# McKesson Corporation

## Dental Program
## Summary Plan Description

**Effective January 2004**

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# INTRODUCTION

This Summary Plan Description (SPD) summarizes the dental program for Employees of McKesson Corporation. This SPD explains your dental coverage in plain language so that it will be easier to understand. However, the information provided here does not cover every situation and is not intended to replace the Plan Documents or to change their meaning.

Dental provisions of the McKesson Corporation Health Plan (the Plan) are summarized in this SPD. This description does not state all of the plan terms and conditions. In all cases, the Plan and Trust Documents – and not this summary – will govern the benefits paid from the Plan. For more information about your rights as a participant in the McKesson Corporation Health Plan, see the section entitled "Your Rights as a Plan Member".

In the event of any discrepancy between the Plan and Trust Documents or any applicable Insurance Policy and this SPD, the Plan and Trust Documents or Insurance Policy will govern.

## Plan And Trust Documents

Copies of the Plan and Trust Documents can be requested for a nominal fee by contacting:

Vice President,
Compensation and Benefits
McKesson Corporation
One Post Street
San Francisco, CA 94104-5296

There is a copying charge of $0.10 per page.

## Plan Amendment And Termination

Nothing in the McKesson Corporation Health Plan or this SPD 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 change or terminate the Plan at any time and for any reason. This includes, but is not limited to, increasing contributions or reducing benefits.

## Plan Interpretation And Authority To Delegate

Except as expressly provided in the Insured HMO Program contracts or agreements under the CIGNA Dental HMO Program, the Plan Administrator has the sole and exclusive right and discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising thereunder or in connection with the administration thereof, and to delegate such authority and discretion to designated person or persons.

## No Vested Interest

No individual shall have any rights under the Plan or in the trust fund or other assets of this Plan except as and only to the extent expressly provided in the official Plan Document.

## No Employment Contract
Nothing in the Plan or this description shall confer any rights of continued employment on any Employee or in any way prohibit changes in the terms and conditions of, or the termination of, employment of any Employee covered by the Plan.

## Notice Of Change
Notice of a change in Dependent status should be provided to the McKesson Call Center. Forms for a change of address can be requested from your HR Representative at your work location or by contacting the McKesson Call Center.

## About The Dental Plan
Your McKesson Corporation Health Plan (the "Plan") dental programs include the:

- McKesson Dental Program provided through the CIGNA Preferred Provider Organization (PPO) Program (hereinafter, "Dental Program"); and

- CIGNA HMO Dental Program

McKesson offers dental coverage through the CIGNA PPO Program or, in some areas, under the CIGNA HMO Dental program. In general, the information in the "General Provisions" section on eligibility, enrollment and termination of coverage applies to both programs.

## What's Covered In This SPD
This SPD summarizes the dental coverage provided under the CIGNA PPO Program ("Dental Program"). If you are eligible for CIGNA HMO Dental Program coverage, you'll receive information about that program, including benefits, coverage of services and supplies, limits on benefits, pre-authorization requirements, provider networks, claims and appeals, right of reimbursement and subrogation, and coordination of benefits, when you first become eligible and during the annual enrollment period. That information is provided separately by CIGNA. Network provider lists for the CIGNA HMO Dental Program are also provided automatically as a separate document.

## Choice Of Coverage
Once each year, usually at year-end, the Company expects to hold an annual enrollment period. During this period, active employees may drop dental coverage, or they may enroll if they previously waived coverage. In addition, active employees may transfer between the Dental Program and the CIGNA HMO Dental Program (if eligible).

# GENERAL PROVISIONS

## Eligibility
### Yourself
All regular and part-time Employees, as defined in the **Glossary**, scheduled to work 30 hours or more each week throughout the year.

You are not eligible for dental coverage if you're covered by a collective bargaining agreement that does not provide for dental coverage under the Plan or if you are eligible for any other dental plan provided by the Company. Seasonal and temporary employees are also not eligible for dental coverage under the Plan.

**Eligibility Date**

*With Respect to MIS, Medication Management, and Medical Management Employees*
The first day of the calendar month coinciding with or following date of hire.

*With Respect to All Other Employees*
The first day of the calendar month coinciding with or following completion of two months of service.

**Your Family**
Your Dependents becomes eligible for dental coverage under the Plan when you do. A new spouse, Domestic Partner or child becomes eligible when he or she becomes your dependent. Eligible Dependents are:

- your legally married spouse, including a common law spouse ("Spouse") unless legally separated or your Domestic Partner (subject to certifying his/her Domestic Partner relationship) ("Domestic Partner")

- any unmarried child from birth to age 19;

- any unmarried child age 19 through 23, provided such child meets all of the following conditions:

  — is a regular, full-time student at an accredited secondary school, college, university, vocational or technical training school or institution for the training of nurses; and

  — has legal residence with you; and

  — is wholly dependent on you for maintenance and support.

- any unmarried child over age 19, if the child is mentally or physically disabled and dependent on you for maintenance and support.

The definition of "child" includes:

- the covered Employee's biological children; and

- the covered Employee's legally adopted children (including a child living with the adopting parents during the period of probation); and

- a stepchild residing in the covered Employee's household who is dependent on the support of the covered Employee and his Spouse or Domestic Partner; and

- a child who permanently resides in the covered Employee's household, receives at least half of his support from the covered Employee and is related to the covered Employee by blood or marriage or whose legal guardian is the covered Employee; and

- a newborn infant for whom arrangements to immediately adopt the infant have been made in good faith prior to the infant's birth by the covered Employee or the covered Employee's Domestic Partner , provided such infant shall cease to be a covered dependent if the infant is not adopted or is abandoned by the covered Employee; and

- a child who is the subject of a Qualified Medical Child Support Order (see the following section for a further discussion of Qualified Medical Child Support Orders).

You may be required to provide proof of relationship, financial support, or student status for dependent coverage.

The term "Dependent" shall not include:

- A Spouse, Domestic Partner, or child on active duty in any military, naval or air force of any country; or

- A child who is employed on a full-time basis by an employer other than McKesson Corporation.

No one may be a Dependent of more than one covered Employee and no one may be covered under this Plan as both an Employee and a dependent. Any dependent who is also an Employee of McKesson Corporation may elect not to be covered as an Employee under the Plan.

If you support a child who lives with you permanently but you are not his or her parent, special provisions apply. Check with the McKesson Call Center at 1-866-772-6601 to find out whether the child is eligible for coverage. Your request must be made within 31 days of the date the child takes up residence as a dependent with you.

## Qualified Medical Child Support Order (QMSCO)

If an Employee is required by a qualified medical child support order to provide coverage for his/her children, his/her children can be enrolled in the Plan as required by ERISA. You may obtain a free copy of the procedures for submitting a QMCSO by contacting the Plan Administrator at the following address. Requests for coverage under a medical child support order also should be mailed to the Plan Administrator at the following address within 30 days after the order is issued or as soon as reasonably possible:

McKesson Corporation
c/o Compensation and Benefits
One Post Street
San Francisco, CA 94104-5296

If a child is enrolled as your dependent under a qualified medical child support order, your contribution for health coverage may automatically increase.

## Cost Of Coverage

The Employee contribution rate 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.

## Enrollment

### Regular Enrollment

Enrollment in the applicable dental program is not automatic. You must waive or elect coverage prior to or within 31 days of your eligibility date.

You may enroll:

- Yourself only.
- Yourself and your Spouse or your Domestic Partner (subject to certifying his/her Domestic Partner relationship).
- Yourself and your children.
- Yourself and your Spouse or Domestic Partner and children (including children of your Domestic Partner).

You can, with regard to dependent coverage, make different choices for dental coverage than for medical coverage and you do not have to enroll all eligible children.

If you acquire a new family member after your own enrollment, you may enroll that person no later than 31 days after the date he or she becomes an eligible dependent. You cannot enroll your dependents for coverage in which you yourself are not enrolled.

Please read the *Non-Duplication of Benefits* section before you decide whether to enroll family members who have other group health coverage.

### Changes in Enrollment

In general, you may not change your elections for dental coverage before an annual enrollment period. However, several special rules apply:

- You may change dental programs (but not add or drop dependents) when you move out of the service area of the dental program in which you are enrolled. Your new election must be made no later than 31 days after your move.
- Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents. A Special Enrollment Period is available to a person who meets each of the following conditions:

  — The Employee or dependent was covered under a group plan or had dental insurance coverage at the time coverage under this plan was previously offered to the Employee or dependent.

— The Employee's or dependent's prior coverage was one of the following:

  – COBRA continuation which was exhausted.

  – Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, termination of Domestic Partner relationship, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

— The Employee requests enrollment under this Plan not later than 31 days after the date COBRA coverage is exhausted, non-COBRA coverage terminated, or employer contributions towards such non-COBRA coverage is terminated.

A Special Enrollment Period is also available to Subsequent Dependents acquired by marriage, birth, adoption or placement for adoption. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent. Contact the McKesson Call Center 1-866-772-6601 to enroll.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

Contact the McKesson Call Center 1-866-772-6601 to enroll.

**Enrollment**
During the annual enrollment period, you may change dental programs or drop dental coverage for yourself or your dependents. You also may enroll for dental coverage if you previously waived coverage for yourself and your dependents.

**No Dual Enrollment**
If both you and your Spouse or Domestic Partner are active McKesson employees, the Plan limits how you can enroll for coverage. You and your Spouse or Domestic Partner can enroll for coverage separately, or one of you may enroll the other as a dependent. However, no one can be enrolled as both an Employee and a dependent. In addition, only one of you may enroll any eligible dependent children for coverage.

## When Coverage Begins

**Regular Enrollment**
When you enroll before you become eligible, your coverage usually begins on the date of your eligibility.

If you enroll within 31 days of losing coverage under a Spouse's or Domestic Partner's plan, your McKesson coverage usually begins the day after that other coverage ends.

Coverage for a Subsequent Dependent and any other Dependent who is enrolled at the same time as the Subsequent Dependent is effective:

- For a Spouse, the date of the marriage;
- For a newborn, the date of birth; or
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a Dependent.

The Dependent must be enrolled within 31 days of becoming eligible.

**Annual Enrollment**
When you enroll for dental coverage during the annual enrollment period, your coverage usually begins the first day of the following calendar year.

## When Coverage Ends

**Employee Coverage**
Employee coverage under the Dental Program and the Plan ends on the earliest of the following:

- The day the Dental Program terminates; or
- The day the Plan terminates; or
- The last day of the month in which the Employee terminates employment or loses eligibility; or
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made on a timely basis; or
- The last day of the month in which the Employee enters active military duty unless coverage is continued (See **Coverage During Military Leave**.); or
- The day the Employee becomes covered by a collective bargaining agreement which does not provide for participation in the Dental Program or the Plan; or
- The date you die; or
- The last day of the month for which you request termination of coverage; or
- The date specified by the Company that all coverage under the McKesson Corporation Health Plan will terminate due to fraud or misrepresentation or because the Employee knowingly provided the Plan Administrator with false information, including, but not limited to, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the effective date of coverage and to seek reimbursement of all expenses paid by the Plan.

Coverage usually ends on the last day of the year if you cancel your enrollment during the annual enrollment period.

**Dependent Coverage**
Coverage for all of an Employee's Dependents ends on the earlier of the following:

- The day the Employee's coverage ends.

- The last day of a period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made on a timely basis.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan.

- The last day of the month in which the Dependent's last day of eligibility occurs.

You must inform the McKesson Call Center when a covered child reaches age 19 or 24, marries or otherwise loses eligibility – or when you and your covered Spouse legally separate or divorce or you and your Domestic Partner terminate your relationship.

**Coverage for Incapacitated Children**
Generally, a mentally or physically incapacitated child's coverage will not end solely due to age provided that the child continues to meet all of the following conditions:

- The child is incapacitated; and

- The child is not capable of self-support; and

- The child depends mainly on the Employee for support.

The Employee must provide the McKesson Call Center with proof that the child meets these conditions when requested. The McKesson Call Center will not ask for proof more than once a year.

## Family Medical Leave of Absence (FMLA)
Your McKesson dental coverage may continue while you are out on an approved family medical leave of absence, provided you make timely payment of any required contributions. Contact the McKesson Call Center for more information.

## Coverage During Military Leave
If you voluntarily or involuntarily serve in the uniformed services for a period of five years or less while covered under the Dental Program, you and your covered dependents may elect to continue dental coverage for 18 months or for the period ending on the day after the date the eligible employees fails to apply for or return to employment with McKesson Corporation as determined under § 4312(e) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), whichever is earlier; this period of coverage will run concurrently with COBRA coverage and is conditioned on the timely payment of any required contributions.

This provision applies to:

- employees on active duty; and
- employees on active duty for training; and
- employees on initial active duty for training and inactive duty training in the Armed Forces (including the Reserve components), the Army or Air National Guard and the commissioned corps of the Public Health Service, and to full-time National Guard duty; and
- absences needed to determine the Employee's fitness for duty in the uniformed service.

Coverage will end if you are discharged from the service under other than honourable conditions, or if you are dismissed or dropped from the rolls under conditions that result in loss of reemployment rights under the law.

## Coverage During A Leave Of Absence Or Temporary Layoff

Coverage under the Dental Program may be continued during a period in which the person is away from work due to an approved leave of absence or temporary layoff, provided you make timely payment of any required contributions.

Coverage may end on the following dates:

- Unpaid leaves, except FMLA: the last day of the month following the month in which the leave begins.
- Paid leaves, except FMLA: the last day of the month in which the paid leave terminates.

## Continuation Coverage (COBRA)

Any Health Plan participant – McKesson Employee and/or dependents – may be eligible for a limited period of continuation coverage after regular group coverage ends under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

Continuation coverage is generally the same as regular group coverage. It is available when regular coverage ends as a result of one of the qualifying events described in the following section. Evidence of good health is not required.

**Applying for Continuation Coverage**
Continuation coverage is not automatic. To enroll, you must mail your application within 60 days from the date you receive notice of your eligibility for continuation coverage.

### Eligibility

*Termination of Employment or Reduction in Hours*

If you lose regular group coverage because of a reduction in hours or termination of employment – other than for gross misconduct – you and your covered dependents may elect continuation coverage. You pay the full cost of coverage. Continuation coverage is available for a maximum of 18 months.

You may be eligible to extend your continuation coverage, at an increased cost to you, to a total of 29 months if you were disabled, as determined under the Social Security Act, at any time during the first 60 days of your continuation coverage.

You must notify the McKesson Call Center no later than 60 days after the date on which you receive the Social Security notice and before the end of the initial 18-month period of continuation coverage to extend your continuation coverage because of disability. The McKesson Call Center will then determine whether you are eligible to extend continuation coverage. If you are eligible for this 11-month extension of continuation coverage, so are your covered dependents. If a covered dependent is eligible for this 11-month extension of continuation coverage, so are you and any other covered dependents. If you or your covered dependent fails to notify the McKesson Call Center within the required timeframe, you and your covered dependents will permanently lose the right to the extension of continuation coverage.

If a second qualifying event that gives rise to a 36-month maximum coverage period (see the following paragraphs) occurs within the 18-month or 29-month coverage period, as applicable, your covered dependents will be entitled to a maximum coverage period of 36 months measured from the date of the initial qualifying event, provided notice of the second qualifying event is given to the McKesson Call Center within 60 days of the date of second qualifying event. Failure to provide notice of the second qualifying event within the required timeframe will cause a loss of the right to extend continuation coverage.

*Divorce, Legal Separation, Termination of Domestic Partnership or Loss of Dependent Status*
If a family member loses regular group coverage due to divorce, legal separation, termination of Domestic Partner relationship, the covered Employee's entitlement to Medicare or loss of dependent child status, he or she may elect continuation coverage for a maximum of 36 months. The family member pays the full cost of coverage (102% of the applicable premium for similarly situated individuals who have not had a qualifying event).

It is the responsibility of you and your family member to notify the McKesson Call Center within 60 days after a divorce or legal separation or termination of Domestic Partner relationship or a family member's loss of dependent status under the Plan. If you do not notify the McKesson Call Center within the required timeframe, the family member will permanently lose the right to continuation coverage.

*Your Death*
In the event of your death, your covered family members may elect continuation coverage for up to 36 months. If you qualified for retiree health coverage at the time of your death, your family may be eligible to elect retiree health coverage in place of COBRA continuation coverage.

The Company will pay the full cost of continuation coverage for your Spouse or a Domestic Partner and eligible dependent children for the number of months equal to your years of active service – up to a maximum of 24 months. The Company payment for a dependent child will end earlier if the child no longer qualifies as an eligible dependent under the Health Plan. Your family pays the full cost for the balance of the period of continuation coverage (102% of the applicable premium for similarly situated individuals who have not had a qualifying event).

**Paying for Continuation Coverage**
You must pay for COBRA continuation coverage. COBRA premiums cannot exceed 102% of the applicable premium for similarly situated individuals who have not had a qualifying event. Such premium may be increased to 150% of the applicable premium if COBRA continuation coverage is extended as a result of disability (see explanation above). Payment must be made within 30 days of the due date. The initial COBRA premium payment, however, may be made within 45 days of the COBRA election.

**Early Termination of Continuation Coverage**
Continuation coverage ends before the maximum period of coverage when the Health Plan is discontinued or when the covered individual:

- Fails to timely pay the required premium,
- Cancels coverage,
- Becomes covered by another group health plan after electing continuation coverage – unless coverage under that plan is limited because of a pre-existing condition COBRA continuation coverage will cease at the end of the exclusion period, or
- Becomes entitled to Medicare after electing continuation coverage.

# BENEFIT REDUCTIONS

## Right Of Recovery
The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were made in error or due to a mistake in fact. Benefits paid because you or a dependent misrepresented facts are also subject to recovery. If the Dental Program provides a benefit for you or a covered dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for your or your dependent by the amount of the overpayment.

## Third Party Liability
When charges are incurred by you for services relating to an accident, injury or sickness for which benefits are payable under the Dental Program, and the accident, injury or sickness arises under circumstances that may create a legal liability in another individual or organization, and whenever the Dental Program pays any amount to you or on your behalf (a "Third Party Expense"), your right of recovery (if any) from a third party shall be subrogated to the Plan to the extent of the Third Party Expense.

**Duty of Notification of Third Party Expenses**
If you claim benefits under the Dental Program with respect to Third Party Expenses you must notify the Dental Program of the expenses which are Third Party Expenses at the time a claim for benefits is submitted.

You must submit all information, documents and any other evidence which the Dental Program requests in order to assist the Dental Program in determining whether you have or will be reimbursed by any person for the Third Party Expense.

**Participant's Obligations**
If you are injured through the act or omission of any third person, or if expenses relating to an injury are reimbursable under a contract of no fault automobile insurance, you will receive benefits under the Dental Program only on the condition that you agree in writing to the following:

- To reimburse the Plan for the full amount of the Third Party Expense, not to exceed the amount of recovery received from the third party or no fault automobile insurance. The Plan has the discretion to agree to a lesser amount of reimbursement, if determined to be in the best interest of the Plan. Such amounts shall be payable immediately upon the receipt of any damages collected against a third party or under no fault automobile insurance, whether in a legal judgment, settlement or otherwise; provided, however, that such reimbursement shall not include reasonable expenses in collecting such amount, including reasonable attorneys' fees; and

- To execute and deliver, at the request of the Plan, such instruments, including an assignment to the Plan of any and all claims to recover amounts from any person for a Third Party Expense up to the amount of any benefits that would be paid under the Plan for such Third Party Expense, and do whatever else is reasonably necessary to secure the Plan's rights to reimbursement out of such proceeds; and

- To provide the Plan with a lien and order directing reimbursement of medical payments against any damages collected against a third party or under no fault automobile insurance, whether in a legal judgment, settlement or otherwise; provided, however, that such reimbursement shall not include reasonable expenses in collecting such amount, including reasonable attorneys' fees. Said lien and order shall be equal to the total amount of all benefits paid under the Plan; and

- To agree to a credit against payments to be made under the Plan in the future equal to the amount of any damages collected against a third party or under no fault automobile insurance, whether by legal judgment, settlement or otherwise, less any amount paid to the Plan pursuant to the first bullet point above.

In the event that you fail to comply with the requirements of the above provisions you will not be eligible to receive any further benefits under the Plan until you have so complied.

The Plan shall have the right to intervene in any suit or other proceeding to protect the reimbursement rights hereunder. You shall be responsible for all fees of the attorney handling the claim against the third party.

## Overpayments
If the Plan makes an overpayment on your behalf, for whatever reason, you must reimburse this overpayment. No further benefits will be paid until full reimbursement is received.

## Non-Duplication Of Benefits

This provision applies when you or a dependent is covered by another group medical or dental plan, in addition to a McKesson medical or dental program. One plan pays first, and the other pays second.

### Order of Payment

In general, the following rules determine which plan pays first – the primary plan – and which pays second – the secondary plan.

The plan which covers you as an active employee pays first. The plan which covers you as a dependent or retiree pays second.

### Order of Coverage—Employee and Spouse or Domestic Partner

- If one of the plans does not have a coordination of benefits provision, that plan will pay first.

- If you (or your Spouse) are covered as an employee by one plan and as a dependent by another, the plan that covers the person as employee will pay benefits first. If you or your Spouse are also covered by Medicare and are not actively working:

  — the plan that covers a person as a dependent of an employee is primary,

  — Medicare is secondary, and

  — the plan that covers a person as a retired employee pays third.

- If you or your Spouse are covered as an employee and also as a retired or laid off employee (one of them through another employer) the plan that covers the person as an active employee (or a dependent of an employee) is primary.

### Order of Coverage—Dependent Children

For a covered dependent child whose parents are not divorced or separated and who is covered as a dependent under both parents' plans:

- The plan of the parent whose birthday is first in a calendar year will pay benefits first for the covered child. For example, if the father's birthday is in March and the mother's birthday is in September, the father's plan is primary for the child. This is called the "birthday rule."

- If the parents have the same birthday, the plan that has covered a parent longer will pay benefits first for the child. For example, if the father has had coverage under his plan for five years and the mother has had coverage under her plan for seven years, the mother's plan is primary for the child.

- If the other plan does not use the birthday rule but bases the order of benefits on the gender of the parent so that the plans don't agree on order, the rules of the other plan will determine which plan pays first.

If two or more medical plans cover a dependent child of divorced or separated parents, benefits for the child are determined as follows:

- If under a court decree the parents have joint custody but the decree doesn't state who is responsible for the child's healthcare expenses, benefits will be coordinated the same as for the children of married parents, described previously.

- The medical plan of the parent who has a court decree of financial responsibility will be primary.

- If no court decree exists, and the parent with custody has not remarried, the medical plan of the custodial parent will be primary and the plan of the non-custodial parent will be second.

- If no court decree exists and the parent with custody has remarried:

  — the plan of the custodial parent will be primary,

  — the plan of the stepparent will be second, and

  — the plan of the non-custodial parent will be third.

If none of the above provisions determine which plan is primary, the plan under which the employee or dependent has been covered for the longest period of time shall be the primary plan.

**Amount of Payment**
When the McKesson Plan is the second plan, it will reimburse you only for the difference between what it would have paid if it were the primary payer and what the other plan actually paid. This means that when the McKesson Plan is the secondary payer, 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 by the McKesson Plan.

# DENTAL COVERAGE

The Plan is designed to assist with your dental expenses. It does not cover every type of expense and it generally pays more for routine work than for major services. This section covers benefits provided through the CIGNA PPO Program. For information about the CIGNA HMO Dental Program, refer to your annual enrollment materials or contact CIGNA at 1-800-367-1037.

## Plan Reimbursement

The CIGNA PPO Program reimburses eligible expenses at 50%, 80%, or 100% of the reasonable and customary charge for the service provided. Benefit levels are summarized in the Dental Benefits section. However, the following program features affect all benefits and should be read first.

The CIGNA PPO Program is a Silent Preferred Provider Option (PPO). You can go to any dentist you choose and pay a percentage of the bill. However, if you use a CIGNA "network" dentist, you may receive discounts on the provider's normal fees. A list of providers participating in the CIGNA PPO Program network is provided automatically, free of charge, as a separate document. To locate a network dentist, you may also call 1-888-336-8258, or visit CIGNA's website at *www.cigna.com.*

## Eligible Expenses

Eligible dental expenses are charges for services which are:

- Covered under the Dental Program,
- Provided by a licensed dentist, and
- Determined by the Claims Administrator to be necessary for the repair of teeth broken down by decay or injury, or for semi-annual check-ups.

Charges for services or treatment received from providers who are not a part of the CIGNA PPO Program network which are in excess of the amount the Claims Administrator determines as the reasonable and customary charge for the service provided are not considered eligible expenses.

Charges for orthodontia are not considered eligible expenses unless the charges are for services provided to a child under age 19.

Charges for services provided by an immediate family member are not considered eligible expenses.

### Reasonable and Customary

The Claims Administrator determines the reasonable and customary charge for all dental services, based on periodic reviews of charges made by health care providers throughout the country. To qualify as reasonable and customary, the charge must generally not exceed the provider's usual fee or the fees charged by other providers in the same geographic area for similar services.

## Alternate Benefit

When more than one Dental Service could provide suitable treatment based on common dental standards, the Claims Administrator will determine the dental service on which payment will be based and the expenses that will be included as covered expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed covered expenses. For this reason, the Claims Administrator recommends the use of pre-determination of benefits when major dental services are needed, so that you and your Dentist know in advance what the Dental Program will cover before any treatment begins.

## Annual Deductible

Charges are subject to a per person annual deductible of $50 and a family deductible of $150. This means you pay the first $50 of dental expenses for each family member each year. The deductible does not apply to eligible expenses for semi-annual check-ups or charges for orthodontia.

## Maximum Benefit

The annual maximum benefit for all expenses other than orthodontic charges is $1,500 per covered person. The lifetime maximum benefit for orthodontic charges is $1,000 per covered child.

## Pre-Determination

When your dentist proposes treatment costing $200 or more, you should request an estimate of benefits in advance. Ask your dentist to describe the anticipated services on the claim form and then submit the completed form in the usual way. The Claims Administrator will then send your dentist a statement showing how much of the expense is normally covered by the Dental Program.

Pre-determination informs you whether a particular charge is an eligible expense, and how much the normal benefits are. Pre-determination does not take into account your eligibility at the time the service is performed or provisions relating to non-duplication of benefits or annual maximums. A pre-determination is not a guarantee of payment.

Requesting a pre-determination is not a requirement nor is it considered the submission of a claim. The Claims Administrator will respond to your request based upon the information available at the time of the request. You should be prepared to provide as much information as possible about the service in question. Because the actual claim that you later submit for reimbursement may contain additional or different information, the decision by the Claims Administrator on the pre-determination request is not binding. Once you have received the service, submitted a claim, and all information regarding your claim is received by the Claims Administrator, a final determination of your claim will be made and communicated to you in accordance with the Dental Program's claims procedure.

Full details on how to file a request for a pre-determination of benefits are shown on the claim form.

## Missing Tooth Limitation

During the first twelve months a participant is covered, reduced benefits are paid for treatment of a tooth which was missing on the date coverage began. The program pays one-half of the amount that would have been payable. Procedures under this limitation include partials, dentures and pontics, and any other treatment in connection with the missing tooth.

## Dental Benefits

| Services | Plan Pays | Deductible Applies |
|---|---|---|
| **Basic** covers dental expenses associated with preventive and diagnostic care, and basic restorative services. This includes: | | |
| • Prophylaxes (cleanings), exams, and bitewing x-rays<br>Limited to two per calendar year | 100% | No |
| • Amalgam, silicate cement, plastic and composite fillings | 80% | Yes |
| • Extractions and anesthetics | 80% | Yes |
| • Denture repairs | 80% | Yes |
| • Oral surgery and root canal surgery | 80% | Yes |

| Services | Plan Pays | Deductible Applies |
|---|---|---|
| **Major** covers more complex work, including: | | |
| • Inlays and onlays, gold fillings | 50% | Yes |
| • Crowns | 50% | Yes |
| • Bridges and pontics (artificial teeth) | 50% | Yes |
| • Complete or partial dentures | 50% | Yes |
| **Orthodontia** coverage is limited to treatment for children under age 19 | 50% | No |

# LIMITATIONS AND EXCLUSIONS

You should note that coverage for dental care is limited to services and supplies listed in the Plan Document. You can use the dental pre-determination procedure to find out in advance whether a particular dental service is covered.

Pre-determinations are based on charge and service information, without review of the individual's eligibility. A pre-determination of covered charges is not a guarantee of payment. See the **Dental Coverage** section for further information regarding pre-determinations.

All benefits are subject to the terms and conditions of the Plan. Also, if the Claims Administrator determines that a less expensive procedure would restore your teeth to functional capacity, your reimbursement will be based on the benefit for the less expensive procedure.

## General Exclusions

No benefits will be paid for charges for:

- A condition due to war, declared or undeclared, or any act of war.
- Any sickness covered under any workers' compensation or similar law.
- Appliances or restorations for the purposes of splinting teeth, or to increase vertical dimension or restore occlusion between teeth.
- Cosmetic services or supplies.
- Dental expenses for which the covered member is reimbursed by a third party or his insurer.
- Dental prophylaxis, or cleaning, more frequently than two times every calendar year.
- Dental sealants for anterior teeth and for dependents over age 14.

- Instructions in oral hygiene and plaque control.
- Expenses in excess of the reasonable and customary charge as determined by the Claims Administrator.
- Expenses in excess of the negotiated rates for Network providers.
- Experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled "Caution-limited by Federal law to investigational use."
- Experimental or investigational procedures and treatment methods or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Full mouth x-rays more frequently than once every 36 months.
- General anesthesia for dental treatment, unless in connection with covered oral surgery.
- Orthodontic treatment of participants age 19 and older.
- Prescription and non-prescription drugs.
- Preventive care other than cleaning.
- Replacement of a bridge or denture that can be made useable according to dental standards.
- Replacement of a denture or bridgework that was installed during the preceding five years and for which a Dental Program benefit was payable.
- Replacement of lost or stolen appliances.
- Services or supplies for personal comfort or convenience.
- Services or supplies in connection with an accident, injury or illness due to or in connection with, participation in the commission or attempted commission of any crime.
- Services rendered after coverage terminates, even if an estimate of benefits was made while the individual was covered by the Dental Program, except that crowns, inlays or onlays will be covered if the tooth was prepared while the individual was covered by the Dental Program and such crown, inlay or onlay is installed within three calendar months after the individual's coverage terminates.
- Services that are deemed to be medical services.
- Surgical implant of any type including any prosthetic device attached to it.

- Treatment for which no payment would have been required in the absence of coverage under this Dental Program.

- Treatment of temporomandibular joint (TMJ) disorders.

- Treatment or services determined by the Claims Administrator to be unnecessary for restoration of dental function.

- Treatment provided by an immediate family member. An immediate family member is defined as the Spouse, parent, Domestic Partner, child or sibling of the patient or the patient's Spouse or Domestic Partner.

- Treatment provided in connection with a condition that is in any way connected with the covered person's occupation.

- Charges for or in connection with an intentionally self-inflicted injury which is not inflicted as a result of a medical condition, including physical and mental health conditions.

- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars.

# FILING CLAIMS

## Claims Administrator

The Claims Administrator for the McKesson Corporation Dental Program is:

CIGNA HealthCare
P.O. Box 188041
Chattanooga, TN 37422-8041

## Filing Claims

Dental claims should be submitted to CIGNA HealthCare on a CIGNA claim form.

All claims must be accompanied by an itemized statement of charges from the provider of services. You must submit claims within 12 months from the date of service. No benefits will be paid if you do not file within this time.

Claim forms are available from McKNet, McKesson's Intranet, or by contacting CIGNA at 1-888-336-8258.

In cases of questionable claims, CIGNA may request an independent dental examination.

Generally, if you are requesting a benefit for dental care, service, treatment or supply already received, i.e., a "Post-Service Claim", notify CIGNA immediately. You may obtain the necessary forms to file your claim as stated above. CIGNA will notify you of its benefit determination within 30 days of its receipt of your claim, unless circumstances require an extension of time. If an

extension is required, you shall be given written notice of the extension prior to the expiration of the initial 30 day period. The extension will not exceed 15 days from the end of the initial period. In the event that an extension is necessary because there is insufficient information to decide your claim, your written notice of the extension will specifically describe the required information. You will have at least 45 days from your receipt of the notice to provide the specified information.

### Notice and Payment of Claims

If CIGNA approves your claim in whole or in part, your claim will be paid to you accordingly unless your claim has been properly assigned to your health care provider. If your claim is denied, CIGNA will provide you with written notice of its decision and the procedure for filing an appeal.

### If Your Claim Is Denied

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

- The reason(s) for the denial, including references to specific Dental Program provision(s), as applicable, upon which the denial was based.
- The additional materials or information needed to support your claim and why such information or materials are necessary if the claim was denied because you did not furnish complete information or documentation;
- The appeals procedures and the time limits that apply to them; and
- Your right to bring a civil action under Section 502(a) of ERISA after completion of all levels of appeal required by the Dental Program.

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 such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

If the claim is denied on the basis of 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 Dental Program to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

## Filing Appeals

### First Appeal

If CIGNA denies your request for benefits, you or your authorized representative may appeal the denial. The Dental Program provides for a two-level appeal process. To begin the appeal process, you must file a written notice of the appeal with CIGNA within the time limit specified in the table that follows. In your notice, you should state why you believe your claim should be paid. CIGNA is the named fiduciary with respect to appeals and have the sole discretion and authority to interpret the terms of the Dental Program as well as any other information relating to claims and appeals.

You may submit written comments, documents, records, and other information relating to your claim in connection with your appeal. 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 First Level Appeals**
The time limits described in the following table describe the time by which you are required to submit first level appeals to CIGNA and the time by which CIGNA is required to provide you with notice of its determinations of first level appeals.

| | **Post-Service Claims** |
|---|---|
| Your deadline to file a first appeal | 180 days after receiving claim denial notice |
| Plan notice of first appeal decision | Not later than 30 days after receipt of a first level appeal |

**Procedure on Appeal**
The review of your appeal will take into account all comments, documents, records, and other information submitted by you that relate to your claim. In addition, the decision maker on appeal will be different from the decision maker at the initial claim level, as will any health care 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 with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, CIGNA will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who was consulted in connection with the denial of the claim that is the subject of the appeal (nor the subordinate of such individual).

Upon request, CIGNA will provide the identification of any medical or vocational experts whose advice was obtained on behalf of Dental Program, in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

**Notice of Determination on Appeal**
Within the time prescribed in the table above, the Claims Administrator will provide you with written notice of its decision. If CIGNA determines that benefits should be paid, CIGNA will take whatever action is necessary to pay them as soon as possible.

If your first appeal is denied, the notice will explain:

- The reason(s) for the denial, including references to specific Dental Program provisions, as applicable, upon which the denial was based; and

- 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; and

- The procedure for filing a second appeal and the time limits associated with bringing a second appeal; and

- Your right to bring an action under Section 502(a) of ERISA following an adverse benefit determination after a second appeal.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

If the 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 Dental Program to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

**Filing A Second Level Appeal**
If CIGNA denies your first appeal, you or your authorized representative may file a second appeal of the adverse benefit determination. To begin the process for the second level of appeal, you must file a written notice of the appeal CIGNA within the time limit specified in the table that follows. In your notice of appeal, you should provide an explanation of why your claim should be paid.

You may submit written comments, documents, records, and other information relating to your claim that you did not submit with your previous appeal. 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 Second Level Appeals**
The time limits described in the following table describe the time by which you are required to submit second level appeals to CIGNA and the time by which CIGNA is required to provide you with notice of its determinations of second level appeals.

| | **Post-Service Claims** |
|---|---|
| Your deadline to file a first appeal | 180 days after receiving claim denial notice |
| Plan notice of first appeal decision | Not later than 30 days after receipt of a second level appeal |

**Procedure on A Second Appeal**
The procedural steps that are applicable to first level appeals also apply to second level appeals.

**Notice of Determination on A Second Level Appeal**
Within the time prescribed in the table above regarding second level appeals, CIGNA will provide you with written notice of its decision. If CIGNA determines that benefits should be paid, CIGNA will take whatever action is necessary to pay them as soon as possible.

If your appeal is denied, the notice will include the information described in the section **Notice of Determination on Appeal**, as appropriate.

**Right to File A Legal Action**
No legal action may be taken to gain benefits from the Dental Program after four years from when the loss occurred for which a claim was made. No legal action may be taken to gain benefits from the Dental Program until you have:

- Submitted a written claim for benefits; and
- Been notified by CIGNA that the claim is denied; and
- Filed a written request for a first level appeal of the denied claim with CIGNA; and
- Been notified in writing that claim denial has been affirmed at the first level of appeal; and
- Filed a written request for a second level appeal of the denied claim with CIGNA; and
- Been notified in writing that the claim denial has been affirmed at the second level of appeal.

# GLOSSARY

(These definitions apply when the following terms are used.)

**Calendar Year**
A period of one year beginning with each January 1.

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

**Covered Family Members or Covered Person**
The Employee and the Employee's spouse or Domestic Partner and/or Dependent children and/or children of the Domestic Partner who are covered under the Plan.

**Employee**
An active Employee on the U.S. Payroll of the Company, its subsidiaries or 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; provided, however, that this requirement will not apply to a group of Grandfathered MIS Employees who were working 20 hours but less than 30 hours per week and who were eligible for and enrolled in health care coverage under any other health plan sponsored by the Company as in effect on December 31, 1999; and

- Is performing in the customary manner all of the regular duties of his occupation either at one of the Company's business establishments or at some location to which Company business requires the Employee to travel or is not performing his regular duties due to illness, provided that he has already commenced performing his regular duties of his employment prior to his illness; and

- Is not in one of the excluded categories described in the following bulleted list.

The term Employee also includes designated former Employees of either the Company or a company formerly affiliated with the Company, who by written agreement with the Company or pursuant to a written policy adopted by the Company, are allowed to continue participation in the Plan for the definite period of time provided in such agreement or policy. 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 is:*

- Covered by a health plan established pursuant to collective bargaining (other than this Plan); or

- Covered by another health plan to which the Company contributes; or

- Designated by the Company, its subsidiaries or affiliates as a seasonal or temporary Employee; or

- Compensated for services by a person other than the Company, its subsidiaries or affiliates and for any reason is deemed to be an Employee; or

- Not on the U.S. Payroll of the Company, its subsidiaries or affiliates and for any reason is deemed to be an Employee; or

- A leased Employee within the meaning of Section 414(n) of the 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 affiliates; or

- 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 service will no longer be required by the Company.

If, during any period, the Company, its subsidiaries or affiliates has not regarded an individual as an Employee and, for that reason, has not withheld employment taxes with respect to that individual, then that individual shall not be 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 shall be determined by the Company, its subsidiaries or affiliates and all such determinations shall be 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; provided, however, that any such entity shall cease to be a subsidiary or affiliate when that entity ceases to be a subsidiary or affiliate of McKesson Corporation.

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

**Payroll**
The system used by an entity 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 an entity uses 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.

**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 the 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.

# YOUR RIGHTS AS A PLAN MEMBER

**ERISA Rights**
As a Participant in the McKesson Corporation Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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

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

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

**Continue Group Health Plan Coverage**
Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, of 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.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

# ADDITIONAL PLAN INFORMATION

**Name of Plan**
McKesson Corporation Health Plan

**Type of Plan**
The Plan is a group health plan which provides medical, dental and vision benefits. This SPD only describes the dental coverage available under the Plan to eligible Employees and their eligible Dependents.

**Plan Number**
501

**Plan Sponsor**
McKesson Corporation
One Post Street
San Francisco, CA 94104

**Plan Administrator**
McKesson Corporation
c/o Vice President, Compensation and Benefits
One Post Street
San Francisco, CA 94104
Telephone: (415) 983-8300

**Sponsor's Employer Identification Number**
94-3207296

**Plan Administrator's Employer Identification Number (EIN)**
94-2352918

**Claims Administrator**
CIGNA HealthCare
McKesson Dental Program
P.O. Box 188041
Chattanooga, TN 37422-8041

**Benefits Administrator**
McKesson Call Center
2601 Research Forest Drive
Dept. 1362
The Woodlands, TX 77381
1-866-772-6601

**Plan Trustee**
Wells Fargo Bank
405 Montgomery Street
San Francisco, CA 94104

**Type of Administration**
The Sponsor has contracted with contract administrators to administer its component programs. CIGNA provides administrative services with respect to the dental benefits furnished under the CIGNA PPO dental program component of the Plan pursuant to an administrative services only agreement.

The Plan's dental HMO component (CIGNA HMO Dental Program) is fully insured. The Plan Sponsor has entered into an agreement with CIGNA to provide dental benefits under the Plan. Claims for benefits are sent directly to the CIGNA, which is financially responsible for paying claims under the CIGNA HMO Dental Program.

**CIGNA DHMO**
CIGNA Dental HMO
300 N.W. 82nd Avenue
Plantation, FL 33324

**Funding Medium**
Plan contributions are deposited in a trust fund maintained by the Plan Trustee.

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

**Source of Contributions**
The plan is funded by Employee and Company contributions, which are deposited into a trust operated for the sole benefit of Plan participants. The Employee rate of contribution is set by the Company and may be adjusted from time to time. The balance of the cost of the Plan is paid by the Company.

**Service of Legal Process**
Service of legal process should be directed to:

Vice President, Compensation and Benefits
McKesson Corporation
One Post Street
San Francisco, CA 94104

Service of legal process may also be made on the Plan Trustee or the Plan Administrator, McKesson Corporation.

**Notice of Change**
Notice of a change in Dependent status should be provided to the McKesson Call Center Forms for a change of address can be requested from your HR Representative at your work location or by contacting the McKesson Call Center.

**Participating Employers**
A participating employer is any corporation which is a subsidiary of or affiliated with McKesson Corporation, whose employees are authorized by the Company to participate in the Health Plan as described in this SPD. 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.