McKesson Corporation

Definity Health Option
Summary Plan Description

Effective January 2005

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DEFINITY HEALTH OPTION HIGHLIGHTS

The Definity Health Option allows the Company to provide you comprehensive health and wellness coverage that gives you a unique way to pay routine health expenses and provides a safety net of coverage for major health care expenses.

The Definity Health Option:

- Lets you choose your provider (no referrals required).

- Allows you to spend or save Benefit Dollars in your Personal Care Account ("PCA") for health expenses.

- Covers many Preventive Care services at 100% if received from a provider or facility that has contracted with Definity Health to provide health care services to eligible participants of the McKesson Corporation Health Plan at discounted rates ("In-Network Provider or Facility", "In-Network"). See the **Preventive Care** section of **What's Covered Under the Definity Health Option.**

- Provides four coverage levels – Employee only, Employee plus Spouse or Domestic Partner, Employee plus Children, or Family – so you can pick a coverage level appropriate for you and your family.

- Offers the added benefit of a personal care consultant to help you make informed decisions about your family's health care purchases (for more information, visit *www.definityhealth.com*).

The Definity Health Option is a combination of two separate programs, the Health Coverage Program and the Health Expense Reimbursement Program:

- The Health Coverage Program provides major medical coverage, except that the deductible (the amount you have to pay) may be higher than you have experienced under similar health plans.

- The Health Expense Reimbursement Program allows the Company to set up a Personal Care Account ("PCA") in your name. The Company will allocate Benefit Dollars on a yearly basis to your PCA for the payment of covered expenses. Your PCA is part of the Health Expense Reimbursement Program.

The Definity Health Option is part of the McKesson Corporation Health Plan ("Plan"). It is a term used to refer to the two separate programs described above. The Definity Health Option adds value by administering these otherwise separate programs together to help you maximize your health benefits.

Provisions of the McKesson Corporation Health Plan are summarized in this Summary Plan Description ("SPD"). This description does not state all of the Plan's 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 Plan, see the section **Your Rights as a Plan Member**.

Each year, the Company will allocate a certain number of "Benefit Dollars" to your Personal Care Account (PCA). Benefit Dollars are not real dollars. You may use Benefit Dollars in your PCA to help pay for the deductible or other out-of-pocket expenses under the Health Coverage Program, or you may use them to pay for certain health expenses covered by the Health Expense Reimbursement Program but not by the Health Coverage Program.

If you don't spend all your Benefit Dollars in a year, they will carry forward into the next year. In this manner your PCA may "grow," almost like a savings account. But keep in mind that Benefit Dollars under your PCA are subject to two restrictions: first, they may only be used for covered expenses as defined in this SPD, and second, you will lose your Benefit Dollars when you terminate employment or retire, unless you elect COBRA Continuation Coverage**.** Benefit Dollars will not be reinstated if you reenroll more than 30 days after terminating coverage under the Health Coverage Program and Health Expense Reimbursement Program. The amount of Benefit Dollars that the Company allocates to your Personal Care Account each year depends on the level of coverage you choose. See the section **Personal Care Account**, under **How the Definity Health Option Works**, for the amount of Benefit Dollars allocated by the Company.

If more expensive medical care is needed, the Health Coverage Program provides additional protection. Under the Health Coverage Program, you may see any doctor, specialist or health care facility you wish, as long as the services you receive are covered under the programs; however, the Health Coverage Program will pay a greater percentage of covered expenses when In-Network Providers are utilized (except as stated in the **Out-of-Area Schedule**). The Health Coverage Program has a deductible and an out-of-pocket limit that is based on the calendar year, and pays a percentage of covered expenses.

Definity Health is a private health care administrator, whose goal is to provide you with the tools to make wise health care decisions. Definity Health is also the Claims Administrator. However, Definity Health is not an insurance company, and does not guarantee any benefits. The Company is solely responsible for paying health benefits described in this summary.

Please read this booklet thoroughly to learn how the Definity Health Option works. If you have any questions, call the toll-free Definity Health customer service number at 1-866-333-4648.

HOW THE DEFINITY HEALTH OPTION WORKS

The Definity Health Option consists of two separate programs: 1) The Health Expense Reimbursement Program, and 2) The Health Coverage Program. Your Personal Care Account will be established under the Health Expense Reimbursement Program.

Personal Care Account

Each year, the Company allocates a certain amount of Benefit Dollars to a Personal Care Account ("PCA") set up in your name. You use the Benefit Dollars in your PCA to pay regular health care expenses, such as your deductible, prescription drugs and certain health costs that may not be covered under the Health Coverage Program. The amount of Benefit Dollars the Company allocates to your PCA is determined annually. The amount of Benefit Dollars that the Company has allocated to PCAs this year is as follows:

Coverage Category	Benefit Dollars
• Employee only	$ 750 + $25 for completion of one HRA* = $775
• Employee plus Spouse or Domestic Partner	$1,100 + $25 for completion of one HRA* = $1,125; or $1,100 + $50 for completion of two HRAs* = $1,150
• Employee plus Children	$1,100 + $25 for completion of one HRA* = $1125
• Family	$1,500 + $25 for completion of one HRA* = $1,525; or $1,500 + $50 for completion of two HRAs* = $1,550

*If you choose to participate in the online Health Risk Assessment (HRA) offered by Definity Health, the amount shown for your PCA Benefit Dollars will increase by such applicable amount.

See the **Eligibility and How to Enroll** section regarding special rules for mid-year enrollments and mid-year enrollment changes and how this affects your PCA.

Earning Extra PCA Benefit Dollars
You and your Spouse/Domestic Partner may earn an additional $25 deposit into your PCA by completing the online Health Risk Assessment (HRA) offered by Definity Health. The HRA is an interactive questionnaire designed to help you identify your healthy habits as well as your health risks. All assessments are kept confidential and your participation in this assessment will not impact your benefits or eligibility for benefits in any way.

As a subscriber in the Definity Health Option, you and your Spouse or Domestic Partner are eligible to participate in the online Health Risk Assessment, if enrolled.

To find the Health Risk Assessment, log in to your personal website at *www.definityhealth.com*, click on the Health Resources tab, then click the Health Assessment icon. If you need assistance with the online assessment, please call Definity Health Member Service at 1-866-333-4648.

Additional PCA Dollars for Participation in Special Disease Management Program
In addition, you and your Spouse/Domestic Partner may participate in a special disease management program for people with certain chronic conditions, offered by Definity Health. The chronic conditions include:

- Diabetes;
- Asthma;
- Chronic obstructive pulmonary disease;
- Coronary artery disease; and
- Chronic heart failure.

If the results of your HRA questionnaire results indicate that you have such a condition – or a high risk of developing one – a health coach at Definity Health will call you directly and invite you to

participate in this program. If you actively take part in the program for at least three consecutive months, McKesson will make an additional $100 contribution to your PCA. You can also contact Definity directly at 1-866-333-4648 to find out if you are eligible for this program.

The information you provide to Definity Health through the HRA questionnaire and disease management program will be kept completely confidential, as protected by law. The Company will only receive reports summarizing results for all employees – not your individual information.

When you go to the doctor, show your Definity Health ID card and your cost will be deducted from your PCA based on your balance at the time Definity Health processes your claim. You use your PCA to pay for health care expenses, including those not covered under the Health Coverage Program – such as your deductible, coinsurance and any covered expense listed under **Covered Under the Personal Care Account Only**. You do not need to spend your Benefit Dollars for Preventive Care received from an In-Network Provider; those benefits are covered In-Network – with no deductible – through the Health Coverage Program (a complete list of Preventive Care Expenses covered under this program can be found in the section, **What's Covered Under the Definity Health Option, Preventive Care – Scheduled Benefits**).

In most cases, your expenses are paid through your PCA first. Once you've met your deductible, the Health Coverage Program kicks in. Keep in mind that expenses paid through the PCA may not also be claimed as a deduction on your tax return or submitted for reimbursement through a flexible spending account.

For More Information

For more information about your PCA, visit Definity Health at *www.definityhealth.com* or call customer service at 1-886-333-4648.

Your user ID and password to access *www.definityhealth.com* will be sent to you with your Definity Health Option ID card.

You can keep track of the Benefit Dollars in your PCA by going online to *www.definityhealth.com*, calling the toll-free Definity Health customer service number, or checking your Definity statement. Any Benefit Dollars left in your PCA at the end of the year stay in your PCA for your use during the following year provided that you continue to be enrolled in the Definity Health Option. If you use all the Benefit Dollars in your PCA, you are responsible for meeting the remainder of your deductible and paying your share of any additional health care costs you incur during the year.

What are Benefit Dollars?

Benefit Dollars represent the amount the Company will pay for certain health expenses that are not paid for under the Health Coverage Program. Think of Benefit Dollars as IOUs that may only be used for covered expenses as described in this SPD. The Company does not set aside any actual dollars into a fund or account, and claims for benefits from your PCA will be paid from the Company's general assets. Benefit Dollars are only good for covered expenses you incur while covered under the Definity Health Option.

PCA and Flexible Spending Accounts

While your PCA is similar to a health care flexible spending account, they are not the same thing – and are used for different purposes. You may participate in both if you feel that best meets your family's needs. Keep in mind:

- The PCA is only available if you enroll in the Definity Health Option – you cannot elect it separately and you can't drop out of it, unless you drop out of the Definity Health Option. Your participation in the health care flexible spending account is not related to your participation in one or more of the Company's health programs.

- While the PCA and the health care flexible spending account may cover some of the same types of expenses, the health care flexible spending account may be funded with pre-tax contributions under a salary reduction arrangement. You are not permitted to contribute any amount of your income to the PCA.

- Eligible expenses reimbursed through the PCA cannot also be reimbursed through the health care flexible spending account.

- Eligible expenses must be reimbursed through the PCA prior to the health care flexible spending account, if any. No expenses may be reimbursed from the health care flexible spending account, if any, unless the PCA has first been depleted.

Health Coverage Program

Under the Health Coverage Program, you may see any doctor, specialist or health care facility you wish; however, the Health Coverage Program will pay a greater percentage of covered expenses when In-Network Providers are utilized. The Health Coverage Program has a deductible, an Out-of-pocket Limit, and pays a percentage of covered expenses. The deductible does not apply to Preventive Care – Schedule of Benefits; these costs will be covered at 100% of the eligible expense if received from an In-Network Provider.

Deductible

The Health Coverage Program requires you to satisfy a calendar year deductible ("deductible"), as documented in the **Schedule of Benefits**, before it begins to pay benefits. Benefit Dollars in your PCA can be used towards satisfaction of your deductible, so in essence the Company pays part of your deductible (or all of your deductible in subsequent years in which you rollover an applicable amount of PCA Benefit Dollars – see below for explanation). After you satisfy the deductible, your Health Coverage Program begins.

Member Responsibility Phase of Deductible

If you deplete the Benefit Dollars in your PCA, you enter the Member Responsibility phase of the deductible. This means that you are responsible for paying additional health care expenses incurred during the year, up to the amount of your deductible. This is referred to as "Bridging Your PCA and Health Coverage."

The amount of your Member Responsibility can vary each calendar year.

Initial Calendar Year
The Member Responsibility amount is your deductible minus your PCA Benefit Dollars. If you choose to spend your PCA Benefit Dollars on PCA Only covered expenses, the Member Responsibility amount will increase by such amount up to the amount of your deductible.

Subsequent Calendar Years
The Member Responsibility amount is your deductible minus your PCA Benefit Dollars adjusted (if applicable) as follows:

- If you rollover PCA Benefit Dollars from the previous calendar year, the Member Responsibility amount is decreased by such amount.

- If you choose to spend your PCA Benefit Dollars on PCA Only covered expenses, the Member Responsibility amount will increase by such amount, up to the amount of your deductible.

- If the date on which Definity Health processes your claim falls within any subsequent calendar year for expenses you incurred from a previous calendar year, a deduction from your PCA Benefit Dollars in such amount will occur, thus increasing your Member Responsibility amount up to the amount of your deductible (assuming you have depleted your PCA Benefit Dollars in such previous Plan Year).

It is important to note that your Member Responsibility amount can vary each calendar year; however, it will never increase above your deductible amount, nor will it decrease to a negative amount.

Coverage Category (Standard Plan and Out-of-Area Plan)	**Deductible**
• Employee only	$2,000 Deductible minus $750 PCA Benefit Dollars* = $1,250 Member Responsibility**
• Employee plus Spouse or Domestic Partner	$3,000 Deductible minus $1,100 PCA Benefit Dollars* = $1,900 Member Responsibility**
• Employee plus Children	$3,000 Deductible minus $1,100 PCA Benefit Dollars* = $1,900 Member Responsibility**
• Family	$4,000 Deductible minus $1,500 PCA Benefit Dollars* = $2,500 Member Responsibility**

*If you choose to participate in the online Health Risk Assessment (HRA) offered by Definity Health, the amount shown for your PCA Benefit Dollars will increase by such applicable amount.

**Your Member Responsibility (your portion of the deductible) will be less if you rollover PCA Benefit Dollars from the previous calendar year. However, the Member Responsibility could increase, up to the amount of your deductible if you choose to spend your PCA Benefit Dollars on PCA Only covered expenses.

Covered expenses that are reimbursed through your PCA and Health Coverage Program will count towards your deductible. Expenses covered only under the PCA will not count toward your deductible. For a list of PCA Only expenses, see the section **Covered Under the Personal Care Account Only.**

Coinsurance and Out-of-Pocket Limits

Once you have met the applicable deductible, the Health Coverage Program pays the documented coinsurance ("coinsurance"), as shown in the **Schedule of Benefits**, for In-Network charges as well as charges for services received from providers or facilities that are not In-Network Providers or Facilities ("Out-of-Network," "Out-of-Network Provider or Facility"), subject to any limits or exclusions shown in the Health Coverage Program; you pay the remainder in coinsurance.

After you incur covered expenses and pay coinsurance that meet the Program's In-Network and Out-of-Network out-of-pocket limits, the Health Coverage Program pays 100% of In-Network charges and 100% of reasonable and customary Out-of-Network charges for covered expenses for the rest of the year, subject to any maximum individual limit and any other limitations.

If you only satisfy the out-of-pocket limit for In-Network charges, the Health Coverage Program pays 100% of In-Network charges for the rest of the year but pays only the coinsurance amount for Out-of-Network charges, up to the reasonable and customary amount, for the rest of the year until the out-of-pocket limit for Out-of-Network charges is met. If you have Employee plus Spouse or Domestic Partner coverage, Employee plus Children coverage, or Family coverage, covered expenses incurred by all covered individuals will be combined for purposes of meeting the applicable out-of-pocket limit.

Standard Plan		
Coverage Category	**Out-of-Pocket Limit In-Network** (Excludes Deductible)	**Out-of-Pocket Limit Out-of-Network** (Excludes Deductible)
• Employee only	$1,500	$3,000
• Employee plus Spouse or Domestic Partner	$2,250	$4,500
• Employee plus Children	$2,250	$4,500
• Family	$3,000	$6,000

Out-of-Area Plan		
Coverage Category	**Out-of-Pocket Limit In-Network** (Excludes Deductible)	**Out-of-Pocket Limit Out-of-Network** (Excludes Deductible)
• Employee Only	$1,500	$1,500
• Employee plus Spouse or Domestic Partner	$2,250	$2,250
• Employee plus Children	$2,250	$2,250
• Family	$3,000	$3,000

SCHEDULE OF BENEFITS – STANDARD PLAN

Expenses are covered differently under the PCA and under the Health Coverage Program portions of the Definity Health Option. Expenses eligible under the PCA are paid by the Plan FIRST and covered at 100%, up to the balance in your PCA. Expenses eligible under the Health Coverage Program are subject to a deductible, coinsurance limit and certain other limitations as shown in the following table:

Standard Plan				
Benefit	**In-Network**		**Out-of-Network**	
Deductible (combined In- or Out-of-Network)	Employee only		$2,000 Deductible minus $750 PCA Benefit Dollars* = $1,250 Member Responsibility**	
	Employee plus Spouse or Domestic Partner		$3,000 Deductible minus $1,100 PCA Benefit Dollars* = $1,900 Member Responsibility**	
	Employee plus Children		$3,000 Deductible minus $1,100 PCA Benefit Dollars* = $1,900 Member Responsibility**	
	Family		$4,000 Deductible minus $1,500 PCA Benefit Dollars* = $2,500 Member Responsibility**	
	*If you participate in the online Health Risk Assessment (HRA), the amount shown for your PCA Benefit Dollars will increase by such applicable amount. **Your Member Responsibility (your portion of the deductible) will be less if you rollover PCA Benefit Dollars from the previous calendar year. However, the Member Responsibility could increase, up to the amount of your deductible, if you choose to spend your PCA Benefit Dollars on PCA Only covered expenses.			
Coinsurance	90% of covered expenses after the deductible		70% of covered expenses after the deductible up to R&C	
Out-of-Pocket Limit (Excludes deductible)	Employee only	$1,500	Employee only	$3,000
	Employee plus Spouse or Domestic Partner	$2,250	Employee plus Spouse or Domestic Partner	$4,500
	Employee plus Children	$2,250	Employee plus Children	$4,500
	Family	$3,000	Family	$6,000

Standard Plan		
Benefit	**In-Network**	**Out-of-Network**
Maximum Individual Limit • Infertility treatment and related prescription drugs (combined In- or Out-of-Network)	$10,000 per person	
Maximum Individual Limit • Combined In- or Out-of-Network	$1,500,000 per person (includes any other maximum individual limit)	
Preventive Care Services • See Preventive Care list	100% of scheduled benefits; deductible and PCA does not apply	70% after the deductible
Lab and X-ray	90% after the deductible	70% after the deductible
Prescription Drugs • Retail: up to a 90-day supply • Mail Order: up to a 90-day supply • Per unit limits may apply to certain prescriptions (e.g., erectile dysfunction medication)	90% after deductible if you use a Network pharmacy, your Definity Health ID card, and generic substitution when available. Prescriptions are subject to Maximum Allowable Cost. If you choose a brand name when a generic is available, you will pay 100% of the difference between the brand name drug and the generic drug.	Not covered
Physician Services	90% after the deductible	70% after the deductible
Office Visits	90% after the deductible	70% after the deductible
Maternity Care • Minimum 48-hour stay for normal vaginal birth; 96-hour stay for normal cesarean birth	90% after the deductible	70% after the deductible
Hospital Care - Inpatient • Semi-private room required	90% after the deductible	70% after the deductible
Hospital Care - Outpatient	90% after the deductible	70% after the deductible
Emergency Room	90% after the deductible	70% after the deductible if Definity Health determines that the circumstances did not necessitate Emergency Care.

Standard Plan		
Benefit	**In-Network**	**Out-of-Network**
Emergency Room (con't)		90% after the deductible if Definity Health determines that the circumstances necessitated Emergency Care.
Urgent Care • Facilities designed to treat minor medical problems that require immediate attention when your doctor is not available. • Examples of conditions appropriate for Urgent Care include: upper respiratory infections, sore throats, flu, sprains, strains, cuts and minor burns.	90% after the deductible	70% after the deductible if Definity Health determines that the circumstances did not necessitate urgent care. 90% after the deductible if Definity Health determines that the circumstances necessitated Emergency Care.
Ambulance • Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat illness. • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse. • Emergency air ambulance.	90% after the deductible	70% after the deductible. 90% after the deductible if Definity Health determines that the circumstances necessitated Emergency Care.
Substance Abuse **Inpatient** • Limited to 30 days per year **Outpatient** • Limited to 26 visits per year. **Maximums** • Lifetime maximum: 60 inpatient days or 60 outpatient visits • Combined In- or Out-of-Network • 2 days intensive outpatient or 2 days partial hospitalization = 1 day inpatient treatment. • 1 day residential treatment = 1 day inpatient treatment	90% after the deductible	70% after the deductible

Standard Plan		
Benefit	**In-Network**	**Out-of-Network**
Mental Health - Inpatient • Limited to 30 days per year. (combined In- or Out-of-Network) • 2 days intensive outpatient or 2 days partial hospitalization = 1 day inpatient treatment. • 1 day residential treatment = 1 day inpatient treatment	90% after the deductible	70% after the deductible
Mental Health - Outpatient • Limited to 26 visits per year. (combined In- or Out-of-Network) • 2 days intensive outpatient or 2 days partial hospitalization = 1 day inpatient treatment.	90% after the deductible	70% after the deductible
Chiropractic Care • 35 visits per year (combined In- or Out-of-Network)	90% after the deductible	70% after the deductible
Acupuncture Treatment • 35 visits per year (combined In- or Out-of-Network)	90% after the deductible	70% after the deductible
Durable Medical Equipment	90% after the deductible	70% after the deductible
Hospice	90% after the deductible	70% after the deductible
Home Health Care • Limited to 100 visits per year (combined In- or Out-of-Network) • One visit = four consecutive hours in a 24 hour period	90% after the deductible	70% after the deductible
Skilled Nursing Facility • Limited to 100 days per year (combined In- or Out-of-Network)	90% after the deductible	70% after the deductible
Transplants	90% after the deductible	70% after the deductible
Home Infusion Therapy	90% after the deductible	70% after the deductible
Medical Supplies	90% after the deductible	70% after the deductible
Physical Therapy	90% after the deductible	70% after the deductible
Speech Therapy	90% after the deductible	70% after the deductible
Occupational Therapy	90% after the deductible	70% after the deductible

Standard Plan		
Benefit	**In-Network**	**Out-of-Network**
Inpatient Rehabilitation • Limited to 100 days per year (combined In- or Out-of-Network)	90% after the deductible	70% after the deductible
Radiation/Chemo Therapy	90% after the deductible	70% after the deductible
Surgery for Morbid Obesity	90% after the deductible	70% after the deductible
Surgery for TMJ	90% after the deductible	70% after the deductible

In-Network Providers
When you use an In-Network physician or hospital, you'll save money. In-Network Providers have agreed to charge participants in the Definity Health Option a discounted rate. Therefore, you can make your PCA go farther by using In-Network Providers. In addition, the Health Coverage Program will pay a greater percentage of covered expenses incurred from In-Network Providers. To determine if a provider is in the network, you may log onto *www.definityhealth.com* and click under the "find a provider" tab or call 1-866-333-4648 and a customer service representative can locate a provider in the network or send you a list of In-Network Providers.

If you require a service that is not available from an In-Network Provider or Facility within 30 miles of your home or within the nationwide network (provided you are eligible to use the nationwide network), the Health Coverage Program will pay covered expenses at the In-Network benefit level (subject to deductibles and other restrictions) from an Out-of-Network Provider or Facility. Although not required, requests for this benefit should be made before services are utilized by calling 1-866-333-4648, to make sure that no In-Network Provider or Facility is available.

Limitations on Selection of Providers: Your selection of an Out-of-Network Provider is limited when you require a specific covered expense that is not available from an In-Network Provider within 30 miles from your home. The Plan will not pay for a covered expense at the In-Network Provider benefit level for services received from an Out-of-Network Provider when you must travel a greater distance to an Out-of-Network Provider and an In-Network Provider is available to you at the same or shorter distance.

SCHEDULE OF BENEFITS – OUT-OF-AREA PLAN

(To be eligible for coverage under the Out-of-Area Plan, an employee's permanent place of residence must be more than 35 miles from an In-Network Provider)

Expenses are covered differently under the PCA and under the Health Coverage Program portions of the Definity Health Option. Expenses eligible under the PCA are paid by the Plan FIRST and covered at 100%, up to the balance in your PCA. Expenses eligible under the Health Coverage Program are subject to a deductible, coinsurance limit and certain other limitations as shown in the following table:

Out-of-Area Plan				
Benefit	**In-Network**		**Out-of-Network**	
Deductible (combined In- or Out-of-Network)	Employee only		$2,000 Deductible minus $750 PCA Benefit Dollars* = $1,250 Member Responsibility**	
	Employee plus Spouse or Domestic Partner		$3,000 Deductible minus $1,100 PCA Benefit Dollars* = $1,900 Member Responsibility**	
	Employee plus Children		$3,000 Deductible minus $1,100 PCA Benefit Dollars* = $1,900 Member Responsibility**	
	Family		$4,000 Deductible minus $1,500 PCA Benefit Dollars* = $2,500 Member Responsibility**	
	*If you participate in the online Health Risk Assessment (HRA), the amount shown for your PCA Benefit Dollars will increase by such applicable amount. **Your Member Responsibility (your portion of the deductible) will be less if you rollover PCA Benefit Dollars from the previous calendar year. However, the Member Responsibility could increase, up to the amount of your deductible, if you choose to spend your PCA Benefit Dollars on PCA Only covered expenses.			
Coinsurance	80% after the deductible		80% after the deductible	
Out-of-Pocket Limit (excludes deductible)	Employee	$1,500	Employee	$1,500
	Employee plus Spouse or Domestic Partner	$2,250	Employee plus Spouse or Domestic Partner	$2,250
	Employee plus Children	$2,250	Employee plus Children	$2,250
	Family	$3,000	Family	$3,000

Out-of-Area Plan		
Benefit	**In-Network**	**Out-of-Network**
Maximum Individual Limit • Infertility treatment and related prescription drugs (combined In- or Out-of-Network)	$10,000 per person	
Maximum Individual Limit • Combined In- or Out-of-Network	$1,500,000 per person (includes any other maximum individual limit)	
Preventive Care Services • See Preventive Care list	100% of Scheduled Benefits; deductible and PCA does not apply	80% after the deductible
Lab & X-ray	80% after the deductible	80% after the deductible
Prescription Drugs • Retail: up to a 90 day supply • Mail Order: up to a 90 day supply	90% after deductible if you use a Network pharmacy, your Definity Health ID card, and generic substitution when available. Prescriptions are subject to Maximum Allowable Cost. If you choose a brand name when a generic is available, you will pay 100% of the difference between the brand name drug and the generic drug.	No benefits Out-of-Network
Physician Services	80% after the deductible	80% after the deductible
Office Visits	80% after the deductible	80% after the deductible
Maternity Care • Minimum 48-hour stay for normal vaginal birth; 96-hour stay for normal cesarean birth	80% after the deductible	80% after the deductible
Inpatient Hospital Care • Semi-private room required	80% after the deductible	80% after the deductible
Outpatient Hospital Care	80% after the deductible	80% after the deductible
Emergency Room	80% after the deductible	80% after the deductible
Urgent Care • Facilities designed to treat minor medical problems that require immediate attention when your doctor is not available.	80% after the deductible	80% after the deductible

Out-of-Area Plan		
Benefit	**In-Network**	**Out-of-Network**
• Examples: upper respiratory infections, sore throats, flu, sprains, strains, cuts and minor burns.		
Ambulance • Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat illness. • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse. • Emergency air ambulance.	80% after the deductible	80% after the deductible
Substance Abuse **Inpatient** • Limited to 30 days per year **Outpatient** • Limited to 26 visits per year. **Maximums** • Lifetime maximum: 60 inpatient days or 60 outpatient visits • Combined In- or Out-of-Network • 2 days intensive outpatient or 2 days partial hospitalization = 1 day inpatient treatment. • 1 day residential treatment = 1 day inpatient treatment.	80% after the deductible	80% after the deductible
Mental Health **Inpatient** • Limited to 30 days per year. (combined In- or Out-of-Network) • 2 days intensive outpatient or 2 days partial hospitalization = 1 day inpatient treatment. • 1 day residential treatment = 1 day inpatient treatment **Outpatient** • Limited to 26 visits per year. (combined In- or Out-of-Network) • 2 days intensive outpatient or 2 days partial hospitalization = 1 day inpatient treatment.	80% after the deductible	80% after the deductible

Out-of-Area Plan		
Benefit	**In-Network**	**Out-of-Network**
Chiropractic Care • 35 visits per year (combined In- or Out-of-Network)	80% after the deductible	80% after the deductible
Acupuncture Treatment • 35 visits per year (combined In- or Out-of-Network)	80% after the deductible	80% after the deductible
Durable Medical Equipment	80% after the deductible	80% after the deductible
Hospice	80% after the deductible	80% after the deductible
Home Health Care • Limited to 100 visits per year (combined In- or Out-of-Network) • 1 visit = 4 consecutive hours in a 24-hour period	80% after the deductible	80% after the deductible
Skilled Nursing Facility • Limited to 100 days per year (combined In- or Out-of-Network)	80% after the deductible	80% after the deductible
Transplants	80% after the deductible	80% after the deductible
Home Infusion Therapy	80% after the deductible	80% after the deductible
Medical Supplies	80% after the deductible	80% after the deductible
Physical Therapy	80% after the deductible	80% after the deductible
Speech Therapy	80% after the deductible	80% after the deductible
Occupational Therapy	80% after the deductible	80% after the deductible
Inpatient Rehabilitation • Limited to 100 days per year (combined In- or Out-of-Network)	80% after the deductible	80% after the deductible
Radiation/Chemo Therapy	80% after the deductible	80% after the deductible
Surgery for Morbid Obesity	80% after the deductible	80% after the deductible
Surgery for TMJ	80% after the deductible	80% after the deductible

ELIGIBILITY AND ENROLLMENT

Who is Eligible

You are eligible to participate in the Definity Health Option if you are a regular full-time or part-time employee scheduled to work 30 hours per week on a regular and continuous basis; provided, however, that this requirement will not apply to a group of Grandfathered MPT 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.

Coverage Levels and Eligible Dependents

You can choose from the following coverage levels:

- Employee only;
- Employee plus spouse or domestic partner;
- Employee plus children; or
- Family.

Your eligible dependents include:

- Your spouse ("Spouse") unless legally separated or your domestic partner (subject to certifying his/her Domestic Partnership 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.
  - — Has legal residence with you.
  - — 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 residence requirement does not apply when your child does not live with you under a decree of divorce, separation or paternity which provides that you may be entitled to a deduction for such child, your child is a full-time student, or your child resides in an institution.

The definition of "child" includes:

- The covered employee's blood descendants of the first degree;

- Legally adopted children (including a child living with the adopting parents during the period of probation);

- 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;

- 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;

- A newborn infant who is not a blood descendant of the first degree if before the birth of the infant, good faith arrangements had been made by the covered employee or the covered employee's Domestic Partner 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 covered employee without any period of residence with either biological parent (except for that period necessary if the birth takes place in the home of the biological parent), provided, however, that such a newborn infant shall cease to be a covered dependent as of the first date on which either the covered employee's or Domestic Partner's attempt to adopt the infant is finally disapproved by competent authorities or is abandoned by the covered employee; and

- A child who is the subject of a Qualified Medical Child Support Order (see the **When Your Coverage Ends** 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 the Company.

Parents, grandparents and adult siblings are not eligible for coverage.

To continue coverage for a disabled child beyond the age 19, you will be asked to provide proof of your child's disability within 31 days after the date your child reaches age 19. The Plan has the right to request an examination of your child as often as needed, but not more often than once a year after two years from the date your child turned 19. The Plan considers your child disabled if your child cannot earn a living due to a physical or mental disability and depends mainly on you for support and maintenance and is unmarried.

You cannot be covered under the Definity Health Option as both an employee and a dependent. An individual cannot be covered as a dependent of more than one employee (for example, if both parents are eligible employees, both parents cannot cover the same child under the Definity Health Option). If you are married to another employee or have a Domestic Partner who is an employee of the

Company, you may both elect individual coverage or one of you can elect Employee plus Spouse or Domestic Partner coverage, Employee plus Children coverage, or Family coverage. (If you choose Family coverage, your Spouse must decline medical coverage.)

How to Enroll

You'll receive a packet of information including a personalized benefits worksheet shortly after you begin work. You'll use the benefits worksheet to enroll in (or decline) the Definity Health Option and authorize the Company to deduct your contributions from your pay. You must make your elections within 31 days after you become eligible to participate in the Definity Health Option. Also, you must enroll any eligible dependent(s) within 31 days after you become eligible to participate in the Definity Health Option.

Cost

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 and your contributions are made on a pre-tax basis. You are not permitted to make any contribution to your PCA. Your PCA is an "unfunded" account, and benefits that are payable from the PCA are paid solely from the general assets of the Company.

When Coverage Begins

Employees of McKesson Provider Technologies, Medication Management and McKesson Medical Management: You are eligible for health program benefits on the first day of the calendar month coinciding with or following your date of hire.

All Other Employees: You are eligible for health program benefits the first day of the calendar month coinciding with or following completion of two months of service.

If You Don't Enroll

If you don't enroll within 31 days after you become eligible to participate in the Definity Health Option, you must wait until the next annual enrollment period to enroll, unless you become entitled to special enrollment rights as described in the following section.

Enrolling as a Special Enrollee or Changing Coverage

You can change your coverage each year for the following year during annual enrollment. If you fail to elect coverage for yourself or your dependents following the date you became eligible to participate in the Definity Health Option, you or your dependents may enroll as a Special Enrollee, provided you become entitled to special enrollment rights under the Health Insurance and Portability and Accountability Act (HIPAA). Under HIPAA, you may enroll a new dependent you acquire through marriage, birth, adoption or placement for adoption, within 31 days of the date of the marriage, birth, adoption or placement for adoption. You may also enroll if you lose other coverage, but only under the following situations.

- You were covered under a group health plan or had other health insurance coverage at the time coverage under the Definity Health Option was previously offered; and

- You lost the other coverage because of one of the following circumstances:

— If the other coverage was COBRA Continuation Coverage, your coverage ended because you reached the maximum length of coverage permitted under law.

— The other coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment).

— Employer contributions toward the other coverage were terminated.

You have 31 days to enroll in the Definity Health Option when you become entitled to a special enrollment right.

You may also enroll an eligible dependent during the year if a court orders you to cover an eligible dependent (e.g., a Qualified Medical Child Support Order (QMCSOs). The Company will enroll your dependent within a reasonable period of time after its receipt of a QMCSO. Coverage will take effect from the date of the court order.

Annual Enrollment

Your participation in the Definity Health Option will continue each year (unless you change it). However, during annual enrollment, you can elect coverage if you previously declined it, or change your coverage level for the following calendar year (i.e., from Employee only to Family coverage. You may also be able to elect a different coverage option (if available in your location).

Qualified Medical Child Support Orders (QMCSOs)

QMCSOs are orders, decrees or judgments issued by a court or administrative agency that requires a group health plan to provide health benefit coverage to a participant's child, often because of the participant's legal separation or divorce. A QMCSO may require the programs available through the McKesson Corporation Health Plan to make coverage available to your child even though, for income tax or plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address (or the name and mailing address of the substituted state or local official);

- Describes the type of coverage to be provided, or how the type of coverage will be determined; and

- States the period to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that it does not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions.

You and the affected child will be notified if an order is received and will be provided with a copy of the Company's QMCSO procedures. You may also request a copy of these procedures from the Plan Administrator.

Benefit Dollars and Deductibles for Mid-Year Enrollments

If you are hired mid-year and enroll in the Definity Health Option, or enroll mid-year for other reasons described above, the Company will allocate a pro-rated number of Benefit Dollars to your PCA and you will be subject to a prorated deductible under the Health Coverage Program.

Benefit Dollars and Deductibles for Mid-Year Enrollment Changes

If you make an allowable change to your coverage level (see section **Coverage Levels and Eligible Dependents**) during the year, for the reasons described above, the Company will adjust the Benefit Dollars in your PCA and your deductible to your new coverage level less the amount of Benefit Dollars you have already used and the amount of deductible you have already satisfied during the year.

WHEN COVERAGE ENDS

When Your Coverage Ends

Your coverage ends on the earliest of the following:

- The last day of a period for which contributions for the cost of your coverage have been made, if the contributions for the next period are not made on a timely basis;
- The last day of the month in which you terminate employment with the Company;
- The last day of the month in which you are no longer an eligible employee;
- The day you become covered by a collective bargaining agreement which does not provide for participation in the Definity Health Option;
- The date Definity Health Option is terminated; or
- The date the Plan is terminated.

When Your Dependents' Coverage Ends

Coverage for your dependents ends on the earliest of the following:

- The last day of the month that your dependent ceases to be a dependent under the Plan;
- The date your dependent becomes covered as an employee;
- The last day of a period for which contributions for the cost of your dependent's coverage have been made if the contributions for the next period are not made on a timely basis;
- The date indicated in a Qualified Medical Child Support Order;
- The date you cease to be an eligible employee;
- The date dependent coverage is discontinued under the Plan;

- The date you request termination of dependent coverage;
- The date the Definity Health Option is terminated; or
- The date the Plan is terminated.

WHAT'S COVERED UNDER THE DEFINITY HEALTH OPTION

As shown below, the Definity Health Option covers many medically necessary services and supplies, subject to any limits or exclusions in the Health Coverage Program. The Health Coverage Program only covers care provided by health care professionals or facilities licensed, certified or otherwise qualified under state law to provide health care services.

Preventive Care – Scheduled Benefits

The Company feels strongly about not only treating, but preventing, health care problems. That's why the Health Coverage Program covers the following preventive services at 100% – with no deductible and no need to use your PCA when you utilize an In-Network Provider.

The Health Coverage Program covers one routine physical exam per calendar year plus the laboratory charges and vaccinations as described below. The following is a list of items that are treated as Preventive Care, and covered under the Health Coverage Program at 100% In-Network, with no need to use the PCA or satisfy the deductible:

Well-Child Care

- Routine office visits and examinations, as follows:
  - Six visits from 0 – 12 months.
  - Three visits from 12 – 24 months.
  - Annual visits from 24 months through age 18.
- Immunizations and screenings associated with the above routine office visits are as follows:
  - Two doses of Hepatitis A.
  - Three doses of Hepatitis B.
  - Six doses of Diphtheria, Tetanus, Pertussis (DtaP).
  - Four doses of Haemophilus Influenza type b.
  - Four doses of Polio.

— Four doses of Pnuemococcal Conjugate.

— Two doses of Varicella.

— Two doses of Measles, Mumps, Rubella.

— Influenza vaccine (flu shot) one dose each Plan Year for children over the age of 8 years; two doses (administered separately by at least 4 weeks) each Plan Year for children up through 8 years of age.

- Screenings:

— Lead level testing, one between ages 9 to 12 months and one at 24 months or after.

— Vision screening conducted at time of well-child visit at ages 3, 4, 5, 6, 8, 10, 12, 15, and 18.

— Hearing screening conducted at time of well-child visit at ages 4, 5, 6, 8, 10, 12, 15, and 18.

— Pap smear and routine pelvic exam annually beginning at age 18 or the onset of sexual activity, whichever comes first.

Well-Adult Care
Well-adult care includes one annual routine office visit and examination after age 18 years for a covered male and two routine office visits and examination after age 18 years for a covered female.

Included immunizations and screenings associated with the above routine office visits are as follows:

- Immunizations:

— Tetanus / Diphthesia (Td) Booster once every 10 years.

— Influenza Vaccination (flu shot) annually.

— Pneumococcal Vaccination (Pneumovaz) one dose for persons 65 and over.

- Screenings

— Cholesterol screening including triglycerides, LDL, HDL, or lipid panel once every 5 calendar years beginning at age 20.

— Mammogram annually starting at age 40.

— Pap Smear and Routine Pelvic Exam once per calendar year beginning at age 18.

— Bone density test for osteoporosis every two years for women age 65 years and over.

— Colorectal Cancer Screenings, you have the choice of the following:

  – Fecal occult blood test (FOBT) once per calendar year and flexible sigmoidoscopy once every 5 calendar years both beginning at age 50.

  – Colonoscopy once every 10 calendar years beginning at age 50.

  – Double contrast barium enema once every five calendar years starting at age 50.

- Digital rectal examination (DRE) and prostate specific antigen (PSA) test once per calendar year starting at age 45 years.

Any services that fall outside of the above well-child and well-adult lists, including all prescriptions, will not be eligible under this Preventive Care benefit but will be considered for coverage under the PCA and Health Coverage Program.

For more information about Preventive Care and health and wellness-related products, visit the Definity Health Web site at www.definityhealth.com.

Standard Services

The Health Coverage Program covers a wide range of medical expenses, provided they are determined to be medically necessary or usual to the treatment of an illness or injury, as determined by the Claim Administrator's medical staff or an independent medical physician review panel. However, some expenses are covered only under the Personal Care Account, while others are covered under both the PCA and the Health Coverage Program.

Covered Under the Personal Care Account Only

The following is a list of items that are included as covered expenses under your Personal Care Account only. Such items will NOT count toward satisfaction of your Plan Year deductible. The Internal Revenue Service has specific guidelines that must be followed for many of these items. For more information on a specific benefit please call 1-866-333-4648.

- Amounts over Reasonable and Customary;

- Amounts in excess of any Health Coverage Program limits;

- Contraception devices such as IUDs, Depo Provera, Norplant and Norplant-like inserts (including contraceptive services associated with insertion of IUDs, Norplant, Norplant-like inserts, and Depo-Provera injections); and

- The difference in cost between brand name prescription drugs and generic prescription drugs.

Covered Under the Personal Care Account and the Health Coverage Program

Medical expenses covered under both the PCA and the Health Coverage Program include (these expenses will go towards satisfaction of your Plan Year deductible):

- Acupuncture treatment.
- Allergy injections, testing and serum.
- Alternative care settings (such as skilled nursing facilities, hospice or home care).
- Ambulance service to and from the nearest facility where you can receive needed medical care and services (air ambulance will be covered when it is the only acceptable means of transporting the patient).
- Anesthesia.
- Blood and blood plasma transfusions and blood not donated or replaced.
- Chemical dependency treatment.
- Chemotherapy.
- Chiropractic care.
- Circumcision.
- Cochlear implants.
- Contraception (oral contraceptives, emergency products and contraceptive services and devices, such as IUDs, Norplant, Depo-Provera injections).
- Diabetic supplies and insulin.
- Dialysis.
- Durable medical equipment including: orthotics, prosthetic appliances, rental (not more than the purchase price) or, if less costly, purchase, of durable medical equipment and related supplies. Certain types of durable medical equipment may need to be reviewed by the Claims Administrator to determine if the equipment is medically necessary. This also includes 1st pair of lenses and frames for diseases of the eye following surgery or injury.
- Emergency room and urgent care center.
- Genetic testing and counseling.
- Home infusion therapy when ordered by a physician, including solutions and pharmaceutical additives; pharmacy compounding and dispensing services; ancillary medical supplies; nursing

services to train you or your caregiver or to monitor the home infusion therapy, provide emergency care, collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings, or other eligible home health supplies and services provided during home infusion therapy.

- Hospital services such as nursing care, drugs and medicines, x-rays and laboratory tests.
- Impotence medication as prescribed.
- Infertility treatment and related prescription drugs.
- Inhalation therapy (provided by a registered or licensed therapist) when needed to correct a functional disorder due to an illness or injury.
- Inpatient physician care.
- Inpatient rehabilitation.
- Mammography.
- Maternity care (including services and supplies provided by a birthing center or midwife).
- Medical supplies and services as deemed medically necessary by a physician and charged by a hospital and administered during any hospital confinement or received for treatment on an outpatient basis.
- Mental health care.
- Nutritionists, when required to treat a medical condition.
- Occupational therapy (by a licensed therapist).
- Outpatient (ambulatory) surgery.
- Outpatient cardiac rehabilitation services.
- Outpatient x-ray and laboratory charges.
- Oxygen and other gases.
- Physicians' visits.
- Physical therapy (provided by a licensed physical therapist).
- Pre-admission testing.
- Pregnancy termination (voluntary).

- Prescription drugs (see **Prescription Drug Coverage** section for more information).
- Pulmonary rehabilitation.
- Semi-private room and board for hospital stays and alternative care settings (private rooms are covered only if medically necessary).
- Speech therapy to restore speech lost due to a congenital condition for which corrective surgery cannot be performed, or due to injury or illness.
- Sterilization and reversal of sterilization.
- Surgery for morbid obesity, provided it is determined to be medically necessary by your physician and you meet clinical criteria as determined by your Plan Administrator.
- Surgical care (if two or more surgical procedures are performed through the same incision or in the same operative field, the Health Coverage Program will pay up to 100% of the major procedure and 50% of each additional procedure. If more than one procedure is performed through separate incisions, the Health Coverage Program will pay up to 100% of the major procedure and 50% for each additional procedure. No additional payment will be made for an incidental procedure performed through the same incision).
- TMJ (temporomandibular joint syndrome) surgical treatment by a dentist or physician (excludes orthodontic treatment).
- Transplants, see **Organ, Bone Marrow and Tissue Transplants** for more information.
- Virtual colonoscopy when performed in connection with diagnostic testing only.
- Weight loss medications, as determined to be medically necessary.
- Retin-A up to age 36 years, as determined to be medically necessary.
- X-ray, radium, radio, isotope treatments.

See the sections, **Benefit Limits** and **Exclusions Under the Health Coverage Program** for additional information**.**

Important Notes

The Newborns' and Mothers' Health Protection Act of 1996 provides that no group health plan or health insurer that provides hospitalization benefits in connection with childbirth may restrict the period of hospitalization after birth for which benefits are payable to less than 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. Exception: The minimum length of stay provisions shall not apply in any case in which the decision to discharge the mother or her newborn child prior to these stated minimums is made by an attending provider in consultation with the mother. Moreover, the attending provider may not be required to obtain an authorization from the group health plan or health insurance issuer for prescribing a length of stay that is less than these stated minimums.

The Women's Health and Cancer Rights Act of 1998 states that health plans that provide mastectomy coverage must also provide coverage for reconstructive surgery, including:

- Reconstruction of the breast that has been removed;
- Surgery and reconstruction of the other breast for a symmetrical appearance; and
- Prostheses and treatment of any physical complications of the mastectomy, including lymphedemas.

Coverage must be provided in a manner determined in consultation with the attending physician and the patient.

What if I'm Traveling?
If you are traveling outside your network and you need medical care, you should contact customer service at 1-866-333-4648 or log onto the Web site at *www.definityhealth.com* for assistance in locating the nearest Definity Network Provider. If you need Emergency Care, however, go ahead and get the care you need. The Definity Health Option will pay your claim at the In-Network level (based on billed charges) regardless of the provider's network status, provided Definity Health determines that your circumstances necessitated Emergency Care.

What is Considered an Emergency?
Emergency care is medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such 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 or survival 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.

PRESCRIPTION DRUG COVERAGE

Your pharmacy benefit is designed to cover medications for most diseases, including short-term illness, such as an ear infection, as well as long-term diseases, such as high blood pressure. Such medications will only be covered if provided by a member of the McKesson Pharmacy Provider Network (MPPN), or the Caremark Network, if you live outside the MPPN service area. No pharmacy benefits are available if provided by an Out-of-Network pharmacy.

To receive pharmacy benefits, present your Definity Health ID card to a network pharmacy with your prescription. If you do not have your Definity Health ID card with you when you fill your prescription, you will need to pay for your prescription up front and file a claim for reimbursement. In that case you will be reimbursed at the contracted price for the prescription – see Scenario Four below.

The Definity Health Option encourages the use of generic and preferred drugs to minimize your out-of-pocket expenses. If your doctor prescribes a generic drug or a preferred drug and you choose to fill the prescription with the brand name drug equivalent of the generic drug or a drug that is not on the preferred drug list, you may be required to pay for a part for your prescription at the pharmacy (this amount will not apply to your deductible or Out-of-Pocket Limit). Your doctor, however, can request that a specific brand be dispensed instead of the available generic, in this case you will not be required to pay any extra out of your pocket.

Prescription Drugs are covered under the Plan based upon one of the following scenarios:

Scenario One: When you go to an In-Network pharmacy**,** if you have a PCA balance, the prescription will be paid from your PCA and the amount will be applied to your Plan Year deductible.

Scenario Two: When you go to an In-Network pharmacy, you do not have a PCA balance and you have not met your Plan Year deductible, the cost becomes part of your deductible.

The Plan will not advance the cost of the drug and the amount will be applied to your Plan Year deductible. You will have to pay the entire cost at the time you purchase your prescription. The monthly statement you receive from Definity Health will identify how the cost of the drug was applied to your Plan Year deductible.

Scenario Three: When you go to an In-Network pharmacy and you do not have a balance in your PCA but you have met the Plan Year deductible, the Plan will pay according to the Schedule of Benefits. You will pay your applicable coinsurance amount at the time you purchase your prescription.

Scenario Four: If you do not have your Definity Health ID Card with you when you fill your prescription, you will have to pay the entire cost at the time you purchase your prescription. You may then file a claim for reimbursement with Definity Health from your PCA (assuming you have a PCA balance) or from your Health Coverage Program (assuming you have depleted your PCA and met your Plan Year deductible). You will be reimbursed by the Plan as shown in the Schedule of Benefits at the In-Network contracted rate for a covered expense. If you have depleted your PCA balance, and have not met the Plan Year deductible, the cost becomes part of your deductible. The monthly statement you receive from Definity Health will identify how the cost of the drug was applied to your Plan Year deductible.

Your prescriptions can be filled through a retail In-Network pharmacy, or through mail order services. It is important to know that not every drug can be obtained with your Definity Health ID card through a pharmacy. Your prescriptions will be covered in accordance with the Health Coverage Program (see the **Schedule of Benefits**) and with state and federal regulations.

Where to Call

To find an In-Network pharmacy near you or to request a claim reimbursement form, you may call the toll-free Definity Health Customer Service number at 1-866-333-4648 or visit the Web site at *www.definityhealth.com.* A list of In-Network pharmacies is also provided automatically, without charge, to you as a separate document.

Preferred Drug List

A preferred drug list is a list of the most common medications prescribed. While the preferred drug list does not assure coverage of every product listed, the list summarizes the best value in prescription products for you. A copy of the preferred drug list is available, without cost, upon request. For maximum savings, ask your physician to prescribe a generic and/or a preferred drug. Your pharmacist can recommend generic medications and will know if your claim is for a preferred drug when it is processed.

Prescription Drug Program Exclusions

The prescription drug program portion of the Health Coverage Program does not cover every drug, but some of the drugs it excludes may be provided under other portions of the Health Coverage Program (e.g., immunizations, see section **Preventive Care – Scheduled Benefits**). Items that are excluded from the prescription drug program are as follows:

- Non-prescription or over-the-counter medications.
- Immunizations, vaccines, allergy agents for injection.
- Blood and blood plasma.
- Hearing aids.
- Durable medical equipment such as crutches, wheelchairs, or mobility aids.
- Non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria).
- Products used at or dispensed at an outpatient or inpatient facility, clinic, or doctor's office, including hospitals, extended/nursing care homes, home care service, home infusion services.
- Products not approved for use in the United States, or experimental therapy.
- Products purchased outside the United States unless in an emergency situation.
- Therapy for anyone other than the recipient of the prescription, as eligibility permits.
- Prescriptions exceeding a reasonable quantity as designed by the plan (e.g., Imitrex tablets are limited to 18 tablets per month, and impotence medication including Viagra, Edex and Uprima are limited to 6 pills per 30-day supply).
- Growth hormones except for the following indications: Adults with hypophyseal dysfunction resulting in symptomatic growth hormone deficiency; Pediatric human growth hormone deficiency; Gonadal dysgenesis (Turner Syndrome); Growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant; Prader-Willi Syndrome; Adult growth hormone deficiency syndrome; AIDS related cachexia (Serostim only); and Small for Gestational Age (SGA) for children over age two years.

- Infertility expenses above 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.

- Smoking cessation products.

- Weight loss medications, unless they are medically necessary.

- Anti-wrinkle medications, except that Retin-A is covered to age 36 as medically necessary.

- Hair growth and hair removal treatments.

- Cosmetic therapies.

DEFINITY HEALTH PERSONAL CARE SUPPORT

Definity Health has designed a comprehensive care management system called Personal Care Support. It consists of a suite of services designed to provide comprehensive support, including:

- Access to a health coach who can provide coaching, advocacy, and help with care coordination;

- Access by phone and on the Web to information regarding costs and quality, to help maximize your benefit health care dollars;

- Sophisticated software tools to help you and your physicians identify potential medical errors and patient safety issues; and

- A notification process for all inpatient admissions and some outpatient procedures.

NOTE: Information obtained through the Definity Health Personal Care Support is based on current medical literature and on physician review; however, is not intended to replace the advice of a doctor. The information is intended to help people make better health care decisions and take a greater responsibility for their own health. *Definity Health is not responsible for the results of your decisions resulting from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care or specific treatment based on the text.*

Health Coach

If you have a specific medical question you can call 1-866-333-4648 to discuss your situation with a health coach. Health coaches are registered nurses and other health care professionals who are available 24 hours a day, 365 days a year. They provide information and coaching to you on any health topic over the phone, via the Internet, or through material mailed directly to your home. Depending upon your situation you may be connected to a Definity Health Care Coordinator for further assistance.

Chronic Condition Coaching
Definity Health provides responsive disease management programs that identify, assess, and support members with specific chronic conditions. Chronic Condition Support is available for:

- Asthma.
- Diabetes.
- Coronary artery disease (CAD).
- Congestive heart failure (CHF).
- Chronic obstructive pulmonary disease (COPD).

If you are interested in one of these programs you may request information from a health coach.

Phone and Web Tools
You can access information on the cost of health care services and prescription drugs, find providers in your area, and receive quality information on hospitals via your Definity Health personal member Web site or by calling 1-866-333-4648.

Patient Safety
Definity Health addresses the issue of patient safety by identifying potential errors in your medical care by using a software program that provides retrospective, claims-based identification of potential medical errors of omission and commission of care. Through this process patients are identified whose care is inconsistent with established standards of clinical excellence. This information can include problems with patient compliance, omissions of effective Preventive Care, testing or medications, and treatments that may be inappropriate or harmful. Definity Health will notify you and your doctor if potential errors are identified.

Notification
To help you receive the best care in the most appropriate facility, we strongly suggest that you call Definity Health at 1-866-333-4648 before a scheduled inpatient admission or undergoing certain outpatient procedures. Definity Health can assist you with health care recommendations, information, and decision support coaching including cost estimates for the procedure, In-Network discounts, how the procedure will affect your Personal Care Account, deductible, and health coverage and possible alternative procedures.

Notification is also important to help you understand how the medical expenses you incur will be paid for under the Health Coverage Program or through your PCA. For example, it is possible that only part of an extended hospital stay would be "medically necessary" under the Health Coverage Program. Notification gives Definity Health the opportunity to work with you in advance to reduce the risk of incurring uncovered expenses.

You should notify Definity Health of:

- **All inpatient admissions.** This includes any time you are admitted for an overnight stay including hospital, rehabilitation, hospice, skilled nursing and mental health facilities. Notification of acute

or unexpected admissions should be provided within 24 hours of admission. Notification of planned or elective admissions should be provided seven days before admission, or as soon as you know of the admission.

- **Outpatient procedures.** You should notify Definity Health of the following procedures and equipment needs as soon as you know that these services are required.

  — MRI Scans (magnetic resonance imaging).

  — Magnetic resonance angiography (MRA).

  — CT or CAT scans (computer aided tomography).

  — Imaging Cardiac Stress Tests (nuclear cardiology, Myoview, myocardial perfusion scans, cardiac echo stress tests).

  — Endoscopic procedures.

  — Durable medical equipment (crutches, wheelchairs and accessories, portable oxygen, IV equipment, others).

ALTERNATIVE CARE SETTINGS

There are often times when care can be delivered more comfortably and cost-effectively in an alternative setting, such as a skilled nursing facility, your home, or a hospice. Thus, Definity Health should also be notified of any inpatient admissions in any alternative care settings.

Skilled Nursing Facility
The Health Coverage Program pays up to the benefits shown in the **Schedule of Benefits** for 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 the injury or illness;
- The care is ordered and approved by a physician and is not custodial care; and
- Such confinement takes the place of a hospital confinement or immediately follows a hospital confinement for the same illness.

Covered expenses include the facility's charge for a semiprivate 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 per year of inpatient care.

Home Health Care
The Health Coverage Program pays for covered expenses for treatment of a disease or injury in the patient's home instead of a hospital or skilled nursing facility. The charge must be made by a "home health care agency." Home health care must be prescribed by a physician and given under a "home

health care plan" in the patient's home. Coverage is limited to 100 visits in a year by a home health care professional. A visit equals four consecutive hours within a 24-hour period. Custodial care is not covered.

The Health Coverage Program covers the following home health care expenses (up to the Program maximums):

- Part-time or occasional care by a licensed nurse.
- Intermittent home health aide services.
- Services of a medical social worker.
- Physical, occupational, speech and inhalation therapy.
- Medical supplies and medicines prescribed by a physician.
- Services of a nutritionist.

The Health Coverage Program does not cover services provided by a person who usually lives with you or is a member of your or your Spouse's or Domestic Partner's family, or transportation costs.

Hospice Care
Hospice care provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill and has less than six months to live. The Health Coverage Program pays for the following services:

- Confinement in a licensed hospice facility or skilled nursing facility.
- Home hospice care provided by an approved hospice team.
- Nursing care by or under supervision of a registered nurse (R.N.).
- Physical and/or occupational therapy.
- Medical social services.
- Home health aide services.
- Counseling services provided such services are rendered during a 12-month period beginning on date of the prognosis of six months or less of life. Counseling services are limited to 12 visits per family.
- Drugs or medical supplies.

Emergency Care
If you need emergency care and cannot arrange for care from an In-Network Provider, the Health Coverage Program will pay your claims at the In-Network level, regardless of the provider's network

status, provided the circumstances necessitated the provision of emergency care as determined by Definity Health. Once you are able to direct your care, you must use an In-Network Provider in order to receive the highest benefit level. See the **What's Covered Under the Definity Health Option** section for a definition of emergency care.

OTHER COVERED SERVICES

In addition, the Health Coverage Program covers certain special services such as podiatric and chiropractic care, mental health treatment and substance abuse and organ and tissue transplants.

Chiropractic Care

The Health Coverage Program covers chiropractic care provided by a licensed chiropractor, including medically necessary exams, manipulations, diagnostic x-rays and laboratory services, up to 35 visits per calendar year.

Mental Health Care

The Health Coverage Program covers consultation, diagnosis or treatment of any mental/nervous condition when services are provided by a:

- Hospital.
- Physician.
- Licensed consulting psychologist (LCP).
- Psychiatrist.
- Licensed psychologist (LP).
- Licensed social worker.
- Mental health professional.

The provider must be licensed or approved by the state in which the services are provided. All care must be provided by licensed, eligible providers – such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.

The Health Coverage Program covers up to 30 days of inpatient care and up to 26 outpatient visits per calendar year.

Organ, Bone Marrow and Tissue Transplants

Services, supplies, drugs, organ procurement and/or acquisition, and related aftercare are covered for the following human organ and bone marrow transplant which are determined to be medically necessary, and which are not experimental, investigational or an unproven service. Experimental, investigational or unproven services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or

devices that, at the time Definity Health makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration ("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; or

- 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.

Notwithstanding the foregoing, Definity Health, in its judgment, may deem an experimental, investigational or unproven service covered under the Health Coverage Program for treating a life-threatening sickness or condition if it is determined by Definity Health that the experimental, investigational or unproven service at the time of the determination:

- Is proven to be safe with promising efficacy;

- Is provided in a clinically controlled research setting; and

- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

- Allogeneic and syngeneic bone marrow transplants.

- Autologous bone marrow transplants.

- Heart or heart/lung.

- Liver (cadaver or living).

- Lung (single or double).

- Pancreas for a diabetic with end stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

- Kidney (cadaver or living).

- Cornea.

- Small bowel.

Bone marrow transplants include stem cells from bone marrow, peripheral blood, and umbilical cord blood sources.

In addition, the transplant program provides living donor coverage for kidney, liver, and bone marrow transplants, testing of potential donors, donor evaluation and workup, and hospital and professional services related to organ procurement. In the case of living donors, Definity Health will coordinate benefits with the donor's health coverage (see **Coordination of Benefits** section).

When care is provided by a United Resources Network ("URN") facility more than 50 miles from the patient's home, the Health Coverage Program will pay for certain travel and lodging expenses for one person (if the patient is a minor, both parents will receive travel benefits). A per diem allowance of $50 per person for lodging and $32 per person for meals will be allowed, up to a maximum of $5,000 per transplant. Definity Health must approve all travel and lodging expenses in advance. Travel and lodging expenses that are not approved in advance will not be paid. This travel benefit is not applicable for non-URN facilities.

Podiatric Care
The Health Coverage Program covers treatment of any condition resulting from weak, unstable or flat feet when an open cutting operation is performed or for treatment of corns, calluses or toenails, when at least part of the nail root is removed. Treatment of bunions is covered when an open cutting operation or arthroscopy is performed.

Pregnancy and Reproductive Care
The Health Coverage Program pays pregnancy-related benefits the same as any eligible medical expense. The Health Coverage Program will cover a minimum 48-hour stay for a normal vaginal birth and a minimum 96-hour stay for a normal cesarean birth.

Substance Abuse Treatment
Services and supplies for treatment of alcoholism, chemical dependency or drug addiction will be limited to the maximums shown in the following section. The treatment plan must be recommended by a physician and be completed to be eligible for coverage. All care must be provided by licensed, eligible providers – such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.

The Plan covers up to 30 days of inpatient care per calendar year and up to 26 outpatient visits per calendar year. There is a lifetime maximum benefit of 60 inpatient days or 60 outpatient visits.

Transition of Care
If you are in the midst of a cycle of treatment or are in your third trimester of pregnancy when your coverage through the Definity Health Option begins, care received from your current provider, regardless of your provider's network status, may be covered at In-Network levels for up to 120 days. This benefit is not automatic, for more information on how to qualify please call 1-888-333-4648, and choose the care consultant option. If Definity Health, in its sole discretion, approves your

request, your PCA and the Health Coverage Plan will pay covered expenses at the In-Network level (subject to Definity Health Option deductibles and other restrictions) until your pregnancy or cycle of treatment is complete or the end of the 120-day period beginning on the date your coverage under the Definity Health Option began, whichever is earlier.

BENEFIT LIMITS

Creditable Coverage Under HIPAA
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), when you lose coverage the Company will issue a certificate of creditable coverage describing the period during which you were a Plan participant, the length of COBRA coverage (if applicable) and the Plan's waiting period (if applicable).

"Creditable coverage" means your prior medical coverage, including other group or individual coverage, Medicare or Medicaid, military-sponsored health care, a state health benefits risk pool, a program of the Indian Health Service, the Federal Employees' Health Benefit Plan, a public health plan or any health benefit under Section 5(e) of the Peace Corps Act.

BENEFIT MAXIMUMS

In addition to the exclusions listed below, refer to the **Schedule of Benefits** for the maximum individual limit(s) and any calendar year limits applicable to certain covered expenses. Calendar year limits are met by:

- Day, visit, or dollar limits paid by your PCA under the Plan;
- Day, visit, or dollar limits paid by you as part of your deductible; and
- Day, visit, or dollar limits paid by the Health Coverage Program under the Plan.

EXCLUSIONS UNDER THE HEALTH COVERAGE PROGRAM

In addition to other limits described herein and in the Plan, the Health Coverage Program does not cover charges that are not medically necessary, or charges for:

- Adoption or surrogate expenses.
- Any care of military service connected conditions for which an employee is legally entitled to service and for which facilities are reasonable accessible. This includes any charges incurred while on active duty with the armed services of any country or international organization.
- Any charges for treatment, services or supplies that are not medically necessary or usual to the treatment of an illness or injury as determined by the claims administrator's medical staff or an independent medical physician review panel.
- Any charges of a physician or health professional for services he or she provides to herself or himself or to any close relative (close relative means spouse, brother, sister, parent, grandparent or child and the spouse's brothers, sisters, parents, grandparent or child).

- Any dental care, including accidental dental care, treatment, implants, surgery, or supplies under the medical portion of the Health Coverage Program, except for inpatient or outpatient hospital and anesthesia expenses related to dental work, if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition.

- Any diagnostic admission if the test can be performed on an outpatient basis.

- Any illness for which any 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 covered services under the Definity Health Option.

- Any illness or injury for which benefits or payments are received (or could be received if claims were made) under any worker's compensation law, employer's liability law or similar act.

- Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community**.**

- Arch supports, foot orthotics not prescribed by a medical doctor**,** 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 part of the initial care for treatment of a medically necessary condition.

- Augmentative communications devices.

- Autopsies.

- Breast pumps.

- Charges for a drug, device, diagnostic or screening procedure, or a medical treatment or procedure of an Experimental or Investigative nature or an Unproven Service as determined by the Claims Administrator. This does not include drugs that: a) have been granted treatment investigational new drug (IND) or Group C/treatment IND status; b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or c) for which available scientific evidence demonstrates, that the drug is effective or shows promise of being effective for the disease as determined by Definity Health.

- Charges for 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.

- Charges for gender transformation surgery, hormones related to the surgery and any related expenses.

- Charges for or related to fetal tissue transplants.

- Charges related to organ transplants except as specified in the section **Organ, Bone Marrow and Tissue Transplants**.

- Charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are eligible.

- Charges for duplicating and obtaining medical records.

- Charges for telephone consultation by a health professional or to keep a scheduled visit, mailing, shipping and handling expenses, completing any form, or for medical information.

- Charges for the treatment of compulsive gambling.

- Charges that exceed the allowed amounts and/or the Reasonable and Customary charge, except as specifically stated in the section **Covered Under the Personal Care Account Only**.

- Custodial care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional;

- Donor ova and sperm and artificial or intrauterine insemination procedures and related services, surgical procedures and prescription drugs for infertility treatment above the $10,000 lifetime maximum. Services for, or related to, assisted reproductive technology (ART) procedures, including, but not limited to, in vitro fertilization (IVF), gamete intracryopreservation or frozen embryo transfer, unless the procedure is specifically listed as covered.

- Enteral feeding formulas, except for the following:

  — Prescription and over the counter enteral feeding formulas when considered a sole source of nutrition and given via a feeding tube. This includes tube feeding supplies.

  — Oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally.

- Full body scans or EBCT (heart scans).

- Expenses for outpatient prescriptions filled by a pharmacy which does not participate in the MPPN or the Caremark Network.

- Expenses used to satisfy Health Coverage Program deductibles and/or coinsurance.
- Expenses eligible for consideration under any other plan, including Medicare.
- Expenses not specifically listed as covered expenses under the Definity Health Option.
- Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling.
- Gene therapy as a treatment for inherited or acquired disorders.
- Health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation.
- Health services performed before the effective date or after the termination of coverage under the Definity Health Option.
- Hearing aids, whether external or implantable or any related expenses.
- Hypnotism.
- Lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition.
- Liposuction.
- Marriage counseling.
- Massage therapy or rolfing.
- Non-emergency admissions greater than 24 hours in advance of the procedure, unless specified by your physician.
- Non-medical counseling or training services.
- Non-prescription drugs or medicines; prescription drugs that have not been classified as effective by the FDA; bio-engineered drug therapy that has not received FDA approval for the specific use being requested; prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- Personal comfort items while hospitalized such as telephone or television; hospital room and board expenses that exceed the semiprivate room rate unless a private room is approved as medically necessary.
- Phototherapy devices for Seasonal Affective Disorder.

- Physician charges for injections that can be self-administered.
- Private duty nursing services.
- Products purchased outside of the U.S., unless in an unexpected, emergency situation.
- Recreational or educational therapy or forms of non-medical self care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing.
- Routine physical exams and immunizations for employment, travel or insurance purposes.
- Sales tax on items other than durable medical equipment and on items that have been determined by Definity Health to be cove red that have not also been itemized on an invoice, receipt or explanation of benefits.
- Services for, or related to, systemic candidasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not medically necessary.
- Services of the clergy.
- Services or confinements ordered by a court or law enforcement officers that are determined not medically necessary (an initial court-ordered exam for a dependent child under age 18 is considered medically necessary).
- Services, chemotherapy, supplies, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered under the Health Coverage Program.
- Services rendered by anyone other than a covered health care provider.
- Services that are prohibited by law or regulations.
- Services provided mainly for rest cures, the ease of a household, or sanitarium care.
- Services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician.
- Transportation other than local ambulance service for a medical emergency to the nearest hospital that can provide care.
- Travel and/or lodging expenses of a physician or a patient, except as specified in the organ transplant section.
- Treatment while confined in a state, federal or Veterans Administration hospital for which charges are not imposed.

- Ventilator-dependent communication services while confined in a hospital or other medical facility.

- Vision therapy (eye muscle exercises).

- Vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high-risk pregnancies, asthma, or cancer programs.

FILING CLAIMS

When you receive care from your health care provider, you will present your Definity Health ID card. Your provider should submit a claim for payment directly to Definity Health. This amount will be deducted from your Personal Care Account based on your balance at the time Definity Health processes your claim. Once you have used up your Personal Care Account, any additional covered expenses you incur will be applied to your Health Coverage Program's deductible. Once your deductible is met, the Health Coverage Program will pay a portion of your covered expenses until you meet the out-of-pocket limit – after which the Health Coverage Program will pay 100% of any additional covered expenses you incur for the rest of the calendar year. If your provider does not file a claim on your behalf, follow the procedures under **Submitting a Claim**.

When your claim is processed at Definity Health two important dates are used:

- The date on which you received a service from your provider is used to process claims for the Health Coverage Program. This allows your deductible, coinsurance, and out-of-pocket limits to account for the moment in time when you receive health care services.

- The date on which Definity Health processes your claim is used when deducting Benefit Dollars from your PCA. This allows the Benefit Dollars in your PCA to act like a savings account, available for your use when your claim is paid.

Submitting a Claim
There may be times when you will be responsible for submitting a claim directly to Definity Health. For example, if you use an Out-of-Network Provider or Facility or if you incur a health expense that is only eligible under your PCA. You may download traditional claim forms from the Definity Health Web site. If you are unable to print a claim form, call the toll-free Definity Health customer service number at 1-866-333-4648 to request a copy. You must include a receipt from your provider (a cancelled check is not sufficient).

Submit your claims to:

Definity Health Claims
P.O. Box 9525
Amherst, NY 14226-9525

You must report claims to Definity Health promptly, but no later than 15 months after the date of the service.

If you have a question regarding how or if a certain service will be covered under the Definity Health Option, you may call customer service and request a predetermination of benefits. Requesting a predetermination is not a requirement nor is it considered the submission of a claim. Definity Health 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 Definity Health on the predetermination request is not binding. Once you have received the service, submitted a claim, and all information regarding your claim is received by Definity Health, a final determination of your claim will be made and communicated to you in accordance with the Plan's procedure.

Claim Decisions
Definity Health will notify you of its decision regarding your claim no more than 30 days after Definity Health receives the claim. Definity Health may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Definity Health's control. You will be provided with notice of any extension prior to the initial 30-day period; such notice will specify the circumstances requiring the extension of time and the date by which Definity Health expects to render a decision. If an extension is needed because Definity Health needs further information from you to decide the claim, the notice of extension will describe the required information. You will have at least 45 days from your receipt of the notice to provide the additional information.

If further information is required to decide the claim, by your application, you have agreed to allow all providers to give the Definity Health Option needed information about the care they provide to you. The Definity Health Option keeps all such information strictly confidential. If a provider requires specific authorization to release records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Benefits will be paid as soon as the necessary proof to support the claim is received. All benefits are payable to you. However, the Definity Health Option has the right to pay any health benefits to the service provider and will do so, unless you have informed Definity Health otherwise by the time you file the claim.

You must file separate claims for each covered individual.

APPEALING A CLAIM

If your claim for benefits is denied in whole or in part, you or your authorized representative may appeal the decision. If you appeal the decision, Definity Health will notify you or your authorized representative of the benefit determination on review according to the schedule described in this section.

If you are denied a claim for benefits, you will receive in writing:

- An explanation of the specific reason(s) for the denial.

- Specific references to pertinent Plan provisions on which the denial is based.

- A description of any additional material or information necessary for you to properly establish the claim and an explanation of why such material or information is necessary.

- If the claim is denied based on 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 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 such explanation will be provided free of charge upon request.

- An explanation of the steps you or your beneficiary can take to submit the claim for review and the time limits applicable to this procedure.

- A statement of your right to bring a civil action under ERISA § 502(a) following an adverse benefit determination on second review.

To appeal a denied claim, you or your authorized representative must, within 180 days after receiving the notice of denial, submit a written request to Definity Health asking that your claim be reconsidered.

Rights on Appeal
You will have the following rights on appeal:

- You or your authorized representative will have the right to submit written comments, documents, records, and other information relating to your claim.

- You or your authorized representative will also have the right to request, 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 review on appeal will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination and will not afford any deference to the initial benefit determination.

- The appeal will not be conducted by the individual who made the initial claim decision nor a subordinate of such individual.

- If the appeal 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, Definity Health shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such health care professional shall not be the individual who was consulted in

connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of such individual).

- Upon request, Definity Health will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of Definity Health in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Definity Health will notify you or your authorized representative of its decision in writing within 30 days of receiving your first level appeal request.

Notice of Determination on Appeal
If your claim is denied on review, the notice shall state:

- The reason(s) for the denial, including references to Plan provisions upon which the denial was based.

- That you are entitled 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.

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

- A description of any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures.

- A statement of your right to bring an action under section 502(a) of ERISA following an adverse determination on second review.

Right to a Second Appeal
If on first review, Definity Health affirms the denial of your claim, you or your authorized representative may appeal the denial by submitting a written request for a second review of the claim to Definity Health. You must make the request within 60 days after receiving the first appeal denial notice. Second level appeal requests requiring clinical review, are reviewed by an independent review organization and handled by Definity Health. Definity Health reviews second level claims appeals that do not require a clinical review.

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. The rights and procedures that apply to the first review on appeal will apply to the second review.

Timing of Appeal Determinations on Second Review
Second level appeal decisions will be communicated to you in writing within 30 days.

If your claim is denied on second review, the notice shall include the information specified in the above section **Notice of Determination on Appeal**.

COORDINATION OF BENEFITS

If you have health care coverage available through another employer, this section is for you. For example, you may be covered as a dependent under your spouse's medical plan. This "coordination of benefits" provision prevents duplicating benefit payments when you or your dependent(s) also have coverage through another group plan. Coordination of benefits also determines which plan pays first.

How Coordination of Benefits Works
Covered expenses not reimbursed by the primary plan will first coordinate with your Personal Care Account. If there isn't enough money in your PCA to cover those expenses, the remaining expenses will be submitted to the Health Coverage Program for payment.

Here's how coordination of benefits works: The first step is to determine which plan is primary and which plan is secondary. The primary plan always pays benefits first. When the Definity Health Option is secondary, benefits are coordinated so that the total benefits from all the plans are no more than the maximum allowed by the Definity Health Option.

Example: Assume your spouse is covered under his or her own employer's plan and as your dependent under the Definity Health Option, and incurs a $100 expense for an office visit. Let's also assume the Definity Health Option considers the allowable expense for the office visit is the full $100. If your spouse's plan covers the visit at 80% ($80), the Definity Health Option will pay $20 ($100 - $80). In this example you would be reimbursed a total of $100 ($80 + $20).

Order of Coverage – Employee and Spouse
- 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.

  — 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 health care 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.

  — The parent with custody has remarried:

    – The plan of the custodial parent will be primary.

    – The plan of the stepparent will be secondary.

    – The plan of the non-custodial parent will be third.

Coordination with Medicare
If you keep working for your current employer and you or a covered dependent becomes eligible for Medicare as a result of age, the Definity Health Option will remain your primary plan and Medicare will be secondary. If you are a disabled employee eligible for Medicare, Medicare will generally pay first.

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 Definity Health Option 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 for services relating to an accident, injury or sickness for which any benefits are payable under the Definity Health Option, and the accident, injury or sickness arises under circumstances that may create a legal liability in another individual or organization, and whenever the Definity Health Option 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 Definity Health Option with respect to third party expenses, you must notify Definity Health of the expenses which are third party expenses at the time a claim for benefits is submitted under this Program.

You must submit all information, documents and any other evidence which Definity Health requests in order to assist it 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 Definity Health Option 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. McKesson Corporation Health 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.

- To execute and deliver, at the request of Definity Health, such instruments, including an assignment to Definity Health 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.

- 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.

- 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 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.

Right of Recovery
The Plan has the right to recover benefits it has paid on you or your dependent's behalf that were made in error, due to a mistake in fact, advanced during the time period of meeting the Member Responsibility phase of the Plan Year deductible, or advanced during the time period of meeting the coinsurance Maximum for the Plan Year. Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your 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.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the Member Responsibility phase of the Plan Year deductible; and/or meeting the coinsurance maximum for the Plan Year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan; and

- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

CONTINUING YOUR COVERAGE

Continuing Coverage During a Period of Disability

Coverage under the may continue under the Definity Health Option during a period in which you are away from work due to a Company-approved disability leave, provided you make timely payment of any required contributions.

Continuing Coverage During a Leave of Absence or Temporary Layoff

Depending on your situation, you may be eligible to continue participating in the Definity Health Option while you are 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.

Continuing Coverage During Family Medical Leave (FMLA

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 ("FMLA"), you may continue to participate in and receive coverage under the Definity Health Option during the leave if the following conditions are met:

- Any required contribution for the cost of your coverage is paid by you when due; and

- Your leave has been approved by the employer.

You may continue to participate in the Definity Health Option until the end of the leave period required by the FMLA. If you cancel your coverage while you are on an approved FMLA leave and you return to work as an eligible employee immediately following your approved FMLA leave or your approved leave of absence that includes an approved FMLA leave, you can restore coverage as an employee.

If you do not return to work following an approved FMLA leave, you (and your Spouse and Dependent Children, if any) may be eligible for COBRA Continuation Coverage as of the date you terminate your employment with the employer. Please contact the McKesson Call Center at 1.866.772.6601 for details.

Continuing 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 Definity Program, you and your covered Dependents may elect to continue medical and prescription drug coverage for 18 months (24 months for elections made on or after December 10, 2004) or for the period ending on the day after the date the eligible Employee 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 Continuation Coverage.

This provision applies to:

- Employees on active duty;
- Employees on active duty for training;
- 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 services.

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

Continuation of Health 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 or "COBRA") and as outlined in this section. The entire cost of such Continuation Coverage is payable by the covered person.

Continuation Coverage for covered persons who selected Continuation Coverage under a prior plan which was replaced by Coverage under the Definity Program shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in the **Termination Events for Continuation Coverage** section, whichever is earlier.

In no event shall Definity Health 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 Call Center in a timely manner of the covered person's election of Continuation Coverage.

Eligibility for Continuation Coverage

In order 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 Dependents, including with respect to the eligible Employee's children, a child born or placed for adoption with an eligible Employee during a period of Continuation Coverage; or
- An eligible Employee's former Spouse or Domestic Partner.

Qualifying Events for Continuation Coverage
If a Qualified Beneficiary's coverage will terminate upon the occurrence of any of the following Qualifying Events, he or she will be entitled to elect Continuation Coverage. The Qualified Beneficiary is entitled to elect to continue the same coverage that he or she had on the day before the Qualifying Event.

- Termination of the eligible Employee from employment with the Company (for any reason other than gross misconduct) or reduction in hours of employment;
- Death of the eligible Employee;
- Divorce or legal separation or termination of Domestic Partnership of the eligible Employee; or
- Loss of eligibility by an enrolled Dependent who is a child.

Coverage may be continued for 18 months or 36 months, depending upon the Qualifying Event:

Qualifying Event	Individuals Eligible for Continuation Coverage	Coverage Period from Initial Qualifying Event
Your employment ends	Employee, Spouse or Domestic Partner, Children	18 months
Your hours are reduced (e.g., approved leave)	Employee, Spouse or Domestic Partner, Children	18 months
You divorce or become legally separated	Spouse, Children	36 months
Termination of Domestic Partner relationship	Domestic Partner, Children	36 months
Your Dependent child loses Dependent status	Child losing coverage	36 months
You die*	Spouse or Domestic Partner, Children	36 months

The actual number of months you may pay for Continuation Coverage will be reduced by the number of months, if any, that employer-paid coverage continues after the Qualifying Event.

*If you qualified for retiree medical coverage at the time of your death, your family may be eligible to elect retiree health coverage in place of Continuation Coverage.

Extension of Continuation Coverage
Subject to the notice requirements described below, if a Qualified Beneficiary is entitled to 18 months of Continuation Coverage, Continuation Coverage may be extended if any of the events described below occurs.

Disability. Qualified Beneficiaries may obtain an up to 11-month extension of Continuation Coverage under certain circumstances for a total Continuation Coverage period of up to 29 months if a Qualified Beneficiary has been determined to have been disabled by the Social Security Administration within 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 or 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 Partner relationship or a covered child's termination of 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 or 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 or Domestic Partner and Dependent children is 36 months from the date of the Employee's Medicare enrollment. For example, if you became enrolled in Medicare 8 months prior to the Qualifying Event, your Spouse or Domestic Partner and Dependent children would be eligible for 28 months of Continuation Coverage (36 – 8 = 28).

Notification Requirements

Qualifying Event

The eligible Employee or Qualified Beneficiary must notify the McKesson Call Center within 60 days of his or her divorce, legal separation, termination of Domestic Partner relationship, or an Enrolled Dependent's loss of eligibility as an enrolled Dependent. If the eligible Employee or Qualified Beneficiary fails to notify the McKesson Call 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 or adoption or placement for adoption during such Continuation Coverage must notify the McKesson Call Center within 60 days of the birth or adoption of the child 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; and

- Address of the Qualified Beneficiary.

If the eligible Employee dies while covered under Continuation Coverage, the eligible Employee's Dependent must notify the McKesson Call Center of this second Qualifying Event.

If the McKesson Call Center receives timely notice from the eligible Employee or the eligible Employee's Dependent, the McKesson Call Center will provide a COBRA election notice within 14 days of its receipt of the notice. If the McKesson Call 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.

If the eligible Employee is terminated from employment or had a reduction in hours of employment, the Company will notify the McKesson Call Center of this Qualifying Event. If the eligible Employee dies while employed with the Company, the Company will notify the McKesson Call Center of this Qualifying Event. The McKesson Call Center will provide a COBRA election notice within 44 days of the Qualifying Event.

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 Plan Administrator 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 such 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 Call 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 such 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 or her Medicare card to the McKesson Call 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 Call Center within 30 days of the enrollment. The Qualified Beneficiary will be required to provide a copy of his or her Medicare card to the McKesson Call Center.

Notice to the McKesson Call Center

All notices required that relate to Continuation Coverage must be provided to the McKesson Call Center at the following address:

McKesson Call Center
2601 Research Forest Drive
The Woodlands, TX 77381

Notice of Unavailability of Continuation Coverage
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 Call Center determines that the individual who provided the notice is not entitled to Continuation Coverage or extended Continuation Coverage, the McKesson Call Center will provide the individual with a notice explaining the reasons why Continuation Coverage is not available.

Termination Events for 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 such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, Continuation Coverage shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services, which are subject to the preexisting condition limitation or exclusion.

- The date, after electing Continuation Coverage, that the Qualified Beneficiary becomes entitled to Medicare (and actually enrolls in Medicare).

- The date the employer cases 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 Call Center will provide a notice to the affected individuals as soon as practicable following the McKesson Call 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
You must pay for Continuation Coverage. Continuation Coverage 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 Continuation Coverage is extended as a result of disability (see explanation above).

The first payment covers the cost of Continuation Coverage retroactive to the date the Company-paid coverage ended. You are responsible for ensuring that the amount of your first payment is enough to

cover this entire period. You may contact the McKesson Call Center to confirm the correct amount of your 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 your Continuation Coverage payments are late, you will lose your Continuation Coverage rights.

If the Qualifying Event is the eligible Employee's death, the Company will pay the full cost of Continuation Coverage for your Spouse or 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 Plan. Your family pays the full cost for the balance of the period of Continuation Coverage.

Continuation Coverage Payment Shortfalls

If you or your Dependent remits a timely monthly contribution to the Plan Administrator that is significantly less than the actual Continuation Coverage payment due for the month, your or your Dependent's Continuation Coverage will be terminated immediately. If you or your Dependent remits a payment 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 Plan Administrator notifies you or your Dependent of the amount of the deficiency and permits you or your Dependent to pay the deficiency within 30 days of the date of the notice of deficiency. You or your Dependent are responsible for paying all deficiencies.

Electing Continuation Coverage

Continuation Coverage must be elected within 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator. If you fail to timely elect Continuation Coverage, you will permanently lose your right to Continuation Coverage. 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 or 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 or her Dependent children, the Dependents' parent (the Employee's Spouse or Domestic Partner or other parent or legal guardian) may elect Continuation Coverage for them. If the Employee and Spouse or Domestic Partner declines to cover a Dependent child, that child has an independent right to elect Continuation Coverage for him/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 Call Center is notified within 30 days of birth or placement for adoption. The Employee or his or her Spouse or 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. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition

exclusions if you do not elect Continuation Coverage for the maximum time available to you. This guaranteed right will only be preserved if you elect Continuation Coverage. Finally, you should take into account that you have special enrollment rights under Federal law. You have 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's or Domestic Partner's employer) within 30 days after your group health coverage ends because of the Qualifying Event giving rise to your right 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.

Special COBRA Rights for Trade Displaced Employees

If you lost coverage under the Plan because the Company shut down its plant because of a shift of production to another country or because of an increase in imports, you may be eligible for a tax credit for your Continuation Coverage payments, provided you qualify for trade adjustment assistance or alternative trade adjustment assistance from the federal government and your state government. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the new tax provisions, eligible individuals can take a tax credit on their tax returns of 65% of premiums paid for qualified health insurance, including Continuation Coverage. Advance payments of the tax credit may also be available.

If you become eligible to receive trade adjustment assistance within six months of losing Plan medical coverage and did not elect Continuation Coverage when you were initially eligible, you may also be entitled to a second COBRA election period. To obtain this second COBRA election period, you must provide a copy of the certificate issued to you by your state workforce agency entitling you to federal trade adjustment assistance to the McKesson Call Center. The McKesson Call Center will provide you with a COBRA election notice. Your election to continue coverage must be made during the 60-day period that begins on the first day you become eligible for trade adjustment assistance, but no later than six months after you lost Plan medical coverage. If you elect COBRA during this period, COBRA will commence on the first day of the second election period. Your COBRA period, however, will be measured from the date you lost Plan coverage. The second election period does not extend the COBRA period available to you.

If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at

1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Keep the Plan Informed of Address Changes

To protect your and your family's rights, you must keep the McKesson Call 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 Call Center.

For More Information

If you have any questions concerning your rights to Continuation Coverage under COBRA, call the McKesson Call Center at 1-866-772-6601 or write to:

McKesson Call Center
2601 Research Forest Drive

The Woodlands, TX 77381

GLOSSARY

Calendar Year
Means a 12-month period of time that follows the Plan's Effective Date and each subsequent 12-month period this Plan remains in force (January 1st through December 31st).

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

Covered Expense
Means the expenses as defined and listed in the sections, **What's Covered Under the Definity Health Option**, **Covered Under the Personal Care Account Only**, and **Covered Under the Personal Care Account and the Health Coverage Program**.

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 MPT Employees who were working 20 hours but less then 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.

- Is performing in the customary manner all of the regular duties of his or 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 is not performing his or her regular duties due to illness, provided that he or she has already commenced performing his or her regular duties of employment prior to his or her illness.

- Is not in one of the excluded categories described in the following 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);

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

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

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

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

- 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.

Maximum Lifetime Limit
The Plan will pay benefits limited to the maximum individual limit shown in the **Schedule of Benefits**. This applies individually to you and each of your eligible dependents. When benefits in such amount have been paid or are payable under this Plan for you or your eligible dependents, all coverage for that person under this Plan will terminate. This term does not mean that benefits under the Plan are guaranteed for a covered person's or covered Dependent's lifetime.

Medically Necessary
"Medically necessary" means health care services and supplies which are determined by Definity Health to be medically appropriate and:

- Necessary to meet the basic health needs of the participant.

- 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 health care coverage organizations or governmental agencies that are accepted by Definity Health.

- Consistent with the diagnosis of the condition.

- Required for reasons other than the convenience of the patient or his or her physician.

- 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.

  — 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, the term "life-threatening" is used to describe sicknesses or conditions which 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 as defined above. The definition of medically necessary used relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.

Member Responsibility
The Member Responsibility is your portion of the deductible that you must pay out-of-pocket on covered expenses after you deplete the Benefit Dollars in your PCA and before the Health Coverage Program "kicks" in - often referred to as "Bridging your PCA and Health Coverage." This amount is specified in the **Schedule of Benefits**. Your Member Responsibility will be less if you rollover PCA Benefit Dollars from the previous Plan Year. However, the Member Responsibility could increase, up to the amount of your deductible, if you choose to spend your PCA Benefit Dollars on "extra" non-traditional covered expenses – refer to **Covered Under Your Personal Care Account Only** for a listing of such expenses.

Out-of-Pocket Limit
Means the specified maximum amount of percentage you pay out-of-pocket under the Health Coverage Program – referred to as coinsurance. Such coinsurance has a dollar cap - defined here as out-of-pocket limit. After you meet the Plan's out-of-pocket limit for that calendar year, the Plan pays 100% of covered expenses for the remainder of the calendar year, for an In-Network Provider and 100% of Usual and Customary for an Out-of-Network Provider, subject to any limits under the Plan. Coinsurance you pay out-of-pocket for covered expenses from all covered family members are combined to reach the out-of-pocket limit. Satisfaction or partial satisfaction of the Out-of-Network out-of-pocket limit will be considered towards satisfaction or partial satisfaction of the In-Network out-of-pocket limit and vice versa. The out-of-pocket limit is in addition to the Member Responsibility phase of the deductible.

Out-of-Network Provider
Means a provider not under contract as an In-Network Provider. Also referred to as Out-of-Network Provider or Facility.

Reasonable and Customary
The Definity Health Option provides benefits for covered expenses up to the "reasonable and customary" amount when an Out-of-Network Provider or Facility is used. Reasonable and customary (R&C) means the charge that is:

- Customarily made by physicians, health care providers or suppliers for the same service or supply;
- The amount normally charged by the provider for similar services and supplies; and
- Accepted by the health community in the locality where the service or supplies are provided as being reasonable and necessary for the same services or supplies.

The Definity Health Option will cover the lesser of:

- The provider's usual charge for furnishing the service or supply; or
- The reasonable and customary charge.

To determine the reasonable and customary charge for a service or supply, Definity Health will consider:

- The complexity of the service or supply;
- The degree of skill needed;
- The provider's specialty;
- The range of services or supplies provided by a facility; and
- Similar charges in other areas.

YOUR RIGHTS AS A PLAN MEMBER

As a participant in the Plan, you are entitled to certain rights and protections under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). You have the right to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office, 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 Pension and Welfare Benefit 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 the 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, 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.

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 create 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 the Company, 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 in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such case, the court may require the Plan Administrator to provide the materials and

pay up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit 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 Pension and Welfare Benefits Administration.

ADDITIONAL PLAN INFORMATION

Name of Plan
McKesson Corporation Health Plan

Type of Plan and Plan Number
The McKesson Corporation Health Plan ("Plan") of which the Health Coverage Program and Health Expense Reimbursement Program are a part, is a group health plan which provides medical and prescription drug benefits. The Plan number is 501.

Plan Sponsor
The Health Coverage Program and the Health Expense Reimbursement Program are a part of the McKesson Corporation Health Plan which is sponsored by:

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

Plan Sponsor's Employer Identification Number (EIN)
94-3207296

Plan Administrator
McKesson Corporation
c/o Vice President, Compensation and Benefits
One Post Street
San Francisco, CA 94104
1-415-983-8300

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

Plan Administration and Interpretation
All decisions concerning the interpretation and application of the Health Coverage Program and the Health Expense Reimbursement Program shall be vested in the sole discretion and authority of the Plan Administrator. The Plan Administrator shall have total and complete discretionary authority to determine conclusively for all parties all questions of eligibility for coverage and benefits, and the status of participants. The decision of the Plan Administrator shall be final, conclusive and binding on all persons, subject to the claims procedure set forth in this summary. The Plan Administrator will exercise its discretion in a nondiscriminatory manner. You can contact the Plan Administrator as follows:

McKesson Corporation
c/o Vice President, Compensation & Benefits
One Post Street
San Francisco, CA 94104-5296
1-415-983-8300

Claims Administrator
The Company has delegated authority to Definity Health to administer benefits under the Definity Health Option. The Company has also appointed Definity Health as its ERISA fiduciary, but solely for the purpose of providing a full and fair review of claims and appeals. To this end, the Company has delegated to Definity Health the discretionary authority to construe and interpret the terms of the Health Coverage Program and the Health Expense Reimbursement Program (your Personal Care Account), and to make final, binding determinations concerning the availability of benefits under these programs. You may contact the Claims Administrator at the following address:

Definity Health
1600 Utica Ave South
Suite 900
St. Louis Park, MN 55416
1-952-277-5500

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

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

Type of Administration
The Plan is administered by the Plan Sponsor.

Cost of Administering the Definity Health Option
The Company intends to pay certain administrative expenses. The administrative costs of the Definity Health Option are paid out of the applicable trust fund, unless the Company (at its sole discretion) chooses to pay those costs.

Contributions and Benefits
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. Employee contributions are taken before taxes and will be deducted as soon as administratively possible. The balance of the cost of the Plan is paid by the Company.

The payment of benefits from the Health Expense Reimbursement Program (your Personal Care Account) are made solely by the Company from its general assets.

Plan Year
The financial records of the Plan, of which the Health Coverage Program and the Health Expense Reimbursement Program are a part, are kept on a Plan year basis from April 1 to March 31.

Agent for Service of Legal Process
The agent for service of legal process is the Plan Administrator:

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

Plan Documents Control
This summary is provided in accordance with Federal law. It is intended to be a summary of the Plan documents identified above, and may not always be consistent with the terms of those documents. To the extent that this summary is inconsistent with the terms of the Plan documents above, the Plan documents will control. The Plan documents will also control over inconsistent verbal statements or written communications from the employer or Definity Health.

Plan Changes and Termination
The Company may terminate, suspend, withdraw, amend, or modify the Plan or any of the programs comprising the Plan, including the Definity Health Option or any portion thereof at any time.

Tax Effect
Neither the Company nor Definity Health makes any warranty or other representation as to whether any payments or benefits you receive from the programs offered through the Definity Health Option will be treated as includable in gross income for federal or state income tax purposes.

No Employment Rights
Neither the adoption of the Definity Health Option, nor your status as a participant in any underlying program of the Definity Health Option shall constitute a guarantee of continued employment with the employer. Also, you cannot sell, transfer or assign either voluntarily or involuntarily the value of your benefit under the Definity Health Option.

Participating Employers

A participating employer is any corporation which is a subsidiary with McKesson Corporation, whose employees are authorized by the Company to participate in the Definity Health Option as described in this SPD. A complete list of participating employers and information regarding whether a particular employer participates in the Definity Health Option may be obtained on written request to the Plan Administrator.