
HSA and HSA Plus Medical Plans

(Aetna, Anthem, Cigna and CVS Caremark)



Summary Plan Description
Effective January 1, 2017

Introduction

The HSA and HSA Plus plans offer low premiums in exchange for a high deductible and also provide the opportunity to contribute to a tax-advantaged health savings account.

We hope that the information provided in this summary plan description (SPD) will answer most of the questions you have regarding your benefits. When you need assistance or have specific questions, contact the resources listed on the back cover of this SPD.

Provisions of the HSA and HSA Plus plans are summarized in this SPD. This description does not state all plan terms and conditions. The information provided here does not cover every situation and is not intended to replace the plan documents — or to change their meaning. In all cases, the plan documents — and not this summary — will govern benefits paid under the plan.

Refer to the Glossary for definitions of terms used in this SPD that may be unfamiliar to you or that have unique meanings under the HSA and HSA Plus plans.

HR Support Center

855.GO.MCKHR (855.466.2547)

Your source for benefits information and gateway to an advocate.

Press 1 for the McKesson Benefits Center for Health, Vitality and Pension questions. Benefit experts are available 7 a.m. - 6 p.m. Central time, M-F.

Oprime 1 para asistencia en español a través del McKesson Benefits Center.



Enroll in Healthcare Coverage to Avoid a Fee

Under the Affordable Care Act (ACA), you're required to have minimum essential healthcare coverage. If you don't have health coverage for yourself, your spouse and dependents, you may have to pay a fee when you file your taxes. You'll also have to pay all of the costs of your family's healthcare. If you enroll in HSA or HSA Plus plan coverage for yourself, your spouse and dependents, you won't have to pay the fee for the months you're covered under the HSA or HSA Plus plan. For additional information about the fee, visit <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision>.

The benefits described in this SPD apply to coverage in effect as of January 1, 2017.

McKesson Corporation reserves the right at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add benefits or terminate the McKesson Corporation Health Plan, in whole or in part and in its sole discretion, without prior notice to or approval by plan participants and their beneficiaries. To the extent required by the Employee Retirement Income Security Act (ERISA), if there is a material reduction in covered services or benefits under the plan, the reduction will be disclosed to you no later than 60 days after the date on which the reduction is adopted or as soon as required by applicable law.

The plan's terms can't be modified by written or oral statements to you from Human Resources representatives or other personnel. In the event of any discrepancy between the plan documents and this document or written or oral statements, the plan documents will govern.



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Although this summary plan description summarizes your coverage under the plan, the information provided does not cover all of the plan's terms and conditions. In all cases, the plan documents — and not this summary — will govern benefits paid under the plan.

Claims Administrators

Claims Administrators

Carriers/Claims Administrators

CVS Caremark is the prescription drug carrier/claims administrator for all plan members. Aetna, Anthem and Cigna are the medical plan carriers/claims administrators. You choose your medical plan carrier when you enroll in the plan. All plan members have a choice of at least two medical plan carriers — Aetna or Cigna — and depending on where you live, you may have three carriers to consider, as shown below.

Carriers/Claims Administrators		
States (your home residence)	Medical	Prescription Drug
All states except Hawaii	Aetna www.aetna.com 877.286.3900	CVS Caremark www.caremark.com 800.378.0822 800.875.0867 (mail order)
CA, FL, MI, PA	Anthem www.anthem.com/ca 866.820.0763	
All states except Hawaii	Cigna www.mycigna.com 800.CIGNA24 (800.244.6224)	



The HSA and HSA Plus plans are available in all states except Hawaii.

If you move, there's a good chance that the medical plan carrier you've chosen is available in your new state. For example, Aetna and Cigna are available to all HSA and HSA Plus plan members, regardless of location (except Hawaii). If you move to a state where your current carrier isn't available, your coverage continues to be administered by that carrier until the end of the calendar year in which you move. You can call your carrier or check their website to find in-network providers in your new location.

Keep in mind that the HSA and HSA Plus plans aren't available in Hawaii. If you're moving to Hawaii, you can find medical plans available in that state by calling the HR Support Center at 855.GO.MCKHR (855.466.2547). Press 1 for Health, Vitality and Pension questions.

Changing Carriers During Annual Enrollment

You can review your choice of medical plan carriers each year during Annual Enrollment. If you make a change, your new carrier will be effective on the January 1 following Annual Enrollment.

Plan Features

The HSA and HSA Plus plans qualify as high-deductible health plans under federal guidelines. This provides important differences from more traditional medical coverage. The plans:

- Have lower premiums in exchange for higher deductible amounts.
- Allow eligible plan members to contribute to tax-advantaged health savings accounts as long as they meet specific eligibility requirements.

A brief overview of the plans' coverage is shown below. More details on these features are provided in this summary plan description.

In-Network Preventive Care Plan pays 100%	Services necessary for immunizations or screenings — such as routine physicals, mammograms and colonoscopies — that are identified as recommended preventive services under federal law. In-network services are covered at 100%.
Health Savings Account* You can choose to contribute before-tax or tax-deductible dollars to your account. You own and control all the dollars in your account, including McKesson's contributions under the HSA Plus plan.	An interest-generating savings account that allows you to use before-tax or tax-deductible dollars to pay eligible healthcare expenses. You own your health savings account — you keep it if you change coverage, change employers or retire. You can't contribute to a health savings account during any period of time that you (and your spouse/domestic partner, if you have family coverage) have non-HDHP coverage, such as a consumer-driven health that doesn't qualify as a high deductible health plan, HMO or EPO health coverage or have coverage under a health reimbursement account or a standard healthcare flexible spending account.
Deductible You pay	The amount you need to pay out of pocket before you and the plan begin sharing costs. Amounts paid from your health savings account apply to your deductible.
Coinsurance Once the deductible is met, both you and the plan share the cost — you pay less by using in-network providers.	The percentage you and the plan pay for eligible expenses after the deductible is met. The plan pays a higher percentage (80%) when you use in-network providers and purchase generic drugs. (See p. 41 for information on brand name drug purchases.) Prescription drugs are covered only when purchased through in-network pharmacies.
Out-of-Pocket Maximum Once your coinsurance payments reach a set limit, the plan pays 100%.	A safety net that limits how much you pay out of pocket for eligible expenses each calendar year. The out-of-pocket maximum includes the amount you pay for your deductible and coinsurance. There are different maximums for in- and out-of-network care. For example, if you reach the in-network out-of-pocket maximum, the plan pays 100% of eligible in-network expenses for the rest of the calendar year.

■ Plan Pays
 ■ You Pay

Prescription drugs are generally covered the same way as any other healthcare expenses under the plan. You can choose to use your health savings account dollars to pay for eligible prescription drug purchases. If you use all of your health savings account dollars, you pay out of pocket until the deductible is met. Then, coinsurance amounts apply until you reach your out-of-pocket maximum. Keep in mind that prescription drugs are covered only when purchased at an in-network pharmacy. More information is provided in the Prescription Drug Benefits section on pp. 41-45.

* Health savings accounts are personal savings accounts and are not a part of the HSA and HSA Plus plans or any other Employee Retirement Income Security Act (ERISA) plan established or maintained by McKesson. Health savings account holders have sole responsibility for contributing and using funds in accordance with the requirements of the tax code. References to health savings accounts in this summary plan description are provided only to notify plan members that these accounts may be available to them. Health savings account highlights are provided on pp. 12-15. For more information, visit www.irs.gov/pub/irs-pdf/p969.pdf. You can also find information (but not tax advice) on the Fidelity website at www.netbenefits.com.

Medical Benefits

Coverage

When you enroll in your plan, you elect coverage for employee only, employee + spouse/domestic partner, employee + child(ren), or employee + family. The coverage you choose determines your deductible, coinsurance and maximum out-of-pocket amount as shown in the Medical Schedule of Benefits.

Medical Schedule of Benefits

Your plan's medical benefits are summarized below. (The Prescription Drug Schedule of Benefits is shown on p. 41.) All benefits under the plan are subject to limitations and exclusions, as summarized in this summary plan description.

Plan Feature		
Lifetime Maximums for Non-Essential Health Benefits • Infertility treatment* • Transportation and lodging expenses for transplants	Plan Pays	
	\$10,000 per person	
Non-Notification Penalty Failure to obtain advance approval when required (see pp. 20-23).	You Pay	
	In-Network	Out-of-Network
Deductible** • The amount you need to pay out of pocket before you and the plan begin sharing costs. Amounts paid from your health savings account apply to your deductible. – You can choose to use dollars in your health savings account to pay eligible expenses that apply to your deductible. – If there aren't enough dollars in your health savings account to pay the entire deductible, you pay the remainder of your deductible. <u>Health Savings Account Annual Allocation</u> • The amount McKesson puts in your health savings account is based on who's covered under your plan.	None	\$500
	Deductible	
		HSA Plan
		HSA Plus Plan
	Employee Only	\$3,500
	EE + Spouse/DP or EE + Child(ren)***	\$5,250
	Family	\$7,000
	Health Savings Account	
	Annual Allocation	HSA Plan
		HSA Plus Plan
	Employee Only	\$0
	EE + Spouse/DP or EE + Child(ren)***	\$0
	Family	\$0

* Services not considered as part of the diagnosis and/or treatment of the underlying cause of infertility apply to the \$10,000 lifetime maximum.

** The deductible amount applies each calendar year. For example, amounts applied to your deductible during one calendar year don't carry over to apply to your deductible in the next calendar year.

*** EE = Employee; DP = Domestic Partner.

Plan Feature

Coinsurance

- The amount you need to pay out of pocket in coinsurance expenses each calendar year after meeting your annual deductible.
- Amounts used to satisfy the in-network coinsurance amount apply to out-of-network coinsurance and out-of-pocket maximum amounts.

You Pay — Coinsurance				
Coverage	HSA Plan		HSA Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee Only	\$2,750	\$5,500	\$2,500	\$5,000
EE + Spouse/ DP or EE + Child(ren)*	\$4,125	\$8,250	\$3,750	\$7,500
Family	\$5,500	\$11,000	\$5,000	\$10,000

Maximum Out-of-Pocket Amount

The most you pay for all eligible expenses during the calendar year (includes your annual deductible + coinsurance).

You Pay — Maximum Out-of-Pocket Amount				
Coverage	HSA Plan		HSA Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee Only	\$6,250	\$9,000	\$4,625	\$7,125
EE + Spouse/ DP or EE + Child(ren)*	\$9,375	\$13,500	\$6,925	\$10,675
Family	\$12,500	\$18,000	\$9,250	\$14,250

If you're enrolled in coverage other than Employee Only, an individual out-of-pocket maximum of \$6,850 is embedded in your plan so that no individual member pays more than \$6,850 a year for in-network services.

*** EE = Employee; DP = Domestic Partner.

You may be able to contribute to a health savings account to use tax-advantaged dollars to help pay your deductible and coinsurance amounts (see pp. 12-15).

Medical Benefits

Medical Schedule of Benefits (continued)

Coinsurance Benefits  You can choose to use health savings account dollars to help pay your portion of coinsurance.	Plan Pays (for covered expenses after deductible is met and before out-of-pocket maximum is met)	
	In-Network[†]	Out-of-Network^{††}
Emergency Care - Ambulance - Emergency room	80%	60% (80% if charges are billed in conjunction with an emergency room visit) 80% (60% if the medical plan carrier determines that circumstances didn't necessitate emergency care)
Extended Care & Other Services - Durable medical equipment - Home healthcare (<i>limited to 100 visits per calendar year combined in-network and out-of-network</i>) - Home infusion therapy - Hospice - Medical supplies - Radiation/chemo therapy - Skilled nursing facility (<i>limited to 100 days per calendar year combined in-network and out-of-network</i>) - Transplants	80%	60%
Family Planning - Contraceptive counseling - Infertility services for artificial insemination, in vitro, gamete intrafallopian transfer, zygote intrafallopian transfer and injectable fertility drug expenses are limited to the \$10,000 lifetime maximum - Voluntary sterilization (vasectomy and tubal ligation)	80% (100% for certain services, such as contraceptive counseling and tubal ligation/sterilization, as required by federal law)	60%
Hospital Services – Inpatient - Hospital inpatient services including semi-private room, board, lab, x-rays and inpatient drugs; inpatient stays for delivery of a child includes a minimum 48-hour stay for vaginal birth and 96-hour stay for cesarean birth - Physician or surgeon services	80%	60%
Hospital Services – Outpatient Hospital outpatient services	80%	60%

[†] In-network provider reimbursements are based on the discounted charge for the service or supply, as specified in the contract with your carrier.

^{††} Out-of-network provider reimbursements are based on the maximum reimbursable charge for the service or supply, as determined by your carrier. You are responsible for any charges in excess of the maximum reimbursable charge.

Coinurance Benefits  You can choose to use health savings account dollars to help pay your portion of coinsurance.	Plan Pays (for covered expenses after deductible is met and before out-of-pocket maximum is met)	
	In-Network[†]	Out-of-Network^{††}
Mental Health/Substance Use Disorders • Inpatient care • Outpatient care	80%	60%
Outpatient Care • Lab and x-rays • Office visits • Outpatient surgery • Physician services	80% ^{†††}	60%
Outpatient Rehabilitation Therapy • Acupuncture <i>(limited to 35 visits per calendar year combined in-network and out-of-network)</i> • Chiropractic care <i>(limited to 35 visits per calendar year combined in-network and out-of-network)</i> • Occupational therapy • Physical therapy • Speech therapy	80%	60%
Preventive Care • Routine physical exams, screenings, immunizations, and other services and supplies that are recommended preventive services under federal law	100% (deductible is waived)	60%
Urgent Care • Urgent care facility or other outpatient facility services	80%	60% ^{††††}

[†] In-network provider reimbursements are based on the discounted charge for the service or supply, as specified in the contract with the medical plan carrier.

^{††} Out-of-network provider reimbursements are based on the reasonable and customary (R&C) charge for the service or supply, as determined by the medical plan carrier. You're responsible for any charges in excess of the R&C charge.

^{†††} Walk-in clinic visits that are also considered preventive care will be covered at 100%, as required by federal law.

^{††††} 80% for Cigna

A separate schedule of benefits applies to prescription drug benefits (see p. 41).

Medical Benefits

In-Network Providers

You can make your healthcare dollars go further when you use in-network providers and facilities because they agree to charge plan participants discounted rates for services. In addition, the coinsurance benefits under the plan pay a greater percentage of eligible expenses for services received from in-network providers (80% instead of 60%).

Network providers are independent practitioners and aren't employees of McKesson or the Claims Administrator. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but doesn't assure the quality of the services provided.

To determine if a provider participates in the HSA or HSA Plus plan network, visit your medical plan carrier's website. The network names are shown below. For example, if your medical plan carrier is Anthem, visit Anthem's website to find providers that participate in the Anthem National PPO/BlueCard PPO network.

- Aetna — Aetna Choice® POS II
- Anthem — National PPO/BlueCard PPO
- Cigna — Cigna Open Access Plus

Through your medical plan, you also have access to Best Doctors and Castlight. Best Doctors is a free and confidential expert second-opinion service to help you understand your diagnosis and treatment options. Castlight helps you find quality care at the right price by comparing doctors, medical facilities and costs. You can learn more about these programs on the Total Rewards Library at www.mckesson.com/totalrewardslibrary or contact Best Doctors and Castlight at:

Best Doctors

members.bestdoctors.com
866.904.0910
7 a.m. - 8 p.m. Central time, M-F

Castlight

www.mycastlight.com/mckesson
866.970.8174
7 a.m. - 8 p.m. Central time, M-F

In-network providers contract with the medical plan carrier to participate in the network. You can obtain a list of in-network providers at no charge by calling your medical plan carrier or visiting their website (see p. 4). Under the terms of this contract, an in-network provider may not:

- Balance bill you for amounts in excess of rates specified in the contract. For example, if your provider normally charges \$110 for a service that has a specified contract rate of \$100, the provider may not bill you for the extra \$10.
- Charge you or your medical plan carrier for certain expenses. For example, the provider generally can't charge for any services or supplies that are not medically necessary as determined by your medical plan carrier. However, if you agree with the in-network provider to pay charges for services or supplies that are not medically necessary, the in-network provider will charge you for those services and supplies. These charges will not be covered and will not be payable by the plan.

Coverage if an In-Network Provider Is Not Available

If you are unable to locate an in-network provider in your area who can provide you with a service or supply that is covered under the plan, you must call the number on your ID card to obtain authorization for out-of-network provider coverage. If you obtain authorization for services provided by an out-of-network provider, benefits for those services will be covered at the in-network benefit level.

Coverage During Transition of Care

If you are receiving a course of treatment or are in your third trimester of pregnancy when your coverage under the plan begins, care received from your current provider — regardless of your provider's network status — may be covered at the in-network benefit level for up to 90 days. This benefit is not automatic — contact your carrier for more information. If transition of care is approved, the plan will pay covered expenses at the in-network benefit level until your pregnancy or course of treatment is complete or until you have been covered under the plan for 90 days, whichever is earlier.

Coverage While Traveling

If you are traveling and need medical care, contact your medical plan carrier for assistance in locating the nearest in-network provider. If you need emergency care, however, seek treatment from the nearest healthcare facility available. If your carrier determines that your circumstances necessitated emergency care, those services will be eligible for the in-network benefit level regardless of the provider's network status.

If you are traveling, you may be eligible for emergency medical benefits under the McKesson Travel Accident Plan. Call ACE American Insurance Company at 800.336.0627 or the HR Support Center for information. For 24-hour service, you may also call 800.243.6124 or 202.659.7803 (collect call phone number for those traveling outside the U.S.).

Out-of-Network Providers

The plan pays covered expenses at the out-of-network benefit level if you receive services from an out-of-network provider.

Reasonable & Customary Charges

When you receive a service or supply from an out-of-network provider, benefits are based on the reasonable and customary (R&C) charge for that service. The provider may bill you for the difference between the provider's normal charge and the Reasonable and Customary Charge, in addition to applicable deductibles, copayments and coinsurance.

You can find the definition of R&C in the Glossary on p. 95. For more information, you and your out-of-network provider are encouraged to contact your medical plan carrier before services are received.

Emergency Care

Services for emergency care (as defined in the Glossary) received from an out-of-network provider are payable at the in-network benefit level. However, when the emergency care has ended, you need to:

- Obtain approval for applicable services and supplies, as summarized in the Advance Approval provision on pp. 20-23.
- Obtain further services and supplies from an in-network provider to be eligible for the in-network benefit level.

Keep in mind that further services and supplies, including follow-up care, are not considered an emergency. Once you have been treated and discharged from the emergency room, services and supplies are payable at the in-network benefit level only if they are received from in-network providers. Services and supplies received from out-of-network providers, including follow-up care, are payable at the out-of-network benefit level.

Medical Benefits

Annual Deductible

Your annual deductible is the amount you need to pay out of pocket before you and the plan begin sharing costs. Amounts paid from your health savings account apply to your deductible. Refer to the Medical Schedule of Benefits on p. 6 to view deductible amounts.

After the deductible has been met, your coinsurance benefits apply to eligible expenses. For example, if you have family coverage, coinsurance will begin applying to you and your covered family members' expenses after the family deductible amount has been met.

You need to satisfy a new deductible each calendar year. Expenses that are applied to your deductible don't carry over from one calendar year to the next.

An expense is considered incurred on the date you receive services. For example, if payment is made in January for a physician's office visit that occurs at the end of the previous year, that expense is considered an expense for the previous year and wouldn't apply to your current year's deductible.

Health Savings Account Highlights

Because the HSA and HSA Plus medical plans qualify as high-deductible health plans under federal law, health savings accounts are available to eligible plan members. As the name implies, a health savings account allows you to save dollars to pay healthcare expenses on a tax-advantaged basis. But these accounts offer even more — here are some highlights:

- You are eligible for a health savings account as long as you:
 - Are covered by a high-deductible health plan, such as the McKesson HSA and HSA Plus medical plans.
 - Do not have non-HDHP medical coverage, a standard healthcare flexible spending account or a health reimbursement account (for example, under plans available through your spouse/domestic partner's employer).
 - Are not enrolled in Medicare or Veteran's benefits (Tricare).
 - Are not eligible to be claimed as a dependent on another person's federal tax return.
- Health savings account contributions reduce your state income taxes (except in Alabama, California and New Jersey) and federal income taxes (in all states).
- Account balances earn interest and you can choose among investment options once your balance reaches a specified amount.
- Account earnings accumulate on a tax-free basis. (Earnings may be subject to state taxes if you live in Alabama, California, New Jersey, New Hampshire or Tennessee.)

Health savings accounts are personal accounts and are not a part of the HSA and HSA Plus medical plans or any other Employee Retirement Income Security Act (ERISA) plan established or maintained by McKesson. References to health savings accounts in this summary plan description are provided only to notify plan members that these accounts may be available to them. Health savings account holders have sole responsibility for contributing and using funds in accordance with the requirements of the tax code. For more information on health savings accounts, visit www.irs.gov/pub/irs-pdf/p969.pdf. You can also find information (but not tax advice) on the Fidelity website at www.netbenefits.com.

Health savings accounts are allowed under federal law to give individuals a tax-advantaged option to help pay out-of-pocket healthcare expenses associated with high-deductible health plans, such as the HSA and HSA Plus plans. You can use the money in your health savings account to help pay your deductible and coinsurance amounts.

- You can use your health savings account dollars to pay eligible healthcare expenses for yourself and individuals who qualify as your dependents for federal income tax purposes.
- Dollars you use from your account to pay eligible medical and prescription drug expenses can be applied to your deductible.
- Unused dollars carry over from year to year; there is no government “use it or lose it” requirement.
- Your health savings account is always 100% vested — you keep any balance in your account, even if you switch medical plans, change jobs, stop working or retire.
- You can withdraw dollars from your account before age 65 for non-healthcare expenses; however, these withdrawals are subject to income tax and a 20% penalty tax.
- Dollars can be withdrawn for any purpose after age 65, although funds not used for healthcare expenses are taxable.

Health Savings Account Contribution Amounts

There are limits to the amount you may contribute to a health savings account. For 2017, the annual limits are:

- \$3,400 if you have employee-only HSA or HSA Plus medical coverage.
- \$6,750 if you have employee and dependent(s) HSA and HSA Plus plan medical coverage.

Annual limits are established by the IRS and can vary from year to year.

Your health savings account contribution limit during a year may be lower than the annual limit for that year. This is because federal law establishes monthly contribution limits (annual contribution amount shown above divided by 12) and your annual health savings account contribution can't be more than the total of the monthly limits for all months in which you are health savings account-eligible. For example, if you are a new employee, enroll for HSA or HSA Plus plan coverage for your family, and become eligible to contribute to a health savings account on July 1, your maximum contribution amount would be \$3,375 ($\$6,750 \div 12 \text{ months} \times 6 \text{ months of health savings account eligibility}$).

An additional annual catch-up amount of \$1,000 (also established on a monthly basis) may be contributed if you are age 55 or over. Please note that there are special rules that apply when determining health savings account contribution limits for married individuals.

You can find contribution information in IRS Publication 969, “Health Savings Accounts and Other Tax-Favored Health Plans” at www.irs.gov/pub/irs-pdf/p969.pdf. Because individual limits are complex and subject to change by the IRS, we encourage you to consult a tax advisor about contribution amounts.

Medical Benefits

Health Savings Account Contribution Amounts (continued)

Health savings accounts and Flexible Spending Accounts (FSAs)

If you are participating in a standard healthcare FSA — like the McKesson healthcare FSA — you are not eligible to contribute to a health savings account. This applies if your spouse/domestic partner has a standard healthcare FSA through his/her employer.

You can contribute to a health savings account if you meet other eligibility requirements and you or your spouse/domestic partner are participating in an HSA-compatible FSA (also sometimes referred to as a limited-purpose FSA). If you have both a health savings account and an HSA-compatible FSA, keep in mind that FSA dollars can be used only for eligible dental and vision expenses, even after you have met your deductible.

Most participants who have both a health savings account and FSA choose to use FSA dollars first to avoid forfeiture of those dollars. Dollars you contribute to a McKesson FSA during one year and do not use by December 31 of that same year are forfeited. Health savings account dollars continue to carry over regardless of the balance in your account.

Refer to the Flexible Spending Accounts Summary Plan Description available on UPoint.

Eligible Expenses

You can use health savings account dollars for eligible healthcare expenses as defined by Section 213(d) of the Internal Revenue Code. The primary purpose of the expense must be to alleviate or prevent a physical or mental defect or illness. Examples include prescriptions and physicians' office visits. Health savings account dollars used for these expenses can be applied to your deductible.

You can also spend health savings account dollars on vision and dental care, as well as some other healthcare expenses not covered by your medical plan. However, these expenses can't be applied toward your deductible. Examples of expenses that do not qualify include most cosmetic surgery, health club dues, maternity clothing, and toiletries.

Expenses are eligible only if they are incurred after the health savings account is established (as regulated by state law). The expenses must be for:

- You.
- Your spouse (domestic partner expenses generally are not eligible for reimbursement).
- Anyone you claim as a dependent on your personal income tax — even if that person is not covered under your high-deductible health plan.
- Anyone you could have claimed as a dependent on your federal tax return except that (1) the person filed a joint return; (2) the person had gross income of \$4,050 or more in 2016; or (3) you, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

Note that you normally can't spend health savings account dollars on expenses for adult children between ages 24 and 26. While healthcare reform mandates that children up to age 26 can be covered under your medical plan, they are not considered dependents for health savings account purposes unless you claim them (or could have claimed them except for the factors indicated above) as dependents on your personal income tax. These children may want to review health savings account rules to determine if they are eligible to set up their own health savings accounts through their banks or other health savings account vendors to help pay healthcare expenses.

Spending Health Savings Account Dollars on Non-Healthcare Expenses

You may use your health savings account dollars for whatever purpose you wish. But if you use your health savings account dollars for other than eligible healthcare expenses, those withdrawals are subject to the normal income tax and a 20% tax penalty. You must report those withdrawals accordingly on your tax return. The 20% tax penalty does not apply if the withdrawal is made after you reach age 65, become completely and permanently disabled, or die; however, normal income tax continues to apply.

Fidelity Health Savings Accounts

Fidelity partners with McKesson to provide health savings accounts for eligible employees. The Fidelity health savings account allows you to have before-tax contributions deducted from your paychecks and deposited into your account. (You can choose a health savings account vendor other than Fidelity — for example, your bank. Although this will not provide the convenience of before-tax payroll deductions, you receive the tax advantages by taking a tax deduction for your contributions when you file your tax return.)

When you enroll in the HSA or HSA Plus plan, a Fidelity health savings account is automatically set up for you if you accept the account terms and conditions and select a contribution amount on UPoint. You can increase, decrease, stop or restart contributions you make to your Fidelity health savings account on a monthly basis by updating your contribution information on UPoint. If you are not eligible for a health savings account because you do not meet IRS eligibility rules or do not wish to use this account, you must set your contribution amount to \$0 on UPoint.

Account Information

You can also use the HealthExpense tool to manage your expenses, payments and claims. Learn more at www.netbenefits.com > **Health Savings Account** > **Quick Links** > **HealthExpense Claims and Payments**.

If you don't have enough money in your health savings account to pay for an eligible expense, you'll need to pay by some other means. You can reimburse yourself for that expense only after your health savings account has enough dollars available to cover the expense.



If you sign up for a Fidelity health savings account on UPoint, you'll receive a kit from Fidelity that provides information about your account. You can also find information:

- In the Health Savings Account FAQs (available on the Total Rewards Library at www.mckesson.com/totalrewardslibrary under the **Health Savings Account** tab).
- On the Fidelity website at www.netbenefits.com.

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Medical Benefits

Deductible and Qualified Status Changes

If you experience a qualified status change that results in a coverage level change (e.g., from employee only to family coverage), your deductible amount will be adjusted to reflect your new coverage level minus any deductible amount that has already been paid for the current calendar year.

Coinsurance Benefits

The plan’s coinsurance benefits apply after you meet the annual deductible. Coinsurance refers to the percentages you and the plan pay for covered expenses. As the Medical Schedule of Benefits on pp. 6-9 shows, the plan pays a majority of the cost (80% in-network and 60% out-of-network) and you pay the remainder for eligible expenses at the coinsurance rate until you reach your out-of-pocket maximum amount.

The following example shows the difference in coinsurance benefits when you use in-network and out-of-network providers.

	In-Network	Out-of-Network	Comments
Billed charge/ maximum reimbursable charge (MRC)	Billed*: \$900	Billed: \$1,200 MRC: \$1,000	In-network discounts normally result in lower billed charges
The plan's coinsurance amount	\$720 (80% of billed charge*)	\$600 (60% of MRC charge)	The plan doesn't pay coinsurance toward amounts in excess of MRC charge
Your coinsurance amount	\$180 (20% of billed charge*)	\$400 (40% of MRC charge)	
Your cost for charges in excess of MRC	\$0	\$200	You are responsible for out-of-network amounts in excess of MRC charge
Your total cost	\$180	\$600	In this example, you save \$420 by using an in-network provider

* The billed charge reflects the contracted amount agreed to by your medical plan carrier and the in-network provider for the applicable service.

All benefit payments under the plan are subject to limitations and exclusions, as summarized in this summary plan description.

If you contribute to a health savings account (see pp. 12-15), you can use those dollars to help pay your share of the deductible and coinsurance.

Maximum Out-of-Pocket Amount

The maximum out-of-pocket amount is the most you need to pay each calendar year toward eligible expenses. It includes your deductible and coinsurance. Once you meet your maximum out-of-pocket amount, eligible expenses are payable at 100% for the rest of the calendar year. The Medical Schedule of Benefits on p. 6 shows the out-of-pocket maximums for in-network and out-of-network services and supplies.

If you have dependents covered under the plan, expenses incurred by all covered individuals are combined for purposes of meeting the out-of-pocket maximum. For example, if you have family coverage, the in-network out-of-pocket maximum will be met once your eligible expenses combined with your covered family members' eligible expenses reach the family in-network maximum amount. Generally:

- If you satisfy only the out-of-pocket maximum for in-network charges, the plan pays:
 - 100% of covered in-network charges for the rest of the calendar year.
 - The specified coinsurance amount for eligible out-of-network charges until the out-of-network maximum out-of-pocket amount is met.
- If you satisfy the out-of-pocket maximum for out-of-network charges, the plan also pays 100% of eligible in-network charges for the rest of the calendar year.
- Once you meet both the in-network and out-of-network out-of-pocket maximums, the plan pays 100% of eligible in-network charges and 100% of eligible maximum reimbursable out-of-network charges for the rest of the calendar year.

If you're enrolled in coverage other than Employee Only, an individual out-of-pocket maximum of \$6,850 is embedded in your plan so that no individual member pays more than \$6,850 a year for in-network services.

The maximum out-of-pocket amount is subject to plan limitations and exclusions. For example, coverage wouldn't be available for chiropractic visits in excess of the 35 visits per calendar year limit. Also, coverage wouldn't be available for skilled nursing facility days in excess of the 100 day per calendar year limit.

The maximum out-of-pocket amount acts as a safety net that limits how much you pay toward eligible expenses each calendar year. There are different maximums for in- and out-of-network care.

Expenses That Don't Apply to the Maximum Out-of-Pocket Amount

The following expenses don't apply toward the in-network or out-of-network out-of-pocket maximums and you'll continue to pay these out-of-pocket expenses even after your out-of-pocket maximum has been reached:

- Charges not paid and non-notification penalties applied because advance approval was not obtained (see pp. 20-23).
- Charges for services or supplies that aren't eligible under the plan.
- Amounts above the out-of-network maximum reimbursable charge.
- Premiums you pay for coverage.

Lifetime Maximums for Non-Essential Health Benefits

There is a lifetime maximum infertility treatment benefit of \$10,000 per person. There is also a lifetime maximum of \$10,000 per person for transportation and lodging expenses associated with transplants.

Medical Benefits

Coverage Examples

HSA Plan Example

The following examples show how the deductible, coinsurance benefits and maximum out-of-pocket amount apply. Both examples assume that Mary has elected employee-only coverage under the plan and will use in-network providers throughout the year. Mary is in good health but incurs some medical expenses after a car accident.

HSA plan	
Plan premium	
Mary's premium is based on her pay of \$50,000 a year and the maximum savings she earns by participating in Vitality.	
\$5.10	per month (\$61.20 annual)
Health savings account	
\$3,400	contributed by Mary
+ \$0	contributed by McKesson
\$3,400	total 2017 account dollars
Mary's healthcare expenses	
\$1,150	
How Mary's healthcare expenses are paid	
\$1,150	Mary chooses to pay from her health savings account to pay eligible expenses.
	If Mary has an HSA-compatible FSA, she can use those before-tax dollars to pay vision and dental expenses only.
Amount Mary pays out of pocket	
\$61.20	Mary's annual payroll deductions to pay the plan premium
\$61.20	out-of-pocket total
Remaining account balance	
\$3,400	total 2017 account dollars
- \$1,150	account dollars used to pay eligible expenses
\$2,250	account balance remaining at the end of the year

If you contribute to a health savings account (see pp. 12-15), those dollars may be used to help pay your deductible and coinsurance amounts.

HSA Plus Plan Example

HSA Plus plan	
Plan premium	Mary's premium is based on her pay of \$50,000 a year and the maximum savings she earns by participating in Vitality.
\$59.50	per month (\$714 annual)
Health savings account	
\$2,650	contributed by Mary
+ \$750	contributed by McKesson
\$3,400	total 2017 account dollars
Mary's healthcare expenses	
\$1,150	
How Mary's healthcare expenses are paid	
\$1,150	Mary chooses to pay from her health savings account to pay eligible expenses.
If Mary has an HSA-compatible FSA, she can use those before-tax dollars to pay vision and dental expenses only.	
Amount Mary pays out of pocket	
\$714	Mary's annual payroll deductions to pay the plan premium
\$714	out-of-pocket total
Remaining account balance	
\$3,400	total 2017 account dollars
- \$1,150	account dollars used to pay eligible expenses
\$2,250	account balance remaining at the end of the year

If you contribute to a health savings account (see pp. 12-15), those dollars may be used to help pay your deductible and coinsurance amounts.

Medical Benefits

Advance Approval

Advance approval gives you the opportunity to work with your medical plan carrier before receiving services to:

- Understand your health condition.
- Review treatment information including possible alternative procedures.
- Explore appropriate facilities and network discounts that may be available.
- Understand how your eligible medical and prescription drug expenses will be paid under the plan and review services that may not be covered.

Advance approval activities aren't a substitute for the medical judgment of your physician, and the ultimate decision as to what medical care you or your dependents actually receive needs to be made by you and your physician. If you don't comply with advance approval requirements, however, benefits will be reduced as summarized in this section.

Advance Approval Resources

Advance approval is the general term used under your plan for this process. Each medical plan carrier uses slightly different terms to identify their specific approval processes. And each carrier has a designated resource for you to call for approval as shown in the table below.

Medical Plan Carrier	Carrier Terminology	Resource Name	Phone Number
Aetna	Precertification	Patient Management	877.286.3900
Anthem	Precertification	Customer Service	866.820.0763
Cigna	• In-Network: – Prior Authorization/Pre-Authorized • Out-of-Network: – Pre-Admission Certification (PAC) – Continued Stay Review (CSR) – Outpatient Certification	Review Organization	800.244.6224

Call the number on your ID card whenever you're considering treatment to determine if advance approval is required. Failure to contact your medical plan carrier may result in reduction of benefits and non-notification penalties, as summarized on p. 23.



Services That Require Advance Approval by All Medical Plan Carriers

All medical plan carriers require advance approval for the services shown below (except in emergency situations).

Non-Emergency Services Requiring Advance Approval	
Service	You, your physician or the facility needs to contact your medical plan carrier's advance approval resource
Confinement during pregnancy without delivery of a child	Prior to admission
Confinement for delivery of a child if the confinement for mother or child is expected to continue beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section	Prior to the end of the 48/96 hour limits
Gender confirmation (transgender) surgery	At least 14 days prior to admission
Home healthcare	Prior to receiving services
Hospice	At least 14 days prior to admission
Hospital confinement for any reason	At least 14 days prior to admission
Mental health/substance use disorder inpatient and partial hospitalization/day treatment	At least 14 days prior to admission
Skilled nursing facility confinement	At least 14 days prior to admission
Transplants	As soon as possible prior to the scheduled date of any of the following: evaluation, donor search, organ procurement/tissue harvest, transplant

Emergency Care Notification — When emergency care is required and results in a confinement, you need to call your medical plan carrier at the number on your ID card within 48 hours of the date the confinement begins. Out-of-network benefits are subject to the \$500 non-notification penalty (see p. 23) if the medical plan carrier isn't called within the time limit. The non-notification penalty applies to each confinement. The 48-hour time limit excludes Saturdays, Sundays and state or federal holidays. If it isn't reasonably possible to call within 48 hours, the medical plan carrier needs to be notified as soon as reasonably possible.

Pregnancy Notification — Although not required, it's highly recommended that you contact your medical plan carrier during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for mothers to participate in any prenatal programs that may be available under the plan.



See p. 22 for additional services requiring advance approval based on medical plan carrier.

Medical Benefits

Advance Approval (continued)

Additional Advance Approval Requirements Based on Medical Plan Carrier*

Aetna

- Amytal interviews
- Biofeedback
- Electroconvulsive therapy
- Intensive outpatient programs for mental health or substance use disorder
- Neuropsychological testing
- Non-emergency outpatient services (call at least 14 days prior to service)
- Outpatient detoxification
- Partial hospitalization programs for mental health or substance use disorder
- Private duty nursing
- Psychiatric home care services
- Psychological testing
- Rehabilitation facility confinement
- Residential treatment facility confinement for treatment of mental health or substance use disorder
- Urgent care (due to onset of or change in illness, diagnosis of illness, or injury) hospital confinement

Cigna

- Advanced radiological imaging, such as CT scans, MRI, MRA or PET scans
- Biofeedback
- Cosmetic or reconstructive procedures
- Dialysis (to direct patient to a participating facility)
- Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- Experimental and investigational procedures
- External prosthetic appliances
- Hysterectomy
- Infertility treatment
- Injectable drugs (other than self injectables)
- Long-term acute care facilities
- Mental health/substance use disorder residential treatment
- Non-emergency ambulance services
- Outpatient facility services
- Rehabilitation hospital or sub-acute facility confinement
- Speech therapy

Anthem

- Cosmetic/reconstructive procedures
- Durable medical equipment including external (portable) continuous insulin infusion pumps
- Electronic or externally powered and certain other prosthetics
- Home infusion therapy
- Long-term acute rehabilitation
- Morbid obesity surgery

Precertification applies to additional services. For a current listing, call Customer Service at 866.820.0763.

* Services that may require advance approval include, but may not be limited to, items listed. Contact your medical plan carrier for a current list.

Requesting Advance Approval

You can request advance approval by calling the toll-free number on your ID card. For purposes of requesting advance approval, “you” includes you, your authorized representative or your physician.

In-network providers normally handle advance approval processes for you. If your advance approval is for a service or supply that will be provided by an in-network provider, ask your provider if he/she is obtaining approval from your medical plan carrier.

You’re always responsible for obtaining advance approval for out-of-network services or supplies.

The advance approval process determines the medical necessity of covered services and supplies. No benefits are payable unless the medical plan carrier determines the covered services and supplies are medically necessary and covered under the plan. A letter confirming the results of the advance approval review will be sent to you, your physician and the healthcare facility.

Reduction of Benefits

Benefits are reduced as follows if you don’t contact the medical plan carrier when required:

- If the medical plan carrier determines that the services received are not medically necessary, no benefits are payable.
- Out-of-network benefits are subject to the non-notification penalty if the medical plan carrier isn’t called before out-of-network inpatient services are received.

Non-Notification Penalty

The non-notification penalty applies to covered expenses for services/treatment given by an out-of-network provider if Cigna is not contacted as required under this plan. The amount of the non-notification penalty is \$500; however, the penalty amount will never be more than the amount of the covered expenses.

Advance approval doesn’t guarantee that benefits are payable under the plan. Benefits are based on:

- The services and supplies actually being performed or given.
- Whether those services and supplies are covered under the plan on the date performed or given.
- The patient’s eligibility under the plan on the date the services and supplies are performed or given.
- The deductible, coinsurance benefits, maximum limits and all other terms under the plan.

Medical Benefits

Covered Services and Supplies

As summarized below, the plan covers a wide range of medical expenses. To be eligible, the services need to be:

- For recommended preventive care under federal law or medically necessary/usual to the treatment of an illness or injury as determined by your carrier's medical staff or an independent medical physician review panel, and
- Provided by healthcare professionals or facilities licensed, certified or otherwise qualified under state law to provide healthcare services.

This listing is not intended to be all inclusive. If you have questions about whether a service or supply is covered or limitations that may apply, contact your carrier.

All coverage is subject to other terms, conditions, limitations and exclusions under the plan.

Acupuncture

Charges for acupuncture treatment by a physician or licensed acupuncturist for anesthesia, injury or disease, or to alleviate chronic pain as medically necessary. Covered services are limited to 35 visits per calendar year combined in-network and out-of-network.

Allergy Treatment

Charges for allergy treatment, injections and serum when dispensed in a physician's office.

Ambulance

Charges for transportation by professional ambulance to a medical facility (or from one medical facility to another medical facility, or the patient's home) when other means of transportation would be considered unsafe due to the medical condition, as determined by your carrier.

Anesthetics

Charges for anesthetics.

Behavioral Health

Charges for services that are provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance use disorder unless otherwise limited or excluded under the plan.

Behavioral health services and supplies are those that are provided:

- For mental health/substance use disorder treatment (as defined in the Glossary)
- While the person is covered under the plan
- By one of the following providers:
 - Physician
 - Psychologist
 - Licensed counselor
 - Other provider
 - Hospital
 - Treatment center
 - Social worker

However, a service or supply is not automatically covered because it's prescribed by a provider listed above. Covered behavioral services and supplies include but aren't limited to:

- Assessment
- Crisis intervention
- Diagnosis
- Individual, family and group psychotherapy
- Medication management
- Psychological testing
- Treatment planning

In addition to meeting other conditions for coverage, the treatment needs to:

- Include follow-up treatment, and
- Be for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental health disorders as summarized on the next page.

Inpatient Treatment — Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during a stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if the condition requires services that are available only in an inpatient setting.

In addition, coverage for substance use disorder includes treatment in a hospital for medical complications of substance use disorder only when the hospital does not have a separate treatment facility section. Medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

Inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health/substance use disorder (MH/SUD) treatment for a sickness identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) are considered MH/SUD treatment, except in the case of multiple diagnoses. If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered MH/SUD treatment.

MH/SUD treatment does not include:

- Detoxification services given prior to and independent of a course of psychotherapy or substance use disorder treatment
- Prescription drugs

Partial Hospitalization — Partial hospitalization services (less than 24 hours per day) provided in a facility or program for short-term or medically-directed intensive treatment may also be covered. Contact your carrier for partial hospitalization coverage information.

Outpatient Treatment — Eligible expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Clinical Trials

Coverage is provided for services and supplies for routine patient costs received as a participant in an approved clinical trial. Coverage is limited to eligible services under the plan. An approved clinical trial is a Phase I, Phase II, Phase III or Phase IV clinical trial that studies the prevention, detection or treatment of cancer, or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

- Federally funded trials approved or funded by one or more of the following:
 - The National Institutes of Health,
 - The Centers for Disease Control and Prevention,
 - The Agency for Healthcare Research and Quality,
 - The Centers for Medicare and Medicaid Services,
 - A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants or
 - Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - The Department of Veterans Affairs,
 - The Department of Defense or
 - The Department of Energy.
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Medical Benefits

Covered Services and Supplies (continued)

Clinical Trials, continued

When a service is part of an approved clinical trial, it's covered even though it may otherwise be an investigative service as defined by the plan. Participation in the clinical trial needs to be recommended by a physician after determining participation has a meaningful potential to benefit the participant.

Routine patient costs don't include the costs associated with any of the following:

- The investigational item, device or service itself.
- Any item or service provided solely to satisfy data collection and analysis needs, and that isn't used in the clinical management of the patient.
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Any item, device or service that is paid for, or should have been paid for, by the sponsor of the trial.



Participants are financially responsible for the costs associated with non-covered services.

Chemotherapy

Charges for chemotherapy treatment.

Chiropractic Care

Charges made for diagnostic and treatment services provided in an office setting by a chiropractor or specialist:

- Services provided by manual or mechanical means for the detection or correction (manipulation) of structural imbalance or distortion in the spine.
- Services for spinal care caused by nerve damage.

Covered services are limited to 35 visits each calendar year.

No benefits are payable for:

- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.
- Treatment of scoliosis.

Cochlear Implants

Charges for cochlear implants.

Dialysis

Charges for dialysis.

Durable Medical Equipment

Charges for durable medical equipment (DME) that is:

- Intended for repeated use and is not a consumable or disposable item,
- Used primarily for a medical purpose, and
- Appropriate for use in the home.

Examples of DME are:

- Appliances that replace a lost body organ or part or help an impaired one to work
- Equipment needed to increase mobility, such as a wheelchair
- Hospital-type beds
- Orthotic devices, such as arm, leg, neck and back braces
- Respirators or other equipment for the use of oxygen

Eligible expenses include charges by a DME supplier for the rental of equipment or, instead of rental:

- The initial purchase of DME if:
 - Long-term care is planned, and
 - The equipment can't be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
- Replacement of purchased equipment if:
 - The replacement is needed because of a change in the patient's physical condition, and
 - It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Emergency Care

Charges for emergency care (as defined in the Glossary) are covered in accordance with federal law.

Family Planning

Charges for certain contraceptive and family planning services, as determined by your medical plan carrier.

Family Planning Services — Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an illness or injury.

Contraception Services — Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices administered in a physician's office provided they have been approved by the Federal Drug Administration (oral contraceptives not administered in a physician's office may be covered under prescription drug benefits).
- Related outpatient services, such as:
 - Consultations
 - Counseling
 - Exams
 - Procedures
 - Other medical services and supplies

The following are not covered:

- Charges for services that are covered to any extent under any other part of the plan or any other group plan sponsored by the Company.
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning Services — Covered expenses include charges for family planning services, including:

- Voluntary sterilization
- Voluntary termination of pregnancy

The plan does not cover the reversal of voluntary sterilization procedures including related follow-up care.

Foot Care

Charges for the care and treatment of the feet, if needed due to severe systemic disease. Routine care, such as removal of warts, corns or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches and chronic foot strain, is a covered service only if medically necessary due to severe systemic disease.

Gender Confirmation (Transgender) Surgery

The plan covers inpatient or outpatient charges for the treatment of gender identity disorder. Associated surgery must be approved in advance by your medical plan carrier. In general, the plan covers hormone therapy, related surgery, including some secondary characteristic surgeries, laboratory testing, and follow-up care.

Gender confirmation surgery is considered medically necessary when the following conditions are met:

- Requirements for mastectomy for female-to-male patients:
 - Single letter of referral from a qualified mental health professional,
 - Persistent, well-documented gender dysphoria,
 - Capacity to make a fully informed decision and to consent for treatment,
 - Age of majority (18 years of age or older), and
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.

A trial of hormone therapy is not a prerequisite to qualifying for a mastectomy.

- Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):
 - Two referral letters from qualified mental health professionals, one in a purely evaluative role,
 - Persistent, well-documented gender dysphoria,
 - Capacity to make a fully informed decision and to consent for treatment,
 - Age of majority (18 years or older),
 - If significant medical or mental health concerns are present, they must be reasonably well controlled, and
 - Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones).

Medical Benefits

Covered Services and Supplies (continued)

- Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female):
 - Two referral letters from qualified mental health professionals, one in a purely evaluative role,
 - Persistent, well-documented gender dysphoria,
 - Capacity to make a fully informed decision and to consent for treatment,
 - Age of majority (age 18 years and older),
 - If significant medical or mental health concerns are present, they must be reasonably well controlled,
 - Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones), and
 - Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

The following list includes services that are generally covered by the plan for these types of services (the list is not all inclusive):

- Subcutaneous injection of filling material (e.g. collagen)
- Rhytidectomy (face-lifting)
- Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
- Suction assisted lipectomy
- Mastopexy
- Reduction mammoplasty
- Mammoplasty, augmentation
- Immediate or delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
- Nipple/areola reconstruction
- Genioplasty
- Rhinoplasty (both primary and secondary)
- Thyroidectomy, partial laryngectomy
- Voice feminization surgery
- Gluteal augmentation
- Hair reconstruction/transplant
- Pectoral implants

The following list includes services that are not generally covered by the plan for these types of services (the list is not all inclusive):

- Dermabrasion
- Chemical peel
- Blepharoplasty
- Electrolysis epilation
- Augmentation, mandibular body or angle; prosthetic material or with bone graft, onlay or interpositional (includes obtaining autograft)

Call your medical plan carrier for additional details on what is covered under the plan.

Genetic Testing

Charges made for genetic testing that use a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- The covered person has symptoms or signs of a genetically-linked inheritable disease,
- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome, and
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing and genetic diagnosis prior to embryo transfer is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease. Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three visits per calendar year for both pre- and post-genetic testing.

Home Healthcare

Charges for any of the following home healthcare services if given by a home healthcare agency:

- Temporary or part-time nursing care by a registered nurse (RN) or licensed vocational nurse (LVN) and supervised by an RN or a physician.
- Temporary or part-time care by a home health aide.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy or respiratory therapy.
- Services for home infusion therapy when ordered by a physician.
- Services of a medical social worker.
- Medically necessary supplies.

Eligible services are limited to 100 visits each calendar year. Each period of care of up to two hours given in the same day counts as one visit. Each visit by any other member of the home healthcare team will count as one visit.

The following are not covered charges for home healthcare services:

- Custodial care.
- Services of a person who usually lives with the covered person or who is a member of the covered person's family or the covered person's spouse/domestic partner's family.
- Services or supplies that are not part of the home healthcare plan.
- Transportation.

Hospice Care

Charges for any of the following if made by a hospice care program for or on behalf of a covered person who has been certified by a physician as terminally ill with six months or less to live:

- Room and board.
- Other services and supplies.
- Part-time nursing care by or supervised by an RN.

- Home healthcare services as summarized under home healthcare (the limit on the number of visits shown for home healthcare services does not apply to hospice patients).
- Counseling for the patient and covered family members.
- Bereavement counseling for covered family members. (Services must be given within 12 months of the date the patient has been certified as terminally ill with six months or less to live. If hospice care benefits are received, bereavement counseling must be provided by a licensed practitioner practicing within the scope of his/her license).

Services for the patient must be given in an inpatient hospice facility or in the patient's home. Any counseling services given in connection with a terminal illness will not be considered as mental health treatment, provided the service is billed by the hospice care agency.

Hospital

Charges for any of the following covered services if provided by a hospital:

- Emergency room (only if it is determined that the services are for emergency care as defined in the Glossary).
- Room and board (covered expenses for a private room are limited to the regular daily charge made by the hospital for a semi-private room).
- Other services and supplies.

Hospital — Inpatient

Charges made by a hospital, on its own behalf, during a period of hospital confinement, for semi-private room and board and other medically necessary services and supplies except as otherwise limited under the plan. In connection with childbirth, the plan does not restrict benefits for any hospital length of stay for the mother or newborn to less than 48 hours for vaginal deliveries and 96 hours for cesarean section, unless the mother and attending physician decide on an earlier discharge.

Hospital — Outpatient

Charges made by a hospital, on its own behalf, for medical care and treatment provided on an outpatient basis.

Medical Benefits

Covered Services and Supplies (continued)

Infertility

Certain infertility services are covered under your plan.

Aetna

Charges made by a physician to diagnose and treat the underlying medical cause of infertility. Infertility services for artificial insemination, in vitro, gamete intrafallopian transfer, zygote intrafallopian transfer and injectable fertility drug expenses are limited to a \$10,000 lifetime maximum (p. 8).

Even though not incurred for treatment of an illness or injury, covered expenses include expenses incurred by an eligible covered female for infertility if all of the following criteria are met:

- The patient has a condition that is a demonstrated cause of infertility which has been recognized by a gynecologist or an infertility specialist, and the physician who diagnosed the patient as infertile, as documented in medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- The infertility isn't caused by voluntary sterilization of either one of the partners (with or without surgical reversal) or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.

Comprehensive Infertility Services Benefits — If the above eligibility requirements are met, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon advance approval by Aetna, subject to plan limitations and exclusions including the maximum benefit shown in the Medical Schedule of Benefits on p. 6.

- Injectable fertility drugs.
- Intrauterine insemination.

Advanced Reproductive Technology (ART) Benefits — ART is defined as:

- In vitro fertilization (IVF)
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)

Eligibility for ART Benefits — To be eligible for ART benefits, the patient needs to meet the requirements above and all of the following criteria:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services don't result in a pregnancy in which a fetal heartbeat is detected.
- Be referred by the patient's physician to Aetna's infertility case management unit.
- Obtain advance approval from Aetna's infertility case management unit for ART services by an ART specialist.

Covered ART Benefits — The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to plan limitations and exclusions:

- Subject to the maximum benefit as shown in the Medical Schedule of Benefits on p. 6 of any combination of the Comprehensive Infertility services and following ART services per lifetime (where lifetime is defined to include all Comprehensive Infertility and ART services received, provided or administered by Aetna) which only include IVF, GIFT or ZIFT.
- IVF, GIFT or ZIFT; subject to the maximum benefit shown in the Medical Schedule of Benefits on p. 6 while covered under this plan.
- Charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture.
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this plan.

Limitations and Exclusions — Unless otherwise specified above, the following charges won't be payable as covered expenses under this plan:

- Any services or supplies provided without advance approval from Aetna's infertility case management unit.
- ART services for a female attempting to become pregnant who hasn't had at least one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or six months or more of timed, unprotected coitus, or six cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program.

- ART services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.).
- Donor egg purchases and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy).
- Donor sperm purchases and any charges for the storage of sperm.
- Drugs related to the treatment of non-covered benefits.
- Gestational carrier charges (all charges associated with a gestational carrier program for the covered person or the gestational carrier).
- Home ovulation prediction kits.
- Infertility services that aren't reasonably likely to result in success.
- Ovulation induction and intrauterine insemination services if the patient isn't infertile.
- Reversal of sterilization surgery.

Anthem and Cigna

Charges made by a physician to diagnose and treat the underlying medical cause of infertility. Infertility services for artificial insemination, in vitro, gamete intrafallopian transfer, zygote intrafallopian transfer and injectable fertility drug expenses are limited to a \$10,000 lifetime maximum (p. 8).

Charges include those made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but aren't limited to:

- Approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy.
- Artificial insemination.
- Diagnostic evaluations.
- Embryologist services.
- Gamete intrafallopian transfer (GIFT).
- In vitro fertilization (IVF).
- Infertility drugs that are administered or provided by a physician, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy.
- Laboratory tests.
- Sperm washing or preparation.
- Zygote intrafallopian transfer (ZIFT).

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- Any experimental, investigational or unproven infertility procedures or therapies.
- Cryopreservation of donor sperm and eggs.
- Donor charges and services.
- Infertility services when the infertility is caused by or related to voluntary sterilization.
- Reversal of male and female voluntary sterilization.

Laboratory Tests and X-Rays

Charges for laboratory tests or x-rays for diagnosis or treatment.

Mammograms

Charges for mammograms, other than routine mammograms covered as preventive care, to diagnose specific symptoms or observations.

Medical Benefits

Covered Services and Supplies (continued)

Morbid Obesity

Non-surgical treatment is covered only if services are provided by a physician, licensed or certified dietician, nutritionist or hospital for the following weight management services:

- An initial medical history and physical exam.
- Diagnostic tests given or ordered during the first exam.

Surgery is covered only if:

- It is determined to be medically necessary by the patient's physician.
- The patient meets clinical criteria as determined by your carrier.

Limitations — Unless otherwise specified in this summary plan description, charges for the following services are not covered:

- Exercise programs, exercise or other equipment.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.
- Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Limits may also apply to surgical procedures and related outpatient services and follow-up visits. For example, normally only one surgery is covered (unless multi-stage surgical procedures are planned) and related services must be received within specified time limits before and after surgery.

Nurse Practitioner

Charges for services provided by a licensed or certified nurse practitioner acting within the scope of that license or certification.

Nutritional Evaluation

Charges for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Other Charges

Charges (other than charges made by a hospital, on its own behalf, for medically necessary services and supplies) made for:

- Anesthesia and its administration.
- Blood transfusions and blood not donated or replaced.
- Diagnostic x-ray and laboratory examinations.
- Dressings.
- Initial lenses and frames that are prescribed as a result of covered surgery or physical injury to the eyes.
- Oxygen and other gases and their administration.
- Prosthetic appliances.
- Radiation therapy.
- Radium and radioactive isotope treatment.
- Rental of an oxygen breather.
- Rental of durable medical equipment prescribed for temporary therapeutic treatment.
- Rental of wheelchairs and hospital beds.

The plan has the discretion to include as covered medical expenses, the purchase price rather than the rental charge for an oxygen breather, durable medical equipment, wheelchairs or hospital beds.

Outpatient (Ambulatory) Surgery

Charges for outpatient surgery.

Pervasive Developmental Disorder

Charges for speech, occupational and physical therapy for pervasive developmental disorders (including autism) for children who are under age five, subject to plan limitations and exclusions. Therapy for individuals age five or older is not covered.

Physician

Charges for physician services for:

- Emergency room services.
- Hospital, office and home visits.
- Medical care and treatment.

Pre-Admission Testing

Charges for pre-admission testing.

Pregnancy and Maternity

Charges for pregnancy and maternity services:

- Birth center services.
- Inpatient care for the mother and newborn child, for up to 48 hours following a vaginal delivery and 96 hours following a cesarean section (Carrier authorization is required for longer lengths of stay).
- Routine well-baby care given during a newborn child's initial hospital confinement, including hospital services for nursery care, other services and supplies given by the hospital, services of a surgeon for circumcision, and physician services.
- Services of a licensed or certified nurse-midwife.

Prescription Drugs

Charges for prescription drugs and medicines for inpatient services. Information on outpatient prescription drugs is provided in the Prescription Drug Benefits section on pp. 41-45.

Preventive Care (No Cost for In-Network Care)

Preventive care services and supplies, as well as certain well-woman and well-baby services and supplies, are covered free of charge without any cost sharing — such as a deductible or coinsurance — if:

- They are:
 - Evidenced-based items or services and supplies that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
 - Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
 - 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 (HRSA).
 - With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

- Services and supplies are obtained from an in-network provider.
- The primary purpose for visiting the provider is preventive care.
- The physician or the facility where services/supplies are received indicates those services/supplies are for preventive care when they submit claim information to your carrier.

For additional information on 100% coverage for in-network preventive care, visit www.healthcare.gov/prevention, call your medical plan carrier or visit your medical plan carrier's website (see back cover).

Cost sharing will apply to services or supplies that are not coded as preventive care in claim information submitted by your provider to your medical plan carrier. Therefore, it is very important that your provider accurately code the services and supplies that he/she is providing so that you can receive the preventive services at no cost to you.

The cost-sharing rules for office visits are as follows:

- If a preventive care service/supply is billed separately (or is tracked as individual encounter data separately) from an office visit, then cost sharing may apply to the office visit.
- If a preventive care service/supply is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the preventive care service/supply, then cost sharing does not apply.
- If a preventive care service/supply is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of a preventive care service/supply, then cost sharing may apply.

Even though qualifying in-network preventive care is covered 100%, your medical plan carrier may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive care service/supply to the extent it is not specified under federal guidelines.

Medical Benefits

Covered Services and Supplies (continued)

Following are examples of how cost-sharing rules apply.

Example 1 — Mary visits an in-network physician and is screened for cholesterol abnormalities. (The screening has a rating of A or B in the current recommendations of the United States Preventive Services Task Force [USPSTF] with respect to Mary.) The physician bills the plan separately for an office visit and for the laboratory work associated with the cholesterol screening. Mary pays \$0 (no cost sharing) for the separately-billed laboratory work; however, because the office visit is billed separately from the cholesterol screening, there may be cost sharing for the office visit.

Example 2 — Same facts as in Example 1. As a result of the screening, Mary is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations of the USPSTF. Because the treatment is not included in the USPSTF recommendations, cost sharing may apply to the treatment.

Example 3 — Mary visits an in-network physician to discuss recurring abdominal pain. During the office visit, Mary has a blood pressure screening that has a rating of A or B in the current recommendations of the USPSTF. The physician bills the plan for an office visit. Since the blood pressure screening is provided as part of the office visit that did not have a primary purpose of preventive care, cost sharing may apply to that office visit.

Example 4 — Mary's child, Billy, visits an in-network pediatrician to receive an annual physical exam included as part of the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). During the office visit, Billy receives additional services and supplies that are not supported by the HRSA or other qualifying preventive care regulations. The pediatrician bills the plan for an office visit; however, the service is not billed as a separate charge. Since the primary purpose for the visit was to deliver services/supplies described as part of the comprehensive guidelines supported by the HRSA, cost sharing does not apply to Billy's office visit.

Preventive Care Service/Supply Examples — Following are examples of covered preventive care services/supplies. (Visit www.healthcare.gov for more information.) You can ask your physician which specific services are appropriate for your age, gender and health status. If you have questions, contact your medical plan carrier.

Services and Supplies for Adults

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Depression screening
- Type 2 diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults — doses, recommended ages, and recommended populations vary:
 - Hepatitis A (HepA)
 - Hepatitis B (HepB)
 - Herpes zoster (shingles)
 - Human papillomavirus (HPV)
 - Influenza (flu)
 - Measles, mumps, rubella (MMR)
 - Meningococcal (meningitis)
 - Pneumococcal (PCV)
 - Tetanus, diphtheria, pertussis (Td/Tdap)
 - Varicella (chickenpox)
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users

Certain prescribed preventive care medications, such as aspirin and oral contraceptives, may be covered under prescription drug benefits (see p. 42). For example, coverage is provided for prescribed:

- Aspirin for men and women of certain ages to prevent cardiovascular disease.
- Folic acid supplements for women who may become pregnant.
- Iron supplements for children ages 6-12 months who are at risk for anemia.

Services and Supplies for Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- Breast cancer gene testing (BRCA) and counseling about genetic testing for women at higher risk
- Breast cancer chemoprevention counseling for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling (FDA-approved oral contraceptives are covered under prescription drug benefits; see p. 42.)
- Domestic and interpersonal violence screening and counseling
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk

- Hepatitis B screening for pregnant women at their first prenatal visit
- Human immunodeficiency virus (HIV) screening and counseling for sexually active women
- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually transmitted infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Well-woman visits to obtain recommended preventive services/supplies

Services and Supplies for Children

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages (ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years)
- Blood pressure screening for children (ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years)
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders (ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years)
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns

Medical Benefits

Covered Services and Supplies (continued)

- Hearing screening for all newborns
- Height, weight and body mass index (BMI) measurements for children (ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years)
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
 - Diphtheria, tetanus, pertussis (Td/Tdap)
 - Haemophilus influenzae type b
 - Hepatitis A (Hep A)
 - Hepatitis B (Hep B)
 - Human papillomavirus (HPV)
 - Inactivated poliovirus (IPV)
 - Influenza (flu)
 - Measles, mumps, rubella (MMR)
 - Meningococcal (meningitis)
 - Pneumococcal (PCV)
 - Rotavirus (RV)
 - Varicella (chickenpox)
- Lead screening for children at risk of exposure
- Medical history for all children throughout development (ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years)
- Obesity screening and counseling
- Oral health risk assessment for young children (ages: 0-11 months, 1-4 years, 5-10 years)
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis (ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years)
- Vision screening

Limitations and Exclusions

- Services and supplies that are not recommended as preventive care by the U.S. Preventive Services Task Force or do not have an A or B rating from that task force. (Visit www.healthcare.gov/prevention for information.)
- Services and supplies that do not follow the government's age, gender, frequency or family history recommended guidelines.
- Services and supplies that are not coded by the patient's provider as preventive care in claim information submitted to your medical plan carrier. These may include, but are not limited to services and supplies, such as:
 - Services and supplies provided to diagnose a condition, treat a specific illness, or monitor an existing condition.
 - Additional services and supplies recommended or required as a result of a preventive care visit.
 - Services and supplies provided to treat a condition or diagnosis that is detected through preventive care.
 - Any part of services/supplies received that are not coded as preventive care during a visit (for example, if part of the office visit is for treatment of a condition or if part of the lab work is to check the status of a known condition).
- Non-routine exams, vaccinations and immunizations.
- Services and supplies that are covered to any extent under any other part of your plan.
- Services and supplies that are for diagnosis or treatment of a suspected or identified illness or injury.
- Services and supplies not given by a physician or under his/her direction.
- Exams given during an inpatient stay for medical care.
- Psychiatric, psychological, personality or emotional testing or exams.
- Physical exams, testing, vaccinations, immunizations, or treatments when:
 - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Required to obtain or maintain a license of any type.

- Preventive care medications. Certain medications may be covered under prescription drug benefits (see p. 42).
- One manual breast pump per pregnancy in conjunction with childbirth.

Aetna Preventive Care Limits — If your medical plan carrier is Aetna, the following limits apply to preventive counseling visits and breast pump purchases:

- Alcohol/substance abuse counseling is limited to five visits per calendar year.
- Electronic breast pump purchases are limited to one every 36 months.
- Contraceptive counseling is limited to two visits every 12 months.
- Lactation counseling is limited to six visits every 12 months.
- Obesity counseling is unlimited up to age 22; if age 22 or older, counseling is limited to 26 visits per calendar year, 10 of which can be used for healthy diet counseling.
- Tobacco abuse counseling is limited to eight visits per calendar year.

In determining the visit maximums, each session of up to 60 minutes equals one visit.

Out-of-Network Preventive Care Is Not Covered at 100%

If you receive preventive care services or supplies from an out-of-network provider, coverage will be provided at the out-of-network benefit level shown in the Medical Schedule of Benefits on p. 8.

Private Duty Nursing

Charges for private duty nursing provided on an outpatient basis by a registered nurse (RN) or licensed vocational nurse (LVN) only when approved as part of a home healthcare plan.

Prosthetic/Medical Appliances

Charges for:

- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts, and medically necessary repair, maintenance or replacement of those appliances.
- The initial purchase and fitting of external prosthetic devices that are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct sickness, injury or congenital defect, including only artificial arms and legs and terminal devices, such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

Short-Term Rehabilitative Therapy

Charges for short-term rehabilitative therapy that is a part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac rehabilitation, respiratory and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting. Therapies must be ordered and monitored by a physician, given in accordance with a written treatment plan approved by a physician, provided by a qualified therapist, and progress reports must be submitted at the intervals stated in the treatment plan.

Rehabilitation therapy applies only to:

- Inpatient services of a hospital or rehabilitation facility for room, board, care and treatment during a confinement.
- Inpatient rehabilitative therapy for intensive and multidisciplinary rehabilitation care that is necessary to improve the patient's ability to function independently.
- Outpatient services of a hospital or comprehensive outpatient rehabilitation facility.

Medical Benefits

Covered Services and Supplies (continued)

Short-Term Rehabilitative Therapy, continued

The following limitations apply:

- Occupational therapy is covered only for purposes of training members to perform the activities of daily living.
- Speech therapy is covered only when the therapy is for speech loss or impairment due to sickness, or to surgery on account of sickness or injury. In the event the loss or impairment is due to a congenital anomaly, speech therapy is available if corrective surgery can't be performed or if corrective surgery is performed prior to therapy.
- Speech, occupational and physical therapy are covered for pervasive developmental disorders (including autism) only for children who are under age five, subject to plan limitations and exclusions.

Short-Term Rehabilitative Therapy Exclusions

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include pervasive developmental disorders (including autism) for individuals who are age five or older, Down's syndrome and cerebral palsy, as they are considered both developmental and/or chronic in nature.
- Services for the treatment of delays in speech development, unless resulting from illness, injury or congenital defect. Speech therapy is not covered when it is used to improve speech skills that have not fully developed, considered custodial or educational, intended to maintain speech communication, or not restorative in nature.
- Services not performed by a physician or under the direct supervision of a physician.
- Services provided by a physician or therapist who resides in the covered employee's home, is a member of the covered employee's family or his/her spouse's family, or is the covered employee's domestic partner.
- Special education to instruct a person whose speech has been lost or impaired to function without that ability. This includes lessons in sign language.

Skilled Nursing Facility

Covered expenses while the patient is confined as a bed patient in a skilled nursing facility as long as:

- 24 hour-a-day nursing care is necessary for recuperation from an injury or illness,
- The care is ordered and approved by a physician and is not custodial care, and
- The confinement takes the place of a hospital confinement or immediately follows a hospital confinement for the same injury or illness.

Covered expenses include the facility's charge for a semi-private room and all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance.

Benefits are limited to 100 days of inpatient care per calendar year.

Limitations — Unless specified above, charges for the treatment of the following are not covered:

- Alcoholism
- Drug addiction
- Mental retardation or any other mental illness
- Senility

Surgical Care

Charges for surgical procedures and services:

- Assistant surgeon services performed by a physician. Covered expenses for these services are limited to a portion of the amount of covered expenses for the surgeon's charge.
- Multiple surgical procedures that are performed during the same operative session. Covered expenses for multiple surgical procedures are limited as follows:
 - Covered expenses for a secondary procedure are limited to 50% of the covered expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
 - Covered expenses for any subsequent procedure are limited to 25% of the covered expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

- Reconstructive breast surgery following a medically necessary mastectomy.
- Reconstructive surgery if performed to improve the function of a body part when the malfunction is the direct result of birth defect, sickness, accidental injury, or surgery to treat a sickness or accidental injury.
- Reconstructive surgery to remove scar tissue on the neck or head if the scar tissue is due to sickness or accidental injury.

Time limits may apply to reconstructive surgery. For example, certain surgical procedures may be required to begin within a certain period or be completed within twelve months following an accident. Contact your carrier for information.

Surgical Supplies

Charges for surgical supplies (such as bandages and dressings) given during surgery or a diagnostic procedure.

Consider the Centers of Excellence Program for Hip or Knee Replacement Surgery

If your doctor recommends either hip or knee replacement surgery, you may be eligible to have the procedure completed at a reduced cost to you through the Centers of Excellence (COE) program. This program partners with hospitals that have a high rate of successful patient outcomes for these types of surgeries. General eligibility requirements are that you must have:

- A condition that meets specific clinical requirements,
- An adult caregiver who is able to travel with you to a COE hospital and assist you during your care, and
- A local doctor who agrees to provide follow-up care.

The program is administered by Health Design Plus and final eligibility decisions are determined by their policies.

The COE program is separate from the HSA and HSA Plus plans. However, once you've met your plan deductible, the COE program coordinates with your benefits to provide 100% coverage for eligible surgery expenses, including consultations, hospital stay, travel, lodging and daily living expenses for you and your caregiver. This means you do not have to pay coinsurance amounts for these expenses. Other services, such as x-rays, prescription drugs and rehabilitation therapy, are covered under your plan benefits as they would be for any other eligible procedures.

The program is completely voluntary. For more information, call Health Design Plus at 800.656.1064 between 8:30 a.m. and 8 p.m. Eastern time, Monday-Friday. Have your employee ID number and Social Security Number available when you call.

Medical Benefits

Covered Services and Supplies (continued)

Telemedicine Services

You can have a face-to-face or telephonic visit with your doctor using your computer or camera-equipped mobile device. You may access telemedicine services with Anthem and Cigna. To learn more about these services, contact your carrier's telemedicine program.

Anthem

www.livehealthonline.com

Cigna

www.mdlive.com/McKesson

TMJ

Charges for the diagnosis and surgical treatment of conditions affecting the temporomandibular joint (TMJ) when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a congenital anomaly, developmental defect or pathology. The plan does not cover charges for orthodontic treatment or for services that are dental in nature.

Transplants (Organ, Bone Marrow and Tissue)

Charges for organ/tissue transplants:

- Artificial support machines while awaiting a human organ or tissue transplant and other approved devices, such as pacemakers and kidney dialysis machines.
- Evaluation.
- Donor search.
- Organ procurement/tissue harvest.
- Search for bone marrow/stem cells from non-biologically related donors.
- Transplant procedure.
- Transportation and lodging subject to a lifetime maximum benefit of \$10,000.

Special programs and provisions apply to qualified procedures for organ/tissue transplants at a designated transplant facility, including medical care and treatment, and transportation and lodging. The covered person needs to obtain advance approval from his/her medical plan carrier (as summarized in the Advance Approval provision on pp. 20-23) prior to the scheduled date of the service or as soon as reasonably possible. Note: it's the covered person's responsibility to understand benefit levels for the facility used. The covered person may be required to use an in-network facility for benefits to be payable under the plan.

The following summarizes additional transplant information for each medical plan carrier.

Aetna — If your medical plan carrier is Aetna, the in-network level of benefits will apply only for transplant services received at an Aetna Institutes of Excellence facility. Services received at other facilities — including Aetna in-network facilities — will be covered at the out-of-network level of benefits.

Unless specified above, charges for the following aren't eligible:

- Services that are covered under any other part of this plan.
- Services and supplies furnished to a donor when the recipient isn't covered under this plan.
- Home infusion therapy after transplant.
- Harvesting or storage of organs, without the expectation of immediate transplant for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplant within 12 months for an existing illness.
- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

Anthem — If your medical plan carrier is Anthem, the in-network level of benefits will apply only for transplant services received at an Anthem Center of Medical Excellence. Services received at other facilities — including Anthem in-network facilities — aren't covered.

Cigna — If your medical plan carrier is Cigna, transplant services (except cornea transplant services*) are covered at 100% when received at Cigna LifeSOURCE Transplant Network® facilities. Transplant services received at other in-network facilities that specifically contract with Cigna for transplant services are payable at the in-network level of benefits. Transplant services received at any other facilities, including out-of-network facilities and in-network facilities that don't specifically contract with Cigna for transplant services, aren't covered.

* Cornea transplants aren't covered at Cigna LifeSOURCE Transplant Network facilities.

Prescription Drug Benefits

Prescription Drug Benefits

Prescription drug benefits cover most outpatient medications, including those for short-term illnesses, such as an ear infection, as well as those for chronic conditions, such as high blood pressure. However, not every drug is covered under the plan. Coverage is subject to the limitations and exclusions summarized in this summary plan description and all prescriptions are subject to state and federal regulations. In addition, no coverage is available for purchases made at out-of-network pharmacies.

Prescription drug coverage works the same way your coverage for medical expenses works:

- You pay prescription drug expenses until your deductible amount is reached, unless your prescription drug is on the HSA Preventive Therapy Drug List — www2.caremark.com/mckesson > **Drug Lists** > **HSA Preventive Therapy Drug List**.
- Once you meet your deductible, the coinsurance benefits shown in the Prescription Drug Schedule of Benefits apply.



If you have dollars in a health savings account (see pp. 12-15), those dollars may be used to help pay your deductible and coinsurance amounts.

Prescription Drug Schedule of Benefits

Outpatient prescription drug benefits under the plan are summarized in the following table. All benefits under the plan are subject to limitations and exclusions, as summarized in this summary plan description.

Plan Feature	Retail/Mail Order/Specialty Pharmacies (in-network only — out-of-network purchases are not covered)
Lifetime Maximum	Plan Pays
• Infertility Treatment	\$10,000 (part of the lifetime infertility treatment maximum as shown in the Medical Schedule of Benefits on p. 6)
Coinsurance Benefits	Plan Pays (for non-preventive care medications, coinsurance applies after deductible is met and before out-of-pocket maximum is met, as summarized in the coinsurance provisions on pp. 16-18)
• Preventive generic drugs on the HSA Preventive Therapy Drug List	100% (deductible is waived)
• Brand name drugs on the HSA Preventive Therapy Drug List	90% (deductible waived)
• Generic and preferred brand name drugs (outside of the preventive drugs lists)*	80%
• Non-preferred brand name drugs	60%
Supply Limit	The amount prescribed by your physician, but no more than a 90-day supply; per unit limits may apply to certain prescriptions (e.g., smoking cessation medications and erectile dysfunction medications) as well as specialty pharmacy purchases
• Maximum quantity for each prescription or refill	

* If you purchase a brand name drug that is part of the step therapy program (see p. 42) and a generic is available, you will pay the full cost of that brand name drug. Coverage will be available for that drug only when your physician and CVS Caremark agree that there is a medical reason why a lower-priced drug is not appropriate for your condition. If you purchase a brand name drug that is not part of the step therapy program and a generic is available, you must pay the difference in cost between the generic and the brand name drug. For example, if you choose to purchase a preferred brand name drug that costs \$65 and the generic drug cost is \$20, you will pay \$45 before plan benefits apply to the purchase. In this example, you would pay the \$45 difference in price plus 20% coinsurance (\$4) on the remaining \$20 for a total out-of-pocket cost of \$49.

An expense is considered incurred on the date you purchase a prescription drug. For example, if you receive a medication from the mail order pharmacy in January that the pharmacy processed at the end of the previous year, that expense is considered an expense for the previous year and would not apply to your current year's deductible.

Prescription Drug Benefits

Eligible Expenses

Eligible outpatient prescription drug expenses include eligible charges for:

- Drugs that may be dispensed only with a written prescription from a physician.
- Insulin, insulin needles and syringes, and diabetic test supplies when prescribed by a physician.
- Over-the-counter drugs that are recommended for preventive care by the federal government (have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force) and are prescribed by a physician.

Only those charges that CVS Caremark determines to be eligible are covered. When a new drug becomes available, the CVS Caremark panel of experts considers the latest information available about the drug’s effectiveness and decides whether to cover the new drug.

Preventive Care Medications — Charges for certain preventive care medications (e.g., aspirin, folic acid supplements, iron supplements and oral contraceptives) are covered free of charge without any cost sharing — such as a deductible or coinsurance — if they:

- Are prescribed by a physician,
- Are recommended for preventive care by the federal government (have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force), and
- Are purchased at an in-network pharmacy.

The prescription requirement applies even if the medication is an over-the-counter drug. In this event, you do not need to give the prescription to your pharmacist, but you do need it to document your claim for benefits. Obtaining a prescription for an over-the-counter medication can be as simple as calling your physician’s office and asking them to mail the prescription to you. The prescription must state the name of the patient and the name of the over-the-counter medicine, and must be signed and dated by a licensed healthcare professional.

Step Therapy

Step therapy requires that you try cost-effective, generic drugs before purchasing (or “stepping up to”) more expensive medications. This feature is designed to help you make educated choices by considering medication options that can save healthcare dollars.

You and your physician continue to make final decisions about which medications are right for you; however, coverage will be available for brand name medications only when your physician and CVS Caremark agree that there is a medical reason why a lower-priced drug is not appropriate for your condition. **If your brand name drug is not approved under step therapy, you will pay the full cost for that drug.**

How Step Therapy Works When You Visit a Pharmacy

The pharmacist enters your prescription information into the CVS Caremark computer system.

If your prescription is for a first step medication or your physician has a current medical necessity exception on file with CVS Caremark, the pharmacist will fill your prescription.

If you are required to try a more cost-effective medication, you have the following options:

- You can pay the full price for your medication, or
- You or your pharmacist can call your physician to:
 - Change your prescription to a more cost-effective medication.
 - Ask your physician to request a medical necessity exception from CVS Caremark.

If you submit a brand name medication prescription to the mail order pharmacy that does not meet step therapy purchase requirements, the pharmacy will not fill your prescription. It will notify you by mail.

Preferred and Non-Preferred Brand Name Drugs

Step therapy encourages the use of generic drugs; however, there may be occasions when you need to purchase a brand name drug — for example, if a generic drug is not available. See the Prescription Drug Schedule of Benefits for information about brand name drug costs.

CVS Caremark reviews brand name drugs and designates them as preferred or non-preferred based on their success in effectively treating certain conditions, as well as their relative cost-effectiveness. Preferred brand name drugs are covered at the 80% coinsurance level. The plan's coinsurance pays 60% for other brand name drug purchases.

When a new brand name drug becomes available, CVS Caremark considers the latest information available about the drug's effectiveness and decides whether to add the new drug to its preferred list. If you have questions about brand name drugs, contact CVS Caremark.

Retail Pharmacies

Only purchases from pharmacies that participate in the CVS Caremark network are covered under the plan.

You can obtain a list of in-network pharmacies at no charge by going to www.caremark.com (if you're not registered on this CVS Caremark website, you can go to www2.caremark.com/mckesson).

Each time you make a purchase, you must present your CVS Caremark ID card or provide your Social Security Number to your pharmacist.

Mail Order

You may choose to fill maintenance drug prescriptions through the mail order program. To receive the maximum benefit under the mail order program, ask your physician to prescribe a "90-day supply plus refills" for your maintenance drug prescriptions when clinically appropriate. The mail order pharmacy will fill your prescription for the exact quantity of medication that your physician prescribes, up to the supply limit. You can order refills by phone, online or by using the order form that is included with your prescription drug shipment.

FastStart

FastStart provides quick access to the mail order program. Your medication will usually arrive within 10 days of your order. You can connect to FastStart:

- By Internet: Log on to www.caremark.com. Click **Start a New Prescription** and select **FastStart**.
- By Phone: Call 800.875.0867 (Monday through Friday from 7 a.m. to 7 p.m., Central time). Have your plan ID number*, prescription name, physician's name and phone number, mailing address and payment information ready when placing an order.
- Through Your Physician: Ask your physician to call in your prescription using the FastStart physician number (800.378.5697). Your physician will need your mailing address, date of birth and plan ID number*.

* Your plan ID number is shown on your CVS Caremark ID card.

Automatic Prescription Renewals and Refills

CVS Caremark allows you to automatically refill your prescriptions when they are due and request a new prescription from your physician when you are out of refills. This service is available for most maintenance medications (some medications, such as controlled substances and specialty drugs, require that you contact your physician directly). You can enroll in this program by logging on to www.caremark.com and clicking **Refill Prescriptions**. Select the check box for **Auto Refill** and/or **Auto Renew** for each medication. Then choose phone, email or text message as your preferred method for receiving updates on your prescriptions.

Prescription Drug Benefits

Specialty Pharmacy

The specialty pharmacy specializes in drugs that target and treat complex conditions, such as cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C and HIV/AIDS.

If you or a covered family member are using specialty drugs, we encourage you to contact the specialty pharmacy by visiting www.CVSCaremarkSpecialtyRx.com or calling CaremarkConnect® at 800.237.2767. Their services can help you get more benefit from your specialty drug treatment. Services include:

- Access to an on-call pharmacist 24 hours a day, seven days a week.
- Coordination of care with you and your physician.
- Convenient delivery directly to you or your physician's office.
- Medication- and disease-specific education and counseling.
- Online support, including disease-specific information and interactive areas to submit questions to pharmacists and nurses.

Some specialty drugs require review for safety and appropriate use.

Condition Support Program

If you have asthma, diabetes, heart disease, high blood pressure or high cholesterol, consider participating in the Condition Support Program.* This program provides expert advice on:

- Getting a better understanding about your condition.
- Helping you detect symptoms of a problem.
- Following your physician's treatment plan.
- And more.

Take action by calling your condition support manager.

Aetna In Touch Care
888.257.0411

Anthem Condition Care
866.820.0763

Cigna Personal Health Team
800.244.6224

* Not everyone who has one of the five conditions listed will be eligible because a number of factors relating to the condition determine eligibility.

Prescription Drug Exclusions

Your prescription drug benefits do not cover every drug. Items that are specifically excluded are listed below. Keep in mind that some of the excluded drugs may be covered under the plan's medical benefits. For example, certain immunizations and contraceptive methods are covered under your preventive care benefits.

- Anti-wrinkle medications, except that Retin-A is covered to age 36 as medically necessary.
- Blood and blood plasma.
- Cosmetic therapies.
- Compounding bases, bulk powders and other ingredients (i.e., kits).
- Durable medical equipment, such as crutches, wheelchairs or mobility aids.
- Hair growth and hair removal treatments.
- Hearing aids.
- Allergy agents for injection.
- Infertility expenses in excess of the plan's \$10,000 per person lifetime maximum benefit (prescription drug expenses for infertility treatment are combined with medical expenses for infertility treatment for purposes of the \$10,000 lifetime maximum).
- Medical devices or equipment.
- Non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria).
- Non-prescription or over-the-counter medications (except for preventive care medications prescribed by your physician).
- Prescriptions exceeding a reasonable quantity as designated by the plan (e.g., Imitrex tablets are limited to 18 tablets per month, smoking cessation medication is limited to a 24-week supply per calendar year, and impotence medication, including Viagra, Edex and Uprima, is limited to 6 pills per 30 day supply).
- Products not approved for use in the United States.
- Products for experimental therapy.
- Products purchased outside the United States unless in an emergency situation.
- Products used at or dispensed at an outpatient or inpatient facility, clinic or physician's office, including hospitals, extended/nursing care homes, home healthcare services or home infusion services.
- Therapy for anyone other than the recipient of the prescription, as eligibility permits.

General Limitations and Exclusions

General Limitations and Exclusions

In addition to other limitations and exclusions referenced in this summary plan description, the plan does not cover expenses relating to, arising out of, or in connection with the services summarized in this section. (For purposes of this listing, “services” includes services, treatments, therapies, supplies, equipment, devices and drugs.) No benefits are payable unless your carrier/CVS Caremark determines the services are covered under the plan and for a medically necessary service/supply or for a recommended preventive service under federal law. Your carrier/CVS Caremark may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information. Contact your carrier/CVS Caremark for additional information.

If you're not sure the service you are considering is covered, call the applicable carrier (your medical plan carrier or CVS Caremark) for information before you receive the service.

Custodial Care, Maintenance Care, Education and Training

Custodial care, maintenance care, education or training. Also see Custodial under Mental Health/Substance Use Disorder exclusions on p. 48.

Deadlines and Service Dates

Claim Filing Date	Any claim that's received by the claims administrator more than one year after the service has been provided.
Service Date	Services received before the individual becomes covered under the plan or after the date his/her coverage under the plan ends.

Equipment, Rental Costs and Other Related Items

Communication Devices	Augmentative communications devices.
Durable Medical Equipment	Durable medical equipment other than breast pump rental/purchase and the rental/purchase of wheelchairs, hospital beds and similar medically-necessary equipment for temporary therapeutic treatment of a covered illness or injury.
Medical Supplies	Medical supplies other than crutches, casts, splints, braces and similar medically necessary items for temporary therapeutic treatment of a covered illness or injury.

Medical Necessity and Other Requirements

Excludable Actions	Services for or in connection with injuries that result from the covered person's commission of a crime or that result when the covered person is the aggressor in a dispute.
	Services for or in connection with war, declared or undeclared, or any act of war.
Experimental, Investigational or Unproven	Services that are experimental, investigational or unproven.
Legal Considerations	Charges to the extent that payment under the plan is prohibited by any law of the jurisdiction in which the covered person resides at the time the expenses are incurred.
	Charges that the covered person is not legally required to pay or for charges which would not have been made if no coverage had existed.
Maximum Reimbursable Charge	Charges that are in excess of maximum reimbursable charges.
Medical Necessity	Services that do not meet generally accepted standards of practice in the medical community.
	Charges that are not for medically necessary services.
Self-Inflicted Injury	Intentionally self-inflicted injury that is not inflicted as a result of a medical condition, including physical and mental health conditions.
Work Related Injury or Sickness	Injury or sickness arising out of, or in the course of, any work for pay or profit.

General Limitations and Exclusions

Providers	
Family Members	Services provided by an immediate family member, or by a person ordinarily living in the same home with the covered person.
Non-Licensed Providers	Any service not recommended and approved by a licensed physician or rendered by anyone other than a licensed healthcare provider.
Outside the U.S.	Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished for care that (1) could not have been foreseen or scheduled prior to the individual's trip or stay outside the United States; and (2) that is in connection with urgent care or for emergency services.
U.S. Government Hospital	Charges from a hospital owned or operated by the United States Government if the underlying services are covered at 100%.
Specific Care or Treatment	
Adoption and Surrogacy	Adoption or surrogate services.
Alternative Care	Alternative treatment services (such as acupressure, aromatherapy, art therapy, hypnotism, massage therapy, rolfing, etc.). Also see Alternative Care on p. 50.
Applied Behavioral Analysis	Applied behavioral analysis therapy.
Artificial Organs	Artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services, unless specifically covered under Prosthetic/Medical Appliances on p. 37.
Autopsy	Autopsies.
Benign Gynecomastia	Benign gynecomastia (abnormal breast enlargement in males) services.
Blood	Blood that has been donated or replaced. Also see Storage on p. 49.
Body Scans	Full body scans.
Cosmetic	Cosmetic or reconstructive surgery and related services, except for the following: • Reconstructive surgery following a covered mastectomy. • Surgery to repair a defect caused by an accidental injury resulting in a functional impairment. • Reconstructive surgery related to or following surgery that was needed due to an injury, sickness or other disease of that part of the body. • Cosmetic or reconstructive surgery to repair a dependent child's congenital or developmental defect. Time limits may apply. For example, certain surgical procedures may be required to begin within a certain period or be completed within twelve months following an accident. Contact your carrier for information.
Counseling	• Clergy services • Marriage counseling Also see Weight Control and Non-Medical Counseling or Training on p. 49, and Mental Health/Substance Use Disorder limitations and exclusions on pp. 50-51.
Court Orders	Court-ordered services or confinements (including orders by a law enforcement officer) unless prescribed by a physician and determined to be medically necessary.
Dental	Treatment of the teeth or periodontium, the use of orthodontic appliances or devices, including use related to a temporomandibular joint disorder (TMJ), unless the expenses are incurred for: • Charges made for dental work necessitated by injury to sound natural teeth sustained while the individual is covered under the plan, and • Charges made by a hospital for room and board or medically necessary services, or • Charges made by a physician for a surgical procedure subject to the restrictions and limitations under the plan.

General Limitations and Exclusions

General Limitations and Exclusions (continued)

Specific Care or Treatment, continued	
Drugs and Medicines	Outpatient drugs available without prescription, even when prescribed by a physician (unless covered under prescription drug benefits as part of preventive care). Non-prescription drugs or medicines, prescription drugs that have not been classified as effective by the FDA, bioengineered drug therapy that has not received FDA approval for the specific use being requested, or prescription drugs that are not administered according to generally accepted standards of practice in the medical community. Prescription drugs or medicines, except as provided while a patient at a hospital or as covered under prescription drug benefits. Also see Prescription Drug Exclusions on p. 45.
Dietary Supplements and Vitamins	Dietary supplements and vitamins, except iron supplements for children ages six to 12 months who are at risk for anemia. Also see Therapy and Counseling on p. 49.
Foot	Arch supports, foot orthotics not prescribed by a physician, and orthopedic shoes, such as biomechanical evaluation, range of motion measurements and reports, and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery or is a medically necessary part of the initial care for treatment of a condition.
Gambling	Counseling for compulsive gambling
Hearing and Vision	Routine vision exams (except vision screening for all children), eyeglasses, contact lenses, radial keratotomy, photorefractive keratectomy (PRK), laser assisted in situ keratomileusis (LASIK), routine hearing exams (except for all newborns), hearing aids, or examinations for prescription or fitting of eyeglasses, contact lenses or hearing aids. This does not apply to the initial lenses and frames that are prescribed as a result of covered surgery or physical injury to the eyes. (Routine hearing and vision screenings may be covered under preventive care when provided as part of a routine physical exam.)
Hospital/Inpatient	Diagnostic tests performed on an inpatient basis that could have been performed on an outpatient basis. Hospital room and board expenses that exceed the semi-private room rate unless a private room is approved as medically necessary by your carrier. Personal comfort items while hospitalized, such as telephones or televisions.
Infertility	Donor ova or sperm for artificial insemination. Infertility services as a result of voluntary sterilization of either one of the partners (with or without surgical reversal) or a hysterectomy. Reversal of voluntary sterilization procedures including related follow-up care. Treatment of infertility in excess of the lifetime maximum of \$10,000. Also see Adoption and Surrogacy on p. 47.
Injections	Physician charges for injections that can be self-administered
Jaw	Jawbone surgery (upper and lower), except as required for the direct treatment of acute traumatic injury, dislocation, tumor or cancer. Orthognathic surgery and jaw alignment, except as treatment of obstructive sleep apnea.
Mental Health/Substance Use Disorder	See Mental Health/Substance Use Disorder limitations and exclusions on pp. 50-51.
Private Duty Nursing	Private duty nursing services, unless they have been approved by your carrier as part of a home healthcare program.

General Limitations and Exclusions

Specific Care or Treatment, continued	
Storage	Long-term (more than 30 days) storage of blood, blood products, umbilical cord, or other materials, such as cryopreservation of tissue.
Therapy and Counseling	Applied behavioral analysis therapy. Nutrition-based therapy, food, vitamins, minerals and nutritional counseling except where specifically identified as a covered service under the plan. Counseling for a healthy diet will be covered as preventive care if the counseling is intensive behavioral dietary counseling of an adult patient with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease if provided by a primary care clinician or by a physician referral to a specialist, such as a nutritionist or dietitian. Short-term rehabilitative therapy to treat pervasive developmental disorders (including autism) other than speech, occupational and physical therapy for children under age five.
Training	Vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high-risk pregnancies, asthma or cancer programs.
Travel and Transportation	Transportation other than professional ambulance service to or from the nearest hospital where medical care and treatment necessary for the patient can be provided. Travel or transportation expenses, even if ordered by a physician, except where specifically identified as a covered service under the plan.
Vision	See Hearing and Vision on p. 48.
Weight Control	Any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, except as summarized in morbid obesity information on p. 32. However, preventive care, including obesity screening and counseling for all adults and diet counseling for adults at higher risk for chronic disease is free and covered as preventive care.
Non-Medical Expenses, Services and Other Non-Covered Charges	
Administration	Duplicating and obtaining medical records (includes mailing, shipping and handling expenses, completion of any form).
Missed Appointments	Charges for failing to keep a scheduled visit.
Non-Medical Counseling or Training	Non-medical counseling or training services.
Other	Treatment in excess of any visit, day or supply limitations.
Payable Under Other Insurance or Other Programs	
Any Source	Injury or sickness for which the covered person is entitled to a recovery from any source, including settlements and recoveries derived from workers' compensation, a liable third party or responsible party, or from other insurance coverage (e.g., homeowners' insurance, MedPay, personal injury protection, no-fault, underinsured and uninsured motorist insurance). The claims administrator may, however, advance plan benefits, subject to an automatic lien for the amount of the advanced plan benefits against any recovery from other sources.
Automobile Insurance	Any services for which benefits are received or could be received if claims were made under any automobile insurance policy to the extent that the policy provides benefits for services covered under this plan.
Public Programs	To the extent that the covered person is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public program. For purposes of this exclusion, any individual who, at any time, was entitled to enroll in all or any portion of Medicare but who did not enroll will be considered to be entitled to reimbursement in an amount equal to the amount to which he/she would have been entitled, if any, if he/she were enrolled.

General Limitations and Exclusions

General Limitations and Exclusions (continued)

Mental Health/Substance Use Disorder

In addition to other limitations and exclusions under the plan, benefits are not available for the mental health/substance use disorder services listed below. (For purposes of this listing “services” includes services, treatments, therapies, supplies, equipment, devices and drugs.) Exclusions apply regardless of whether the services:

- Are recommended or prescribed by a provider, and/or
- Are the only available treatment options for the condition.

The plan does not cover services relating to, arising out of, or given in connection with the following.

Mental Health/Substance Use Disorder	
General	Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM). Services except for the initial diagnoses, for primary diagnoses of mental retardation; learning, motor skills and communication disorders; pervasive developmental disorder (including autism) for individuals who are age five or older; conduct disorder; dementia; sexual and paraphilia disorders; and personality disorders. Services for mental health/substance use disorder treatment that, in the reasonable judgment of your carrier, are any of the following: • Not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder, • Not consistent with prevailing national standards of clinical practice for the treatment of those conditions, • Not consistent with prevailing professional research demonstrating that the service will have a measurable and beneficial health outcome, or • Not consistent with your carrier's best practice as modified from time to time. Examination or treatment, unless it otherwise qualifies as a behavioral health service, when: • Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage, or adoption, • Ordered by a court except as required by law, • Conducted for purposes of medical research, or • Required to obtain or maintain a license of any type.
Alternative Care	Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
Counseling	Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan. Note that nutritional counseling may be covered as preventive care in certain circumstances.
Custodial	Custodial care except for the acute stabilization and return back to the patient's baseline level of individual functioning. Care is determined to be custodial when it: • Provides a protected, controlled environment for the primary purpose of protective detention and/or provides services necessary to assure competent functioning in activities of daily living, or • Is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary to function outside a structured environment. This applies when there is little expectation of improvement in spite of any treatment attempts.

General Limitations and Exclusions

Mental Health/Substance Use Disorder, continued	
Equipment	Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
Experimental, Investigational or Unproven	Services that are considered experimental, investigational or unproven because they do not meet generally accepted standards of medical practice in the United States. This applies even if that service is the only available treatment for a particular condition.
Legal Considerations	Behavioral health services for which the patient has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the plan.
No Reasonable Expectation of Successful Outcome	Repeated and volitional non-compliance with treatment recommendations that results in a situation in which there can be no reasonable expectation of a successful outcome.
Other Coverage	Services provided under another plan. Service or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto or similar legislation. If coverage under workers' compensation or a similar law is optional because the covered person could elect it or could have it elected for him/her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
Personal Convenience Items	Personal convenience or comfort items including, but not limited to, TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
Private Duty Nursing	Private duty nursing services while confined in a facility.
Providers	Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the provider's licensure. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself/herself. Services performed by a provider with the same legal residence as the patient.
Records	Charges for record processing except as required by law.
Surgery	Any surgical services or procedures.
Testing	Neuropsychological testing when used for the diagnosis of attention deficit disorder.
Therapy	Applied behavioral analysis therapy. Therapies to treat pervasive developmental disorders (including autism) other than speech, occupational and physical therapy for children under age five.
Transportation	Travel or transportation expenses unless your carrier has requested and arranged for the patient to be transferred by ambulance from one facility to another. Also see Travel and Transportation on p. 49.
War/Armed Forces	Behavioral health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when the covered person is legally entitled to other coverage.
Weight Control	Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans, or any related products or supplies.

Circumstances That May Affect Benefits

Coordination of Benefits

When you are covered under this plan and another plan with which this plan coordinates benefits, one plan is primary and the other is secondary. The primary plan will pay benefits without regard to the other plan. If this plan is secondary, it will coordinate its payments with those of the other plans.

This plan coordinates benefits with the following plans (excluding individual insurance policies, which include private health insurance obtained through an Exchange/Health Insurance Marketplace) providing medical, prescription drug or dental benefits:

- Insurance and any other arrangement of benefits for individuals of a group,
- Prepayment coverage or any other coverage for which an employer or labor union makes contributions or remits payroll deductions,
- A labor-management trustees plan, collectively bargained welfare plan, employer organization or employee organization plan,
- Any governmental program or coverage required to be provided by statute, and
- Medicare.

If This Plan Is Secondary

If this plan is secondary, benefits that would otherwise be paid by this plan during the calendar year will be reduced by the benefits payable by the other plan. This reduction applies even if a claim is not filed with the other plan.

This means that this plan will reimburse you only for the difference between what it would have paid if it were the primary plan and the actual amount paid by the other plan.

No benefit is paid unless the amount paid by the primary plan for total charges is less than the benefit that would have been payable under this plan.

Rules for Determining Primary Status

For all plans other than Medicare, the primary plan is determined as follows:

- If the other plan has no coordination of benefits provision, it is primary.
- A plan is primary if it covers the person as an employee and is secondary if it covers the person as a dependent or former employee.

For example: Mary's husband is covered as an employee under his employer's medical plan and as a dependent under this plan. His employer's plan will pay benefits first.

- If a child is covered under two or more plans, the plan that covers him/her as a dependent of the parent whose birthday occurs earliest in the calendar year is primary (the "birthday rule") except as follows:
 - If the parents have the same birthday, the plan that has covered the parent the longest is primary.
 - If the other plan does not use the birthday rule but bases primary/secondary status on the parent's gender, then the rules of the other plan will determine which plan is primary.
 - If parents are separated or divorced, the plan of the parent with responsibility for the child under a court decree is primary.
 - If the parents are separated or divorced, the custodial parent has not remarried and no court decree exists, the plan of the custodial parent is primary.
 - If the parents are divorced and the custodial parent remarries, the plan of the custodial parent is primary, the plan that covers the child as a dependent of the stepparent is secondary and the plan that covers the child as a dependent of the parent without custody is third.
 - If the parents are separated or divorced and have joint legal custody of the child and the court decree does not state which parent is responsible for the child's healthcare expenses, the birthday rule applies.

If none of the above determine which plan is primary, the plan that has covered the person the longest is primary.

Circumstances That May Affect Benefits

Coordination of Benefits With Medicare

If a person is covered by this plan and Medicare, Medicare is primary and this plan is secondary except as summarized below and as otherwise required by applicable law. A person is considered to be covered by Medicare for any expenses incurred at any time he or she was entitled to enroll in Medicare.

This plan is the primary plan with respect to Medicare for the following expenses:

- For expenses incurred by a person who is either a McKesson employee or a dependent who is a spouse of a McKesson employee, all covered expenses incurred during the period starting on the first day of the first month in which the person is eligible for Medicare based on age (e.g., attaining age 65) and ending on the day on which the person ceases to be a McKesson employee or a dependent of a McKesson employee.
- For expenses incurred by a person who is a McKesson employee or a dependent of a McKesson employee, all covered expenses incurred during the period when the person is entitled to Medicare based on disability or end-stage renal disease (ESRD) or covered on account of current McKesson employment.

Under a special rule, Medicare is primary after the end of the 30 month period starting on the first month that a person becomes entitled to Medicare based on ESRD, whether or not the person applies for ESRD-based Medicare.

In no event will Medicare payments, combined with benefits under this plan, exceed 100% of the total allowable expense.

If you're entitled to enroll in all or any portion of the Medicare program but don't enroll, you're considered to be entitled to reimbursement in an amount equal to the amount to which you would have been entitled (if any), if you were so enrolled. This means no HSA or HSA Plus plan benefit may be payable if you fail to enroll in Medicare, for example, in cases where the HSA or HSA Plus plan is secondary to Medicare because you're covered as a former employee. Carefully consider whether to enroll in Medicare, as failure to do so may result in a significant financial penalty to you. McKesson doesn't provide individual Medicare enrollment advice. You may obtain personalized health insurance counseling at no cost to you from your local State Health Insurance Assistance Program (SHIP).

Right to Exchange Information

The claims administrator needs certain information to coordinate benefit payments. It may obtain needed facts from or give them to any other organization or person. The claims administrator does not need to tell you or obtain your consent to do this.

You must give the claims administrator requested information about other plans. If you can't furnish all the information needed by the claims administrator, the claims administrator has the right to obtain this information from any source. If any other organization or person needs information to apply its coordination of benefits provision, the claims administrator has the right to give that organization or person the information. Information can be given or obtained without your consent for this purpose.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. If this occurs, the claims administrator may pay that plan, organization or person for the amount of benefits that the claims administrator determines it should have paid. That benefit amount will be treated as if it was paid under this plan and this plan will not have to pay that amount again.

If this plan makes payments that exceed the amount it is required to pay under the plan's coordination of benefits provisions, the claims administrator has the right to recover the excess amounts from any individuals to whom (or for whom or with respect to whom) these payments were made, any insurance companies, service plans and/or any organizations.

Circumstances That May Affect Benefits

Right of Recovery for Overpayments

If an overpayment is made, the plan has the right to reimbursement in the amount of the overpayment. If you believe that an overpayment may have been made, you must promptly notify the claims administrator of the overpayment.

If the claims administrator determines that an overpayment has been made, you will be notified in writing and you will be required to reimburse the amount of the overpayment to the claims administrator within 30 days of the date the notification was mailed to you. If the overpayment was made on your behalf to another person (e.g., your physician), you will be responsible for taking any action required by the claims administrator to ensure that the overpayment amount is recovered for reimbursement to the plan. You must grant the plan a lien with respect to that recovery up to the reimbursement amount owed and agree to hold that recovery as the plan's trustee until the lien is satisfied. You must pay the recovery to the plan immediately.

If the overpayment is not reimbursed within 30 days following the date the notification is mailed, the claims administrator may:

- Reduce subsequent benefit payments by the amount of the outstanding overpayment, or
- Use any other methods to recover the overpayment amount as determined by the claims administrator.

You will be required to cooperate with the claims administrator and take any action that may be necessary to ensure that the plan is reimbursed for the overpayment amount.

The plan's rights with regard to overpayments won't be affected, reduced, compromised or eliminated by any doctrines limiting its rights such as, but not limited to, the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other defense. The claims administrator has the right to deduct any amount previously overpaid to any person (including, but not limited to, any participant, dependent or provider to whom there has been an assignment of benefits) from any subsequent claim filed by such person, regardless of whether such claim relates to the same person or the same group health plan or qualifies as an overpayment. Contractual setoff or offset rights won't be limited to deductions from benefit payments to the same person or under the same group health plan.

Rights of Recovery

Certain benefit payments are subject to the plan's rights of recovery and are primary to the plan. This includes, but is not limited to, benefit payments related to first party coverage, such as medical payment benefits, personal injury protection, and underinsured motorist/uninsured motorist coverage.

As a condition of receiving benefits under these circumstances, each covered person authorizes and acknowledges the plans' rights of subrogation, reimbursement and restitution. These rights apply regardless of:

- Whether the covered person recovers full damages for their losses.
- Whether the covered person has been made whole or how the recovery is itemized, structured, allocated, denominated or characterized. For example, the covered person's recovery may be specified as a recovery for lost wages, damages, attorneys' fees, etc. rather than for medical expenses — this does not affect the plan's recovery rights. The plan will not be responsible for any costs or attorneys' fees associated with the recovery unless specifically agreed to in writing.

For example: Mary's injuries in a car accident are determined to be the fault of the other driver and his insurance company has agreed to a settlement in the amount of Mary's medical expenses. When Mary receives payment from his insurance company, she must reimburse the plan for any medical expenses the plan has paid for treatment of her injuries.

Circumstances That May Affect Benefits

When the plan pays benefits under this provision, the covered person automatically grants to the plan (as a condition of the payment) a lien to any property (including money) that is directly or indirectly related to benefits paid under this provision regardless of the type of property or the source of the recovery including, but not limited to:

- Any recovery from the payment or compromise of a claim, including an insurance claim.
- A judgment or settlement of a lawsuit.
- Resolution through any alternative dispute resolution process, including arbitration.
- Any insurance, including insurance on the covered person, no-fault coverage, and uninsured and/or underinsured motorist coverage.

The lien applies without regard to the identity of the property's source or holder, or whether the property exists, is segregated, or the covered person has any rights to it. Each covered person also agrees that until the lien is completely satisfied, the holder of the property (whether the holder is the covered person, the covered person's attorney, an account or trust set up for the covered person's benefit, an insurer or any other entity) will maintain possession as the plan's trustee. Accordingly, the trustee agrees to immediately pay over the property as directed by the plan to the extent necessary to satisfy the lien.

Payment of benefits under this provision also imposes other obligations on covered persons. As examples, the covered person must:

- Not assign any applicable rights or causes of action he/she may have against others (including those under insurance policies) without the express written consent of the plan.
- Take possession of any property that is subject to the plan's lien in his/her own name, place it in a segregated account within his/her control, and keep it in his/her possession until the lien is satisfied.
- If the property is not in the covered person's possession, immediately take whatever steps possible to gain possession or have possession transferred to the plan as directed by the plan.
- Cooperate with the plan and take any action that may be necessary to protect its interests under this provision.

Notice Requirement

Each covered person must promptly notify the plan of any of the following:

- The possibility that benefits paid may be subject to the plan's rights to subrogation, reimbursement and restitution.
- The submission of any claim or demand letter, the filing of any legal action, or the request for any alternative dispute resolution regarding any property that may be subject to this provision.
- The commencement date of any trial or alternative dispute resolution process related to any property that may be subject to this provision (the notice should be provided at least 30 days in advance).
- An agreement that any property that may be subject to this provision will be paid to him/her or on his/her behalf whether the agreement results from resolution of a claim, legal action, alternative dispute resolution proceeding, or otherwise.

Priority of Plan Rights

The plan's right to subrogation, reimbursement, restitution, to a lien, and as beneficiary of a trust will not be affected, reduced, compromised or eliminated by any doctrines limiting its rights such as, but not limited to, the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other defense. The plan administrator or its delegate has the full discretion and authority to administer the plan's rights to reimbursement, subrogation and restitution, including, but not limited to, the right to interpret the terms of the plan, including this provision.

Plan Legal Actions

While the plan's subrogation rights include the right to file an independent legal action or an alternative dispute resolution proceeding against a third party (or to intervene in an action or proceeding brought by the covered person or on his/her behalf), it has no obligation to do so.

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Claim Information

Claims Administrators

The medical plan carrier you select when you enroll in the plan (see p. 4) also serves as your medical claims administrator. The outpatient prescription drug claims administrator for all plan members is CVS Caremark.

The claims administrators are the named fiduciaries for purposes of claims and appeals under the plan. They have sole discretionary authority to interpret the terms of the plan as well as any other information relating to claims and appeals. The claims administrators are responsible for decisions regarding the certification of healthcare services, claim payment, interpretation of applicable plan provisions, benefit determinations and eligibility for benefits.

Claims Administrators (also referred to as medical plan carriers and prescription drug carrier)	
Medical	Outpatient Prescription Drugs
Aetna www.aetna.com 877.286.3900	CVS Caremark www.caremark.com 800.378.0822 800.875.0867 (mail order)
Anthem www.anthem.com/ca 866.820.0763	
Cigna www.mycigna.com 800.CIGNA24 (800.244.6224)	

The claims administrators, in their discretion and as applicable, calculate covered expenses following evaluation and validation of provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals or publications.

References to the “claims administrator” in this section refer to the claims administrator for the applicable claim. For purposes of filing claims and appeals, references to “you” also include your authorized representative.

Filing Claims

The claims filing process varies depending on whether your expenses are for in-network services or out-of-network services as summarized below.

In-Network

When you use medical in-network services, your in-network providers are responsible for filing claims with the claims administrator. (Keep in mind that you must obtain advance approval before you receive certain services and supplies as summarized in the Advance Approval provisions on pp. 20-23.) If you receive any bill for a network service that requires payment of more than your normal deductible or coinsurance amount, call or write your claims administrator.

To obtain prescription drug benefits, present your ID card or provide your Social Security Number to the pharmacist when you have a prescription filled at an in-network pharmacy. (Prescriptions filled at other pharmacies are not covered under the plan.) If you do not present your ID card or provide your Social Security Number when you have a prescription filled, send your outpatient prescription drug claim to CVS Caremark. Claim forms are available on your carrier's website or by calling the number on the back of your medical ID card.

Out-of-Network

When you use out-of-network services, claims must be submitted to the claims administrator on the appropriate claim forms. Claim forms are available on your carrier's website or by calling the number on the back of your medical ID card.



Prescriptions filled at out-of-network pharmacies are not covered.

You must submit out-of-network claims as soon as possible, but no later than 12 months after the date the expense is incurred. An expense is considered to be incurred on the date that the covered service or supply is performed or provided. No benefits will be paid if you do not file your claim within this time limit except in the absence of legal capacity.

For example: If you receive medical care on May 27, your claim must be received by your carrier on or before May 27 of the following year. If your claim is not received by that date, no benefits will be payable under the plan.

Each claim must be accompanied by an itemized statement of charges from the provider of services. If the claim is questionable, the claims administrator may request an independent medical examination.

Types of Claims

Claims are classified in one of the following four categories:

- Pre-Service Claims — any claim for a benefit for which the plan requires you to obtain approval in advance of receiving services or supplies. Therefore, any benefit that requires advance approval from a claims administrator is a pre-service claim.
- Urgent Care Claims — any claim for a benefit for care or treatment for which the application of the time periods for making non-urgent care determinations could, as determined by a physician with knowledge of your medical condition, either:
 - Seriously jeopardize your life or health or your ability to regain maximum function.
 - Subject you to severe pain that can't be adequately managed without the care or treatment that is the subject of the claim.

You can help your claims administrator quickly identify urgent care claims by writing "Urgent Care" at the top of your claim form.

- Post-Service Claims — any claim for a benefit that is neither a pre-service nor an urgent care claim.
- Concurrent Care Claims — any claim for a benefit regarding an ongoing course of treatment that was previously approved under the plan for a specific period of time or number of treatments.

You may be able to request assistance in filing a claim or appeal from your state's consumer assistance program or ombudsman. To determine if your state has a resource available, refer to the U.S. Department of Labor website at www.dol.gov/ebsa/capupdatelist.doc or call the Department of Labor Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272). If your state does not have a resource, visit www.healthcare.gov/using-insurance/managing/consumer-help to find other agencies that may be able to provide assistance.

Claim Information

Filing Claims (continued)

Time Limits for Processing Claims

The Time Limits for Processing Claims table summarizes time limits that:

- The claims administrator follows in providing notices of decisions, notices of extensions and notices of the need for additional information to you.
- You are required to follow when you are asked to provide additional information to complete your claim or to correct your claim.

Time Limits for Processing Claims			
Type of Notice or Claim Event	Type of Claim		
	Urgent Care	Pre-Service	Post-Service
Claims administrator's deadline for providing notice of failure to follow proper claim filing procedures	72 hours after receiving improper claim	15 days after receiving improper claim	30 days after receiving improper claim
Your deadline for providing additional information required to decide your claim	48 hours after receipt of notice that additional information is required	45 days after receipt of notice that additional information is required	45 days after receipt of notice that additional information is required
Claims administrator's deadline for providing notice of initial claim decision	• 24 hours after receipt of proper and complete claim • If you have been asked to provide additional information, the earlier of: – 48 hours after receipt of the additional information – 48 hours after the expiration of your 48-hour deadline for providing the additional information	• 15 days after receipt of claim unless an extension of up to 15 days is necessary due to matters beyond the control of the plan* • If you have been asked to provide additional information, the earlier of: – 15 days after receipt of the additional information – 15 days after the expiration of your 45-day deadline for providing the additional information	• 30 days after receipt of claim unless an extension of up to 15 days is necessary due to matters beyond the control of the plan* • If you have been asked to provide additional information, the earlier of: – 15 days after receipt of the additional information – 15 days after the expiration of your 45-day deadline for providing the additional information

* If an extension is needed, you will be notified of the reason for the extension and the date by which the claims administrator expects to make its decision.

Concurrent Care Claims — If you have a concurrent care claim that is also an urgent care claim to extend a previously approved ongoing course of treatment provided over a period of time or number of treatments, the claims administrator will make a determination as soon as possible. The claims administrator will notify you of the determination within 24 hours after receipt of the claim, provided that the claim was received at least 24 hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your request for extended treatment is not received at least 24 hours prior to the end of the prescribed period of time or number of treatments, the request will be treated as an urgent care claim and decided according to the time-frames described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment under non-urgent circumstances, your request will be considered a new claim and decided according to the post-service claim or pre-service claim time limits, whichever applies. If there is a reduction or termination of the previously approved ongoing course of treatment (other than by plan amendment or termination), the claims administrator will notify you before the end of the previously approved period of time or number of treatments. The notification will be made sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit.

Notice and Payment of Claims

The claims administrator makes claim determinations on behalf of the plan in accordance with the plan. If the claims administrator approves your claim in whole or in part, benefits will be paid to you unless your claim has been properly assigned to your healthcare provider. (For purposes of mental health/substance use disorder claims, proper assignment includes a court order for your dependent to undergo evaluation or treatment.)

If Your Claim Is Denied

If all or part of your claim is denied, you will receive a written notice that identifies:

- The reason(s) for the denial, including references to specific plan provision(s) upon which the denial was based.
- The additional materials or information needed to support your claim and why the information or materials are necessary if the claim was denied because you did not furnish complete information or documentation.
- The appeal procedures and the time limits that apply to them.
- Your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) after completion of the plan's appeal process.

If the claim is denied on the basis of an internal rule, guideline, protocol or other similar criterion, the notice will:

- Either state the specific rule, guideline, protocol or other similar criterion, or include a statement that the rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination.
- Advise you that a copy of the rule, guideline, protocol or other criterion will be provided free of charge upon request.

If the claim is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the medical circumstances, or include a statement that the explanation will be provided free of charge upon request.

If the notice of denial involves an urgent care claim, the notice may be provided orally. In this event, a written or electronic confirmation will be sent to you within three days.

Right to Appeal

You have the right to appeal any decision or action taken to deny, reduce or terminate the provision of or payment for healthcare services covered by the plan, or to retroactively terminate ("rescind") your coverage. The claims administrators are fiduciaries with respect to claims and appeals determinations and they have the full discretion and authority to determine entitlement to and the payment of plan benefits, including the right to construe and interpret the terms of the plan and the summary plan description, which may include other incorporated documents that govern the provision of benefits.

When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, healthcare setting, level of care or effectiveness of the healthcare service, you also have the right to have the decision reviewed by an external review organization not associated with your claims administrator, as summarized beginning on p. 61. Except where life or health would be seriously jeopardized, you must first complete the internal appeal process before your request for an external independent review will be granted. However, if the plan does not strictly adhere to the internal claims and appeals processes, you will be considered to have completed the internal appeal process for purposes of initiating an external review.

The claims administrators take steps to avoid conflicts of interest in the appeal process and ensure independence and impartiality of the individuals making claims decisions. As examples:

- Individuals who process internal claims appeals are appointed without regard to the likelihood that the individual would support claim approvals or denials.
- External review processes are conducted by professionals who have no material affiliation or interest with the claims administrators.

Claim Information

Filing an Appeal

To begin the appeal process, you must submit a written notice of the appeal to the claims administrator within the time limit specified in the Time Limits — Appeals table. In your notice, you should state why you believe your claim should be paid.

You may submit written comments, documents, records and other information relating to your claim in connection with your appeal. If your appeal involves an urgent care claim, information may be provided by phone or fax. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records and other information relevant to your claim for benefits.

Time Limits for Processing Appeals

The following table summarizes time limits by which:

- You are required to submit appeals to the claims administrator.
- The claims administrator is required to provide you with notice of determinations of appeals.

Time Limits — Appeals			
Time Limits	Type of Claim		
	Urgent Care	Pre-Service	Post-Service
Your deadline for filing an appeal	180 days after receipt of claim denial notice	180 days after receipt of claim denial notice	180 days after receipt of claim denial notice
Claims administrator's deadline for providing notice of appeal decision	72 hours after receipt of appeal	15 days after receipt of appeal	30 days after receipt of appeal*

* 60 days after receipt of appeal for outpatient prescription drug claims

Appeals Procedure

The review of your appeal will:

- Take into account all comments, documents, records and other information submitted by you that relate to your claim.
- Be decided by a decision maker who is different from the decision maker at the initial claim level. This also applies to any healthcare professional who is consulted at the appeal level.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the claims administrator will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professional consulted will not be the individual who was consulted in connection with any denial of the claim that is the subject of the appeal (nor his/her subordinate).

Upon request, the claims administrator will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, whether or not the advice was relied upon in making the benefit determination. (Contact CVS Caremark for information on the availability of pharmaceutical expert identification.)

If any new or additional evidence has been considered, or rationale relied upon during the appeal process, it will be provided to you at no charge in sufficient time to allow you the opportunity to respond before the notice of determination on appeal is issued.

Notice of Determination on Appeal

Within the time limit shown in the Time Limits — Appeals table, the claims administrator will provide you with written notice of its decision. If your appeal is approved, the claims administrator will take whatever action is necessary to pay benefits as soon as possible. If your appeal is denied, the notice will identify:

- The reasons for the denial, including references to any specific plan provisions upon which the denial was based.
- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.
- The procedure and time limits for requesting an external review of your appeal.
- Your right to bring an action under Section 502(a) of ERISA following an adverse benefit determination after an appeal.

If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, the notice will:

- Either state the specific rule, guideline, protocol or other similar criterion, or include a statement that the rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination.
- Advise you that a copy of the rule, guideline, protocol or other criterion will be provided free of charge upon request.

If your claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the medical circumstances, or include a statement that the explanation will be provided free of charge upon request.

External Claim Reviews

If your appeal is denied, you have the opportunity to have your claim reviewed under an external review process. The external review process for each claims administrator is summarized in this section.

You must complete the appeal process before you can request an external review or bring legal action. However, if the claims administrator does not strictly follow all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the plan's appeal requirements ("deemed exhaustion rule") and may request external review or pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Deemed Exhaustion Rule Exception — The rule does not apply if your claims administrator did not follow all requirements but the violation was minor and not likely to influence a decision or harm you, or if the violation was:

- For good cause,
- Beyond the claims administrator's control, or
- Was part of an ongoing good faith exchange between you and the claims administrator.

You may request a written explanation of the violation from the claims administrator, and the claims administrator will provide the explanation within 10 days, including a specific description of why the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects your request for immediate review because the claims administrator met the standards for the exception, you may resubmit your claim under the internal appeal process. In this event, you will receive notice of the opportunity to resubmit your claim within 10 days or the date of the external reviewer/court rejection. Time periods for re-filing the claim will begin on the date you receive the notice.

Claim Information

External Claim Reviews (continued)

Aetna External Review

Aetna's external review process gives you the opportunity to request review of a denied claim by an independent review organization/external review organization (ERO) or by your state's insurance commissioner (if applicable). Your request will be eligible for external review if:

- Aetna, or the plan, or its designee does not strictly adhere to all claim determination and appeal requirements under federal law, or
- The plan's appeal process has been completed, or • The appeal relates to a cancellation or discontinuance of coverage that has been applied retroactively.

A claim denial based on eligibility is not eligible for external review.

Request for External Review — The notice of claim denial that you receive from Aetna will describe the steps to follow if you wish to request an external review and will include a copy of the Request for External Review Form. **You need to submit the Request for External Review Form to Aetna within 123 calendar days of the date you receive the appeal claim denial notice.** (If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.) You must include a copy of your claim denial notice and all other related information that supports your request.

A request for external review is voluntary — you are not required to go through this process before pursuing legal action. If you request an external review, any applicable statute of limitations will be extended by the number of days taken for the review process and your request will not affect your rights to any other benefits under the plan.

Preliminary Review — Within five business days following the date of receipt of your external review request, Aetna will conduct a preliminary review to determine that:

- You were covered under the plan at the time the service was requested or provided,
- The claim denial does not relate to eligibility,
- You have completed the appeal process, and
- You have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, Aetna will issue a written notification to you. If the request is complete but not eligible for external review, the notification will include the reasons why it is not eligible and contact information for the Employee Benefits Security Administration — the Employee Benefits Security Administration's toll-free number is 866.444.EBSA (866.444.3272). If the request is not complete, the notification will describe the information or materials needed to make the request complete and Aetna will allow you to provide the information/materials within the 123 calendar day filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to External Review Organization — If your request for an external review is approved, it will be referred to an ERO for assignment to a neutral, independent clinical reviewer that has appropriate expertise in the area in question and is accredited as required by federal law. The assigned ERO will notify you in writing of your request's eligibility and acceptance for external review. You will have 10 days following your receipt of the notice to provide any additional information that the ERO must consider when conducting the review. Within one business day after the ERO makes its decision, the ERO will notify you, Aetna and the plan.

The ERO is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process. The ERO reviews the information and documents received by the deadline as well as other available documents and information the organization considers appropriate, including:

- Your medical records.
- The attending healthcare professional's recommendation.
- Reports from appropriate healthcare professionals and other documents submitted by the plan, you or your treating provider.
- The terms of the plan to ensure that the ERO's decision is not contrary to those terms, unless the terms are inconsistent with applicable law.
- Appropriate practice guidelines, which include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations.
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the plan or with applicable law.

- The opinion of the ERO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and considered appropriate by the clinical reviewer(s).

The ERO will provide written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO will send the notice of final external review decision to you, Aetna and the plan.

If the review decision reverses the claim denial, the plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

After the review decision is made, the ERO maintains records of all claims and notices associated with the external review process for six years. The ERO makes these records available for examination by you, the plan and state or federal oversight agencies upon request, except where the disclosure would violate state or federal privacy laws.

The decision of the independent external expert reviewer is binding on you, Aetna and the plan unless otherwise allowed by law.

Expedited External Review — You may request an expedited external review if:

- Your claim denial involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal claim appeal, or
- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the claim denial concerns an admission, availability of care, continued stay, or healthcare item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of your request for an expedited external review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard external review. Aetna will immediately send you a notice of its eligibility determination.

If your request is eligible for an expedited external review, Aetna will assign an ERO. The ERO will render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice of the decision is not in writing, the ERO will provide written confirmation of the decision to you, Aetna and the plan within 48 hours after the date of providing that notice.

Anthem Blue Cross External Review

If your claim is denied in the appeal process, you may be eligible for an independent external review free of charge in accordance with federal law. This is not an additional step that you must take in order to fulfill your appeal procedure obligations. Your decision to seek an external review is voluntary and will not affect your rights to any other benefits under the plan. You must submit your request for external review to the claims administrator within four months of the notice of your appeal determination. The request must be in writing unless:

- The claims administrator determines that it is not reasonable to require a written statement, or
- Your request is for an expedited external review of a preservice claim involving urgent or concurrent care (as summarized below).

You do not have to resend the information that you submitted for your appeal. However, you are encouraged to submit any additional information that you think is important for review.

The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

The request and any additional information you wish to provide should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159
Los Angeles, CA 90054

Claim Information

External Claim Reviews (continued)

For pre-service claims involving urgent or concurrent care, you may request an expedited external review without filing an internal appeal or while you are pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request the expedited external review 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 phone number shown on your ID card and provide at least the following information:

- Claimant's identity,
- Date(s) of the medical service,
- Specific medical condition or symptom,
- Provider's name,
- Service or supply for which approval of benefits was requested, and
- Any reasons why the appeal should be processed on a more expedited basis.

Cigna External Review

The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

If you are not fully satisfied with the decision of Cigna's appeal review regarding your medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna, or any of its affiliates.

The independent review process is a voluntary program arranged by Cigna. There is no charge for you to initiate an external review and using the process will not affect your rights to any other benefits under the plan.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a medical necessity or clinical appropriateness determination by Cigna. Administrative, eligibility, or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by Cigna's Physician Reviewer, the review will be completed within three days.

Cigna will abide by the decision of the Independent Review Organization.

CVS Caremark External Review

The external review process gives you the opportunity to request review of a denied claim by an independent review organization (IRO). An IRO is an entity that conducts independent external reviews of adverse benefit determinations according to the requirements of the Patient Protection and Affordable Care Act.

CVS Caremark is responsible only for conducting the preliminary review of a member's request for external review, ensuring that the member is timely notified of the decision as to eligibility, and for assigning the request to an IRO. The actual external review of a member's appeal is conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the external review.

Request for External Review — If your claim is denied in the appeal process, you may request an external review of the claim. Your request must be in writing and submitted within four months following the date you receive the notice of determination on appeal. Your request should include your name, contact information (including mailing address and daytime phone number), your member ID number, and a copy of the notice of determination. Send your request and supporting documentation by mail or fax to:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 866.443.1172

Preliminary Review — Within five days of receiving your request, 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 provided,
- The adverse benefit determination relates to your failure to meet the plan's eligibility requirements (these determinations are not eligible for external review),
- You have completed the plan's appeal process, unless your claim is deemed exhausted (see p. 61), and
- You have provided all information and forms necessary to process the external review.

In addition, CVS Caremark will determine whether your request is for review of a claim involving medical judgment. This means that it is a claim for prescription drug benefits involving (but not limited to) decisions based on the plan's standards for medical necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit, or determinations as to whether a treatment is experimental or investigational.

Only claims involving medical judgment are eligible for external review. If CVS Caremark determines that your request does not involve a claim involving medical judgment, it will forward your request to an independent review organization (IRO) for further review. The IRO will determine whether your request for external review involves a claim involving medical judgment as soon as possible.

Within one day after completing its preliminary review, CVS Caremark will notify you in writing that your request for external review is:

- Complete, and may proceed,
- Not complete, and additional information is needed (along with a list of the information needed to complete the request), or
- Complete, but not eligible for review.

Referral to IRO — If your request for external review is complete and your claim is eligible for external review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify you of its acceptance of the assignment and you will have ten days to provide the IRO with any additional information you want the IRO to consider.

The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the plan and the plan sponsor. 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 to ensure that the IRO's decision is not contrary to those terms (unless those terms are inconsistent with applicable law),
- Appropriate practice guidelines, which includes applicable evidence-based standards and may include any other practice guidelines developed by the federal government, 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 your request for external review, to the extent that information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

The IRO will provide you and CVS Caremark 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, such as the date or dates of service, the healthcare provider, the claim amount (if available), 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,

Claim Information

External Claim Reviews (continued)

- 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 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
- Contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

If the review decision reverses the claim denial, the claims administrator will immediately process the claim for benefits.

Expedited External Review Process — You may request an expedited external review if:

- Your claim involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, and/or could result in your failure to regain maximum function, and you have filed a request for an expedited internal appeal, or
- Your claim involves: 1) a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health, and/or could result in your failure to regain maximum function, or 2) an admission, availability of care, continued stay, or a prescription drug benefit for which you have received emergency services, but have not been discharged from a facility.

You or your physician may request an expedited external review by calling Customer Care toll-free at the number on your ID card or contacting their benefits office. Provide your name, contact information (including mailing address and daytime phone number), member ID number, and a description of the coverage denial. Alternatively, your request and supporting documentation may be faxed to the CVS Caremark External Review Appeals Department at 866.689.3092. All requests for expedited reviews must be clearly identified as “urgent” when they are submitted.

Immediately upon receipt of your request for an expedited external review, CVS Caremark will determine whether the request meets the reviewability requirements described on p. 64 for standard external review and notify you of its eligibility determination.

If your request is eligible for expedited external review, CVS Caremark will assign an IRO and transmit all necessary documents and information to the IRO electronically, by telephone, by fax, or by any other available expeditious method. The IRO will review provided documents and information to reach a decision – the review will not be bound by the decisions or conclusions reached on behalf of the plan during the internal claims and appeals process.

The IRO will provide you and CVS Caremark 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 the request for external review. If the notice is not provided in writing, the IRO will provide written confirmation of its decision within 48 hours after providing the initial notice.

Right to File a Legal Action

No legal action may be taken to gain benefits under the plan after four years from the date the loss occurred for which a claim was made. No legal action may be taken to gain benefits under the plan until you have:

- Submitted a written claim for benefits.
- Been notified by the claims administrator that the claim is denied.
- Filed a written request for appeal of the denied claim with the claims administrator.
- Been notified in writing that your appeal has been denied.

Eligible Employees

You become eligible for coverage on the first day of the calendar month following your date of hire if you:

- Are a regular full-time or part-time employee of the Company who is regularly scheduled to work 30 hours or more each week,
- Are on the Company's U.S. payroll, and
- Live within the your medical plan's network service area.

You are not eligible for coverage under the plan if you are:

- Covered by another health plan to which McKesson contributes (e.g., the U.S. Oncology Health Plan),
- Covered by a health plan established pursuant to collective bargaining (other than this plan),
- Designated by McKesson as a seasonal or temporary employee,
- Compensated for services by a person other than McKesson,
- A leased employee, or
- Subject to a written agreement that provides that you are not eligible to participate in the plan.

If, during any period, you have not been regarded as a McKesson employee and for that reason, employment taxes have not been withheld from your pay, then you are not eligible to participate for that period. This applies even if you are retroactively determined to have been a McKesson employee during all or any portion of that period.

Eligible Dependents

Your eligible dependents include:

- Your opposite-sex or same-sex spouse unless legally separated or divorced (including a common-law spouse if recognized in your state of residence) or your domestic partner.
- Your child or your domestic partner's child under age 26 (regardless of whether that child qualifies as your "dependent" for tax purposes).
- Any unmarried child age 26 or older, if the child is mentally or physically disabled and dependent on you for maintenance and support. The child's disabling sickness or injury must have begun prior to age 26.

Refer to the Glossary for definitions of children and domestic partners who are eligible for coverage under the plan.

You may be required to provide periodic proof of relationship for eligible dependents and, for those children age 26 or older, you may also be required to provide periodic proof of disability and support. Additional information may be required for a domestic partner or the child of a domestic partner to determine whether the benefit is taxable and if your contributions for coverage will be made on a before-tax or after-tax basis (see p. 68).

Eligible Dependents Do Not Include

A spouse or domestic partner on active duty in any military, naval or air force of any country is not eligible.

No one may be covered as a dependent of more than one employee and no one may be covered under this plan as both an employee and a dependent. A dependent that is also an employee of the Company may elect not to be covered as an employee under the plan.

Appendix A

Eligibility and Cost

Cost

The employee contribution for coverage is set by the Company and may increase from year to year. The Company currently shares the cost of employee and dependent coverage with you. Current contribution information is available from the HR Support Center or UPoint at digital.alight.com/mckesson.

Generally, under federal law, only your spouse and children under age 27 as of the end of the calendar year (regardless of their residency, marital, student, employment or dependent status) are eligible for tax-favored treatment of employer-provided healthcare benefits. (“Tax-favored” means that you can pay for their coverage with before-tax dollars and the dollar value of the coverage paid by McKesson for these dependents is not taxable to you.) These children are your biological children, stepchildren, adopted children, children placed for adoption and foster children.

Coverage for any other individual — such as a domestic partner, the child of a domestic partner or a disabled child who is not under age 27 as of the end of calendar year — is not eligible for tax-favored treatment unless the individual meets the requirements of a “dependent” under Section 105(b) of the Internal Revenue Code. Generally, in order to qualify as a dependent under Section 105(b), an individual must meet most, but not all, of the requirements to be a “qualifying child” or a “qualifying relative” under Section 152 of the Internal Revenue Code. Your cost of coverage for an individual who does not qualify for tax-favored treatment must be paid with after-tax dollars and the Company-provided value of this coverage is reported as taxable income to you (referred to as “imputed income”).

Although federal law allows coverage for certain adult children who are under age 27 as of the end of the calendar year to be provided on a tax-favored basis, some states have not adopted this rule. If you reside in a state that has a state income tax and that does not follow federal law, you will pay for that dependent’s coverage with after-tax dollars. In addition, McKesson’s portion of the value for this coverage is reported as imputed income to you for state tax purposes. If you have specific questions about your situation, please contact a tax professional.

Employee contributions are automatically deducted on a before-tax basis; however, as noted above, contributions for individuals who are not eligible for tax-favored status must be deducted on an after-tax basis. You may wish to consult your individual tax advisor on the “tax-dependent” status of your domestic partner and/or children, as applicable.

The McKesson Flexible Benefit Plan (the “125 Plan”) allows most employees to make contributions for coverage and a health savings account on a before-tax basis. This means that contributions are deducted from paychecks before federal income, state/local income (in most cases), and Social Security taxes are withheld. Actual savings depend on contribution amounts, total family income, where you live, and tax deductions and exemptions claimed.

Note that before-tax contributions may lower your earned income, which can affect you:

- Eligibility for the earned income credit.
- Social Security or Medicare benefits.

You can consult a tax advisor to determine how before-tax contributions will affect you.

Appendix B

Enrollment and Effective Date of Coverage

Enrollment

Employees

You may enroll for coverage only during your initial eligibility period, a special enrollment period, within 31 days following a qualified status change, or during an annual enrollment period.

During the enrollment process, you may elect one of the following coverage levels:

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

Dependents

You must be enrolled for coverage as an employee in order to enroll your eligible dependents.

- Initial dependents are those family members who are eligible dependents on the date you first become eligible for employee coverage.
- Subsequent dependents are any family members who become eligible dependents after the date you first become eligible.

If you and your spouse/domestic partner are both eligible employees, only one of you may enroll your eligible dependents for coverage. No one can be covered both as an employee and as a dependent.

Initial Enrollment

The initial eligibility period for you and your initial dependents is the 31-day period that begins on the date your new hire kit is mailed. The initial eligibility period for a subsequent dependent is the 31-day period that begins on the date that subsequent dependent first becomes eligible under the plan.

Your initial enrollment deadline is 31 days from the date your new hire kit is mailed

For example: If you become eligible for coverage on July 1 and your new hire kit is mailed on July 1, you must enroll for coverage on or before July 31.

If you or your dependents do not enroll during the initial eligibility period (or a special enrollment period as summarized on p. 70), you must wait until the next annual enrollment period to enroll for coverage. The annual enrollment period is designated by the Company each year.

You may change your coverage elections only once a year during the annual enrollment period. This means that once you make your elections, you may not add or drop dependents or change your coverage until the next annual enrollment period, except as described below.

Late Enrollees — You are considered a late enrollee if you do not enroll during your initial eligibility period. If you are a late enrollee, you may enroll only during an annual enrollment period to elect coverage for the following calendar year. Under certain circumstances, you may be allowed to enroll or change coverage levels during the year as summarized in the Special Enrollment Periods, Qualified Medical Child Support Order and Qualified Status Changes provisions.

Appendix B

Enrollment and Effective Date of Coverage

Enrollment (continued)

Special Enrollment Periods

You have special enrollment rights if you acquire a new dependent, or if you decline coverage under the plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) — If you decline enrollment for yourself or for an eligible dependent (including your spouse/domestic partner) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program — If you decline enrollment for yourself or for an eligible dependent (including your spouse/domestic partner) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you become eligible for special enrollment, you may choose to newly enroll for coverage for yourself or yourself and one or more of your eligible dependents. You also have the option of adding a new dependent to your current coverage or choosing a different McKesson medical plan.

You must make your coverage choices within the time frame indicated for the event that makes you eligible for special enrollment. You can make your choices on UPoint. However, if your event gives you a 60-day time frame to make choices, you must call the HR Support Center for assistance with changes you are making more than 31 days after the date of the event.

New Dependent by Marriage, Birth, Adoption or Placement for Adoption — If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents in this plan. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program — If you or your dependents (including your spouse/domestic partner) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in the plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for that assistance.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order (QMCSO) to provide coverage for your children, you may enroll your eligible dependent children in the plan as required by the Employee Retirement Income Security Act (ERISA). Mail or fax your request for coverage under a QMCSO within 31 days after the order is issued.

McKesson
Qualified Order Team
P.O. Box 1542
Lincolnshire, IL 60069-1542
Fax: 847.442.0899

You may obtain, without charge, a copy of the plan's procedures governing QMCSOs by contacting the HR Support Center.

Appendix B

Enrollment and Effective Date of Coverage

Qualified Status Changes

In exchange for the tax advantages of paying for coverage with before-tax dollars (as allowed under the McKesson Flexible Benefit Plan), federal law requires that your coverage elections be irrevocable. This means you can't change your coverage elections until the next annual enrollment period unless you are eligible for special enrollment (see p. 70) or experience one of the following qualified status changes, which are allowed under IRS election change regulations:

- You marry, divorce or legally separate.
- You establish or terminate a domestic partnership.
- You acquire a dependent child through birth, adoption, placement for adoption, or appointment of legal guardianship.
- Your spouse or dependent dies.
- Your dependent no longer meets the plan's eligibility requirements.
- Your spouse terminates or begins new employment.
- You or your spouse change from part-time work to full-time work (or vice versa).
- You or your spouse has a significant change in healthcare coverage.
- You are required to provide dependent coverage as a result of a valid court decree that meets the requirements of a qualified medical child support order (QMCSO).
- You move to Hawaii, which is the only state where your plan's in-network coverage is not available. (You may not change your coverage if your dependent moves to Hawaii. In this event, your dependent will need to use out-of-network providers and the out-of-network benefit level will apply.)

Any change you make must result from and be consistent with your qualified status change. All changes are subject to and administered in accordance with federal law.

To change your coverage elections, visit UPoint within 31 calendar days of the date you experience the qualified status change. You may also call the HR Support Center to make your change. If you do not change your coverage election within the 31-day period, you must wait until the next annual enrollment period.



The HR Support Center is your resource for qualified status changes. Call 855.GO.MCKHR (855.466.2547) and press 1 when you have questions or need to make a change (add/drop coverage) as the result of a qualified status change.

Appendix B

Enrollment and Effective Date of Coverage

Enrollment (continued)

The following table highlights changes and corresponding actions.

Change	Action
You become eligible for a special enrollment period because you acquire a new dependent by marriage, establishment of a domestic partnership, birth, adoption or placement for adoption.*	You may enroll yourself and your dependents.
You lose a spouse/domestic partner (divorce, legal separation, annulment, termination of domestic partnership or death).	- You may discontinue coverage only for your spouse/domestic partner. - You may enroll yourself and your dependents who lose eligibility under the spouse/domestic partner's plan if the loss of eligibility results from the divorce, legal separation, annulment, termination of domestic partnership or death.
You gain a dependent (birth, adoption or placement for adoption).*	- You may enroll your newly eligible dependent. - You may discontinue coverage if you or your dependents become eligible under your spouse/domestic partner's plan.
Your dependent is no longer eligible for coverage under the plan.	You must discontinue coverage for the dependent who loses eligibility.
You become eligible for coverage because your employment status changes (e.g., you switch from temporary to regular full-time status).	You may add coverage for yourself and your dependents.
Your dependent becomes eligible to participate in his/her employer's group health plan because he/she starts employment or changes employment status.	- You may discontinue coverage for your dependent if your dependent enrolls in his/her employer's plan. - You may discontinue your coverage to become covered under your spouse/domestic partner's plan.
You are no longer eligible for coverage because of termination of employment or other change in employment status (e.g., you switch from regular full-time to temporary status).	Coverage will be discontinued for you and your dependents.
Your spouse/domestic partner or child loses eligibility under his/her employer's health plan because of termination of employment or change in employment status.	You may enroll your dependents who lost coverage.
You become eligible for a special enrollment period because of loss of other health coverage.*	You may enroll yourself and your dependents who lost coverage.
You become eligible for a special enrollment period because of eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program.*	You may enroll yourself and your dependent who has become eligible for a premium assistance subsidy.
A court order requires you to provide coverage for a child.*	You may enroll that child (and yourself, if you are not already enrolled).
A court order requires that your spouse, former spouse, or other individual provide coverage for a child.*	You may discontinue coverage for that child.

* See p. 70 for information on special enrollment periods and court orders.

Effective Date of Coverage

Your effective date of coverage is the date you become eligible for coverage (see Appendix A) provided you enroll within 31 days of the date your new hire kit was mailed.

The effective date of coverage for your initial dependents is the same date that your coverage becomes effective. The effective date of coverage for a subsequent dependent and any other dependent that is enrolled at the same time as the subsequent dependent is as follows:

- For a spouse, the date of marriage.
- For a domestic partner, within 31 days of the date that he/she qualifies as your domestic partner (as defined on p. 88).
- For a newborn, the date of birth.
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a dependent.

You must enroll the dependent within 31 days of the date he/she first becomes eligible.

Appendix C

Termination of Coverage

Employees

Your coverage under the plan ends on the earliest of the following:

- The day the plan terminates.
- The last day of the month in which you terminate employment or lose eligibility.
- The last day of a period for which contributions for the cost of coverage are made, if the contributions for the next period are not made on a timely basis.
- The last day of the month in which you enter active military duty unless coverage is continued.
- The day you become covered by a collective bargaining agreement that does not provide for participation in the plan.
- The day you die.
- The last day of the month in which you request termination of coverage.
- The day specified by the Company that coverage will terminate due to fraud or misrepresentation or because you knowingly provided the plan administrator or the claims administrator with false material information, including but not limited to, information relating to another person's eligibility for coverage or status as a dependent. In this event, the Company has the right to rescind coverage retroactively to the effective date of coverage and to seek reimbursement of all expenses paid by the plan.
- The day specified by the plan (in a written notice that is sent to you prior to that specified day) if you commit an act of physical or verbal abuse that imposes a threat to McKesson's staff, the medical or prescription drug carrier's staff, a provider, or another covered person.

Dependents

Coverage for all of your dependents will end on the earliest of:

- The day your coverage ends.
- The last day of a period for which contributions for the cost of dependent coverage are made, if the contributions for the next period are not made on a timely basis.
- The day that dependent coverage under the plan is discontinued.

Coverage for an individual dependent ends on the earlier of:

- The day the dependent becomes covered as an employee under the plan and decides not to be covered as a dependent of another employee (no one may be covered as both an employee and as a dependent).
- The last day of the month in which the dependent's last day of eligibility occurs.

Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end solely due to age if that child continues to meet all of the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on you for support.

You must provide your carrier with proof that the child meets these conditions when requested.

Coverage Continuation (COBRA)

A covered person whose coverage would otherwise end may be entitled to elect continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), as summarized in Appendix D. Keep in mind that COBRA coverage must be elected within 60 days after you receive the notice of the continuation right from the McKesson Benefits Center.

Appendix C

Termination of Coverage

Leaves of Absence

Coverage may continue during a period in which you are away from work on a Company-approved leave of absence, provided you make timely payment of any required contributions.

When you need to take a leave of absence for any reason, contact Contact Matrix Absence Management through the Matrix eServices Mobile App, online at www.matrixabsence.com or call 855.GO.MCKHR (855.466.2547) and press 2. You can file for leave the same day you unexpectedly need to be absent from work or up to 30 days before your planned absence.

Coverage During Family Medical Leave Act (FMLA) Leaves

Your coverage continues as long as you pay your portion of required premiums and remain eligible under the plan terms. If your leave is longer than six months, your healthcare coverage ends and you may be eligible for healthcare coverage through COBRA or you may purchase coverage through the Health Insurance Marketplace. For more information, visit www.mckesson.com/totalrewardslibrary > **Leave of Absence** > **FMLA Leave**.

Coverage During Americans with Disabilities Act (ADA) Leave

Your coverage may continue for up to six months from the last day you were actively at work as long as you're receiving McKesson short term disability benefits and pay your portion of the required premiums. You must also remain eligible under the plan terms.

If your leave is longer than six months, your coverage ends and you may be eligible for healthcare coverage through COBRA or you may purchase individual coverage through the Health Insurance Marketplace.

For more information, view the ADA Leave policy on **McKNet**.

Coverage will be made available to the extent required under federal or state law during a leave of absence for medical reasons.

Coverage During Military Leaves

You and your covered dependents may elect to continue coverage for up to 24 months. The period of coverage runs concurrently with COBRA continuation coverage. Or, you may choose to elect coverage under the federal program for the military (TRICARE). For further details about how your Military Leave affects your coverage, contact the HR Support Center at 855.GO.MCKHR (855.466.2547) and press 2.

Appendix D

Continuation Coverage (COBRA)

Continuation Coverage

A covered person whose coverage would otherwise end under the plan may be entitled to elect continuation coverage in accordance with federal law under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Instead of electing COBRA, a covered person may wish to buy coverage from the Health Insurance Marketplace during a special enrollment period that ends 60 days after the loss of coverage. Covered persons may wish to carefully consider buying Marketplace coverage as COBRA coverage may be more expensive than Marketplace coverage. (See Health Insurance Marketplace information on this page for other coverage options that may be available.)

If continuation coverage was elected under a prior plan that was replaced by this plan, that continuation coverage will terminate as scheduled under the prior plan or when a termination event in the Termination of Continuation Coverage provision occurs, whichever is earlier.

In no event will the claims administrator be obligated to provide continuation coverage to a covered person if the plan administrator fails to perform its responsibilities under federal law. These responsibilities include, but are not limited to, notifying the covered person in a timely manner of the right to elect continuation coverage. To obtain continuation coverage, an eligible covered person must notify the McKesson Benefits Center in a timely manner of his/her election of continuation coverage.

Eligibility

To be eligible for continuation coverage, the covered person must meet the definition of a qualified beneficiary. A qualified beneficiary is any of the following persons who were covered under the plan on the day before a qualifying event:

- An eligible employee.
- An eligible employee's enrolled spouse/domestic partner.
- An eligible employee's enrolled children, including a child born or placed for adoption with the eligible employee during a period of continuation coverage.

Medicare entitlement can affect an individual's eligibility to continue coverage under COBRA. If the individual is entitled to (eligible for and enrolled in) Medicare before electing COBRA, eligibility to continue coverage is not affected. However, if the individual is first eligible for Medicare after electing COBRA, continuation coverage will end on the date that he/she is entitled to Medicare. Visit www.medicare.gov to learn about coverage and any penalties that may apply if you don't enroll in Medicare when you are first eligible.

Health Insurance Marketplace

In addition to COBRA, there are other important coverage options available when plan coverage ends. The Patient Protection and Affordable Care Act (PPACA) allows the covered person to buy coverage through the Health Insurance Marketplace when he or she is initially eligible for COBRA due to a loss of coverage and when his or her COBRA coverage is exhausted (referred to as "special enrollment periods"). In addition, a covered person may buy Marketplace coverage during the annual enrollment period or if he or she is determined eligible for any other special enrollment periods. Generally, a covered person has 60 days to enroll in the Marketplace from the time plan coverage ends. In the Marketplace, the covered person could be eligible for a tax credit that lowers his/her monthly premiums right away, and the covered person can see what his/her premium, deductibles and out-of-pocket costs will be before making a decision to enroll. Covered persons may wish to carefully consider buying Marketplace coverage as COBRA coverage may be much more expensive than Marketplace coverage. Being eligible for COBRA does not limit the covered person's eligibility for a tax credit through the Marketplace. If a covered person elects COBRA, he/she won't be able to get Marketplace coverage outside of annual enrollment until the COBRA coverage has been exhausted (usually after 18 months). If the covered person voluntarily drops COBRA coverage or fails to pay the COBRA premium, the person doesn't get a special enrollment period.

For information on the Health Insurance Marketplace, visit www.healthcare.gov.



The covered person may also qualify for a special enrollment opportunity (see p. 70) under another group health plan for which he/she is eligible, such as a spouse's plan. This applies even if that plan does not normally accept late enrollees. Enrollment must be requested within 30 days of losing coverage.

Appendix D

Continuation Coverage (COBRA)

Qualifying Events

The qualified beneficiary may elect continuation coverage if his/her coverage would otherwise terminate because of any of the following qualifying events:

- Termination of the eligible employee from employment with McKesson (for any reason other than gross misconduct) or reduction in hours of employment.
- Death of the eligible employee.
- Divorce, legal separation or termination of domestic partnership of the eligible employee.
- Loss of eligibility by an enrolled dependent who is a child.

The qualified beneficiary is entitled to elect to continue the same coverage that he/she had on the day before the qualifying event.

Coverage may be continued for 18 months or 36 months, depending on the qualifying event:

Qualifying Event	Individuals Eligible for Continuation Coverage	Coverage Period from Date of Initial Qualifying Event
Your employment ends	Employee, spouse/ domestic partner, children	18 months
Your hours of employment are reduced (e.g., approved leave)	Employee, spouse/ domestic partner, children	18 months
You divorce or legally separate	Spouse, children	36 months
You terminate a domestic partnership	Domestic partner, children	36 months
Your child is no longer an eligible dependent	Child losing coverage	36 months
You die	Spouse/domestic partner, children	36 months

Extension of Continuation Coverage

Subject to the notification requirements described below, if a qualified beneficiary is entitled to 18 months of continuation coverage, continuation coverage may be extended if any of the following events occur.

- **Disability.** If the qualifying event is the covered employee's termination of employment or reduction of hours, qualified beneficiaries may obtain up to an 11-month extension of continuation coverage for a total continuation coverage period of up to 29 months if a qualified beneficiary has been determined by the Social Security Administration to have been disabled at any time during the first 60 days of continuation coverage. All other covered family members who are qualified beneficiaries as a result of the same qualifying event and who elect continuation coverage will also be entitled to the 11-month extension.
- **Extension of Continuation Coverage for Spouse/Domestic Partner and Dependent Children.** In certain circumstances, an 18- or 29-month continuation coverage period may be extended up to 36 months. These include:
 - **Second Qualifying Event** (employee's death, divorce, legal separation, termination of domestic partnership, or a covered child's loss of eligible dependent status). If any of these events occur during the 18- or 29-month continuation coverage period, the period of continuation coverage for the spouse/domestic partner and dependent children may be extended for up to a total of 36 months measured from the date of the original qualifying event. A termination of employment following a reduction in hours of employment is not a second qualifying event.
 - **Medicare Entitlement of Employee.** If the employee became entitled to and enrolled in Medicare (under Part A, Part B or both) within 18 months prior to the employee's termination of employment or reduction in hours of employment, the period of continuation coverage for the employee's spouse/domestic partner and dependent children is 36 months from the date of the employee's Medicare enrollment. For example, if the employee became enrolled in Medicare 8 months prior to the qualifying event, the employee's spouse/domestic partner and dependent children would be eligible for 28 months of continuation coverage ($36 - 8 = 28$).

Appendix D

Continuation Coverage (COBRA)

Notification Requirements

Qualifying Event

The eligible employee or qualified beneficiary must notify the McKesson Benefits Center within 60 days of his/her divorce, legal separation, termination of domestic partnership, or an enrolled dependent's loss of eligibility as an enrolled dependent. If the eligible employee or qualified beneficiary fails to notify the McKesson Benefits Center of these events within the 60-day period, the plan is not obligated to provide continuation coverage to the affected qualified beneficiaries. An eligible employee who is continuing coverage under federal law and who acquires a child through birth, adoption or placement for adoption during the continuation coverage period must notify the McKesson Benefits Center within 31 days of the child's birth, adoption or placement for adoption to obtain continuation coverage for the child. The notice must include the following:

- Name of the individual experiencing the qualifying event (the qualified beneficiary).
- Name of the employee and Social Security Number.
- Date of the qualifying event.
- Type of qualifying event.
- Address of the qualified beneficiary.

If the eligible employee dies while covered under continuation coverage, the eligible employee's dependent must notify the McKesson Benefits Center of this second qualifying event.

If the McKesson Benefits Center receives timely notice from the eligible employee or the eligible employee's dependent, the McKesson Benefits Center will provide a COBRA election notice within 14 days of its receipt of the notice. If the McKesson Benefits Center does not receive timely notice, the right to continuation coverage or the right to extended continuation coverage (if the event was a second qualifying event) will be lost.

The Company will notify the McKesson Benefits Center if the eligible employee:

- Is terminated from employment.
- Has a reduction in hours of employment.
- Dies while employed.

The McKesson Benefits Center will provide a COBRA election notice within 44 days of one of these qualifying events.

Disability

To be entitled to the 29-month continuation coverage period as a result of disability, the qualified beneficiary or a covered family member who elects continuation coverage must notify the McKesson Benefits Center of the entitlement to Social Security disability benefits before the end of the initial 18-month continuation coverage period and within 60 days of the Social Security Administration's determination of the qualified beneficiary's disabled status. The notification must include a copy of the Social Security award determination. If this notice is provided, the qualified beneficiary's coverage may be extended up to a maximum of 29 months from the date of the qualifying event or until the first of the month that begins more than 30 days after the date of any final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

If the McKesson Benefits Center does not receive timely notice of the need for a disability extension, the right to the disability extension will be lost.

Each qualified beneficiary must provide notice of any final determination that the qualified beneficiary is no longer disabled within 30 days of that determination by the Social Security Administration.

Medicare Enrollment

To qualify for the Medicare extension, notice of the eligible employee's enrollment in Medicare (Part A, Part B or both) must be provided within 60 days of the qualifying event. The eligible employee will be required to provide a copy of his/her Medicare card to the McKesson Benefits Center.

If, after electing continuation coverage, a qualified beneficiary becomes enrolled in Medicare Part A or Part B, the qualified beneficiary must notify the McKesson Benefits Center within 30 days of the enrollment. The qualified beneficiary will be required to provide a copy of his/her Medicare card to the McKesson Benefits Center.

Notice to the McKesson Benefits Center

All required notices that relate to continuation coverage must be provided to the McKesson Benefits Center at the following address:

McKesson Benefits Center
PO Box 7139
Rantoul, IL 61866-7139

Appendix D

Continuation Coverage (COBRA)

Notice of Unavailability of Continuation Coverage

The McKesson Benefits Center will provide the individual with a notice explaining the reasons why continuation coverage is not available if, after receiving a notice relating to a qualifying event, second qualifying event, or a determination of disability by the Social Security Administration, the McKesson Benefits Center determines that the individual who provided the notice is not entitled to continuation coverage or extended continuation coverage.

Termination of Continuation Coverage

Continuation coverage under the plan will end on the earliest of the following dates:

- At the end of the applicable maximum continuation coverage period (18, 29 or 36 months).
- The date coverage terminates under the plan for failure to make timely payment of the required contribution amounts (such payments, other than the initial payment, are required to be made no later than 30 days after the payment's due date).
- The date, after electing continuation coverage, that coverage is obtained under any other group health plan. If the new coverage contains a limitation or exclusion for any preexisting condition of the qualified beneficiary, continuation coverage will end on the date the limitation or exclusion ends. The other group health plan coverage will be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion. (Note that there are limitations on plans' imposing preexisting condition exclusions and these exclusions will be prohibited beginning in 2014 under the federal Patient Protection and Affordable Care Act.)
- The date, after electing continuation coverage, that the qualified beneficiary becomes entitled to Medicare.
- The date the Company ceases to provide any group health plan to any of its employees.
- The date coverage would otherwise terminate under the plan.

If continuation coverage ends prior to the 18-, 29- or 36-month continuation coverage period, the McKesson Benefits Center will provide a notice to the affected individuals as soon as practicable following the McKesson Benefits Center's determination of the early termination of continuation coverage. The notice will explain the reason for the early termination, the date of the termination, and the availability of alternative group individual coverage, if any.

Paying for Continuation Coverage

The qualified beneficiary must pay for continuation coverage. Continuation coverage premiums can't exceed 102% of the applicable premium for similarly situated individuals who have not had a qualifying event. The premium may be increased to 150% of the applicable premium if continuation coverage is extended as a result of disability.

The first payment covers the cost of continuation coverage retroactive to the date employer-paid coverage ended. The qualified beneficiary is responsible for ensuring that the amount of the first payment is enough to cover this entire period. The McKesson Benefits Center may be contacted to confirm the correct amount of the first payment. The initial premium payment must be made within 45 days of the election of continuation coverage. All subsequent payments must be made within 30 days of the due date. If any of the continuation coverage payments are late, continuation coverage rights will be lost.

If the qualifying event is the eligible employee's death, the Company will pay the full cost of continuation coverage for the spouse/domestic partner and eligible dependent children for the number of months equal to the employee's years of active service — up to a maximum of 24 months. For example, if the employee had five years of active service, the Company will pay the cost of continuation coverage for five months. The Company payment for a dependent child will end earlier if the child no longer qualifies as an eligible dependent under the plan. The family pays the full cost for the balance of the period of continuation coverage.

Continuation Coverage Payment Shortfalls

If a timely monthly contribution is submitted to the McKesson Benefits Center that is significantly less than the actual continuation coverage payment due for the month, the qualified beneficiary's continuation coverage will be terminated immediately. If a payment is submitted that is not significantly less than the actual continuation coverage payment due for the month, the payment will be deemed to satisfy the plan's requirement for the amount that must be paid, unless the McKesson Benefits Center notifies the qualified beneficiary of the amount of the deficiency and permits him/her to pay the deficiency within 30 days of the date of the notice of deficiency. The qualified beneficiary is responsible for paying all deficiencies.

Appendix D

Continuation Coverage (COBRA)

Electing Continuation Coverage

Continuation coverage must be elected within 60 days after the qualified beneficiary receives notice of the continuation right from the McKesson Benefits Center. If he/she fails to timely elect continuation coverage, the right to continuation coverage will be permanently lost. To elect continuation coverage, the qualified beneficiary must follow the procedures described in the COBRA election form. A qualified beneficiary who has not elected continuation coverage may change his/her prior rejection of continuation coverage anytime within the 60-day election period by following the procedures described in the COBRA election form.

Each qualified beneficiary may elect continuation coverage independently. If the employee declines to cover his/her dependent children, a dependent's parent (the employee's spouse/domestic partner, other parent or legal guardian) may elect continuation coverage for them. If the employee and spouse/domestic partner decline to cover a dependent child, that child has an independent right to elect continuation coverage for himself/herself. Furthermore, a child who is born to the employee or placed for adoption with the employee during a period of continuation coverage may be considered a qualified beneficiary provided that the McKesson Benefits Center is notified within 31 days of birth or placement for adoption. The employee or his/her spouse/domestic partner may elect continuation coverage on behalf of all eligible individuals.

Carefully Consider Your Election of Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You should also consider that by electing COBRA, you will not be able to buy Marketplace coverage outside of the annual enrollment period until your COBRA coverage has been exhausted (usually after 18 months). If you voluntarily drop your COBRA coverage or fail to pay your COBRA premiums, you won't get a special enrollment period to buy Marketplace coverage.

Federal law gives you the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse/domestic partner's employer) within 30 days after your group health coverage ends because of the qualifying event that entitled you to elect continuation coverage. You will also have the same special enrollment right at the end of the maximum continuation coverage period available to you.

Keep the Plan Informed of Address Changes

To protect your and your family's rights, you must keep the McKesson Benefits Center informed of any changes in your address and the addresses of covered family members. You should also keep a copy, for your records, of any notices you send to the McKesson Benefits Center.

For More Information

If you have any questions concerning your rights to continuation coverage under COBRA, contact:

HR Support Center
855.GO.MCKHR (855.466.2547)
Press 1 for Health, Vitality and Pension questions.
Benefit experts are available:
7 a.m. - 6 p.m. Central time, M-F.

Send written correspondence to:

McKesson Benefits Center
PO Box 7139
Rantoul, IL 61866-7139

For more information about your rights under ERISA, including continuation coverage under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 866.444.3272. For more information about health coverage options available through the Health Insurance Marketplace, visit www.healthcare.gov.

Appendix E

Administrative Information

Plan Name

McKesson Corporation Health Plan

Plan Type

The plan is a group health plan that provides healthcare benefits. This summary plan description describes your plan's medical and prescription drug coverage available to eligible employees and their eligible dependents.

Plan Number

501

Plan Sponsor

McKesson Corporation
One Post Street, 30th floor
San Francisco, CA 94104-5296

Plan Administrator

McKesson Corporation
c/o Sr. Vice President, Compensation and Benefits
One Post Street, 30th floor
San Francisco, CA 94104-5296
415.983.8300

Plan Document

Copies of the plan document can be requested for a nominal fee by contacting:

McKesson Corporation
c/o Sr. Vice President, Compensation and Benefits
One Post Street, 30th floor
San Francisco, CA 94104-5296

There is a copying charge of \$0.10 per page.

Service of Legal Process

Service of legal process should be directed to:

McKesson Corporation
c/o Sr. Vice President, Compensation and Benefits
One Post Street, 30th floor
San Francisco, CA 94104-5296

Service of legal process may also be made to the plan administrator.

Employer Identification Number (EIN)

Plan Sponsor and Plan Administrator: 94-3207296

Claims Administrators

The plan sponsor has contracted with the following carriers to provide administrative services, including claims administration services, under the plan:

- HSA and HSA Plus plan medical plan carriers — Aetna, Anthem and Cigna
- HSA and HSA Plus plan prescription drug carrier — CVS Caremark

Refer to p. 4 for information on the carriers/claims administrators.

Benefits Administrator

McKesson Benefits Center
PO Box 7139
Rantoul, IL 61866-7139
855.GO.MCKHR (855.466.2547)
Press 1 for Health, Vitality and Pension questions.

Type of Administration

Contract administration — the plan sponsor has contracted with the following carriers/claims administrators to administer its component programs:

- HSA and HSA Plus plan medical plan carriers — Aetna, Anthem and Cigna
- HSA and HSA Plus plan prescription drug carrier — CVS Caremark

The carriers/claims administrators have been delegated the sole discretionary authority to determine claims and their payment. Refer to p. 4 for information on the carriers/claims administrators.

Appendix E

Administrative Information

Funding Medium/Source of Contributions

The medical plan carriers and prescription drug carrier have been hired to process claims. These carriers do not serve as insurers, but simply as claims administrators. They process claims, request and receive funds from McKesson's general assets to pay the claims, and make payment on approved claims to hospitals and other providers.

Premiums for employees and their dependents are paid in part by McKesson out of its general assets, and in part by employees. The employee portion of the cost of coverage may be paid through before-tax or after-tax payroll deductions. The employee contribution rate to pay for coverage is set by McKesson and may be adjusted from time to time. Notwithstanding anything to the contrary in this SPD, no portion of McKesson's general assets (irrespective of whether such assets are held in a separate account) shall be property of the Plan.

Plan Year

All related financial records are kept on a plan-year basis from April 1 to March 31.

Participating Employers

A participating employer is any corporation that is a subsidiary of or affiliated with McKesson, whose employees are authorized by the Company to participate in the plan as described in this summary plan description. A complete list of participating employers and information regarding whether a particular employer participates in any of the plans may be obtained on written request to the plan administrator.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Plan Coverage

Continue healthcare coverage for yourself, spouse (or domestic partner), or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description (see Appendix D) and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Note that the Patient Protection and Affordable Care Act prohibits group health plans from imposing preexisting conditions exclusions effective for plan years beginning on or after January 1, 2014.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan, do not receive them within 30 days, and you have exhausted the plan's claim and appeal procedures, you may file suit in a federal court. In such 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, but only after you have exhausted the plan's claim and appeal procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Appendix F

Your Rights Under the Plan

Your Rights Under ERISA (continued)

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under the Employee Retirement Income Security Act (ERISA), or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

No Employment Contract

Nothing in the plan or this summary plan description gives any rights of continued employment to any employee or in any way prohibits changes in the terms and conditions of, or the termination of, employment of any employee covered by the plan.

No Retroactive Termination of Coverage

Generally, coverage under the plan may not be terminated retroactively. However, coverage will be retroactively canceled or terminated (“rescinded”) if an enrollee acts fraudulently or intentionally makes any material misrepresentation of fact. Each enrollee is responsible for providing accurate and true information to the claims administrators and McKesson representatives. This includes, but is not limited to, providing accurate information about family status, place of residence, age, relationships, Social Security Numbers and other information that is required to enroll in the plan and to receive benefits under the plan.

It is each enrollee’s responsibility to notify the claims administrators and McKesson representatives immediately if any previously furnished information is no longer correct (e.g., if a spouse ceases to be eligible because of divorce or legal separation or if a child ceases to qualify as a dependent). Failure to do so will result in retroactive cancellation of coverage of the enrollee and his/her covered dependents. The enrollee will also be required to make the plan whole for any losses incurred on account of the fraud, misrepresentation or material omission. Coverage is also retroactively cancelled upon an enrollee’s failure to pay any required contributions, regardless of the reason for non-payment.

No Vested Interest

No individual has any rights under the plan except as and only to the extent expressly provided in the official plan document.

Plan Amendment and Termination

Nothing in the plan or this summary plan description shall prevent any future amendments to the benefits provided under the plan, or the contributions or eligibility criteria required for participation in the plan. The Company reserves the right to amend or terminate the plan in whole or in part at any time and for any reason in its sole discretion. This includes, but is not limited to, increasing contributions or reducing benefits.

Plan Interpretation and Authority to Delegate

The plan administrator has the sole and exclusive right and discretionary authority to interpret the terms and provisions of the plan and to determine any and all questions arising in connection with the administration thereof, and to delegate such authority and discretion to designated person or persons, including claims administrators.

Protected Health Information

McKesson is committed to protecting the privacy and security of participants’ health information and has undertaken efforts to comply with all applicable laws and regulations intended to protect the privacy and security of such information, including the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions regarding the plan’s privacy policies and procedures, please refer to the Notice of Privacy Practices provided to you upon your enrollment. If you need another copy of the Notice, please call the HR Support Center.

The plan’s privacy practices may be changed at any time at the plan administrator’s sole discretion. If any material revision is made to the plan’s Notice of Privacy Practices, the revised notice will be distributed in accordance with applicable law.

Special Rights Following Mastectomies

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information, call your claims administrator.

You can visit the following websites for more information:

- U.S. Department of Health and Human Services
www.cms.gov/HealthInsReformforConsume
- U.S. Department of Labor
www.dol.gov/ebsa/consumer_info_health.html

Special Rights Upon Childbirth

Group plans and health insurance issuers generally may not, under the Newborns' and Mothers' Health Protection Act, 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 vaginal delivery, or less than 96 hours following a cesarean section. 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). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Glossary

The following words and phrases when used in this summary plan description will have the meanings as set forth below.

Accidental Injury

Physical harm or disability that is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Acupuncture

Treatment by a licensed provider for anesthesia, injury or disease, or to alleviate chronic pain, as medically necessary.

Advance Approval

The general term used under this plan to identify the process of review and determination as to the medical necessity of services and supplies before those services and supplies are provided. Each medical plan carrier has specific term(s) they use to identify their approval processes.

- Aetna: Precertification
- Anthem: Precertification
- Cigna: In-Network — Prior authorization/Pre-authorized; Out-of- Network — Pre-admission certification (PAC), Continued stay review (CSR), Outpatient certification

Adverse Benefit Determination

A denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. An adverse benefit determination may be based on any of the following:

- An individual's eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit).
- Coverage determinations, including plan limitations or exclusions.
- The results of any utilization review activities.
- A decision that the service or supply is experimental or investigational.
- A decision that the service or supply is not medically necessary.

Applied Behavioral Analysis Therapy

The science in which the principles of the analysis of behavior are applied systematically to improve socially significant behavior, and in which experimentation is used to identify the variables responsible for change in behavior.

Authorized Representative

A person who has been authorized, in writing, to act on another person's behalf. An individual will also be recognized as an authorized representative if a court order gives that individual the authority to submit claims on behalf of another person. In the case of urgent care claims, a healthcare professional with knowledge of a person's condition may act as his/her authorized representative.

Autism/Autism Spectrum Disorder

Neurological disorders, usually appearing in the first three years of life, that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

Birth Center

A specialized facility that is primarily a place for delivery of children following a normal, uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- It meets all of the following requirements:
 - It is operated and equipped in accordance with any applicable state law.
 - It is equipped to perform routine diagnostic and laboratory examinations, such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.
 - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
 - It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO), or registered nurse (RN).
 - It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
 - It maintains an adequate medical record for each patient that contains prenatal history, prenatal examinations, any laboratory or diagnostic tests, and a postpartum summary.
 - It is expected to discharge or transfer patients within 24 hours following delivery.

A birth center that is part of a hospital will be considered a birth center for the purposes of this plan.

Calendar Year

A period of one year beginning each January 1.

Child/Children

Refers to:

- A biological child of the first degree.
- A legally adopted child (including a child living with the adopting parents during the period of probation).
- A stepchild.
- A child of the domestic partner.
- A foster child.
- A child for whom the covered employee is the legal guardian.
- A child permanently residing in the covered employee's household and who receives at least one half of his/her support from the employee, provided the employee is related to the child by blood, marriage or domestic partnership.
- A newborn infant who is not a biological child of the first degree if before the birth of the infant good faith arrangements had been made by the covered employee legally to adopt the infant as soon as practicable after the infant's birth, and these arrangements provide that the infant will reside after birth only in the household of the employee without any period of residence in the household of either biological parent (except for that period necessary if the birth takes place in the home of a biological parent), provided, however, that such a newborn infant will cease to be eligible for coverage as of the first date on which either the employee's attempt to adopt the infant is finally disapproved by competent authorities or the employee abandons the attempt to adopt the infant.
- A child who is the subject of a qualified medical child support order.

Chiropractic Care

The conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Claims Administrator

An outside firm with which the Company contracts to administer benefits under the plan and generally accepted insurance practices. Claims administrators are also referred to as the medical plan carrier and the prescription drug carrier and are identified on p. 4.

Congenital Anomaly

A physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Company

McKesson Corporation and any successor by merger, consolidation or otherwise that assumes the obligations of the Company under the plan.

Comprehensive Outpatient Rehabilitation Facility

A facility that is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or ill persons, and which fully meets one of the following two tests:

- It is approved by Medicare as a comprehensive outpatient rehabilitation facility.
- It meets all of the following requirements:
 - It provides at least the following comprehensive outpatient rehabilitation services:
 - > Services of physicians who are available at the facility on a full- or part-time basis.
 - > Physical therapy.
 - > Social or psychological services.
 - It has policies established by a group of professional personnel (associated with the facility) including one or more physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician.
 - It has a requirement that every patient must be under the care of a physician.
 - It is established and operated in accordance with applicable licensing and other laws.

Cosmetic

A procedure, service, supply or drug that changes or improves appearance without significantly improving physiological function, as determined by the claims administrator. For example, reshaping a nose with a prominent bump may improve appearance, but would not improve the breathing function.

Covered Family Members or Covered Person

The employee, employee's spouse/domestic partner and eligible dependent children who are enrolled in this plan.

Glossary

Covered Health Services

Those health services and supplies that are provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness, substance use disorder or their symptoms.

Services include supplies or pharmaceutical products that the claims administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating sickness, injury or their symptoms,
 - Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below,
 - Not provided for the convenience of the covered person, physician, facility or any other person,
 - Provided to a covered person who meets the plan's eligibility, and
 - Not otherwise limited or excluded under the plan. For purposes of this definition:
 - "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community, and
 - "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines and national specialty society guidelines.
- Services related to watching or protecting a person.
 - Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered.
 - Services not required to be performed by trained or skilled medical or paramedical personnel.

The claims administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. Plan members can access these clinical protocols (as revised from time to time) on their claims administrator's website or by calling the number on the back of the ID card. This information is available to physicians and other healthcare professionals on the applicable claims administrator's website.

Custodial Care

Any services, as determined by the claims administrator, that are of a sheltering, protective or safeguarding nature. Such services may include a stay in an institutional setting, at-home care or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care can also include medical services given mainly to maintain the person's current state of health. These services can't be intended to greatly improve a medical condition; they are intended to provide care while the patient can't care for himself/herself. Custodial services include but are not limited to:

Designated Transplant Facility

A facility designated by the claims administrator to render medically necessary covered services and supplies for qualified procedures under the plan.

Domestic Partner

Refers to:

- A same-sex or opposite-sex couple in a valid civil union as of the date of the civil union as provided under applicable state law, or
- A domestic partnership registered with any state or local government domestic partnership registry as of the date provided under the applicable state or local registry law, or
- A same-sex or opposite-sex partnership as of the date that the partnership meets all of the following requirements: (1) the partnership is an intimate, committed relationship of mutual caring; and (2) the McKesson employee and the domestic partner share the same principal residence; and (3) the McKesson employee and the domestic partner agree to be responsible for each other's basic living expenses during the domestic partnership and also agree that anyone who is owed these expenses can collect from either the employee or his/her domestic partner; and (4) the McKesson employee and the domestic partner are both age 18 or older (or the age of consent in the state of residence) and mentally competent to enter into contracts; and (5) the McKesson employee and the domestic partner are both not currently married nor legally separated; and (6) the McKesson employee and the domestic partner are not currently in a valid civil union; and (7) the McKesson employee and the domestic partner are not so closely related by blood that legal marriage would otherwise be prohibited; and (8) the McKesson employee and the domestic partner do not have a different domestic partner now; and (9) the McKesson employee and the domestic partner have not had a different domestic partner during the six-month period prior to their domestic partnership. (Note: this does not apply if either the McKesson employee or domestic partner had a different domestic partner who died.)

Durable Medical Equipment (DME)

Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Durable medical equipment does not include personal convenience items, such as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas or hot tubs.

Emergency Care

The following services provided for an emergency medical condition (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd):

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate the emergency medical condition, and
- Further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

An “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Examples of emergency medical conditions include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones.

In addition, emergency care includes immediate mental health/substance use disorder treatment when the lack of treatment could reasonably be expected to result in the patient harming himself/herself and/or other persons. This includes screening, examination and evaluation by a physician, or other provider to the extent permitted by applicable law and within the scope of his/her licensure and clinical privileges, to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency, within the capability of the facility.

Employee

An active employee on the U.S. payroll of the Company, its subsidiaries or its affiliates who meets all of the following requirements:

- Is scheduled to work not less than 30 hours per week on a regular and continuous basis;
- Is performing in the customary manner all of the regular duties of his/her occupation either at one of the Company’s business establishments or at some location to which Company business requires the employee to travel, or isn’t performing his/her regular duties due to illness, provided that he/she has already commenced performing his/her regular duties of employment prior to his/her illness, and
- Is not in one of the excluded categories described below.

Notwithstanding the foregoing, the Company may exclude from participation in this plan designated employees or former employees who are covered by another employer’s plan.

Excluded Categories — “Employee” does not include an individual for any period in which he/she is:

- Covered by a health plan established pursuant to collective bargaining (other than this plan).
- Covered by another health plan to which the Company contributes.
- Designated by the Company, its subsidiaries or its affiliates as a seasonal or temporary employee.
- Compensated for services by a person other than the Company, its subsidiaries or its affiliates and for any reason is deemed to be an employee.
- Not on the U.S. payroll of the Company, its subsidiaries or its affiliates and for any reason is deemed to be an employee.
- A leased employee within the meaning of Section 414(n) of the Internal Revenue Code, or would be a leased employee but for the period-of-service requirement of Code Section 414(n)(2)(B), and who is providing services to the Company, its subsidiaries or its affiliates.
- Subject to a written agreement that provides that such individual shall not be eligible to participate in the plan.

A “seasonal employee” means an individual hired to work for a portion of each year on a repetitive basis in a job designed to cover a seasonal operating need. A “temporary employee” means an individual hired to work for a limited period of time to perform a specific project with the understanding that once the project is complete, his/her service will no longer be required by the Company.

Glossary

Employee, continued

If, during any period, the Company, its subsidiaries or its affiliates have not regarded an individual as an employee and, for that reason, have not withheld employment taxes with respect to that individual, then that individual is not an employee for that period, even in the event that the individual is determined, retroactively, to have been an employee during all or any portion of that period.

An individual's status as an employee is determined by the Company, its subsidiaries or its affiliates and all such determinations are conclusive and binding on all persons.

As used in this definition, "subsidiaries and affiliates" means all subsidiaries and affiliates of the Company whose employees are designated by the Company as eligible to participate in the plan on a basis that does not discriminate in favor of officers, shareholders and other highly compensated individuals; however, any such entity will cease to be a subsidiary or affiliate when that entity ceases to be a subsidiary or affiliate of McKesson Corporation.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits

Minimum benefits in the following ten general categories and the items and services within those categories, as determined by the U.S. Department of Health and Human Services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

Experimental, Investigational or Unproven Services

Aetna — Services or supplies that are, as determined by the claims administrator, to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if one or more of the following apply:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the illness or injury involved.
- Approval hasn't been granted for marketing as required by the FDA.
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it's experimental, investigational or for research purposes.
- It's a type of drug, device or treatment that's the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- The written protocols used by the treating facility, or the protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it's experimental, investigational or for research purposes.

Anthem and Cigna — Medical, surgical, diagnostic, psychiatric, substance use disorder or other healthcare services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the FDA to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use.
 - Subject to review and approval by any institutional review board for the proposed use.
 - The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The claims administrator, in its judgment, may deem an experimental, investigational or unproven service covered under this plan for treating a life threatening sickness or condition if it's determined by the claims administrator that the experimental, investigational or unproven service at the time of the determination:

- Is proved to be safe with promising efficacy.
- The usual modalities of conventional, standard treatment have been unsuccessful.
- Is provided in a clinically controlled research setting. • Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, “life threatening” is used to describe illnesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.

FDA

The U.S. Food and Drug Administration.

Generic Drug

A drug that does not bear the trademark of the original manufacturer. Generic drugs are therapeutically equivalent to the original and are less expensive.

Home Healthcare Agency

An agency or organization that provides a program of home healthcare and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.
- It meets all of the following tests:
 - It has the primary purpose of providing a home healthcare delivery system bringing supportive services to the home.
 - It has a full-time administrator.
 - It maintains written records of services provided to the patient.
 - Its staff includes at least one registered nurse (RN) or it has nursing care by an RN available.
 - Its employees are bonded and it maintains malpractice insurance.

Home Healthcare Services

Skilled healthcare services that can be provided during intermittent visits of two hours or less by other healthcare professionals. Coverage is provided for necessary consumable medical supplies, home infusion therapy, and durable medical equipment administered or used by other healthcare professionals in providing home healthcare services. Home healthcare services do not include services of a person who is a member of the covered employee's family or his/her dependent's family, or who normally resides in the covered employee's house or his/her dependent's house. Physical, occupational and speech therapy provided in the home are subject to short-term rehabilitative therapy benefit limitations.

Hospice

An agency that provides hospice care services for a terminally ill individual. Room and board may be provided.

Hospice Care Services — Any services provided by a hospital, skilled nursing facility or a similar institution, home healthcare agency, hospice facility, or any other licensed facility or agency under a hospice care program.

Hospice Care Program — Refers to:

- A coordinated, interdisciplinary program to meet the physical, psychological and social needs of dying persons and their families.
- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness.
- A program for persons who have a terminal illness and for the families of those persons.

Hospice Facility — An institution or part of it which:

- Primarily provides care for terminally ill patients,
- Is accredited by the National Hospice Organization,
- Meets standards established by your carrier, and
- Fulfills any licensing requirements of the state or locality in which it operates.

Glossary

Hospital

Refers to:

- An institution licensed as a hospital that maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of physicians; and provides 24-hour service by registered nurses,
- An institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if the institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations, or
- An institution that specializes in treatment of mental health/substance use disorder or other related illness, provides residential treatment programs, and is licensed in accordance with the laws of the appropriate legally authorized agency.

“Hospital” does not include an institution that is primarily a place for rest, a place for the aged, or a nursing home.

HR Support Center/McKesson Benefits Center

A resource for plan members to obtain benefits information and gateway to an advocate. Call 855.GO.MCKHR (855.466.2547) and press 1 for Health, Vitality and Pension questions. Benefit experts are available 7 a.m. to 6 p.m. Central time, M-F. Written correspondence should be sent to the McKesson Benefits Center at PO Box 7139, Rantoul, IL 61866-7139.

Illness or Sickness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury

An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event, or
- The reasonable unforeseeable consequences of a voluntary act by the person.

An act or event must be definite as to time and place.

In-Network Pharmacy

A pharmacy that participates in the CVS Caremark network.

In-Network Provider

A provider that participates in the respective claims administrator’s network (see p. 10).

- Aetna — an in-network provider is one that participates in the Aetna Choice® POS II network. This includes access to the Aexcel Designated Network, which is made up of specialists that have demonstrated cost-effectiveness in the delivery of care.
- Anthem — an in-network provider is one that participates in the National PPO/BlueCard PPO network.
- Cigna — an in-network provider is one that participates in the Cigna Open Access Plus network.

Intensive Outpatient Program

Distinct levels or phases of treatment that are provided by a certified/licensed mental health or substance use disorder program. Intensive outpatient programs provide a combination of individual, family and/or group therapy over a specified number of hours per week.

Licensed Counselor

A person who specializes in mental health disorder treatment and is licensed as a Licensed Professional Counselor (LPC) or a Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Maintenance Drug

A prescription medication that is commonly used to treat chronic disease states with no therapeutic endpoint. In other words, therapy with these drugs is not considered curative.

Maximum Reimbursable Charge

The maximum reimbursable charge for covered out-of-network services is determined based on the lesser of:

- The provider’s normal charge for a similar service or supply, or
- A policyholder-selected percentage of a schedule developed by your carrier that is based on a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

In some cases, a Medicare based schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of:

- The provider’s normal charge for a similar service or supply, or
- The 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by your carrier.

The maximum reimbursable charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by your carrier. Call your carrier at the number on the ID card for additional information about how your carrier determines the maximum reimbursable charge and for help determining the maximum reimbursable charge for a specified service.

Medicaid

A federal program administered and operated individually by participating state and territorial governments that provide medical benefits to eligible low-income people needing healthcare. The federal and state governments share the program's costs.

Medically Necessary or Medical Necessity

Healthcare services and supplies that are determined by the claims administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the patient,
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply,
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or healthcare coverage organizations or governmental agencies that are accepted by the claims administrator,
- Consistent with the diagnosis of the condition,
- Required for reasons other than the convenience of the patient or his/her physician, and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or
 - Safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, “life-threatening” is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy does not mean that it is medically necessary. This definition relates only to coverage under the plan and may differ from the way in which a physician engaged in the practice of medicine defines medically necessary.

Medicare

Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act.

Medicare Entitlement (COBRA)

For purposes of COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare benefits on the effective date of enrollment in either Part A or B, whichever occurs earlier. Therefore, simply being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

Mental Health/Substance Use Disorder (MH/SUD)

Treatment for the following:

- A sickness that is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- A sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

* Not all sicknesses identified in the DSM are covered under the plan. Contact the claims administrator for information.

Morbid Obesity

A body mass index that is:

- Greater than 40 kilograms per meter squared, or
- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

The body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

Necessary Services and Supplies

Refers to:

- Medical services and supplies (excluding room and board) that are used during hospital confinement and for which charges are made by the hospital on its own behalf,
- Licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided, and
- Services and supplies for the administration of anesthetics during hospital confinement.

Necessary services and supplies do not include any charges for special nursing fees, dental fees or medical fees. See the definition for “other services and supplies.”

Glossary

Non-Preferred Brand Name Drug

A brand name drug that is not on the CVS Caremark list of preferred brand name drugs.

Nurse-Midwife

A person who is licensed or certified to practice as a nurse-midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of nurse-midwives.

Nurse Practitioner

A person who is licensed or certified to practice as a nurse practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of nurse practitioners.

Other Provider

For mental health/substance use disorder (MH/SUD) treatment purposes, a person who is qualified and duly licensed or certified by the state in which he/she is located to furnish MH/SUD treatment.

Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-Network Pharmacy

A pharmacy that does not participate in the CVS Caremark network.

Out-of-Network Provider

A provider that does not participate in the your carrier's network.

Payroll

The system used by the Company to pay those individuals it regards as its common law employees for their services and to withhold employment taxes from the compensation it pays such common law employees. Payroll does not include any system used to pay individuals whom it does not regard as its common law employees and for whom it does not actually withhold employment taxes (including, but not limited to, individuals it regards as independent contractors) for their services.

Physician

A licensed medical practitioner who is practicing within the scope of his/her license and who is licensed to prescribe and administer drugs or to perform surgery. It also includes any other licensed medical practitioner whose services are required to be covered in accordance with applicable law if he/she is:

- Operating within the scope of his/her license, and
- Performing a service for which benefits are provided under this plan when performed by a physician.

Plan

HSA and HSA Plus medical plans, which is part of the McKesson Corporation Health Plan for active employees.

Plan Administrator

McKesson Corporation.

Plan Sponsor

McKesson Corporation.

Plan Year

All related financial records are kept on a plan-year basis from April 1 through March 31.

Preferred Brand Name Drug

A drug that is on the CVS Caremark list of preferred brand name drugs. Preferred brand name drugs are selected based on their success in effectively treating certain conditions, as well as their relative cost effectiveness.

Prenatal Care

Preventive care for pregnancy-related services that are received in a physician's, obstetricians' or gynecologist's office. Coverage is limited to visits including the initial and subsequent history, and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Psychologist

A person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, "psychologist" means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It also includes any other licensed counseling practitioner whose services are required to be covered in accordance with applicable law if he/she is:

- Operating within the scope of his/her license, and
- Performing a service for which benefits are provided under this plan when performed by a psychologist.

Qualified Medical Child Support Order

A judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that creates or recognizes the right of a covered employee's child to receive benefits for which the covered employee is entitled under this plan, and which is determined by the plan administrator to meet the requirements of a qualified medical child support order under Section 609 of ERISA.

Reasonable and Customary Charge

The R&C charge, as defined in this summary plan description, may have a different name under each carrier*. Reasonable and customary charge means the amount up to 200% of the fee payable under the Medicare fee schedule then in effect for the service or supply as determined by the Claims Administrator. Such amount may be greater only if otherwise expressly determined by the Claims Administrator, in its sole and absolute discretion and in accordance with its internal procedures, by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator may determine the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service; and
- The range of services provided; and
- The provider's usual charge for furnishing the service; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

* Recognized Charge (Aetna), Maximum Allowed Amount (Anthem), Maximum Reimbursable Charge (Cigna).

Reconstructive Procedure

A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a reconstructive procedure.

Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Residential Treatment Facility

An institution that:

- Specializes in the treatment of psychological and social disturbances that are a result of a mental health or substance use disorder,
- Provides a subacute, structured, psychotherapeutic treatment program under the supervision of physicians,
- Provides 24-hour care, during which a person lives in an open setting, and
- Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment facility.

A person is considered confined in a residential treatment facility when he/she is a registered bed patient in the facility upon the recommendation of a physician.

Room and Board

Charges made by a hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Sickness

See Illness.

Skilled Nursing Facility

A licensed institution (other than a hospital, as defined) that specializes in:

- Physical rehabilitation on an inpatient basis, or
- Skilled nursing and medical care on an inpatient basis.

The institution must: (a) maintain on the premises all facilities necessary for medical treatment; (b) provide such treatment, for compensation, under the supervision of physicians; and (c) provide nurses' services.

Spouse

The person to whom the covered employee is lawfully married under any state law. This includes individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. For purposes of this definition, "state" means any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, any other territory or possession of the United States, and any foreign jurisdiction having the legal authority to sanction marriages.

Glossary

Subrogation

The substitution of one party for another as creditor, with the transfer of rights and duties.

Treatment Center

For mental health/substance use disorder (MH/SUD) treatment purposes, a facility that provides a program of effective MH/SUD treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a physician and the respective claims administrator.
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A treatment center that qualifies as a hospital is covered as a hospital and not as a treatment center.

Urgent Care

Treatment of minor medical problems that require immediate attention when the patient's physician is not available. Examples of urgent conditions appropriate for urgent care include:

- Upper respiratory infections, sore throats and flu.
- Sprains, strains and cuts.
- Minor burns.

This does not include care that could have been foreseen and/or care that could have been scheduled.

Urgent Condition

A sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of health,
- Can't be adequately managed without urgent care or treatment, and
- Does not require the level of care provided in an emergency room.

Walk-In Clinic

Clinics, such as those at CVS Caremark and Walgreens, that offer healthcare services. They provide an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Emergency rooms and outpatient departments of hospitals are not considered walk-in clinics.

Work Related

Occupational disease or injury that arises out of or in the course of any work for pay or profit.

UPoint

The website resource (digital.alight.com/mckesson) where an employee may access information about health benefits, costs, in-network providers and other information about the Company's health and welfare plans. You can also get to UPoint from McKNet.

Lined area for notes.



Notes

Lined area for notes, consisting of multiple horizontal lines.

Lined area for notes.

Contact Information

Medical Plan Carriers	24-Hour Nurse Advice Line and Condition Support Program	Prescription Drug Carrier
Aetna www.aetna.com 877.286.3900	Aetna Informed Health Line 800.556.1555 For chronic conditions information, call: Aetna In Touch Care 888.257.0411	CVS Caremark www.caremark.com 800.378.0822 800.875.0867 (mail order)
Anthem www.anthem.com/ca 866.820.0763	Condition Care 866.820.0763	CVS Caremark Specialty Pharmacy www.CVSCaremarkSpecialtyRx.com 800.237.2767
Cigna www.mycigna.com 800.CIGNA24 (800.244.6224)	Personal Health Team 800.244.6224	
Additional Programs Castlight www.mycastlight.com/mckesson 866.970.8174 7 a.m. - 8 p.m. Central time, M-F Best Doctors https://members.bestdoctors.com 866.904.0910 7 a.m. - 8 p.m. Central time, M-F		

Health Savings Accounts

Fidelity Investments

www.netbenefits.com
800.544.3716
7:30 a.m. - 7 p.m. Central time, M-F

HR Support Center

855.GO.MCKHR (855.466.2547)

Your source for benefits information and gateway to an advocate. **Press 1** for the McKesson Benefits Center for Health, Vitality and Pension questions. Benefit experts are available 7 a.m. - 6 p.m. Central time, M-F. **Oprime 1 para asistencia en español a través del McKesson Benefits Center.**

UPoint

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Your online destination for reviewing and managing your Total Rewards.

Need help understanding your medical coverage?

Call the HR Support Center — if the benefits expert can't answer your question, an advocate can provide personalized assistance to help you understand how your benefits work, find in-network providers, and answer other medical, dental and vision plan questions.