime, shift differential and any special allowances. For sales representatives, your base pay is as defined in the "exceptions" following the primary definition of benefit pay. Once approved by The Hartford, short-term disability benefits are paid by Cardinal Health through normal payroll processing. **The amount you receive is subject to normal federal income and Social Security taxes as well as your regular paycheck deductions.**

Supplemental short-term disability

If you purchase supplemental short-term disability coverage, you will receive an additional 20 percent of base pay (for a total replacement of 90 percent) for a maximum of eight weeks per new disability.

How your benefits are coordinated with other plans

Your short-term disability benefits are offset by any other disability income you receive, such as from state disability programs and Social Security.

When benefits end

Your short-term disability benefits generally end (or may be denied from the start):

Your short-term disability coverage ends on your last day of active employment.

- Once you are determined by The Hartford to no longer be disabled under this plan, or after you are disabled for 26 weeks, including your seven-day waiting period — whichever comes first;
- Once your employment terminates, or you have a change in employment status rendering you ineligible for benefits under the terms of the plan;
- The day you refuse to follow a treatment plan;
- The day you cease to be under the care of a licensed physician (excluding yourself);
- The day you refuse to submit requested proof of disability;
- The day you refuse to participate in an independent medical examination, testing and/or interview requested by the claims administrator; or
- The day you refuse to adhere to the modifications made to accommodate your disability.

Termination of your short-term disability benefits is an adverse benefit determination requiring notice and opportunity to appeal. See the "Claims and appeals procedures under the plan" section.

If you are still disabled after 26 weeks, you may be eligible for long-term disability benefits.

Recurrent disability feature

If you return to work after you receive short-term disability benefits, and then again become disabled from the same or a related cause, as determined by The Hartford, 45 days or less after your return date, your subsequent disability leave is considered a single disability and is counted as a continuation of your initial claim.

If you become disabled from a different or unrelated disability, as determined by The Hartford, or if your initial disability recurs more than 45 days after the date you return to work, you must file a new claim and meet a new elimination period.

Disabilities not covered under the short-term disability plan

Your short-term disability coverage does not cover all types of disabilities.

Exclusions

You do not receive short-term disability benefits if your benefits end for any of the reasons set forth above. You also do not receive benefits for any disability that results from or is caused by:

- Attempted suicide or self-inflicted injury while sane or insane;
- A war or an act of war, whether or not declared;
- Committing or attempting to commit a felony;
- Any period of disability during which you are incarcerated in a penal or correctional institution if the period of confinement exceeds 30 days;
- An occupational injury or sickness; or,
- Time off for cosmetic surgery (however, any disability as the result of medical complications may be covered).

In addition, you do not receive benefits for:

- Injury or sickness you may experience while serving on full-time active duty in any armed forces;
- The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation (unless it is solely due to your injury or illness); or,
- Substance abuse, unless you are participating in an appropriate state-approved treatment program.

How your long-term disability coverage works

Your long-term disability coverage works with other sources of disability coverage to provide income if you become totally disabled. If you are still disabled after 180 days or the end of the 26-week short-term disability period (whichever is greater), long-term disability benefits may begin.

When you become eligible

Long-term disability coverage is effective on your hire date.

When benefits start

Long-term disability benefits start after you have been continuously disabled for 26 weeks. This 26-week period is referred to as the "elimination period." It is a period of continuous disability that must be satisfied before you are eligible to receive long-term disability benefits. If, during the long-term disability elimination period, you temporarily recover and return to work for 90 days or less, but again become disabled from the same or related condition as determined by The Hartford, your disability will be treated as continuous. The days worked will not count toward the elimination period.

Possible waiver of premium

If you become totally disabled (as defined by The Hartford) and meet other criteria, you may qualify for a waiver of premium. The waiver of premium provision allows you to continue your disability benefits without paying a premium. Contact The Hartford for further information.

How is "disability" defined?

For the first 24 months, the definition of disability for purposes of your long-term disability coverage is the same as the definition on page 178. However, if you are disabled beyond 24 months (the 24-month period starts at the end of the short-term disability period or when you satisfy the long-term disability elimination period), you are considered totally disabled if:

- Your illness or injury prevents you from participating in any occupation for which you are or could become qualified by education, training or experience; and,
- You are under the care of a licensed physician (other than yourself).

Injury or sickness causes physical or mental impairment to such a degree of severity that you are:

- Continuously unable to engage in any occupation for which you are or become qualified by education, training or experience; and,
- Not gainfully employed.

Pre-existing condition exclusions

The long-term disability plan does not pay for a disability that starts within the first 12 months of coverage and that arose from or is related to a pre-existing condition.

For initial enrollment and qualified life events	Annual enrollment (for supplemental long-term disability)
A "pre-existing condition" is one for which medical treatment or advice is rendered, prescribed or recommended within three months prior to the effective date of your long-term disability coverage. A condition is no longer considered pre-existing if it causes a disability that begins after you have been covered under the long-term disability plan for 12 months.	A "pre-existing condition" is one for which medical treatment or advice is rendered, prescribed or recommended within 12 months prior to the effective date of your supplemental long-term disability coverage. A condition is no longer considered pre-existing if it causes a disability that begins after you have been covered under the supplemental long-term disability plan for 12 months. All employees who do not enroll in supplemental long-term disability coverage when they first become eligible will be subject to evidence of insurability if they choose to enroll at a later date.

How long-term disability benefits are paid

Your basic long-term disability benefit equals 50 percent of your current plan year benefit pay, up to a maximum of $10,000 per month.* Here is an example of how your company-provided basic long-term disability benefit works:

- The long-term disability benefit amount is calculated — benefit pay of $30,000 ÷ 12 months = $2,500 × 50 percent = **$1,250 monthly benefit**.
- Then, any other benefits for which you are eligible (e.g., Social Security primary and dependent benefits, Workers' Compensation and state disability — including work-loss provisions, etc.) are taken into account.
- These other benefits — or offsets — are subtracted from the long-term disability benefit amount.
- The result is your long-term disability benefit provided under this plan.

Your long-term disability coverage ends on your last day of active employment. However, termination of coverage will not affect a covered loss that began prior to the date of termination.

The minimum benefit amount is $100 or 10 percent of your gross monthly benefit, whichever is greater.

You generally receive your long-term disability checks directly from The Hartford on a monthly basis. The amount you receive is considered as taxable income and is subject to federal income tax withholding.

* Executives with benefit pay greater than $258,000 can receive a maximum of $14,000 per month.

Supplemental long-term disability coverage

If you purchase supplemental long-term disability coverage, you receive an additional 15 percent of your benefit pay (for a total benefit pay replacement of 65 percent), up to a maximum of $14,000 per month.* As a result, your total benefit equals 65 percent of your benefit pay (less any other sources of income you may be eligible for). The amount you receive also is considered taxable income and is subject to federal income tax withholding.

When benefits end

Your long-term disability benefits generally are paid until the earliest of the following:

- You recover and return to work to your own occupation;
- The end of the maximum benefit period;
- You do not meet the claim requirements (including the appropriate care of a licensed physician);
- The date you earn 80 percent or more of your pre-disability base pay;
- The date the claims administrator determines you are no longer disabled;
- The day you refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan;
- The day you refuse to follow your treatment plan;
- The day you refuse to participate in a medical exam or test as requested by the claims administrator;
- The date you refuse, without good cause, to fully cooperate in a transitional work arrangement;
- The day you are no longer receiving appropriate care for your disability;
- The day you fail to cooperate (e.g., provide information or documents needed to determine whether benefits are payable or the actual benefit amount due) with the administrator who administers your claim; or
- You die.

Termination of your long-term disability benefits is an adverse benefit determination requiring notice and opportunity to appeal. See the "Claims and appeals procedures under the plan" section for further information.

* Executives with benefit pay greater than $258,000 can receive a maximum of $25,000 per month.

Duration of long-term disability benefits

The duration of your benefits depends on your age when you become disabled, as follows:

Age when you become disabled	Maximum benefit period
61 or younger	To retirement age
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Recurrent disability feature

If you return to work after you receive long-term disability benefits and then again become disabled from the same or a related cause as determined by The Hartford, you do not have to meet another 26-week elimination period. Your subsequent disability leave is considered a continuation of your initial claim.

This feature does not apply and you must file a new claim and meet a new elimination period if:

- Your subsequent disability recurs after you work more than six months; or,
- Your second disability results from a cause unrelated to the first.

Limitations

Certain limitations apply to your long-term disability coverage. The plan does not cover any loss caused by any substance abuse-related disability (drug or alcohol) or mental disorder-related disability beyond 24 months after the elimination period. Confinement in a hospital or institution licensed to provide care and treatment for mental illness will not be counted toward the 24-month limit. If you do have a substance abuse-related disability, you must participate in an appropriate treatment program. Benefits are not paid beyond the earlier of the date that:

- The 24 monthly benefit payments have been made;
- You refuse to participate in an appropriate, available treatment program, or you leave the treatment program prior to completion;
- You are no longer following the requirements of your treatment plan; or,
- You complete the initial treatment plan, excluding any after-care or follow-up services.

Work incentive benefit

You may return to work for wage or profit while you are disabled. A work incentive benefit is available if you are disabled and gainfully employed after the end of the 26-week elimination period, but unable to earn greater than 80 percent of your pre-disability salary.

The work incentive benefit is calculated during the first 12 months that you are working as follows:

- Your monthly long-term disability benefit and the wage or salary you earn from working after a disability begins are added together and compared to your monthly pre-disability earnings;
- If the total amount exceeds 100 percent of your pre-disability earnings, the work incentive benefit will be equal to the monthly long-term disability benefit reduced by the amount of the excess; and,
- If the total amount does not exceed 100 percent of your pre-disability earnings, the work incentive benefit will be equal to the monthly long-term disability benefit.

After the first 12 months of working, the work incentive benefit will be equal to the monthly long-term disability benefit less 50 percent of your earnings while disabled.

If your employment ends

Termination of coverage will not affect a covered loss that began prior to the date of termination.

Ability Assist℠

Ability Assist is an assistance program that is available under the long-term disability plan. Services available under this program include access to professional counselors and financial/legal advisors.

Here is how the program works. A disabled employee receives information and the toll-free phone number (**800.964.3577**) for Ability Assist with his or her first long-term disability benefit check. By calling the toll-free number, the disabled employee or an immediate family member receives assistance from a counselor who can help with emotional, financial and/or legal concerns. The counselor maintains the confidentiality of all information and coordinates all services and referrals.

The assistance plan includes the following services:

- Referrals to professional services;
- Telephone access to counselors and financial/legal advisors;
- Face-to-face working sessions; and,
- Referrals to support resources.

Disabilities not covered under the long-term disability plan

Your long-term disability coverage does not cover all types of disabilities.

Exclusions

You do not receive long-term disability benefits if you do not comply with The Hartford's requirements as described above. You also do not receive benefits for any disability that results from or is caused by:

- Attempted suicide or self-inflicted injury while sane or insane;
- A war or an act of war, whether or not declared;
- Committing or attempting to commit a felony;
- A pre-existing condition (as defined on page 173);
- Any period of disability during which you are incarcerated in a penal or correctional institution if the period of confinement exceeds 30 days; or
- A period of disability beyond 24 months after the elimination period if it is because of a mental disorder of any kind. Confinement in a hospital or institution licensed to provide care and treatment of mental illness is not counted as part of the 24-month limit.

In addition, you do not receive benefits for:

- Injury or sickness you may experience while serving on full-time active duty in any armed forces. If you send proof of service, the administrator refunds pro rata any premiums you may pay for coverage during your service;
- The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation (unless it is solely due to your injury or illness); or
- Disabilities beyond 24 months if they are caused by substance abuse (including alcohol).

Applying for benefits

You need to apply to receive short-term disability and long-term disability benefits. First, be sure to contact the myHR Service Center at **866.471.7867** in order to get a Leave of Absence packet and to provide the information needed to update administrative and payroll data. You also may submit a leave of absence request through Workday®.

You must make your disability claim as soon as you become aware that you will be away from work due to a disability for more than seven consecutive days. You should make the call no more than five days after the start of your disability — because if you do not, the absence may be considered unauthorized and your benefits may be delayed.

Reporting claims by phone

Here is what you need to do to report your disability claim:

- Call the myHR Service Center at **866.471.7867** and select the "leave of absence" option to make your claim and speak with a leave specialist. You should be prepared to provide the following information:
  - Your name, address and phone number;
  - Your Social Security number;
  - Your date of birth;
  - Your supervisor's name and phone number and your Cardinal Health work location;
  - Your physician's name, address, fax number and phone number; and,
  - A description of your injury or illness.

Your manager also may call the myHR Service Center on your behalf.

When you call the myHR Service Center to report your disability, they will send you FMLA paperwork. When you receive the packet, complete the Consent to Contact form so that your leave specialist may contact your doctor if more information is needed. You also will need to make an appointment with your doctor to have the Medical Certification form completed. The completed Medical Certification form should be faxed back to the myHR Service Center by your doctor. Both forms should be returned no later than 15 days from the date your leave is reported or your leave of absence may be denied.

When you call to report your disability, the myHR Service Center also will transfer you to a representative at The Hartford to initiate the disability packet. You will receive the disability packet separately from The Hartford, together with an authorization that your doctor should complete.

You need to read and sign this authorization, and give it to your physician. He or she should keep a copy of the authorization at the time he or she certifies your disability. This allows The Hartford to obtain the information that is required to complete the processing of your claim.

If your physician requires a standard authorization for release of medical information, The Hartford will send you two Medical Authorization Forms. Both should be signed and dated by you or your legally authorized representative. You or your doctor should mail one Medical Authorization Form to The Hartford in the postage-paid envelope provided. You should give a copy of the second Medical Authorization Form to your doctor. Be sure to keep the original just in case you require treatment by multiple doctors.

Once you are ready to return to work, you need to work with your leave specialist in the myHR Service Center to ensure that all return to work paperwork is completed prior to coming back to work. The Fitness for Duty form is included in the FMLA packet and is completed by your doctor.

If your disability is due to a work-related injury or illness, you are not eligible for short-term disability benefits. However, you may be eligible to receive long-term disability benefits. Please contact the myHR Service Center at **866.471.7867** for more information.

Survivor Income Benefit

What happens if you die while receiving benefits?

If you die after having received a benefit provided by the policy for at least 12 successive months and during a period for which benefits are payable, a survivor income benefit will be payable. This benefit is equal to the amount you were last entitled to receive for the month preceding death. The survivor income benefit shall be payable on a monthly basis immediately after The Hartford receives written proof of your death. It is payable for six months. The benefit shall accrue from your date of death. This benefit is payable to the beneficiary, if any, named by you under the policy. If no such beneficiary exists, the benefit will be payable in accordance with the "Time of Payment of Claims" provision described below.

Time of Payment of Claims

As soon as The Hartford has all necessary substantiating documentation for your disability claim, your benefit will be paid on a monthly basis, so long as you continue to qualify for it. The Hartford will pay benefits to you unless otherwise indicated. If you die while your claim is open, any due and unpaid disability benefit will be paid to your named beneficiary, if any. If there is no surviving beneficiary, payment may be made, at The Hartford's option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: your:
1) spouse; 2) children including legally adopted children; 3) parents; 4) brothers or sisters; or 5) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, The Hartford may pay up to $1,000 to any relative or beneficiary of yours whom they deem to be entitled to this amount. The Hartford will be discharged to the extent of such payment made by them in good faith.

Flexible spending accounts

An introduction to your flexible spending accounts

Cardinal Health offers you a way to pay certain health and dependent care expenses with before-tax dollars — the flexible spending accounts. As you read about the flexible spending accounts, keep the following in mind:

- Each year during the annual enrollment period, you have the opportunity to decide whether or not to use the accounts and how much to contribute to each.
- New employees making benefits elections during the month of December are restricted from enrolling in a flexible spending account for the current plan year but may make an election for the following plan year.

If you have any questions after reading this section, you can obtain information via the myHR website at **hr.cardinalhealth.com** or you can contact the myHR Service Center at **866.471.7867**. You also can receive flexible spending account information from WageWorks, the company that administers these accounts. You can reach WageWorks by logging on to their website at **wageworks.com** or calling their toll-free number at **877.WAGEWORKS** (877.924.3967).

- The two accounts are designed to help meet your needs. The IRS allows you to set aside tax-free money in one or both accounts.
- The money is not taxed for federal and most state income tax purposes or for Social Security taxes when it comes out of your pay, or when you get it back as reimbursement.
- You need to use the money in your dependent care flexible spending account by the end of the plan year (December 31). With the healthcare flexible spending account, you can carry over up to $500 into the next year. Any balance above $500 will be forfeited. There is no carryover provision for the dependent care account.
- The **healthcare flexible spending account** is designed to help you pay for certain medical, dental, vision and hearing expenses not covered under the health and group benefits program or any other company-sponsored plan. See page 189 for a list of eligible expenses.
- The **dependent care flexible spending account** is designed to help you pay for eligible dependent care expenses you incur while you and your spouse (if you are married) are at work. See page 187 for a list of eligible expenses.

How your flexible spending accounts work

Here is how your flexible spending accounts work.

- **Estimate your expenses:** When you enroll, and at each annual enrollment period, you determine in advance how much you expect to spend on healthcare and/or dependent care expenses for the upcoming plan year. It is important to estimate carefully. Because of the flexible spending accounts' tax advantages, IRS rules apply. As a result, you forfeit any unused flexible spending account funds at the end of the year (other than the $500 which may be rolled over from the healthcare flexible spending account).

Important note: Your contributions are not interchangeable

One additional consideration when estimating your expenses: The healthcare and dependent care flexible spending accounts are treated separately. This means you cannot use money deposited in your healthcare flexible spending account to pay dependent care expenses, and vice versa.

- **Determine how much to contribute:** You then decide how much to contribute to your flexible spending accounts for the upcoming year, on a before-tax basis. You may contribute up to $2,500 in the healthcare flexible spending account and up to $5,000 in the dependent care flexible spending account each plan year.
- After you decide on the dollar amount, divide the amount by the number of pay periods in the year. This amount is deducted before taxes are calculated, then deposited into the appropriate account. The money stays there until you file a claim for reimbursement.
- **Pay for health and dependent care expenses:** WageWorks offers several convenient payment options, including:
  - **WageWorks card:** You can use the WageWorks card like a debit card to pay for eligible healthcare expenses at your doctors' and dentists' offices or at the pharmacy. It deducts money directly from your healthcare flexible spending account.
  - **Pay my provider:** With this option, you tell WageWorks how much to pay your provider, and when you want WageWorks to send the payment. WageWorks will write a check directly from your flexible spending account.
  - **Pay me back:** You also can pay your provider for eligible expenses, and then complete a simple claim form for reimbursement.
  - **Use your smartphone:** With the EZ Receipts mobile app from WageWorks, you can file and manage your reimbursement claims on the spot with a click of your smartphone camera, from anywhere.

– **Receive reimbursement:** If you choose the "Pay me back" option described above, submit a Pay Me Back Claim Form along with the appropriate supporting documentation. See page 202 for more information regarding applying for reimbursement.

  You are reimbursed for the eligible expense with before-tax dollars. For the healthcare flexible spending account, you are reimbursed up to the total amount you elect to contribute for the year — even if you incur the expense at the beginning of the year. For the dependent care flexible spending account, you are reimbursed up to the amount you have in your account on the date your claim is processed.

Maximum and minimum plan year contributions

The chart below shows the maximum and minimum amounts you can contribute to each account per plan year.

	Maximum plan year contribution	Minimum plan year contribution
Healthcare flexible spending account	$2,500	$120
Dependent care flexible spending account	$5,000	$120

Legal limits

Healthcare flexible spending account

If you participate in the healthcare flexible spending account and your spouse participates in a similar flexible spending account through his or her employer, you and your spouse may not use both of your respective accounts to reimburse the same eligible health-related expenses. In addition, if you use your healthcare flexible spending account to reimburse expenses, you give up the opportunity to take an income tax deduction on those same items when you file your taxes. See page 192 for details regarding the income tax deduction.

Dependent care flexible spending account

Under federal law, if you participate in the dependent care flexible spending account and your spouse participates in a similar account through his or her own employer, your combined contributions to the account may not exceed $5,000. This limit applies whether you have one or more dependents receiving care. If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, if you are married, your dependent care account contributions may not exceed the annual income of the lower-paid spouse.

Legal limits for highly compensated employees — If you are a highly compensated employee (HCE), as defined by the IRS, your savings opportunity may be limited. The limit for each year will not be determined until early in that year. In 2014, HCEs at Cardinal Health were limited to a maximum plan year contribution of $2,750.

The Cardinal Health plan year runs from January 1 through December 31. In general, you may not participate in the dependent care flexible spending account if your spouse does not work outside the home. There are two exceptions: if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if he or she is a full-time student. In either of these cases the IRS considers your spouse's earned income to be:

- $3,000 a year if you have one dependent; or
- $6,000 a year if you have two or more dependents.

As a result, these are the maximum amounts you may contribute to the dependent care flexible spending account. If you participate, it is your responsibility to comply with the above limits.

Changing your contributions

In general, you cannot change your contributions during the year unless you have a qualified life event that affects your participation. See the "Overview" section for more details. For mid-year changes, the deduction amount is determined by taking the new annualized coverage, subtracting the actual year-to-date contributions, and dividing that by the number of remaining pay periods. The new goal amount, along with the new deduction, is sent to payroll. Cardinal Health payroll begins applying the new deduction as soon as administratively feasible or as of the effective date, if later. Mid-year changes are only allowed if there is a qualified status change experienced. You cannot reduce the goal amount to less than the current year-to-date amount that has been deducted.

Forfeiture of contributions

If you do not use the entire balance in your dependent care flexible spending account by the end of the plan year or before your eligibility to participate in the account ends, the IRS requires you to forfeit the remaining funds. With the healthcare flexible spending account, you may carry over up to $500 to the next plan year. Any amount over $500 is forfeited. The dependent care flexible spending account does not have a carryover provision. Forfeited funds are not available for future expenses or a refund.

You do have until March 31 (90 days after the prior plan year) to submit claims for expenses incurred during the previous January 1 through December 31 period. This grace period allows you to submit any eligible expense you may have had shortly before the end of the plan year.

This IRS-imposed rule simply means you need to carefully estimate how much to contribute to your flexible spending accounts each year.

If your employment ends

If you leave Cardinal Health, you may submit claims for healthcare expenses you incur through the end of the month in which you terminated. To continue to submit claims for the remainder of the year, you must continue your participation in the healthcare flexible spending account through COBRA. You may, however, continue to submit claims for eligible dependent care expenses incurred during your employment, up to the amount in the account. You may not continue your dependent care flexible spending account under COBRA.

Qualified Reservist Distribution — HEART Act — If you are a "qualified reservist," i.e., a participant who is a reservist called to active duty for at least 180 days or an indefinite period, you may, beginning with the call of duty and ending on the last date reimbursements could otherwise be made for the plan year that includes the call to active duty, request a distribution of all or a portion of your remaining healthcare flexible spending account balance in a "Qualified Reservist Distribution." The portion of the healthcare flexible spending account balance available for a Qualified Reservist Distribution is limited to the amount contributed to the account as of the date of the Qualified Reservist Distribution minus the account reimbursements received as of the date of the request.

More details about the healthcare flexible spending account

You can use the healthcare flexible spending account to reimburse your and your eligible dependents' health-related charges that:

- Are not covered under a health, dental or vision care plan;
- Are eligible for, but not used as, a tax deduction; and,
- Occur during the plan year and within the time frame you are participating in the healthcare flexible spending account.

Important note for Anthem HSA participants

If you are enrolled in an Anthem HSA plan and you contribute to the healthcare flexible spending account, how you may use this money will be limited. You can use this "limited-purpose FSA" for dental, vision and post-deductible medical and prescription drug expenses not covered by the plan. You cannot use the limited-purpose FSA to help meet your deductible. Keep this in mind when you determine how much to contribute to your healthcare FSA.

Eligible dependents

In addition to yourself, you can use the healthcare flexible spending account to pay for out-of-pocket expenses for anyone you claim as a dependent for tax purposes. This includes your spouse and your unmarried dependent children or stepchildren, even if you do not cover them under the Cardinal Health medical, dental or vision plans. IRS regulations do not allow for reimbursement of domestic partner expenses under the healthcare flexible spending account unless the domestic partner qualifies as a dependent under the applicable tax law definition.

Eligible expenses

The following items are examples of eligible expenses under the healthcare flexible spending account. There may be other expenses that qualify for reimbursement.

- Alcoholism or drug dependency treatment and treatment centers;
- Charges that exceed reasonable and customary limits;
- Contact lenses and contact lens solutions;
- If you have a prescription from your doctor, over-the-counter medications used to treat or alleviate personal injuries or sickness;
- Co-payments or co-insurance for prescription medications;
- Deductibles, co-insurance and co-payments under your health, dental or vision plan;
- Eye examinations and prescription eyewear;
- Hearing aids and batteries;
- Radial keratotomy; and,
- Services provided by naturopaths or homeopaths.

Expenses not covered

The following items are examples of expenses that are not eligible for reimbursement under the healthcare flexible spending account.

- Cosmetic surgery, electrolysis, teeth bleaching and hair transplants that are not medically necessary;
- Expenses not permitted as tax deductions on your federal income tax return (except for certain reimbursable over-the-counter medications);
- Medical, dental or vision premiums;
- Exercise fees, athletic fees or health club memberships for general health purposes;
- Expenses you have before your participation in the healthcare flexible spending account begins;
- Marriage counseling;
- Maternity clothes or diaper services;
- Household help (even if recommended by your doctor because you are unable to do housework); or,
- Over-the-counter medications used to maintain your general health (such as dietary supplements). Other over-the counter medications are ineligible for reimbursement without a doctor's prescription.

The eligible and ineligible expenses listed here are only a guide. There may be other expenses in addition to the ones above that are or are not eligible. To learn more, see IRS Publication 502, or contact the myHR Service Center at **866.471.7867**.

More details about the dependent care flexible spending account

You can use the dependent care flexible spending account to pay for many types of dependent care situations. However, to qualify as an eligible expense, the following must be true:

- Care for your dependent(s) must be necessary for you and your spouse (if you are married) to work, look for work or go to school full-time. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation.
- You have the expense during the plan year and within the time frame you are participating in the account.
- Your care provider is anyone other than a person whom you claim as a dependent on your federal income tax return (a son or daughter who provides care must be at least age 19). In addition, you must provide your caregiver's name, address and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization.

Eligible dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your income tax return. An eligible dependent also can be an older dependent (over age 13) who:

- Depends on you for at least half of his or her support;
- Regularly spends at least eight hours a day in your household; and,
- Is physically or mentally unable to care for himself or herself.

Your dependent may be a disabled spouse, an elderly parent or any other relative or dependent, as long as he or she meets all of the above requirements. IRS regulations do not allow for reimbursement of domestic partner expenses under the dependent care flexible spending account unless the domestic partner qualifies as a dependent under the applicable tax law definition.

Eligible expenses

The dependent care flexible spending account can be used to pay for IRS-specified dependent care expenses you incur so that you may work or attend school full-time. It is important to contribute money only for dependent care expenses you know you will have during the upcoming year. Do not forget to subtract the times during which your dependent will not receive care, such as vacation or sick time.

Here are examples of the types of expenses that are considered eligible:

- Dependent care provided in your home, including care provided by a baby-sitter or housekeeper. The provider may be a relative, provided he or she is not your child under age 19, your spouse or any other person whom you claim as a dependent.
- Dependent care provided outside your home, including care provided in a neighbor's home or in an approved daycare center, provided your dependent regularly spends at least eight hours a day in your home. For example, daycare centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more individuals must comply with all federal, state and local regulations governing daycare centers. The provider may be a relative if he or she is not your child under age 19, or any other person whom you claim as a dependent.
- Household services, such as housekeeping or maid services, provided these services are necessary to run your home for the well-being and protection of your eligible dependent.
- Certain expenses for your child not yet in the first grade; for example, nursery school or preschool. Kindergarten expenses qualify for reimbursement under the dependent care flexible spending account only if the expenses are primarily for custodial care and not education.

  For example, let us assume your five-year-old child goes to kindergarten in the morning and in the afternoon he or she attends an after-school day care program at the same school. Let us also assume that your total cost is $3,000 ($1,800 is for the after-school program). If this is the case, only the $1,800 qualifies for reimbursement through the dependent care flexible spending account.
- Before- and after-school programs for children under age 13.
- Day camp services for children under age 13, but not overnight camp.

Expenses not covered

Some expenses do not qualify for reimbursement through the dependent care flexible spending account, including:

- Dependent care expenses that happen before your dependent care flexible spending account participation begins;
- Expenses you claim as an after-tax dependent care tax credit on your federal income tax return, or expenses paid by any other similar flexible spending account;
- Care provided by a round-the-clock nursing home;
- Services provided by your spouse, your child under age 19 or someone you or your spouse claims as a dependent on your tax return;
- Educational expenses for a child in kindergarten and all expenses for first grade (or higher);
- Housekeeping expenses not related to dependent care or for services while you are home from work because of illness;

- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as an unpaid leave of absence or weekend or evening baby-sitting fees);
- Transportation expenses to and from the care site;
- Expenses for overnight camp; and,
- Expenses for food, clothing and entertainment of a qualified dependent, unless charges are incidental and cannot be separated easily from the overall dependent care cost.

The eligible and ineligible expenses listed here are only a guide. There may be other expenses in addition to the ones above that are or are not eligible. To learn more, see IRS Publication 503, or contact the myHR Service Center at **866.471.7867**.

A word about taxes

The amounts you redirect to the flexible spending accounts reduce your taxable income — meaning you pay less in taxes. Your flexible spending account contributions are not subject to:

- Federal income taxes;
- Social Security (FICA) taxes; and,
- In many cases, state and local income taxes.

Rules vary, by state and by city or town. And as you know, state and local taxes often change — so be sure to check with a tax advisor if you are not sure of the tax laws where you live.

An example of how flexible spending accounts help you save

This chart illustrates the potential tax savings when using the healthcare flexible spending account to pay your eligible medical expenses. Assume you are a Cardinal Health employee who earns $45,000 a year, is married, files a joint tax return and has two dependents. If you contribute to the healthcare flexible spending account and use the entire account before the deadline to pay for eligible medical expenses, your federal income tax savings could be as follows:

If your account is:	Your federal income tax savings could be:
$500	$113.25
$1,000	$226.50
$1,500	$339.75
$2,000	$453.00
$3,000	$679.50
$4,000	$906.00

By using the healthcare flexible spending account to pay for up to $4,000 of eligible expenses, you could save up to $906 in federal income taxes for the year. In other words, you spent $3,094 to pay for $4,000 worth of eligible healthcare expenses.

The above illustration assumes a federal income tax rate of 15 percent using the standard deduction and a Social Security (FICA) tax rate of 7.65 percent. If you are subject to state and local income taxes, you could save even more.

When you are deciding whether to contribute to the flexible spending accounts, please keep the following in mind:

- The example provided is for purposes of illustration only — your individual income tax situation may vary.
- Remember that there is a risk of forfeiture with the amount you contribute to a flexible spending account if any unused amounts remain in the account after the plan's deadline under the "use it or lose it" rule.
- You should consult an income tax advisor to determine which accounts are best for your personal situation.

Effect of before-tax contributions on your other benefits

Some of your other benefits, such as medical and long-term disability, are based on your before-tax benefit pay. Your participation in the flexible spending accounts does not reduce the amount of your pay that is used to calculate these benefits.

Before-tax contributions do, however, reduce the Social Security taxes you pay. Therefore, the eventual Social Security benefit you may be eligible to receive may be slightly reduced. This is because both you and Cardinal Health pay Social Security taxes on your pay after your before-tax contributions are subtracted. Because Social Security benefits are based on your career earnings, this reduction will be minimal in most cases. For more information, contact your local Social Security Administration office.

Alternate tax-savings approaches

You may be eligible to take a deduction or tax credit on your income tax return for eligible health and/or dependent care expenses.

Healthcare flexible spending account vs. the income tax reduction

Under current tax laws, healthcare expenses are normally deductible on your federal income tax return if they exceed 7.5 percent of your adjusted gross income. **When you use your flexible spending account to reimburse these expenses, however, you give up the opportunity to take a tax deduction for these same items.** So, when you consider whether or not to enroll in the flexible spending account, decide whether you want to take the deduction on your income tax return, or reimburse the expenses through the flexible spending account. Generally, if you do not itemize deductions, or if your healthcare expenses are less than 7.5 percent of your adjusted gross income, it may be better to use the healthcare flexible spending account.

Dependent care flexible spending account vs. the income tax credit

An alternative to using the dependent care flexible spending account is the tax credit. You may want to consider the tax advantages of both alternatives before you participate.

Under current law, you can pay for eligible dependent care expenses with after-tax dollars. In addition, you can apply some or all of those expenses to the after-tax dependent care tax credit when you file your federal income tax return. Even though you may not apply the same expense to both tax-savings methods, you may apply a portion to the credit and then reimburse yourself from your dependent care flexible spending account for any remaining amounts.

For the care of one dependent, you can generally take a tax credit of up to $3,000 in expenses each year. For two or more dependents, the credit is $6,000. The tax credit amount varies depending on your income. And, if you use your dependent care flexible spending account and the tax credit, the maximum amount deducted through the tax credit is reduced by any amount you receive as reimbursement from the dependent care flexible spending account.

Regarding the tax-savings approaches

It is important to note that any tax savings that may result from your participation in the flexible spending accounts depend on your own personal situation and income level. Tax information included in this SPD is only general information. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax advisor if you have questions about whether to use the flexible spending accounts or to take a tax deduction.

By law, Cardinal Health cannot offer you tax advice, or advise you on your flexible spending account-related decisions. This law is designed to protect you by ensuring that you always get the most up-to-date advice, and that advice is only available from a qualified tax advisor.

Applying for reimbursement

To be reimbursed for your healthcare or dependent care expenses, you must submit a Pay Me Back Claim Form.

If you have any claim questions, please call the myHR Service Center at **866.471.7867**. Or contact WageWorks directly at **877.WAGEWORKS** (877.924.3967).

Healthcare reimbursements

Expenses eligible for reimbursement from another medical, dental or vision plan must be submitted to that plan first. After a payment determination is made, you can submit the unreimbursed expense for reimbursement to your account.

The full annual amount you elect to contribute to your account (less any previous reimbursements) is available for reimbursement of eligible healthcare expenses, regardless of the amount contributed to date. Contributions continue to be deducted from your pay to cover any claims already fully reimbursed from the healthcare flexible spending account.

To obtain reimbursement for an expense, complete and submit a Pay Me Back Claim Form along with:

- The Explanation of Benefits (EOB) from the insurance company; or,
- An itemized bill or receipt for services not covered by insurance, including the name of the service provider, cost of the service and description of the services rendered.

You can obtain a Pay Me Back Claim Form by accessing the WageWorks website at **wageworks.com**.

Dependent care reimbursements

For dependent care flexible spending account claims, you will be reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). If your claim exceeds that amount, you will be reimbursed for the remainder after more money is withheld from future paychecks.

To obtain reimbursement, complete and submit a Pay Me Back Claim Form, along with your provider's bill, itemized receipt or your dependent care provider's signature. You can obtain a Pay Me Back Claim Form by accessing the WageWorks website at **wageworks.com**.

Filing deadline

You may file claims at any time after you have incurred the expense. You have until March 31 of the following plan year to submit claims for expenses that occurred between January 1 and December 31 of the previous plan year.

Remember, funds remaining in the flexible spending accounts are subject to forfeiture if you do not timely incur eligible expenses and submit claims for reimbursement as set forth above. Contact WageWorks at **877.WAGEWORKS** (877.924.3967) or access their website at **wageworks.com** for an up-to-the-minute summary of your account.

If a claim is denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. See the "Overview" section for details regarding the appeals process.

Commuter Benefits

How your commuter benefits work

WageWorks Commuter Benefit

The Commuter Benefit is a pre-tax benefit account used to pay for public transit — including train, subway, bus, ferry and eligible van pool — and qualified parking as part of your daily commute to work.

- Save an average of 30 percent on public transit and parking as part of your daily commute to work.
- Easy to use — download a free mobile app and manage your account with your mobile device.
- No waiting — sign up any time to start saving — and no "use it or lose it" as long as you're enrolled.

How it works

Simply decide how much to contribute up to the allowed monthly limit. Funds are withdrawn from your paycheck for deposit to your account before taxes are deducted. Pause or cancel contributions to your account at any time. There's no "use it or lose it" as long as you're enrolled in the program.

How you use it

Use a variety of convenient payment methods associated with your account. Buy transit and parking passes and vouchers using the WageWorks Commuter Card. Pay your parking provider or automatically load monthly transit passes directly from your account. Get reimbursed for eligible commuting expenses you pay out of pocket.

How you manage it

Manage your account via a secure website on any computer or mobile device that's connected to the Internet or via the WageWorks EZ Receipts® mobile app. Orders must be placed by the 10th of the month and will be effective for the next month. For example, if you order a transit pass by December 10, you will receive a pass to be used for the month of January in the mail at your home address before the end of December.

It is important to understand that the one-month lag to place an order also applies to canceling orders, regardless of the reason for the cancellation. Cancellations placed by the 10th of the month will be effective the first of the following month. For example, if you cancel a transit pass on WageWorks' website on December 9, the cancellation will apply to the January pass. If you cancel the pass on December 11, the cancellation will apply to the February pass. Once the order deadline has passed, you will be responsible for payment for your order, so you need to consider this cancellation provision before placing any orders.

How much you can contribute

Contribute pre-tax up to a maximum of $130 per month for transit and eligible van pools and $250 per month for qualified parking. If your order exceeds the pre-tax limits, the balance will be deducted from your paycheck on a post-tax basis. These limits are subject to change each year.

For more information, log on to **wageworks.com/mycommute**.

Employee assistance program/ Work-Life Solutions

Employee assistance program/Work-Life Solutions

The health and group benefits program includes an employee assistance and work-life program, also known as Work-Life Solutions. This program — offered through Anthem — provides confidential, 24-hour access to resources and referrals for you and your family.

Eligibility

All active employees have access to Work-Life Solutions. If you are eligible for Work-Life Solutions benefits, you and your household members (those who share your residence) may begin accessing those benefits immediately after you are hired. You and your household members will continue to be eligible to access the benefits until you terminate employment. Once you terminate employment, you and your household members may continue to access the benefits for up to 18 months (or 29 months if you would qualify for a disability extension under COBRA, as described earlier in this SPD). Your household members may also continue to access the benefits for 36 months after your death, or after the household member ceases to be a household member (for example, after a divorce).

How the program works

You or a household member may call Work-Life Solutions at any time. Services include:

- Legal and financial consultation, including a 30-day tax assistance program during tax season
- Assisted searches for things such as child or elder care, doggie daycare, vacation planning, etc.
- Free ID monitoring and recovery services
- Access to a savings center for discounts on everything from dining out and travel to electronics
- Free counseling sessions through a nationwide network of providers along with on-site services available at the wellness clinic in Dublin, OH. Issues commonly addressed could include:
  - Alcohol/drug dependence
  - Depression
  - Emotional troubles
  - Parent-child relationship problems
  - Marital and family relationship problems
  - Stress

Work-Life Solutions provides up to eight visits per problem with a network provider. At any point during the counseling sessions, your Work-Life Solutions counselor can refer you to another professional for more in-depth counseling. You are then responsible for any outside counseling costs. However, some of the expense may be covered under the Cardinal Health medical plan, or you may be able to use your healthcare flexible spending account to reimburse the expenses.

This resource is available through the Internet at **anthem.com/wls** or by contacting Work-Life Solutions directly at **855.383.7230**. You also may reach Work-Life Solutions through the myHR Service Center at **866.471.7867**.

Severance Benefit Program

Severance Benefit Program

The Severance Benefit Program is designed to give Cardinal Health, or a successor organization, a basis to provide severance benefits to eligible employees who incur a termination of employment with Cardinal Health (as described in the "Eligibility" section below).

Eligibility

Generally

If you are a regular, active employee who averages at least 20 hours worked per week for Cardinal Health immediately prior to your termination of employment, are eligible as described below and do not fall into one of the ineligible categories described below, you will generally be eligible to participate in the Severance Benefit Program. Average hours worked is calculated on a sliding 12-month period of employment, or your total period of employment if less than 12 months.

There are two ways you may become eligible for a severance benefit or benefits under the Severance Benefit Program (severance benefit):

- Due to a Reduction in Force (a RIF); or,
- If the plan administrator determines you are eligible for a severance benefit.

RIF severance benefit eligibility

To be eligible for a severance benefit due to a RIF (a RIF severance benefit), your employment must terminate because of a RIF and you must continue to work for Cardinal Health until the date it specifies. A RIF occurs when Cardinal Health:

- Eliminates two or more job positions at the same time, which leads to the termination of at least two employees of Cardinal Health; and,
- Designates in a written notice that such elimination of job positions and terminations is a RIF.

If you are part of a RIF and eligible to retire at the time your employment would have otherwise terminated in connection with the RIF, you are still eligible to receive a RIF severance benefit.

Discretionary severance benefit eligibility

The plan administrator has the discretion to determine whether you will receive a severance benefit on account of your termination of employment with Cardinal Health, regardless of whether such termination is due to a RIF (a discretionary severance benefit). If the plan administrator determines you are eligible for a discretionary severance benefit, you will receive a notice detailing your discretionary severance benefit.

Receipt of severance benefit not automatic

If you are otherwise eligible for a severance benefit, you may receive it only if:

- The plan administrator determines you were terminated by Cardinal Health for a reason other than "cause" (as defined on page 208);
- You sign and deliver to Cardinal Health, within the amount of time specified by the plan administrator, a severance agreement and general release provided by Cardinal Health and satisfactory in form and substance to it (Severance Agreement); and,
- You do not revoke any part of the Severance Agreement.

Receipt of all or any portion of a severance benefit also may be conditioned on such other requirements as the plan administrator may specify. At the sole discretion of the plan administrator, your Severance Agreement may contain terms and provisions that are different from the Severance Agreements provided to other employees.

Release requirement

Under the Severance Agreement, you will be required to release any and all legal claims you have or may have against Cardinal Health and all related entities and persons through the date on which the Severance Agreement is signed. The release of claims will include, without limitation, any claims arising out of your employment with, or separation of employment from, Cardinal Health. The release of claims will not affect your eligibility for Workers' Compensation benefits or any vested rights you have under any company employee benefit plan. At the sole discretion of the plan administrator, your Severance Agreement may contain release terms that are different from the release terms provided in the Severance Agreements of other employees.

When you receive your severance benefit

The plan administrator will determine the date by which you must return your signed Severance Agreement, and the Severance Agreement will specify such date and the date on which your severance benefit will be paid and/or start. The date by which you must return your signed Severance Agreement will not be more than 90 days after your last day worked. Also, note if you are a "specified employee," generally defined as one of the top 50 officers by pay, the payment of some or all of your severance benefit may have to be delayed until six months after the date of your separation from service in certain circumstances in order to comply with Section 409A of the Code. If this required delay applies to you, it will be explained and included in the terms of your Severance Agreement.

Ineligible employees

Notwithstanding that you may meet other eligibility criteria, unless otherwise determined by the plan administrator, you will not be eligible to receive a severance benefit if you:

- Are not a regular, active employee of Cardinal Health in good standing on the date of your termination of employment;
- Are covered by a collective bargaining agreement;
- Voluntarily resign your employment with Cardinal Health;

- Are terminated from employment with Cardinal Health for "cause" (as defined below);
- Are on disability leave on the date when your employment with Cardinal Health terminates;
- Have an employment agreement with Cardinal Health that contains a severance pay or similar provision;
- Are offered comparable employment with Cardinal Health or one of its related companies, divisions or business units, or with a successor organization, with any affiliated company or with an unrelated third-party purchaser of all or substantially all of the assets of Cardinal Health or one of its related companies, divisions or business units; or,
- Do not timely sign and deliver the Severance Agreement, or revoke any part of, or breach any obligation under, the Severance Agreement.

For purposes of the Severance Benefit Program, "cause" means you engaged in one or more of the following:

- Neglect or misconduct in the performance of your employment duties and responsibilities;
- A material breach of fiduciary duty;
- Conduct that could injure the integrity, character or reputation of Cardinal Health; or,
- Unsatisfactory job performance.

The plan administrator, in its sole discretion, determines whether you are terminated for cause.

If, based on information received after your employment terminates, the plan administrator discovers that you could have been terminated for cause, you will be treated as having been terminated for cause for purposes of the Severance Benefit Program.

How severance benefits operate

Forms of severance benefits

RIF severance benefit

Subject to all of the eligibility requirements previously listed (including, without limitation, the requirements that you execute and not revoke a Severance Agreement), if your employment terminates due to a RIF and you are eligible for a severance benefit, you will receive a cash amount equal to two weeks of your weekly base pay. For purposes of the Severance Benefit Program, "weekly base pay" means your regular weekly base salary or hourly pay as of your employment termination date, excluding all additional amounts such as any bonuses, vacation, sick leave, overtime, commissions or any other compensation or benefits. In addition, the plan administrator may grant you a discretionary severance benefit, as described below.

Discretionary severance benefit

The plan administrator has full discretion to determine whether you will receive a discretionary severance benefit and, if so, what will comprise your discretionary severance benefit. For instance, a discretionary severance benefit may include, but is not limited to:

- A lump-sum cash payment;
- A continuation of your salary;
- Payment of all or a portion of your annual bonus;
- Outplacement services; and/or,
- A continuation of certain group health benefits that you were receiving at the time of your termination of employment (Welfare Benefit Continuation).

A discretionary severance benefit may be granted in conjunction with a RIF severance benefit or on a stand-alone basis. If Cardinal Health announces enhanced severance benefits in connection with a RIF, such enhanced benefits are considered part of a discretionary severance benefit and are subject to all the requirements related to discretionary severance benefits described in this document.

Payment and provision of severance benefits

If the plan administrator determines that you are to receive a severance benefit, you will be provided with a Severance Agreement that will specify your severance benefit, when your severance benefit will be paid and/or provided and any conditions on payment of such severance benefit. Your entitlement to receive the severance benefit described in the Severance Agreement will not become binding until you execute and return such Severance Agreement, and it becomes irrevocable by you. At the sole discretion of the plan administrator, your Severance Agreement may include severance benefits that are different from the severance benefits contained in the Severance Agreements provided to other employees.

If your severance benefit includes Welfare Benefit Continuation, unless your Severance Agreement provides otherwise:

- During the course of such Welfare Benefit Continuation, you will generally be responsible to pay the portion of premiums that you would have been responsible to pay if you remained actively employed by Cardinal Health; and,
- Any Welfare Benefit Continuation will run concurrent with any COBRA continuation coverage pursuant to Section 601 through 609 of ERISA.

Severance benefit reduction and termination

If your termination of employment is deemed to be covered by the Worker Adjustment and Retraining Notification Act or any similar statute or local law (the WARN Act), any severance benefit that may be payable pursuant to the Severance Benefit Program shall be considered pay in lieu of notice under the WARN Act. Accordingly, any severance benefit that is payable pursuant to the Severance Benefit Program shall, to the extent permitted by law, offset any purported or potential damages or liability of Cardinal Health for insufficient notice under the WARN Act.

If the plan administrator determines that you are not eligible for a severance benefit because it learns that you could have been terminated for cause, then the plan administrator may cancel or stop the payment or provision of any or all of your severance benefit. In addition, if you had already begun to receive a severance benefit under such circumstances, the plan administrator may require that you reimburse Cardinal Health, on a gross basis, for the amount of any severance benefit you already received. Your severance benefit also may be cancelled or stopped if you become re-employed by Cardinal Health or subsequently provide services to Cardinal Health.

The gross amount of any severance benefit payment will be reduced by any amount of taxes required to be withheld by Cardinal Health pursuant to any applicable federal, state or local law or regulation.

Death while receiving a severance benefit

If you die:

- After signing your Severance Agreement, but before you begin to receive your severance benefit; or,
- While receiving a severance benefit,

then your severance benefit will be paid to your beneficiary, as designated on a form prescribed by, and delivered to, the plan administrator during your lifetime. In the absence of a valid beneficiary designation, or if the designated beneficiary has predeceased you or dies at the same time as you, your severance benefit will be paid to your estate.

Program administration

The Severance Benefit Program is administered by Cardinal Health. The plan administrator has the overall responsibility for the administration and operation of the Severance Benefit Program. The plan administrator has the sole authority to administer the Severance Benefit Program subject to its terms, including, but not limited to, the following:

- To determine whether an employee satisfies the eligibility requirements for a severance benefit;
- To award a severance benefit to an employee determined to be eligible for an award;
- To deny a severance benefit to an otherwise eligible employee;
- To determine what, if any, severance benefit should be paid or provided;

- To determine if cause exists;
- To determine whether a severance benefit should be reduced or repaid to Cardinal Health; and,
- To take any other action with respect to any matters related to the plan for which the plan administrator is responsible and to make all other decisions and determinations, including factual determinations, as may be required under the terms of the Severance Benefit Program or as the plan administrator may deem necessary or advisable for the administration of the Severance Benefit Program.

The plan administrator has the complete authority, in its sole and absolute discretion, to correct any defect, supply an omission, reconcile any inconsistency and construe and interpret the terms of the Severance Benefit Program (and any related or underlying documents or policies). All such interpretations and determinations by the plan administrator shall be final, conclusive and binding on all persons, including Cardinal Health and its related companies, an employee, former employee, beneficiary and any other person or entity claiming rights under the Severance Benefit Program. The plan administrator may modify, or take further action not consistent with, its prior action.

Other severance benefit information you should know

Severance benefits unfunded; not guarantee of employment

The severance benefits are intended to be part of an unfunded welfare benefit plan for purposes of ERISA, and a severance pay arrangement within the meaning of Section 3(2)(B)(i) of ERISA. Payments of severance benefits are made out of the Cardinal Health general assets. The Severance Benefit Program is not intended to be a pension plan as described in Section 3(2)(A) of ERISA. Also, the Severance Benefit Program is not a contract of employment, nor does it affect your status as an at-will employee.

Prior severance benefits and plans

The Severance Benefit Program supersedes all prior severance pay plans, policies, practices or arrangements of Cardinal Health or any of its related companies, divisions or business units that may have previously existed with respect to employees of Cardinal Health who are covered by the Severance Benefit Program. This means that you will not be able to receive a severance benefit under any other prior severance plans of Cardinal Health.

Impact on other benefits

Unless otherwise provided in any relevant plan document, severance benefits under this plan are not counted as earnings for purposes of determining benefits under any 401(k), pension or other employee benefit plan maintained by Cardinal Health or any of its related companies, divisions or business units.

Assignment of severance benefit

A severance benefit payable under the Severance Benefit Program will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability that is for alimony or other payments for the support of a spouse, former spouse or

children of yours, or for any other relative of yours prior to actually being received by the person entitled to the benefit under the terms of the Severance Benefit Program; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable under the Severance Benefit Program, will be void. Cardinal Health will not in any manner be liable for, or subject to the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Severance Benefit Program.

Wellness Center

How the Wellness Center works

Dublin Wellness Center

The Wellness Center, located on the Cardinal Health Dublin campus, provides a similar type of medical care to the care you could receive from your primary care physician.

Who can use the Wellness Center

You and any dependent over the age of 2 may use the Wellness Center if you are an employee of Cardinal Health. You do not have to work on the Dublin campus or be enrolled in a Cardinal Health medical plan in order to receive care from the Wellness Center.

When you terminate employment, you and your family members may be able to continue to use the Wellness Center for a certain period of time if you elect and pay for COBRA coverage. Similarly, your spouse and children can continue to use the Wellness Center after certain events if they elect and pay for COBRA coverage. The rules applicable to COBRA for medical coverage also apply to the Wellness Center. See page 45 for details.

If you believe you are eligible to use the Wellness Center but are denied access for some reason, you can follow the claims and appeals procedure described on page 57 to request access.

How it works

Simply make an appointment by calling the Wellness Center at **614.553.3830** or accessing online scheduling at **nextmd.com/ud2/Login/Login.aspx**. Walk-ins are also welcome. You should arrive at the Wellness Center a few minutes before your scheduled appointment time to complete any necessary paperwork. You may also complete your paperwork in advance online. If your family member makes an appointment, he or she will need to provide identification and check in at the front desk before being escorted to the Wellness Center by a Cardinal Health employee.

When you arrive at the Wellness Center, you will need to provide your insurance card. The Wellness Center will bill your health plan, just like your primary care physician would do. If you do not have health insurance coverage, the Wellness Center will bill you directly.

How the Wellness Center is staffed

The Wellness Center is staffed by physician assistants and/or nurse practitioners. These providers are available to see patients by appointment Monday through Friday from 7 a.m. through 5 p.m.

What care is provided

At the Wellness Center, you can receive services similar to the services provided by your primary care physician or by doctors at other convenience clinics. The medical professionals will be able to:

- Administer first aid;
- Provide physicals, immunizations and other preventive care services;
- Treat acute illnesses such as colds and flu;
- Write prescriptions; and,
- Provide other chronic condition treatments.

The medical professionals will not be able to fill prescriptions or perform lab work.

How your information is maintained and protected

The Wellness Center has the responsibility to maintain a confidential medical file for you. With your written permission, the Wellness Center can transfer medical records back and forth with your personal physician, therefore establishing an important working relationship with your doctor. Your medical file helps to ensure continuity of medical care for you, and confidentiality laws are followed to protect the medical information in your file.

Retiree medical coverage

Retiree medical coverage

What you are eligible for

If you have 10 or more years of service with Cardinal Health and its affiliated companies, and you retire after reaching age 55,* you are eligible to continue medical coverage under the Cardinal Health program (provided you were covered under the medical program at the time of your retirement). You also have the option to elect medical coverage for your eligible dependents, provided they also are covered under the medical program at the time of your retirement.

The term "eligible dependents" refers to individuals who meet the following criteria:

- Your "spouse" refers to your legal husband or wife, including a common-law spouse in states that recognize common-law marriages;
- Your domestic partner (same sex or opposite sex);
- Your "child(ren)" refers to:
  - Your unmarried child(ren) up to age 26;
  - Your children (up to age 26) of your domestic partner;
  - Your unmarried child(ren) over age 26 who are totally and permanently disabled due to a mental or physical disability; and,
  - Your legally adopted child(ren), stepchildren and children for whom you are the legal guardian or for whom your domestic partner is the legal guardian.

If you are eligible for retiree medical coverage, you will first be offered COBRA coverage for a period of 18 months. At the conclusion of your COBRA period, you will be offered retiree medical coverage that you may continue up to age 65. If you do not elect retiree medical at the conclusion of your COBRA period, you will not be allowed to enroll in retiree medical at a future date. You must generally enroll yourself and all dependents that you want to cover when you first enroll in COBRA.

* *Employees impacted by a designated Reduction in Force program may be eligible for an additional 24 months of age and/or service credit in order to meet the retiree medical program's eligibility requirements. You must be at least age 53 and have at least eight years of service for this to apply.*

When you initially enroll under COBRA, you may only elect the plan you are covered under as an active employee. For example, if as an active employee you are enrolled in the Anthem CDHP with Funded HRA, you must remain in this plan under COBRA. At the conclusion of the 18-month COBRA period, you will be given the opportunity to enroll in retiree medical at the retiree rate. Again, you can only elect the plan you are currently enrolled in under COBRA. You can change medical plans **only** during the plan's annual enrollment period. You can add or drop covered dependents during annual enrollment or if you experience a qualified life event. However, the reason for adding a dependent — either due to a qualified life event or during annual enrollment — must qualify under the special enrollment rules under HIPAA.

Coverage categories

You can choose from four levels of coverage:

- You only
- You + spouse or domestic partner
- You + child(ren)
- You + family

When coverage ends

Your coverage ends when you become Medicare-eligible, or the end of the month before you turn age 65, whichever comes first. The coverage you elect for your eligible dependents continues until they lose eligibility, turn age 65 or become Medicare-eligible — whichever comes first. If you choose to drop coverage for yourself or a dependent after the enrollment period, you will not be able to re-elect coverage at a later date. Also, if you fail to pay any required premium for the coverage you have elected within 30 days of the date it was due, your and your dependents' coverage will end.

Your healthcare options

The following types of medical programs may be offered — Anthem CDHP with Funded HSA, Anthem CDHP with Funded HRA, Anthem Basic CDHP with HSA, Anthem CDHP Out of Area with Funded HRA and the Kaiser Permanente option (if available in your area). The programs available to you also depend on your home zip code.

Here is a look at the options:

	Deductible individual/family		Co-insurance plan pays/you pay after deductible		PCP required?	Doctor's office co-payment	Out-of-pocket maximum individual/family	
	In-network	Out-of-network	In-network	Out-of-network			In-network	Out-of-network
Anthem CDHP with Funded HRA*	$2,500/ $5,000	$5,000/ $10,000	80 percent/ 20 percent	60 percent/ 40 percent	No	N/A	$3,000// $6,000	$6,000/ $12,000
Anthem CDHP with Funded HSA**	$1,500/ $3,000	$3,000/ $6,000	80 percent/ 20 percent	60 percent/ 40 percent	No	N/A	$2,500//$ 5,000	$5,000/ $10,000
Anthem Basic CDHP with HSA**	$4,000/ $8,000	$8,000/ $16,000	80 percent/ 20 percent	60 percent/ 40 percent	No	N/A	$5,000/ $10,000	$10,000/ $20,000
Anthem CDHP Out of Area with Funded HRA*	$2,500/ $5,000	N/A	80 percent/ 20 percent	N/A	No	N/A	$3,000// $6,000	N/A
Kaiser Permanente	Generally, none	Varies by plan	N/A	N/A	Generally, yes	Generally, $20	Varies by plan	Varies by plan

*You will receive an annual HRA contribution from Cardinal Health, provided you re-enroll in the plan each year.

**No Cardinal Health contribution will be provided. However, you may still make contributions to the HSA plan — until you become enrolled in Medicare — provided you re-enroll in the plan each year.

Anthem CDHP with Funded HRA

If you are a participant in this plan as an active employee and choose to remain in the plan as a retiree, your HRA balance, if any, will transfer into your retiree medical plan. At the end of each year, HRA balances are capped at 1.5 times the plan's out-of-pocket maximum. Any amounts above this cap are transferred to a Healthy Future Fund account in your name. In other words, you can use your HRA and your Healthy Future Fund account to pay for eligible medical expenses.

Anthem CDHP with Funded HSA

If you are a participant in this plan as an active employee and choose to remain in the plan as a retiree, your HSA balance will transfer into your retiree medical plan. Once you retire, you will no longer receive any company contributions; however, you will be able to contribute to your account until you become enrolled in Medicare, provided you re-enroll in the plan each year.

Anthem Basic CDHP with HSA

If you are a participant in this plan as an active employee and choose to remain in the plan as a retiree, your HSA balance will transfer into your retiree medical plan. The Anthem Basic CDHP with HSA offers the tax-saving advantages of an HSA and lower premiums, but provides much less coverage and significantly higher deductibles and out-of-pocket maximums than the other plans. Once you retire, you will be able to contribute to your HSA account until you become enrolled in Medicare, provided you re-enroll in the plan each year.

Anthem Out of Area CDHP with Funded HRA

Cardinal Health also offers an out-of-area option to retirees who live in an area that is not covered by the other Anthem CDHP plans. If you are a participant in this plan as an active employee and choose to remain in the plan as a retiree, your HRA balance, if any, will transfer into your retiree medical plan. At the end of each year, HRA balances are capped at 1.5 times the plan's out-of-pocket maximum. Any amounts above this cap are transferred to a Healthy Future Fund account in your name. In other words, you can use your HRA and your Healthy Future Fund account to pay for eligible medical expenses.

Kaiser Permanente Plan

Cardinal Health offers Kaiser Permanente plans in certain locations. If you enroll in a Kaiser plan, you and your dependents must receive care from network providers to receive benefits. No benefits are paid if you use non-network providers. When you use network providers, preventive care is covered at 100 percent with no deductible to meet. For other types of services, you must meet your deductible before the plan begins to pay benefits. Once you reach your deductible, the plan pays 80 percent of the cost and you pay the remaining 20 percent until you reach the plan's out-of-pocket maximum. There is a separate schedule for prescription drugs. If a Kaiser plan is offered where you live and you are eligible for coverage, it will be listed on the myHR website and in the enrollment overview you receive during the annual enrollment period.

Prescription drug coverage

Getting prescription drug coverage is easy. It is included when you elect any of the Anthem CDHP medical plan options or a Kaiser plan — you do not have to make a separate election. It features both retail prescription coverage and a mail order program.

For the Anthem CDHP plans, prescription drug coverage is administered through CVS Caremark. You can have a prescription filled at a participating pharmacy or through the mail order program. If you have prescriptions you take on a regular basis — such as a medication for asthma or high blood pressure — you can save money by taking advantage of the mail order prescription program. Through this program, you can order up to a 90-day supply of medication through the mail.

To locate a participating pharmacy or determine coverage of a prescription, please visit CVS Caremark at **caremark.com**, or contact customer service at **855.559.1389**.

Under the Kaiser plans, you will obtain your prescriptions through the Kaiser pharmacy of your choice.

Specialty pharmacy

Specialty prescription benefits are provided through OncoSourceRx. OncoSourceRx provides members with complex chronic or genetic conditions enhanced services while keeping costs as low as possible.

In the Anthem CDHP HRA and HSA plans, you can use your HRA or HSA to pay for your drugs. Once these funds have been used, drug costs are subject to the applicable deductible and co-insurance. Once you reach the applicable out-of-pocket maximum, your prescriptions will be covered at 100 percent.

To find out which specialty prescriptions are covered through OncoSourceRx, please contact them at **888.662.6779** to speak with a pharmacy technician.

For more information about your medical options

For more information about your medical options, please see the medical section of the myHR website.

Administering the plans

Administrative information

The Cardinal Health group benefits plan is governed by ERISA (the Employee Retirement Income Security Act of 1974). This section provides important legal and administrative information you may need, including:

- How to identify the plan and each component of the plan;
- Information about the administrators (e.g., carriers and insurance companies) that provide or administer benefits and how to contact them;
- Who the plan administrator is and how to contact the plan administrator; and,
- Other important information you may need to know regarding your health and welfare benefits.

If you have any questions about the administrative details surrounding the plan, you can obtain online information via the myHR website at **hr.cardinalhealth.com**, or you can contact the myHR Service Center at **866.471.7867**.

Official plan name and plan number

When dealing with or referring to your health and welfare benefits (e.g., in the event of a claim appeal or other correspondence), you will receive a more rapid response if you identify the plan fully and accurately. The official name of the plan is the Cardinal Health, Inc. Group Benefit Plan. The plan number is 505.

Benefit type and addresses of the administrators/insurance carriers

The following chart includes the address of each administrator.

<table>
<tr><th>Benefit type</th><th colspan="3">Addresses of the administrators/insurance carriers</th></tr>
<tr><td>Medical</td><td>Anthem CDHP with Funded HRA
Anthem CDHP with Funded HSA
Anthem Basic CDHP with HSA
Anthem CDHP Out of Area with Funded HRA

844.256.4818
anthem.com</td><td>Kaiser Permanente
Northern and Southern California: 800.464.4000
Colorado: 800.632.9700
Georgia: 800.611.1811
Hawaii: 800.966.5955
Maryland: 800.777.7902
kaiserpermanente.org</td><td>Cigna Global Health Benefits
P.O. Box 15050
Wilmington, DE
19850-5050
USA

800.441.2668
302.797.3100 (collect)
cignaenvoy.com</td></tr>
<tr><td>Prescription drugs</td><td colspan="3">CVS Caremark Pharmacy Service Center
P.O. Box 52136
Phoenix, AZ 85072-2136

855.559.1389
caremark.com</td></tr>
<tr><td>Healthy Lifestyles wellness benefits</td><td colspan="3">StayWell
3000 Ames Crossing Road
Suite 100
St. Paul, MN 55121-2520
StayWell Helpline (Health assessment, biometric screenings and flu shots, health advisor calls, health coaching)
healthylifestyles.staywell.com or 866.280.9835</td></tr>
<tr><td>Dental</td><td>Basic and Plus Options
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

800.942.0854
metlife.com/mybenefits</td><td colspan="2">Cigna Global Health Benefits
P.O. Box 15050
Wilmington, DE
19850-5050
USA
800.441.2668
302.797.3100 (collect)
cignaenvoy.com</td></tr>
<tr><td>Vision</td><td>EyeMed Vision Plan
P.O. Box 498488
Cincinnati, OH
45249-8488

866.723.0514
eyemedvisioncare.com</td><td colspan="2">Cigna Global Health Benefits
P.O. Box 15050
Wilmington, DE
19850-5050
USA
800.441.2668
302.797.3100 (collect)
cignaenvoy.com</td></tr>
</table>

Benefit type	Addresses of the administrators/insurance carriers
Life and AD&D • Basic employee life • Supplemental employee life • Dependent life (spouse/domestic partner and/or your dependents/dependents of domestic partner) • Basic employee AD&D • Supplemental AD&D	**Metropolitan Life Insurance Company** Group Life Claims Attn: Team J P.O. Box 1600 Scranton, PA 18505-6100 **800.638.6420** Prompt #2 **mybenefits.metlife.com**
Business travel accident	**The Hartford** P.O. Box 14297 Lexington, KY 40512-9802 **888.563.1124**
Disability • Basic short-term disability • Basic long-term disability • Supplemental short-term disability • Supplemental long-term disability	**The Hartford** Benefit Management Services Minneapolis Disability Claim Office The Hartford P.O. Box 14305 Lexington, KY 40512-4305 The Cardinal Health phone line: **888.445.0040** **thehartfordatwork.com**
Flexible spending accounts	**WageWorks** P.O. Box 69310 Harrisburg, PA 17106-9310 **877.WAGEWORKS** (877.924.3967) **wageworks.com**
Wellness Center	**Dublin Wellness Center** 7200 Cardinal Place Dublin, OH 43017 **614.553.3830** **614.356.4014 (pharmacy)**
COBRA	**Correspondence and payments:** Cardinal Health, Inc. P.O. Box 0579 Carol Stream, IL 60132-0579 **866.866.8525** **resources.hewitt.com/cardinalhealth**

Plan sponsor and administrator

Cardinal Health sponsors the plan and is the official plan administrator. If you have questions that the myHR Service Center cannot answer satisfactorily, you may contact the plan administrator at:

Cardinal Health
Attn: Benefits Department
7000 Cardinal Place
Dublin, OH 43017
614.757.5000

How to reach the myHR Service Center

The myHR Service Center is your primary source of information about the plan. The myHR Service Center can be reached at:

myHR Service Center
7000 Cardinal Place
Dublin, OH 43017
866.471.7867

Employer identification number

The Cardinal Health employer identification number (EIN) is 31-0958666.

Plan year

The plan year for recordkeeping and accounting purposes is January 1 through December 31.

Agent for service of legal process

The agent for service of legal process on the plan is:

Cardinal Health
Attn: Benefits Department
7000 Cardinal Place
Dublin, OH 43017
614.757.5000

Legal process on the plan also may be served on the plan administrator.

Permanency of the plan

Cardinal Health intends to continue the plan indefinitely. However, Cardinal Health reserves the right to make changes to the plan, including the retiree medical program, at any time for any reason, or even terminate the plan or any of the coverages provided under the plan. Changes to the plan, including changes to the retiree medical benefit program, would apply to all plan participants, even those already retired. You have the right to convert or take with you certain coverages if your group coverage ends. Your right to continue certain benefits under the plan is explained in more detail starting on page 43.

Official plan documents

This SPD serves as the official plan summary for the Cardinal Health group benefits plan. Every attempt has been made to make this as detailed an SPD as possible. However, if this SPD inadvertently says anything that disagrees with the official contracts and plan documents that govern each component of the plan, the terms of the contracts and plan documents control and determine your benefits. The plan is to be interpreted and administered in accordance with the plan documents, insurance contracts and other governing documents, and this SPD is merely a summary of those documents and does not contain all of the plan's provisions and details.

Disclosure of grandfather status

Cardinal Health believes that the following plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plans identified below may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost share. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

- Cigna Global Health Benefits Plan

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Cardinal Health
Attn: Benefits Department
7000 Cardinal Place
Dublin, OH 43017
614.757.5000

You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at **866.444.3272** or **dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Patient protection disclosure

The Kaiser Permanente plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Kaiser network and who is available to accept you or your family members. Until you make this designation, Kaiser will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at:

Kaiser Permanenete

Northern and Southern California: **800.464.4000**

Colorado: **800.632.9700**

Georgia: **800.611.1811**

Hawaii: **800.966.5955**

Maryland: **800.777.7902**

kaiserpermanente.org

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser, Anthem, Cigna International or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services following a pre-approved treatment plan or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Kaiser of Colorado at **800.632.9700**, Kaiser of Georgia at **800.611.1811**, Kaiser of Hawaii at **800.966.5955** or Kaiser of Maryland at **800.777.7902** or visit **kaiserpermanente.org**.

Your ERISA rights

As a participant in the health and group benefits plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to the following.

Receive information

- Examine (without charge) at the plan administrator's office and at other specified locations — such as work sites and union halls — all plan documents. These may include insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports (Form 5500 Series) available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report and an updated summary plan description (SPD) by writing to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue group health plan coverage

You can continue healthcare coverage for yourself, your spouse/domestic partner or your dependents/dependents of domestic partner if there is a loss of coverage under the plan as a result of a qualifying event as defined by law. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the program for the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from the health plan or the health insurance issuer when you lose coverage under a health plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your ERISA rights.

Enforce your rights

If your claim for a 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 your ERISA rights. For instance:

- If you request a copy of the plan documents or the latest annual report and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits, which is denied or ignored — in whole or in part — you may file suit in a state or federal court.
- If you disagree with the plan's decision or if the plan does not respond to your request concerning the status of a Qualified Medical Child Support Order (QMCSO), you may file suit in a federal court.
- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the plan, the court decides 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 the plan, you should contact the plan administrator. If you have any questions about the plan 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 (EBSA), 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, NW, Washington, DC 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, logging on to the Internet at **dol.gov/ebsa** or contacting the EBSA field office nearest to you.

Appendix — Anthem and Kaiser claims and appeals process

Claims Administrator

For purposes of this Appendix, the "Claims Administrator" is Anthem if you are enrolled in an Anthem option and Kaiser Permanente if you are enrolled in a Kaiser option.

Please Note: You may have additional rights for addressing claims and disputes under the Kaiser coverage. Please refer to the Kaiser materials for additional details.

Your right to appeal

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission within a reasonable period of time, but no later than 30 days (15 days for a pre-service claim and 72 hours for an urgent care claim) after the Claims Administrator receives your claim; and,
- You are entitled to a full and fair review of the denial or rescission.

The written notice of the denial or rescission may be delayed up to 15 days (unless it is an urgent care claim) if an extension is necessary due to matters beyond the plan's control. You will be notified before the end of the initial period why the extension is necessary and when the plan expects to make a decision. If you failed to submit necessary information, you will have 45 days to provide it.

The procedures the Claims Administrator will use satisfy the minimum requirements for a full and fair review under applicable federal regulations.

Notice of adverse benefit determination

If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved (including the date of service, the healthcare provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);

- The specific reason(s) for the denial (including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim);
- A reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- A description of any additional material or information needed to perfect your claim;
- An explanation of why the additional material or information is needed;
- A description of the plan's internal and external review procedures and the time limits that apply to them, including information regarding how to initiate an appeal and a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- Information about any internal rule, guideline, protocol or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claim denial decision;
- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claim denial decision; and,
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- The Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and,
- The Claims Administrator may notify you or your authorized representative orally and then furnish a written notification within three days.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent).

For claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at the number shown on your ID card and provide at least the following information:

- The identity of the claimant;
- The date(s) of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits is sought; and,
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

> **For Anthem Coverage:** Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 33200, Louisville, Kentucky 40232-3200
>
> **For Kaiser Coverage:** See your Kaiser materials.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. "Relevant" means that the document, record or other information:

- Was relied on in making the benefit determination; or,
- Was submitted, considered or produced in the course of making the benefit determination; or,
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or,
- Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale. The new evidence and rationale will be provided sufficiently in advance of the date on which the appeal notice is required to be provided to give you the opportunity to respond prior to that date.

How your appeal will be decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational or not medically necessary, the reviewer will consult with a healthcare professional who has the appropriate training and experience in the medical field involved in making the judgment. This healthcare professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the outcome of the appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of adverse benefit determination" in addition to a statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Voluntary second-level appeals

If you are dissatisfied with the plan's mandatory first-level appeal decision, a voluntary second-level appeal may be available. If you would like to initiate a second-level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first-level appeal. You are not required to complete a voluntary second-level appeal prior to submitting a request for an independent external review.

External review

If the outcome of the mandatory first-level appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law. Your appeal is eligible for external review if it is based on medical necessity or rescission.

You must submit your request for external review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an external review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator at the number shown on your ID card and provide at least the following information:

- The identity of the claimant;
- The date(s) of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits was sought; and,
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

> **For Anthem Coverage:** Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 33200, Louisville, Kentucky 40232-3200
>
> **For Kaiser Coverage:** See your Kaiser materials.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this healthcare plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the plan's final decision on the claim or other request for benefits. If the plan decides an appeal is untimely, the plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the plan. If your

appeal as described above results in an adverse benefit determination and you exhaust the required appeals process, you have a right to bring a civil action under Section 502(a) of ERISA.

We reserve the right to modify the policies, procedures and time frames in this section upon further clarification from the Department of Health and Human Services and Department of Labor.

Appendix — CVS/Caremark claims and appeals process

Claims procedure

If CVS Caremark denies a claim for prescription drug benefits in whole or in part, you have a right to a full and fair review:

- You will be provided with a written notice of the denial or rescission within a reasonable period of time, but no later than 30 days (15 days for a pre-service claim and 72 hours for an urgent care claim) after CVS Caremark receives your claim; and,
- You are entitled to a full and fair review of the denial or rescission.

The written notice of the denial or rescission may be delayed up to 15 days (unless it is an urgent care claim) if an extension is necessary due to matters beyond the plan's control. You will be notified before the end of the initial period why the extension is necessary and when the plan expects to make a decision. If you failed to submit necessary information, you will have 45 days to provide it.

Notice of adverse benefit determination

If your claim is denied, CVS Caremark's notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved (including the date of service, the healthcare provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- The specific reason(s) for the denial (including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim);
- A reference to the specific plan provision(s) on which CVS Caremark's determination is based;
- A description of any additional material or information needed to perfect your claim;
- An explanation of why the additional material or information is needed;
- A description of the plan's internal and external review procedures and the time limits that apply to them, including information regarding how to initiate an appeal and a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- Information about any internal rule, guideline, protocol or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;

- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and,
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving medically urgent status/concurrent care:

- CVS Caremark's notice will also include a description of the applicable medically urgent status/concurrent review process; and,
- CVS Caremark may notify you or your authorized representative orally and then furnish a written notification within three days.

Your right to appeal

Appealing a denied claim

If CVS Caremark denies a claim for prescription drug benefits in whole or in part, you have a right to a full and fair review.

Appeal procedures

Appealing an adverse benefit determination (prescription drugs)

Right of appeal

You or your authorized representative, if you have designated one, have the right to one full and fair review of a denial, reduction, termination of or failure to provide or make payment (in full or in part) for a prescription drug benefit under the plan, including prior approval claims (e.g., a failure to authorize a medication upon request), pre-service claims (e.g., a claim for a medication that is conditioned on the approval of the benefit in advance of obtaining the requested medical care or service), and post-service claims.

For pre-service claims, you or your authorized representative have the right to further appeal CVS Caremark's decision and request an additional second-level medical necessity review that will be conducted by an independent review organization (IRO). Second-level appeals must be received within 180 days of the initial appeal denial, and should be submitted in writing along with any documentation that will support your appeal, such as a letter from your physician describing why the requested medication is necessary, clinical notes, test results or any other supporting documentation.

For appeals involving a medically urgent situation, you may request an expedited appeal. To do so, please call CVS Caremark at **866.443.1183**.

For appeals that are not a medically urgent situation, you must make your request for a review in writing. All appeals must be made within 180 days from the date you are notified of the adverse decision.

What to include in your appeal

You must submit all relevant information with your initial appeal, including the reason for your appeal. This includes written comments, documents or other information in support of your appeal. You must also submit:

- The name of the person for whom the appeal is being filed;
- Your CVS Caremark identification number;
- Your date of birth;
- A written statement of the issue(s) being appealed;
- The drug name(s) being requested; and,
- Written comments, documents, records or other information relating to the claim.

Where to send your appeal

All appeals should be sent to:

CVS Caremark
Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

Appeals may also be faxed to **866.443.1172**.

Review of appeal

During its prior approval review, first-level review of the appeal of a pre-service claim or review of a post-service claim, CVS Caremark will:

- Take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable plan documents;
- Follow reasonable procedures to ensure that the applicable plan provisions are applied to you in a manner consistent with how such provisions have been applied to other similarly situated persons; and,
- Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual).

If you appeal CVS Caremark's denial of a pre-service claim and request an additional second-level medical necessity review by an IRO, the IRO shall:

- Consult with an appropriate healthcare professional who was neither the professional, nor a subordinate of the professional, who was consulted in connection with the initial adverse benefit determination.
- Identify the healthcare professional, if any, whose advice was obtained on behalf of the plan in connection with the adverse benefit determination.
- Provide for an expedited review process for a medically urgent situation.

Upon request and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination. Any new information or rationale gathered or relied upon during the appeal process will be provided to you and you will have the opportunity to respond or provide additional information.

Decision on appeal

CVS Caremark will notify you of its decision within the time frames described below. You may not start legal action against the plan until you have exhausted the internal appeal procedure.

The notification from CVS Caremark will include all of the information set forth in the above section entitled "Notice of adverse benefit determination" in addition to a statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Prior Approval appeal

CVS Caremark will make a decision on a prior approval request for a covered benefit within 15 days after it receives the request. If the request relates to a medically urgent situation, CVS Caremark will make a decision within 72 hours. A letter explaining CVS Caremark's determination will be faxed to your physician's office and mailed to your home.

Pre-service appeal

CVS Caremark will make a decision on a pre-service claim within 15 days after it receives the appeal. If this decision is further appealed, a decision by the independent review organization (IRO) will be made within 15 days after it receives the further appeal. If the appeal relates to a medically urgent situation, a decision on such appeal will be made within 72 hours after the appeal is received (for both the appeal to CVS Caremark and the IRO, combined).

Post-service appeal

CVS Caremark will make a decision within 60 days after it receives the appeal.

If your appeal is denied

If a decision on appeal (or on second appeal in the case of a pre-service appeal) is adverse, your right to appeal through CVS Caremark is exhausted. You have the right to bring legal action against the plan under ERISA, provided you do so within 12 months after the date you have exhausted the internal appeal process. You may not start legal action against the plan until you have exhausted the appeal process described above.

External review

After exhausting the internal appeal procedure with CVS Caremark, you have the right to request an external review of an adverse determination involving a covered service if the claim involves the use of medical judgment. The types of adverse determinations eligible for external review include determinations involving:

- The appropriate healthcare setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus a rehabilitation facility);
- Whether treatment by a specialist is medically necessary or appropriate;
- Whether treatment involves an emergency or a medically urgent situation affecting coverage or the level of co-insurance;
- The general exclusion of an item or service if the plan covers the item or service in certain circumstances based on a medical condition;
- The frequency, method, treatment or setting for a recommended preventive service, to the extent not specified in the recommendations or guidelines of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in Public Health Service Act section 2713 and its implementing regulations); and,
- Whether the plan is complying with certain provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically listed as not covered by the medical plan option you select in the plan.

Before you can request an external review, you must first exhaust CVS Caremark's internal appeal process unless doing so would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function (see "Expedited external review" below). However, if you have not received a decision regarding the adverse benefit determination within 30 days following the date of your request for an appeal, you are considered to have exhausted the internal appeal process.

Requesting an external review

You or your authorized representative may request an external review of the denied claim within four months after receiving notice of the final adverse benefit determination. The request should be made in writing and include your name, contact information (including mailing address and daytime phone number), CVS Caremark identification number and a copy of the coverage denial.

Your request for external review and supporting documentation may be mailed to:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

You may also fax your request to **866.689.3092**.

Preliminary review

Within five days of receiving a request for external review, CVS Caremark will conduct a "preliminary review" to ensure that the request qualifies for external review. In this preliminary review, CVS Caremark will determine whether:

- You were covered under the plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, you were covered at the time the prescription drug benefit was provided;
- The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for external review;
- You have exhausted the plan's internal appeal process (unless the claim is "deemed exhausted" under applicable law); and,
- You have provided all the information and forms necessary to process the external review.

Within one day after completing this preliminary review, CVS Caremark will notify you in writing that: (i) your request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

Referral to independent review organization (IRO)

If the request for external review is complete and the claim is eligible for external review, CVS Caremark will assign the request to one of the independent review organizations (IROs) with which CVS Caremark has contracted. The IRO will notify you of its acceptance of the assignment. You will then have 10 days to provide the IRO with any additional information you want the IRO to consider.

The IRO will conduct its external review without giving consideration to any earlier determinations made on behalf of the plan. The IRO may consider information beyond the records for your denied claim, such as:

- Your medical records;
- The attending healthcare professional's recommendations;
- Reports from appropriate healthcare professionals and other documents submitted by the plan, you or your treating physician;
- The terms of the plan. This information ensures that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, or national or professional medicine societies, boards and associations;
- Any applicable clinical review criteria developed and used on behalf of the plan (unless the criteria are inconsistent with the terms of the plan or applicable law); and,
- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Decision on appeal

The IRO will provide you and CVS Caremark (on behalf of the plan) with written notice of its final external review decision within 45 days after the IRO receives the request for external review.

The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount [if available], the diagnosis code and its meaning, the treatment code and its meaning and the reasons for the previous denials);
- The date the IRO received the external review assignment from CVS Caremark and the date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to the either the plan or to you;

- A statement that you may still be eligible to seek judicial review of any adverse external review determination; and,
- Current contact information, including phone numbers, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

Expedited external review process

If you have a medical condition for which the time frame for completing an internal appeal or a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you do not need to exhaust the internal appeal process to request an expedited external review of an adverse determination.

If the adverse benefit determination is that the service or treatment is investigational or experimental and the treating physician has certified in writing that delaying the service or treatment would render it significantly less effective, you or your dependent may also have the right to request an expedited external review.

You or your authorized representative may request an expedited external review by calling CVS Caremark Customer Service toll-free at the number on your CVS Caremark ID card. The request should include your or your dependent's name, contact information, including mailing address and daytime phone number, CVS Caremark identification number and a description of the coverage denial.

Alternatively, a request for expedited external review, including contact information, coverage denial description and supporting documentation, may be faxed to the CVS Caremark External Review Appeals Department at **866.689.3092**.

All requests for expedited external review must be clearly identified as "urgent" at submission.

Preliminary review

Immediately upon receipt of a request for expedited external review, CVS Caremark will determine whether the request meets the requirements described above for standard external review. Immediately upon completing this review, CVS Caremark will notify you that: (i) your request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

Referral to independent review organization (IRO)

Upon determining that your request is eligible for expedited external review, CVS Caremark will assign an IRO to review your claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically, by telephone, by fax or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review your claim without regard to any earlier determinations, and will not be bound by the decisions or conclusions reached on behalf of the plan during the internal claims and appeal process.

Timing of the external review determination

The IRO must provide you and CVS Caremark, on behalf of the plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for external review. If this notice is not provided in writing within 48 hours after providing the notice, the IRO will provide you and CVS Caremark, on behalf of the plan, with written confirmation of its decision.

Reversal of the plan's prior decision

If CVS Caremark, acting on the plan's behalf, receives notice from the IRO that it has reversed the prior determination of the appealed claim, CVS Caremark will immediately provide coverage or payment for the claim.

Appendix — EyeMed claims and appeals process

Timeframes for processing claims

First American Administrators, Inc., a third-party administrator and wholly owned subsidiary of EyeMed (hereinafter "FAA") will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Timeframes for appealing claims

If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable;
- The item of your vision coverage that you feel was misinterpreted or inaccurately applied; and,
- Additional information from your eye care provider that will assist FAA in completing its review of your appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request. The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: **513.492.3259**

FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision.

Complaint procedure

If you are dissatisfied with an EyeMed provider's quality of care, services, materials or facility or with EyeMed's plan administration, you should first call EyeMed Customer Care Center at **866.723.0514** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Enforce your rights

If your claim for vision benefits 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.

When you have completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)), see 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

Assistance with your questions

If you have any questions about your plan, you should contact the Plan Administrator. Your human resources department should be able to provide you with the name and contact information of your Plan Administrator. If you have any questions about this summary of vision care services or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

The insured benefits are underwritten by Fidelity Security Life Insurance. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at **eyemedvisioncare.com** or **866.723.0514**.

Other benefits

An introduction to your other benefits

Cardinal Health offers a range of additional benefits that complement the Group Benefit Plan's health and group benefits program. These benefits include:

- StayWell Healthy Lifestyles;
- Tobacco cessation;
- Adoption assistance;
- Tuition reimbursement;
- Bright Horizons back-up child/elder care;
- College Coach;
- International Fitness Club Network; and,
- Paid Time Off/leave.

StayWell Healthy Lifestyles Programs

Available Programs

- Health assessment
- Biometric screenings and flu shot clinics
- Health advisor services
- Health coaching
- Nicotine replacement therapy
- Healthy Lifestyles website and My Incentive Tracker
- StayWell HelpLine

Health assessment

The health assessment is a free and confidential health and lifestyle questionnaire. It covers topics such as nutrition, stress, physical activity and health history. The health assessment will provide a Lifestyle Score that can be compared year-to-year and a personalized plan you can use to take action right away.

Biometric screenings and flu shot clinics

Biometric screenings are a free opportunity for employees to track their health status year-to-year. On-site biometric screenings are offered each fall at Cardinal Health locations with 50 or more employees and include measurements for height, weight, blood pressure, total cholesterol, HDL, LDL, triglycerides and glucose. If you participate in an on-site event, you also will learn whether or not you have the risk factors for metabolic syndrome and you will have an opportunity to get a free flu shot. Employees can use a physician fax form or a home test kit in place of attending an on-site biometric screening event.

Enrolled employees can earn a discount on their annual medical premiums by completing both the biometric screening and health assessment. Enrolled employees can earn a $300 discount on their medical premiums for completing both the health assessment and biometric screening. Enrolled employees can earn an additional $150 discount for completing a qualifying healthy activity during the calendar year. Covered spouses/domestic partners can earn $150 for completing a health assessment and can earn an additional $150 for completing a qualifying healthy activity during the calendar year.

Employees hired on or after September 1 who enroll in an Anthem medical plan will automatically earn a $300 Healthy Lifestyles Kick Start Incentive.

If you enroll in an Anthem medical plan, the cost savings are applied to your premiums. Kaiser plan participants, for 2015 only, will automatically receive the incentives. Beginning in 2015, Kaiser plan participants will need to complete the Healthy Lifestyles incentive initiatives to receive the discounts for the following plan year.

Health advisor services

After completing your health assessment and biometric screening, call **866.280.9835** to talk directly with a health advisor.

The health advisor will set you up for success by providing:

- A personalized review of your health assessment results;
- Information about follow-up programs that address your personal health risks;
- An opportunity to discuss how you can earn incentives; and,
- Referrals to other Cardinal Health-sponsored Healthy Lifestyles benefits.

Health coaching

StayWell health coaching can help you define, reach and maintain your health and wellness goals. You can choose to speak with a coach over the phone, or you can request a series of educational, motivational, interactive mailings to support your behavior change.

Choose from any of the topics listed below:

- Weight management
- Blood pressure
- Cholesterol
- Exercise
- Nutrition
- Back care
- Stress management
- Tobacco cessation

Nicotine replacement therapy

When you participate in a tobacco cessation health coaching program, you can work one-on-one with a health coach to begin the process of quitting tobacco. Your health coach will offer support and encouragement while helping you to set and reach your tobacco cessation goals. In addition, Cardinal Health provides unlimited access to free nicotine replacement therapy (NRT) products, including patches, gum and lozenges. So whatever method of quitting works best for your lifestyle, Cardinal Health is there to support you every step of the way.

There are two program delivery options available in addition to free nicotine replacement therapy. Employees and covered spouses/domestic partners can enroll in a phone- or mail-based tobacco cessation program by calling StayWell at **866.280.9835**.

Please Note: You can also receive a discount on your medical premiums by completing a tobacco cessation program **within 180 days from your hire date**. Employees and covered spouses/domestic partners can complete the free tobacco cessation program through StayWell. For more information about obtaining a discount on your medical premiums, see the "How to enroll" section.

Healthy Lifestyles website and My Incentive Tracker

The Healthy Lifestyles website is your gateway to better health. It is a personalized repository of tools and resources. Each time you log on to the site, you will see information on benefits and resources that support your individual health goals. You also will be able to track your progress toward earning your Healthy Lifestyles Incentive on the My Incentive tab. From the healthiest individuals to those with multiple health risks, there's something for everybody — online health centers, health news, calculators, self-care information, trackers, year-over-year health assessment comparisons and so much more. You can link to the site from the myHR website or go directly to **healthylifestyles.staywell.com**.

StayWell HelpLine

Staff is available to help you log on to the Healthy Lifestyles website or answer questions about the Healthy Lifestyles benefits available. Simply call **866.280.9835** during the hours outlined below.

Monday – Thursday: 9 a.m. – 9 p.m., Eastern time

Friday: 9 a.m. – 7 p.m., Eastern time

Saturday: 9 a.m. – 1 p.m., Eastern time

Adoption assistance plan

Cardinal Health recognizes the importance of family. That is why Cardinal Health provides the adoption assistance plan. This plan offers assistance to eligible employees who adopt children.

Eligibility

All active, regular employees averaging at least 20 hours worked per week have access to the adoption assistance plan. Average hours worked are calculated based on a sliding 12-month period of employment, or your total period of employment if less than 12 months. You must be employed by Cardinal Health at the time the adoption expense was incurred and when you submit the claim. If you are an employee who switched from regular to PRN status at Cardinal Health after incurring the expense but prior to submitting the claim, you may receive reimbursement provided you were otherwise eligible when the adoption began.

About the plan

You may be reimbursed for up to $5,000 per adoption.

Eligible child
For purposes of the adoption assistance plan, an "eligible child" is any child under age 18, or any child who is physically or mentally incapable of caring for himself or herself.

Eligible expenses

Qualified adoption expenses include reasonable and necessary expenses directly related to, and for the principal purposes of, the legal adoption of an eligible child. Eligible expenses include:

- Legal costs, such as attorney fees;
- Court fees;
- Adoption agency fees;
- Pregnancy expenses for the child's birth mother;
- Temporary foster care expenses;
- Costs for the child's required medical examinations; and,
- Your travel expenses incurred in conjunction with the adoption.

How to obtain reimbursement

When you request reimbursement, you will need to provide information about your expenses. This may include:

- Copies of your bills or invoices;
- Expense amounts;
- Dates; and,
- The purpose for the expenses.

To receive a refund for your expenses:

- Obtain an Adoption Assistance Application online at **hr.cardinalhealth.com** or by contacting the myHR Service Center at **866.471.7867**.
- Submit the completed Adoption Assistance Application, along with any other information about your adoption expenses, to the myHR Service Center at the address below:

  Cardinal Health
  Attn: myHR Service Center
  7000 Cardinal Place
  Dublin, OH 43017

  Phone: **866.471.7867**
  Fax: **614.652.0919**

- You will receive your reimbursement through payroll.

Reimbursements by the plan are subject to applicable taxes. Cardinal Health reports the reimbursement amount on your W-2 form at the end of the year.

Tuition reimbursement program

The Cardinal Health tuition reimbursement program is designed to encourage you to broaden your educational background, increase your job competencies and enhance your future with Cardinal Health.

Eligibility

All regular, active employees averaging 20 or more hours worked per week may receive reimbursement for undergraduate and/or graduate tuition expenses pursuant to the tuition reimbursement program. Average hours worked are calculated based on a sliding 12-month period of employment, or your total period of employment if less than 12 months. If you are an employee who switched from regular to PRN status at Cardinal Health after incurring the expense but prior to submitting the claim, you may receive reimbursement provided you were otherwise eligible when the course began.

About the program

An eligible employee will need to obtain prior approval from their first- and second-level manager to be eligible for reimbursement of up to $5,250. The reimbursement will be considered taxable income to the individual receiving reimbursement. Undergraduate courses must be taken at an accredited institution and all courses must be in relation to your current and/or future role with Cardinal Health in order to be reimbursed.

Bright Horizons

Cardinal Health offers a highly customized, high-quality Back-up Care program for child and adult/elder care. Through an extensive network of licensed and qualified childcare facilities and in-home care providers, you can call ahead for Back-up Care when your regular child or adult/elder care is unavailable.

Center-based and in-home options available

You will be able to access this service and experience minimal out-of-pocket expenses. Program options include center-based or in-home childcare and in-home adult/elder care. In-home care is also available to accommodate employees who work during non-standard business hours (before 7 a.m., after 7 p.m., holidays and weekends).

Program option	User	Employee co-payment
Center-based childcare	Well children	$15 per day $25 maximum per family per day
In-home childcare	Mildly ill children	$4 per hour
In-home adult/elder care	Adults/elders	$4 per hour
In-home care during non-standard hours	Children/adults/elders	$6 per hour

Typical turnaround time for urgent requests — defined as requests for care for the same or next day — is two to four business hours for both in-home and center-based care.

Back-up care available throughout the United States

Bright Horizons has the capability to provide Back-up Care in many remote areas through its nationwide network of childcare centers and in-home care providers. You may nominate local childcare centers or in-home care providers to become a part of the network. Go online or call Bright Horizons for more information.

Imputed Income

Under current tax laws, the company reports imputed income for the company's subsidized portion of the cost of the Back-up Care program.

To register in advance

- Call **877.BH.CARES** (877.242.2737); or,
- Visit **brighthorizons.com/advantage** and enter the Cardinal Health username and password
  - **Username:** Cardinal Health
  - **Password:** Bright Horizons 09

You have access to the program for 10 uses per dependent, per year.

College Coach

Purpose of College Coach

Cardinal Health partners with College Coach to guide employees and their families through important educational challenges, such as:

- Selecting the right college savings plan;
- Navigating the complex college admissions process; and,
- Determining the best way to pay for college.

The College Coach program is delivered by industry experts and consists of live webinar events, online support and personalized assistance.

Live webinar events

College Coach provides 60- to 90-minute live webinars that highlight important college admissions and college finance strategy information for parents. Registration is required to receive materials and login information. Please visit the "Live Events" section of the College Coach portal for more information and to register.

Learning Center

College Coach provides this online learning environment where employees can access interactive videos and resources based on student academic level. Access can be obtained 24/7 by logging on to the College Coach portal.

Personalized assistance

College Coach experts are available to provide employees with personalized assistance either on-demand or through scheduled appointments. Personalized assistance can include, but is not limited to, phone counseling, customized college list development, college essay critique and use of "Quick Questions" on the College Coach portal.

Visit the portal: **passport.getintocollege.com** (passcode: **cardinalhealth**)
Call: **866.918.7779**

Special and exceptional needs

Bright Horizons Special Needs, powered by myEdGPS, is an innovative solution that can help you identify learning, attention, behavioral or other developmental issues early, and equip you to better understand, advocate for and support your child with special or exceptional needs from birth through all phases of education into adulthood. The program simplifies education planning by recommending action plans, facilitating school communications, troubleshooting issues, organizing materials and tracking progress. The platform includes:

- Current information on federal special education laws and processes;
- State-by-state timelines, service eligibility guidelines and lead agencies;
- Expert content including tips, tools and videos;
- Letter generators to communicate official requests to the school;
- A secure online binder to organize documents such as evaluations, reports and communications;
- A dynamic calendar to track important school deadlines and milestones; and,
- An opportunity to schedule a live session with an education expert.

Employees get unlimited access to the myEdGPS platform, through Bright Horizons Special Needs, as well as four content-rich, expert webinars offered during the year. Personalized assistance is also available by appointment.

Visit the website: **careadvantage.com/cardinalhealth** (passcode: **cardinalhealth**)

Call: **844.693.3477**

International Fitness Club Network (IFCN)

International Fitness Club Network (IFCN) offers employees, spouses and their dependents preferred pricing on fitness club memberships nationwide, as well as home fitness equipment and fitness and wellness products.

Membership rates

IFCN contracts with quality health and fitness clubs that offer employee discounts on a variety of memberships. The program ensures that you receive the lowest rate for whichever membership you select.

How to use the membership

- To search for a club in your area, visit **preventure.com/ifcn-cardinal-health**. You can also access the website from myHR. Call the health club you are interested in and speak with someone in the membership department. Schedule a time to tour the facility and be sure to present your Cardinal Health proof of employment when you visit the club.
- Discuss with the health club's membership department what the lowest membership rate would be for the type of membership selected. Make sure to mention you have the International Fitness Club Network (IFCN) benefit through Cardinal Health.

Other IFCN programs

IFCN also offers home fitness equipment at a discounted rate for all Cardinal Health employees. Visit the online store at **preventure.com/ifcn-cardinal-health** and select **Home Fitness Equipment Discounts**.

Paid Time Off/leave

Cardinal Health offers Paid Time Off and other leaves of absence as set forth in the HR policies on myHR.

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Cardinal Health
7000 Cardinal Place
Dublin, OH 43017

cardinalhealth.com