McKesson Corporation

Point of Service (POS) Program and Prescription Drug Program Summary Plan Description (CIGNA HealthCare)

Effective January 2005

CONTENTS

INTRODUCTION

This Summary Plan Description (SPD) summarizes certain health coverages provided by the McKesson Corporation Health Plan (the "Plan") for active Employees. The provisions regarding eligibility, termination and continuation of coverage, as well as **Your Rights as a Plan Member**, apply to all programs provided under the Plan. The medical coverage summarized in this SPD is provided through the CIGNA HealthCare Point of Service Medical Program (hereinafter referred to as "POS Program"), and the prescription drug coverage summarized in this SPD is provided through Caremark Inc. ("Caremark"). The Plan is a self-insured health plan. CIGNA HealthCare and Caremark, as the applicable Claims Administrators, are the named fiduciaries regarding claims and appeals under the CIGNA HealthCare Point of Service Medical Program and the Caremark Prescription Drug Program, respectively.

This SPD explains your health care coverage in plain language so that it will be easier to understand. However, the information provided here does not cover every situation and is not intended to replace the Plan Documents – or to change their meaning.

Provisions of the McKesson Corporation Health Plan are summarized in this 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 McKesson Corporation Health Plan, see the section **Your Rights as a Plan Member**.

Plan and Trust Documents

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

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

There is a copying charge of $0.10 per page.

Plan Amendment and Termination

Nothing in the McKesson Corporation Health Plan or this SPD shall prevent any future amendments to the benefits provided under the Plan, or the contributions or eligibility criteria required for participation in the Plan. The Company reserves the right to amend or terminate the Plan at any time and for any reason. This includes, but is not limited to, increasing contributions or reducing benefits.

Plan Interpretation and Authority to Delegate

The Plan Administrator has the sole and exclusive right and discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising thereunder or in connection with the administration thereof, and to delegate such authority and discretion to designated person or persons.

No Vested Interest

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

No Employment Contract

Nothing in the Plan or this SPD shall confer any rights of continued employment on any Employee or in any way prohibit changes in the terms and conditions of, or the termination of, employment of any Employee covered by the Plan.

Notice of Change

Any notice of a change in Dependent status should be provided to the McKesson Call Center. Notice of a change in address should be sent to the HR Representative at your work location.

SCHEDULE OF BENEFITS

McKesson Corporation has contracted with CIGNA HealthCare to provide medical Plan coverage for certain McKesson Employees through its Point of Service (POS) Program. McKesson Corporation has also contracted with Caremark to provide outpatient prescription drug coverage for certain McKesson Employees through its Prescription Drug Program. If you elect coverage under the POS Program, your benefits will be provided by CIGNA HealthCare. An overview of the benefits is provided in the following table.

Medical Benefits

Maximum Benefits	
Lifetime Maximum Benefit, Infertility Treatment	$10,000
Lifetime Maximum Benefit, All Services	$1,500,000
Network Benefits **Co-payments and Out-of-Pocket Maximums**	
Primary Care Physician (PCP) Office Visit Co-payment	$15
Specialist Care Office Visit Co-payment	$15
Preventive Care Office Visit Co-payment	$15
Laboratory and X-ray Co-payment (Includes Radiation Therapy)	No charge for laboratory and x-ray services that are part of the office visit or if results are determined outside the office visit by an independent lab and/or x-ray facility.
Physical Therapy, Speech Therapy, Chemotherapy Office Visit Co-payment	$15
Allergy Injections Office Visit Co-payment	$15

Network Benefits **Co-payments and Out-of-Pocket Maximums (con't)**	
Chiropractic Care Office Visit Co-payment (35 visits maximum per Calendar Year)	$15
Acupuncture Office Visit Co-payment (35 visits maximum per Calendar Year)	$15
Hospital Emergency Room Co-payment Per Visit	$100
Urgent Care Facility/Outpatient Facility Co-payment Per Visit	$50
Network Individual Out-of-Pocket Maximum*	$1,500
Network Family Out-of-Pocket Maximum*	$3,000
Percentage of Covered Expenses Payable	
Covered Expenses Subject to a Co-payment	100%
Outpatient Surgery	90%
• Inpatient Services: Semi-private room, physician visits, surgeon, anesthesia, laboratory, diagnostic and x-ray procedures	90%
Specialized Care, Services and Supplies:	
• Maternity Care	$15 for initial office visit; Plan pays 90% for other charges
• Durable Medical Equipment	100%
• Ambulance	100% with prior authorization; otherwise not covered
• Mental Health and Alcohol/Drug Treatment – Outpatient (26 visits maximum per Calendar Year, combined visits for Network and Non-Network) – Inpatient (30 days maximum per Calendar Year, combined visits for Network and Non-Network)	90%
Extended Care:	
• Skilled Nursing Facility (100-day maximum per Calendar Year)	90%
• Home Health Care (100-day maximum per Calendar Year)	100%
• Hospice Care	90%

Percentage of Covered Expenses Payable (con't)	
Percentage of Covered Expenses Payable After Network Out-of-Pocket Maximum is Reached	100%
Non-Network Benefits **Deductibles and Out-of-Pocket Maximums**	
Non-Network Individual Deductible	$300
Non-Network Family Deductible	$750
Non-Notification Penalty for Inpatient Admissions and Selected Outpatient Procedures/Diagnostic Testing • Benefits are denied for any admission reviewed by CIGNA HealthCare and not certified. • Benefits are denied for any additional days not certified by CIGNA HealthCare. • Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA HealthCare and not certified.	$500
Non-Network Individual Out-of-Pocket Maximum*	$3,000
Non-Network Family Out-of-Pocket Maximum*	$6,000
Percentage of Covered Expenses Payable	
Preventive Care	Not covered
Percentage of Covered Expenses Payable for Emergency Care, Urgent Care and Ambulance Services	Covered same as Network benefit; Not covered if not a true emergency.
Percentage of Covered Expenses Payable for Other Than Emergency and Urgent Care	70%
Percentage of Covered Expenses Payable After Non-Network Out-of-Pocket Maximum is Reached	100%

*Note: All Network covered expenses paid by the Covered Person other than PCP and Specialist office visit Co-payments, emergency room and urgent care Co-payments apply towards the Network Out-of-Pocket Maximum. All Non-Network covered expenses paid by the Covered Person other than Non-Network Deductibles and Non-Notification Deductibles apply towards both the Network and Non-Network Out-of-Pocket Maximums.

Mental Health Benefits and Substance Abuse Benefits – Network and Non-Network

Maximum Mental Health and/or Substance Abuse Benefits	
Calendar Year Mental Health and/or Substance Abuse: Inpatient	30 days
Calendar Year Mental Health and/or Substance Abuse: Outpatient	26 visits
Lifetime Maximum Substance Abuse Only: Inpatient and Outpatient	60 days or 60 visits

Mental Health Benefits and Substance Abuse Benefits are subject to the same Deductibles, Out-of-Pocket Maximums and Percentages as **Medical Benefits**.

Pregnancy Benefits
Pregnancy Benefits are payable in the same manner as **Medical Benefits**.

Preventive Health Care Benefits
Network Preventive Health Care Benefits are payable in the same manner as **Medical Benefits**. Non-Network Preventive Health Care Benefits are not covered by the Plan.

Infertility Benefits
Infertility Benefits are payable in the same manner as **Medical Benefits** and are subject to a lifetime maximum benefit of $10,000 as shown in the **Schedule of Benefits.**

Prescription Drug Benefits

Inpatient drugs are covered on the same basis as other hospital expenses through the POS Program. Outpatient drug coverage is provided through Caremark under the Prescription Drug Program. See the **Prescription Drug Program** section for a further description of the Prescription Drug Program. The prescription drug benefits under the Prescription Drug Program are summarized as follows:

	MPPN Pharmacy in the Caremark Network	**Non-MPPN Pharmacy in the Caremark Network**
You Pay*	10% – Generic Drugs 20% – Preferred Brand on Formulary/Primary Drug List 40% – Non-Preferred Brand Drugs	20% – Generic Drugs 30% – Preferred Brand on Formulary/Primary Drug List 50% – Non-Preferred Brand Drugs
Deductible	$50 per person; $150 per family	
Maximum Allowable Benefit	$10,000 lifetime maximum on Infertility Treatment (part of the lifetime infertility maximum as shown in the **Schedule of Benefits**)	

	MPPN Pharmacy in the Caremark Network	Non-MPPN Pharmacy in the Caremark Network
Day Supply Limit	34-day supply Up to a 90-day supply for certain maintenance drugs**	
Caremark Customer Service	1-800-378-0822 or *www.caremark.com*	

*When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than physician indicates "dispense as written," you will pay the difference between the brand name drug and the generic plus the generic Co-payment.

**Maintenance drugs may also be purchased through Caremark's Mail Order program. The cost per prescription through mail order is $20 for generic drugs; $35 for formulary brand drugs; and $50 for non-formulary brand drugs.

ELIGIBILITY

Eligible Employees

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

When an Employee Becomes Eligible

With Respect to McKesson Provider Technologies, Medication Management, and Medical Management Employees

Your Eligibility date is the first day of the calendar month coinciding with or following your date of hire.

With Respect to All Other Employees

Your Eligibility date is the first day of the calendar month coinciding with or following your completion of two months of service.

Eligible Dependents

Dependents are:

- Your spouse ("Spouse") unless legally separated or your domestic partner (subject to certifying his/her Domestic Partner relationship) ("Domestic Partner");
- Any unmarried child from birth to age 19;
- Any unmarried child age 19 through 23, provided such child meets all of the following conditions:
  - — Is a regular, full-time student at an accredited secondary school, college, university, vocational or technical training school or institution for the training of nurses.
  - — 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 definition of “child” includes:

- The covered Employee’s biological children;

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

- A child who is the subject of a Qualified Medical Child Support Order (see the **Enrollment Requirements** section of this SPD for a further discussion of Qualified Medical Child Support Orders).

If you support a child who lives with you permanently, but you are not his or her parent, special provisions may apply. Check with the McKesson Call Center at 1-866-772-6601.

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.

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

Cost of Coverage
The Employee contribution rate for coverage is set by the Company and may increase from year to year. The Company currently shares the cost of Employee and Dependent coverage with you.

ENROLLMENT REQUIREMENTS

Employee Coverage
An Employee must enroll for coverage during his or her Initial Eligibility Period, a Special Enrollment Period or during the Annual Enrollment Period.

Dependent Coverage
An Employee must enroll for coverage as an Employee in order to enroll his or her eligible Dependents. If a husband and wife or Domestic Partners are both eligible Employees, only one may enroll their eligible Dependents for coverage. A spouse who is legally separated is not eligible for coverage.

No person can be covered both as an Employee and as a Dependent.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are any family members who become eligible Dependents after the date the Employee first becomes eligible under this Plan. Subsequent Dependents may be added during a Special Enrollment Period.

Enrollment Periods
The Initial Eligibility Period is the 31-day period which begins on the date the Employee or Dependent is first eligible under this Plan.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage.

The Annual Enrollment Period is designated by the Company each year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain Dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Employee or Dependent.

- The Employee’s or Dependent’s prior coverage was one of the following:

— COBRA continuation which was exhausted.

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

- The Employee requests enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation coverage period, termination of non-COBRA coverage, or termination of employer contributions.

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

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

Late Enrollees
A late enrollee can enroll only during an Annual Enrollment Period. Coverage usually begins on the first day of the following Calendar Year.

Effective Date of Employee Coverage
The date the Employee becomes eligible for coverage, if the Employee enrolls within 31 days of becoming eligible.

Effective Date of Dependent Coverage
Coverage for Initial Dependents is effective on the same date the Employee's coverage becomes effective.

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

- For a Spouse, the date of the marriage;
- For a Domestic Partner, within 30 days of certifying the Domestic Partner relationship;
- For a newborn, the date of birth; or
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a Dependent.

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

Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, to provide coverage for his or her children, his or her eligible Dependent children can be enrolled as timely enrollees in the Plan as required by ERISA.

Requests for coverage under a medical child support order should be mailed to the Plan Administrator (see the **Additional Plan Information** section) within 30 days after the order is issued or as soon as reasonably possible.

Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders from the Plan Administrator.

TERMINATION OF COVERAGE

If you lose your coverage for any reason, you'll receive a Certificate of Group Health Plan Coverage. This certificate offers proof that you've been covered under the McKesson Corporation Health Plan. It may also allow you to receive credit toward your new health plan's pre-existing conditions waiting period. This applies not only to you as the covered Employee, but to your Dependents as well.

Employee Coverage

Employee coverage under the POS Program and Prescription Drug Program and the Plan ends on the earliest of the following:

- The day the POS Program and/or Prescription Drug Program terminates; or
- The day the Plan terminates; or
- The last day of the month in which the Employee terminates employment or loses eligibility; or
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made on a timely basis; or
- The last day of the month in which the Employee enters active military duty unless coverage is continued (see **Coverage During Military Leave**); or
- The day the Employee becomes covered by a collective bargaining agreement which does not provide for participation in the POS Program and Prescription Drug Program or the Plan; or
- The date you die; or
- The last day of the month for which you request termination of coverage; or
- The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Employee knowingly provided the Plan Administrator or the

Claims Administrator with false material information, including, but not limited to information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the effective date of coverage.

Coverage During a Period of Disability

Coverage under the POS Program and Prescription Drug Program may continue 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.

Coverage During a Leave of Absence or Temporary Layoff

Coverage under the POS Program and Prescription Drug Program may continue during a period in which 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; or

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

Coverage During Family Medical Leave (FMLA)

Coverage may continue while you are out on an approved family or medical leave of absence, provided you make timely payment of any required contributions.

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 POS Program, you and your covered Dependents may elect to continue vision 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.

Dependent Coverage

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

- The day the Employee's coverage ends;
- The last day of a period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made on a timely basis; or
- The day that Dependent coverage under the Plan is discontinued.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan; or
- The last day of the month in which the Dependent's last day of eligibility occurs.

Coverage for Incapacitated Children

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

- The child is incapacitated;
- The child is not capable of self-support; and
- The child depends mainly on the Employee for support.

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

CONTINUATION OF HEALTH COVERAGE (COBRA)

Continuation of 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 POS 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 CIGNA HealthCare or Caremark 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

Qualifying Event	Individuals Eligible for Continuation Coverage	Coverage Period from Initial Qualifying Event
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 up to an 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 ceases to provide any group health plan to any of its employees.

- The date coverage would otherwise terminate under the Plan.

If Continuation Coverage ends prior to the 18-, 29- or 36-month Continuation Coverage period, the McKesson 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 your employer-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 your employer 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

CO-PAYMENTS AND DEDUCTIBLES

Before Medical Benefits are payable, each Covered Person must satisfy certain Co-payments and/or Deductibles.

A Co-payment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Co-payments are not counted toward any Deductible or Out-of-Pocket Maximums. Covered Services and Supplies which require a Co-payment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before Medical Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in the **Schedule of Benefits**.

The amount of each Deductible is shown in the **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Co-payment or Deductible.

PCP Office Visit Co-payment
The PCP Office Visit Co-payment applies to a Network Physician's Services given by a Covered Person's PCP. It applies to all Covered Services and Supplies given in connection with each office visit.

Specialist Care Office Visit Co-payment
The Specialist Care Office Visit Co-payment applies to services given by a Network Provider, other than a Covered Person's PCP. It applies to all Covered Services and Supplies given in connection with each office visit.

The Specialist Care Office Visit Co-payment only applies to the initial prenatal office visit to the Network obstetrician/gynecologist who is primarily responsible for maternity care.

Non-Network Individual Deductible
The Non-Network Individual Deductible applies to Covered Expenses charged by a Non-Network Provider. It applies each Calendar Year.

Non-Network Family Deductible
The most a family will have to pay for Non-Network Individual Deductibles in any Calendar Year, no matter how large a family may be, is the amount of the Non-Network Family Deductible. Only Covered Expenses which count toward the Covered Person's Non-Network Individual Deductible count toward this Deductible.

Non-Notification Penalty
The Non-Notification Penalty applies to Covered Expenses if the Utilization Review Manager is not notified as required. In addition, if the Utilization Review Manager is not notified as required, benefits will be paid at Non-Network levels.

The Utilization Review Manager for the CIGNA HealthCare Point of Service Medical Program is known as "the Utilization Review Organization."

OUT-OF-POCKET MAXIMUMS

Covered Expenses are payable at the percentage shown in the **Schedule of Benefits** until any Out-of-Pocket Maximum shown in the **Schedule of Benefits** has been reached during a Calendar

Year. Then, Covered Expenses are payable at 100% for the rest of that year as shown in the following sections.

Under the CIGNA HealthCare plan, Network Covered Expenses that the Covered Person pays, other than those shown in the following sections, apply toward the Network Out-of-Pocket. Non-Network Covered Expenses that the Covered Person pays, other than those shown in the following sections, apply toward both the Network and Non-Network Out-of-Pocket Maximums.

The following out-of-pocket costs do not count toward any of the POS Program Out-of-Pocket Maximums. These out-of-pocket costs still apply even after the applicable Out-of-Pocket Maximum has been reached:

- PCP Office Visit Co-payment;
- Specialist Care Office Visit Co-payment;
- Emergency Room Co-payment;
- Urgent Care Co-payment;
- Non-Network Deductible; and
- Non-Notification Penalty

Network Individual Out-of-Pocket Maximum
When the Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Network Covered Expenses, other than those out-of-pocket costs listed in Out-of-Pocket Maximums, are payable at 100% for that same person for the rest of that year.

Network Family Out-of-Pocket Maximum
When the Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a Calendar Year, Network Covered Expenses, other than those out-of-pocket costs listed in Out-of-Pocket Maximums, are payable at 100% for all Covered Family Members for the rest of that year.

Non-Network Individual Out-of-Pocket Maximum
When the Non-Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Non-Network Covered Expenses, other than those out-of-pocket costs listed in Out-of-Pocket Maximums, are payable at 100% for that same person for the rest of that year.

Non-Network Family Out-of-Pocket Maximum
When the Non-Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a Calendar Year, Non-Network Covered Expenses, other than those out-of-pocket costs listed in Out-of-Pocket Maximums, are payable at 100% for all Covered Family Members for the rest of that year.

Maximum Benefit
The Maximum Benefit payable for each Covered Person is shown in the **Schedule of Benefits**. This maximum applies to each Covered Person's lifetime.

COVERAGE UNDER THE POS PROGRAM

Primary Care Physician (PCP)

The POS Program pays for Covered Services and Supplies received from either Network or Non-Network Providers. See the **Schedule of Benefits** for the applicable coverage levels. You may choose a Network PCP to coordinate your care and treatment, but you're not required to do so. The Covered Person chooses a Primary Care Physician (PCP) from the list of Primary Care Physicians in the directory of Network Providers. A directory of the Network Providers who participate in the POS Program is provided automatically, free of charge, as a separate document. It may also be obtained at no charge from the McKesson Call Center or online at *www.mycigna.com.*

You can visit any Network or Non-Network Provider without a referral. Your costs are lower when you choose a Network Provider.

Emergency Care

Any Emergency Care is payable at the Network level as shown in the **Schedule of Benefits** regardless of whether the Covered Person receives services from a Network or Non-Network Provider. However, when the Emergency Care has ended, the Covered Person must obtain services from a Network Provider to be covered at the Network level. Otherwise, covered benefits are payable at the Non-Network level.

When Emergency Care is required and results in a confinement, the Covered Person (or that person's representative or Physician) must call the Utilization Review Manager within 48 hours of the date the confinement begins. A working day is a business day of the Claims Administrator. It does not include Saturday, Sunday or a State or Federal holiday. If it is not reasonably possible to call the Utilization Review Manager within 48 hours, the Utilization Review Manager must be notified as soon as reasonably possible.

Benefits are subject to the Non-Notification Penalty if the Utilization Review Manager is not called as shown above. The Non-Notification Penalty applies to each confinement.

Network Provider Charges Not Covered

A Network Provider contracts with the Claims Administrator to participate in the Network. Under the terms of this contract a Network Provider may not charge a Covered Person or the Claims Administrator for certain expenses, except as stated in the following section. A Network Provider cannot charge a covered person or the Claims Administrator for any services or supplies which are not Medically Necessary as determined by the Claims Administrator.

The Covered Person may agree with the Network Provider to pay any charges for services or supplies which are not Medically Necessary. In this case, the Network Provider may make charges to the Covered Person. However, these charges are not Covered Expenses under the POS Program and are not payable by the Claims Administrator.

Non-Network Benefits

The POS Program pays Covered Services and Supplies at the Non-Network level, as shown in **Schedule of Benefits**, if a Covered Person receives services from a Non-Network Provider.

The POS Program pays Mental Disorder Treatment and Substance Abuse Treatment at the Non-Network level if the Covered Person does not get a referral from the Utilization Review Manager before receiving services. In addition, a Non-Notification Penalty will apply if the Utilization Review Manager is not called before Non-Network services are received.

The amount of the Non-Notification Penalty is shown in the **Schedule of Benefits**. The amount of the Non-Notification Penalty will never be more than the amount of the Covered Expenses.

See **Co-payments and Deductibles** for a complete description of the deductibles that apply to Non-Network Benefits.

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness or injury. Covered Services and Supplies must be provided:

- When the POS Program and Prescription Drug Program is in effect;
- Prior to the date that any of the individual termination conditions set forth in this Summary Plan Description become effective; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan, the POS Program and Prescription Drug Program as applicable.

A Covered Service or Supply must meet each of the following criteria:

- It is supported by national medical standards of practice;
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes that are based on trials that meet the following designs:
  - — Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - — Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives; and

- It is a health service or supply that is described in this section, and which is not excluded under **General Exclusions and Limitations**.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

UTILIZATION REVIEW

There are three Utilization Review processes under the POS Program. The type of Utilization Review process depends upon what type of medical care a Covered Person needs and what type of provider he or she uses. The Utilization Review processes consist of the following:

- Primary Care Physician (PCP) - Network Benefits;

- Mental Disorder Treatment and Substance Abuse Treatment, conducted by CIGNA Behavioral Health Care Management; and

- Services Subject to Prior Approval conducted by CIGNA HealthCare's Utilization Review Organization.

The Utilization Review processes are designed to encourage an efficient system of care for Employees and Employees' enrolled Dependents by identifying and addressing possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Utilization Review activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care Employees or their Dependents actually receive must be made by the Employee and his or her Physician.

The Utilization Review process is triggered when the Utilization Review Manager of CIGNA HealthCare receives notification of an upcoming treatment or service. The notification process serves as a gateway to Utilization Review activities and is an opportunity for the Employee to let CIGNA HealthCare know that they are planning to receive specific health care services.

Reduction of Benefits

Benefits under the POS Program are reduced as follows if the Covered Person does not get a referral from the Utilization Review Manager before services are given:

- All benefits are payable at the Non-Network level. Please note that if the Claims Administrator determines that the services received are not Medically Necessary, no benefits will be payable;

- Benefits are subject to the Non-Notification Penalty if the Utilization Review Manager is not called before Non-Network inpatient services are received; and

- Benefits are also subject to the Non-Notification Penalty if the CIGNA HealthCare Utilization Review Manager is not called before selected Non-Network outpatient diagnostic testing and

outpatient procedures are received. Examples of diagnostic testing and outpatient procedures include but are not limited to advanced radiological imaging (CT Scans, MRI, MRA or PET Scans), hysterectomy, and outpatient facility services.

The amount of the Non-Notification Penalty is shown in the **Schedule of Benefits**. The amount of the Non-Notification Penalty will never be more than the amount of the Covered Expenses.

Primary Care Physician (PCP) — Network Benefits

If a Covered Person elects a Primary Care Physician (PCP), the PCP will coordinate the Covered Person's medical care. Either the PCP or Covered Person may start the Utilization Review process for all medical care other than Mental Disorder Treatment and Substance Abuse Treatment.

The POS Program pays Covered Services and Supplies at the Network level, as shown in the **Schedule of Benefits**, if the Covered Person receives the care from a Network Provider.

Benefits under the POS Program are reduced and payable at the Non-Network level if a Covered Person receives Covered Services and Supplies from a Non-Network Provider.

Services for Emergency Care given by a Non-Network Provider is payable at the Network level as shown in the **Schedule of Benefits**. When the Emergency Care has ended, however, your PCP or the Utilization Review Manager, as appropriate, must be called before any additional services that require notification are received. See **Emergency Care Services** in the **Coverage Under the POS Program** section.

Mental Disorder Treatment and Substance Abuse Treatment

The Covered Person must call the Utilization Review Manager before Covered Services and Supplies are given for Mental Disorder Treatment or Substance Abuse Treatment. This call starts the Utilization Review process. The POS Program pays Mental Disorder Treatment and Substance Abuse Treatment at the Network level, as shown in the **Schedule of Benefits**, if the Covered Person receives a referral from the Utilization Review Manager before care is given.

The Utilization Review Manager can be contacted by calling the toll-free number shown on your CIGNA HealthCare ID card.

The Utilization Review Manager performs a Utilization Review to determine the Medical Necessity of Covered Services and Supplies. No benefits are payable unless the Utilization Review Manager determines the Covered Services and Supplies are Medically Necessary.

Emergency Care for Mental Disorder Treatment or Substance Abuse Treatment does not require prior approval by the Utilization Review Manager. When the Emergency Care has ended, however, the Utilization Review Manager must be called within 48 hours after receiving Emergency Care. If it is not reasonably possible to make this call within 48 hours, the call must be made as soon as reasonably possible. See **Emergency Care** in the **Coverage Under the POS Program** section.

Services Subject to Prior Approval

The Covered Person must notify and obtain approval from the Utilization Review Manager prior to receiving any of the services listed in the following list. The Utilization Review Manager determines whether the services or supplies are Covered Services and Supplies . No benefits are payable unless the Utilization Review Manager determines the services and supplies are covered under the POS Program.

The services requiring notification in advance of the receipt of treatment or services include:

- Hospital confinement;
- Skilled Nursing Facility confinement;
- Home Health Care;
- Private duty nursing; and
- Organ/Tissue Transplants.

CIGNA HealthCare also requires prior authorization for selected outpatient procedures and diagnostic testing including but not limited to advanced radiological imaging (CT, PET Scans, MRI/MRA), outpatient facility services, non-emergency ambulance, and residential treatment.

Notifying the Utilization Review Manager

How to Notify the Utilization Review Manager

The Utilization Review Manager is notified by calling the toll-free number shown on your CIGNA HealthCare ID card.

When to Notify Utilization Review Manager

- For inpatient confinement, the Covered Person must notify the Utilization Review Manager of the scheduled admission date at least 48 hours before the start of the confinement. An admission date may not have been set when the confinement was planned. The Covered Person must call the Utilization Review Manager again as soon as the admission date is set.
- Pregnancy is subject to the following notification time periods:
  - Prenatal Programs – the Utilization Review Manager should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in the prenatal program.
  - Inpatient Confinement for Delivery of Child – the Utilization Review Manager must be notified only if the inpatient care for the mother or child is expected to continue beyond:
    - 48 hours following a normal vaginal delivery.
    - 96 hours following a cesarean section.

For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits stated above, the Utilization Review Manager must be notified before the end of these time periods.

— Non-Emergency Inpatient Confinement Without Delivery of Child – Confinement during pregnancy but before the admission for delivery, which is not Emergency Care, requires notification as a scheduled confinement. The Utilization Review Manager must be notified prior to the scheduled admission.

- Organ/Tissue Transplants:

— Special programs may apply to organ/tissue transplants at a designated transplant facility. The Covered Person should notify the Utilization Review Manager as soon as possible to begin the case management process for organ/tissue transplants.

- Outpatient Procedures and Diagnostic Testing: The Covered Person (or that person's representative or Physician) should call the toll-free number on the back of your I.D. card to determine if outpatient certification is required prior to any outpatient procedure or diagnostic testing. Outpatient certification should only be requested for non-emergency procedures or services, and it should be requested at least 4 days (Monday-Friday) prior to having the procedure or the service rendered.

The Utilization Review Manager will then complete a review. The Covered Person, the Physician and the facility will be sent a letter confirming the results of the review.

BENEFITS COVERED UNDER THE POS PROGRAM

Preventive Health Care Benefits

Benefits are payable for Covered Services and Supplies for Preventive Health Care Benefits given to a Covered Person by that person's Primary Care Physician (PCP) or Network Provider while the person is covered under this Plan. No benefits are payable for Non-Network benefits.

The PCP Office Visit Co-payment shown in Co-payments and Deductibles applies to the Covered Services and Supplies on the same basis as it applies to Sickness.

Benefits are payable at 100% of Covered Expenses after the Co-payment has been paid.

Covered Services and Supplies

- Routine physical exam for covered Employees and Dependent Spouses or Domestic Partners, including appropriate laboratory work. Limited to one exam per Calendar Year.

- Child preventive care services given in connection with routine pediatric care, including PKU tests and immunizations.

- Routine well-woman exams (limited to one exam per Calendar Year). A well-woman exam includes the following:

— Breast examination and/or mammogram (beginning at age 40).

— Pelvic examination.

— Pap smear.

- Routine well-man exams (limited to one exam per Calendar Year). A well-man exam includes one PSA test per Calendar Year for individuals over age 40.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Pregnancy Benefits

Benefits are payable for Covered Services and Supplies for pregnancy given to the Covered Person while covered under this Plan.

Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; or

- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The hospital or other provider is not required to get authorization from the Claims Administrator for the time periods stated above. Authorizations are required for longer lengths of stay.

Federal law does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable).

Additional Covered Services and Supplies specific to pregnancy are listed in the following section. These Additional Covered Services and Supplies are subject to the same requirements described in Covered Services and Supplies.

Additional Covered Services and Supplies

- Birth Center Services:

— Room and Board.

— Other Services and Supplies.

— Anesthetics.

— Nurse-Midwife's Services.

- Services of a licensed or certified Nurse-Midwife.

- Routine Well-Baby Care (during newborn's initial hospital confinement). The following services and supplies given during a newborn child's initial Hospital confinement:

  — Hospital services for nursery care.

  — Other Services and Supplies given by the Hospital.

  — Services of a surgeon for circumcision.

  — Physician Services.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Infertility Treatment

Benefits are payable for Covered Expenses for infertility treatment incurred by the Covered Person while covered under the POS Program.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for the Covered Services and Supplies listed in this Benefit. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

These Infertility Benefits are subject to the same co-payments, deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness.

Benefits are limited to a Lifetime Maximum Benefit of $10,000.

Covered Services and Supplies

- Artificial Insemination.

- Assisted Reproductive Technology, including:

  — In vitro fertilization services.

  — Gamete intrafallopian transfer (GIFT).

  — Zygote intrafallopian transfer (ZIFT).

- Reversal of vasectomies or tubal ligations and injectable fertility drugs.

Some restrictions with respect to infertility treatment plan and frequency limits apply. Contact CIGNA HealthCare for specific details on covered services for infertility treatment.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Mental Health Benefits and Substance Abuse Benefits

Benefits are payable for Covered Services and Supplies for Mental Disorder Treatment and Substance Abuse Treatment given to the Covered Person while covered under the POS Program.

These Mental Health and Substance Abuse Benefits are subject to the same Co-payments, Deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness, except as shown in the following.

Mental Health and Substance Abuse Benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family and group psychotherapy;
- Psychological education; and
- Psychological testing.

Covered Services and Supplies for Mental Disorder and Substance Abuse Treatment are subject to the following limitations:

Maximum Mental Health and/or Substance Abuse Benefits	
Calendar Year Mental Health and/or Substance Abuse: Inpatient	30 days
Calendar Year Mental Health and/or Substance Abuse: Outpatient	26 visits
Lifetime Maximum Substance Abuse Only: Inpatient and Outpatient	60 days or 60 visits

Additional Covered Services and Supplies specific to Mental Disorder Treatment and Substance Abuse Treatment are listed in the following section. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in Medical Benefits.

Additional Covered Services and Supplies

- Licensed Provider:
  - — Services of a licensed provider acting within the scope of his or her license for Mental Disorder or Substance Abuse Treatment.

- Treatment Center Services:

  — Room and Board.

  — Other Services and Supplies.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Other Medical Benefits

Acupuncture

Treatment by a Physician or licensed acupuncturist for anesthesia, injury or disease, or to alleviate chronic pain, as Medically Necessary. Covered Services are limited to 35 visits per Calendar Year.

Anesthetics

Chemotherapy

Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- The cancer clinical trial is listed on the NIH web site *www.clinicaltrials.gov* as being sponsored by the federal government;

- The trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease, (2) cannot tolerate standard therapies for the disease, or (3) no effective nonexperimental treatment for the disease exists;

- The person meets all inclusion criteria for the clinical trial and is not treated "off-protocol;"

- The trial is approved by the Institutional Review Board of the institution administering the treatment; and

- Coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- The investigational service or supply itself;

- Services or supplies listed herein as exclusions;

- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs); and

- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Durable Medical Equipment
Durable medical equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item;
- It is used primarily for a medical purpose; and
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

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

The Claims Administrator decides whether to cover the purchase or rental of the equipment.

Emergency Care
Care for emergency services are Covered Services if they meet the definition of "Emergency Care" (See the **Glossary** for the definition of Emergency Care).

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

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

- A person has symptoms or signs of a genetically-linked inheritable disease;

- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer is covered when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and post-genetic testing.

Home Health Care
The following Covered Services must be given by a Home Health Care Agency:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.);

- Temporary or part-time care by a home health aide;

- Physical therapy;

- Occupational therapy; or

- Speech Therapy.

Covered Services are limited to 100 days each Calendar Year. The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g., maximum of 8 visits per day).

Limitations to Home Health Care expenses – the following are not covered charges for Home Health Care:

- Services or supplies that are not part of the home health care plan;

- Services of a person who usually lives with you or who is a member of your or your spouse's or Domestic Partner's family;

- Services of a social worker; and

- Transportation.

Hospice Care
- Room and Board.

- Other Services and Supplies.

- Part-time nursing care by or supervised by a registered graduate nurse (R.N.).

- Home Health Care Services as shown under Home Health Care. The limit on the number of visits shown under Home Health Care does not apply to Hospice patients.

- Counseling for the patient and Covered Family Members.

- Bereavement counseling for Covered Family Members. Services must be given within 12 months of the date the patient has been certified as terminally ill with six months or less to live. Covered Services are limited to a total of 12 visits for each family. If you receive POS Program hospice care benefits, bereavement counseling must be provided by a licensed practitioner practicing within the scope of his or her license. Contact CIGNA HealthCare for further details regarding this benefit.

Services for the patient must be given in an inpatient Hospice facility or in the patient's home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment, provided the service is billed by the hospice care agency.

Hospital Services
- Room and Board. Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.

- Other Services and Supplies.

- Emergency Room.

Emergency room services are Covered Services only if it is determined that the services are for Emergency Care as defined in the **Glossary**.

Internal Prosthetic/Medical Appliances
Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Laboratory Tests and X-rays
X-rays or tests for diagnosis or treatment.

Medical Supplies
- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.

- Blood or blood derivatives only if not donated or replaced.

Medical Transportation Services

- Transportation by professional ambulance, other than air ambulance, to and from a medical facility.

- Transportation by air ambulance to the nearest medical facility qualified to give the required treatment.

Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

Nutritional Evaluation

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

Organ/Tissue Transplants

The Utilization Review Manager must be notified prior to the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation;

- The donor search;

- The organ procurement/tissue harvest; or

- The transplant procedure.

Special programs and provisions may apply to qualified procedures for organ/tissue transplants at a designated transplant facility, including medical care and treatment, and transportation and lodging. The Covered Person must call the Utilization Review Manager to begin the case management process.

Outpatient Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician; and

- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

Outpatient Physical Therapy

Services of a licensed physical therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician; and

- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

Physician Services
- Medical Care and Treatment.

- Hospital, office and home visits.

- Emergency room services.

Surgery
Services for surgical procedures.

- Reconstructive Surgery:

  — Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:

    – Birth defect.

    – Sickness.

    – Surgery to treat a Sickness or Accidental Injury.

    – Accidental Injury.

  — Reconstructive breast surgery following a Medically Necessary mastectomy.

  — Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or Accidental Injury.

- Assistant Surgeon Services. Covered Expenses for such services are limited to 1/5 of the amount of Covered Expenses for the surgeon's charge. An assistant surgeon must be a Physician.

- Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

  — Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.

Prescribed Drugs and Medicines
Prescribed drugs and medicines for inpatient services are covered by CIGNA HealthCare; outpatient prescription drugs are covered by Caremark.

Private Duty Nursing Care
Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

Psychologist Services

Radiation Therapy

Rehabilitation Therapy
- Inpatient:

  — Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.

  — Inpatient rehabilitative therapy is a Covered Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

- Outpatient Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF).

Skilled Nursing Facility Services
- Room and Board. Covered Expenses for Room and Board are limited to the facility's regular daily charge for a semi-private room.

- Other Services and Supplies.

Covered Services are limited to the first 100 days of confinement each Calendar Year.

Speech Therapy
Services of a licensed speech therapist. These services must be given to restore speech lost or impaired due to sickness, or to surgery on account of Sickness or injury. If the loss or impairment is due to a congenital anomaly, surgery to correct such anomaly must have been performed prior to the therapy.

Spinal Manipulations
- Services provided for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

- Services for spinal care caused by nerve damage.

Covered Services are limited to 35 visits each Calendar Year.

No benefits are payable for treatment of scoliosis.

Special Rights Upon Childbirth
Newborns' And Mothers' Health Protection Act Of 1996
Group plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer from prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Rights Following Mastectomies
Women's Health and Cancer Rights Act
Under Federal law, group plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient.

PRESCRIPTION DRUG PROGRAM

Inpatient drugs are covered on the same basis as other hospital expenses through CIGNA HealthCare under the POS Program. Outpatient drug coverage is provided through Caremark under the Prescription Drug Program. The Prescription Drug Program pays a percentage of covered charges, depending on where you have your prescription filled and whether the drug is a generic, preferred or non-preferred brand. When you use a pharmacy which is a member of the McKesson Pharmacy Provider Network (MPPN) you will receive the highest benefit. When you use a pharmacy which is not a member of the MPPN but participates in the Caremark Network, the Plan pays a lower benefit. Prescriptions filled at other pharmacies are not covered.

A list of pharmacies participating in the MPPN and the Caremark Network is provided automatically, free of charge, as a separate document.

Eligible Expenses

Eligible expenses include covered charges for:

- Legend drugs which may be dispensed only with a written prescription from a physician; and
- Insulin, needles and syringes for insulin, and diabetic test supplies when prescribed by a physician.

The Prescription Drug Program only covers those charges which Caremark determines to be eligible expenses, as described above. A list of Caremark's Formulary listing is available upon request by calling Caremark Customer Service at 1-800-378-0822 or accessing *www.caremark.com*. As new drugs become available, Caremark's panel of experts will consider the latest information available about the drug's effectiveness and decide whether to add the drug to Caremark's formulary.

Dispensing Limitations

The usual maximum quantity for each prescription or refill is the amount prescribed by your physician, but no more than a 34-day supply, or a 90-day supply for maintenance drugs.

Not all maintenance drugs qualify under the Caremark Mail Order program. Ask your pharmacist if your drug qualifies when you present your initial prescription.

Mail Order

You may also fill maintenance drug prescriptions through the Caremark Mail Order program. Your mail order Co-payment for a 90-day supply is $20 for generic drugs, $35 for formulary brand drugs and $50 for non-formulary brand drugs.

To receive the maximum benefit under the Caremark Mail Order program, you should remind your doctor to write a "90-day supply plus refills" prescription on your maintenance drug prescriptions, when clinically appropriate. Caremark will fill your prescription for the exact quantity of medication that your doctor prescribes, up to the limits described above.

Coinsurance

	MPPN Pharmacy in the Caremark Network	**Non-MPPN Pharmacy in the Caremark Network**
You Pay*	10% – Generic Drugs 20% – Preferred Brand on Formulary/Primary Drug List 40% – Non-Preferred Brand Drugs	20% – Generic Drugs 30% – Preferred Brand on Formulary/Primary Drug List 50% – Non-Preferred Brand Drugs
Deductible	$50 per person $150 per family	
Maximum Allowable Benefit	$10,000 lifetime maximum on Infertility Treatment (part of the lifetime infertility maximum as shown in the **Schedule of Benefits**)	
Annual Out-of-Pocket Maximum	$500 per person	
Day Supply Limit	34-day supply Up to a 90-day supply for certain maintenance drugs**	
Caremark Customer Service	1-800-378-0822 or *www.caremark.com*	

*When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than physician indicates "dispense as written," you will pay the difference between the brand name drug and the generic plus the generic Co-payment.

*Maintenance drugs may also be purchased through Caremark's Mail Order program. The cost per prescription through mail order is $20 for generic drugs; $35 for preferred brand drugs; and $50 for non-preferred brand drugs.

Rx Out-of-Pocket Maximum

When a members's coinsurance for prescription drugs under the Caremark program total $500 in a Calendar Year, the Prescription Drug Program will pay 100% of that individual's eligible prescription expenses for the remainder of the same Calendar Year. Amounts in excess of the maximum allowable charge, as determined by Caremark, do not count toward the out-of-pocket maximum.

Prescription Drug Program Exclusions

Notwithstanding any provision in this SPD to the contrary, the following expenses are excluded from coverage under the Prescription Drug Program:

- Drugs which may properly be received without charge under local, state or federal programs;
- Drugs prescribed in connection with any sickness or injury arising out of, or in the course of, any employment for wage or profit, and drugs prescribed in connection with a disease covered by any worker's compensation law, occupational disease law or similar legislation;
- Drugs labeled: "Caution limited by Federal law to investigational use" or experimental drugs as determined by Caremark;
- Drugs furnished by a Hospital, rest home, sanitarium, extended care facility or convalescent nursing home in which the participant is confined as a bed patient;
- Refilling of a prescription in excess of the number specified by the Physician, or a refill dispensed one year or more after the date of the Physician's original order;
- Drugs not reasonably necessary for the patient's medical care;
- Therapeutic devices or appliances and other non-medicinal substances, regardless of intended use;
- Immunization agents, biological sera blood, or blood plasma;
- Non-legend drugs other than insulin;
- Administering or injecting any drug; and
- Prescription drugs or supplies not provided by an MPPN pharmacy, Caremark pharmacy or the Caremark Mail Order program.

Refer to your Caremark booklet for information about the Prescription Drug Program.

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan does not cover all expenses. A list of general exclusions is shown in the following list. In addition to these exclusions, the Plan limits eligible expenses to charges for services which are provided by licensed medical practitioners and Medically Necessary for the treatment of a covered illness or injury. Other exclusions may apply, and all benefits are subject to the terms and conditions of the Plan, as set out in the Plan Document. Eligible expenses for preventive care under the POS Program are limited to Network services.

The POS Program does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, or implants;
- Charges for treatment or drugs determined by the Claims Administrator not to meet the definition of Covered Services and Supplies;
- Cosmetic or reconstructive surgery or treatment (This is surgery or treatment primarily to change appearance.) It does not matter whether or not it is for psychological or emotional reasons. See **Medical Benefits** (**Covered Services and Supplies, Physician Services**) for limited coverage for reconstructive surgery;
- Custodial care;
- Education or training;
- Expenses and associated expenses incurred for services and supplies for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for services which are otherwise Experimental, Investigational, or Unproven that are deemed to be in the Claims Administrator's judgment, covered services;
- Expenses in excess of the reasonable charge as determined by the Claims Administrator;
- Expenses for outpatient prescriptions filled by a pharmacy which does not participate in the MPPN or the Caremark Network;
- Eye examinations, eyeglasses, contact lenses, or surgical correction of vision;
- Hearing exams, hearing aids, or the fitting of hearing aids;
- Herbal medicine or homeopathic care, including drugs;
- Illness or injury due to war, whether declared or undeclared, or international armed conflict;
- Liposuction;

- Maintenance care;
- Membership costs for health clubs, weight loss clinics and similar programs;
- Nutritional counseling, except when it is prescribed by a physician and furnished by a provider recognized under the POS Program;
- Orthoptic training (eye muscle exercises);
- Services and supplies for which the Covered Person is not legally required to pay;
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery;
- Services or drugs provided by a U.S. government hospital or facility or governmental program, unless those expenses are recoverable pursuant to Federal law for services rendered in a V.A. hospital;
- Gender transformation surgery or treatment;
- Special foods, food supplements, liquid diets, diet plans or any related products;
- Telephone/Internet consultations;
- Treatment for which no payment would have been made in the absence of coverage under the POS Program;
- Treatment or drugs provided in connection with an injury or illness which is in any way connected with the covered person's occupation;
- Treatment provided by an immediate family member. An immediate family member is defined as the Spouse, Domestic Partner, parent, child, or sibling of the patient or the patient's spouse or domestic partner;
- Charges for or in connection with an intentionally self-inflicted injury which is not inflicted as a result of a medical condition, including physical and mental health conditions;
- Treatment, other than surgery, of temporomandibular joint disorders;
- Treatment for weight reduction or control (unless there is a diagnosis of morbid obesity with a BMI greater than 35);
- Rhinoplasty, blepharoplasty, orthognathic surgeries, dance therapy, movement therapy, applied kinesiology, rolfing, or extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions;

- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease;

- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books;

- Unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations;

- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan;

- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation;

- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an injury or Sickness; or

- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

CLAIMS INFORMATION

Benefits are payable for Covered Expenses that are incurred by the Covered Person while covered under the POS Program and Prescription Drug Program.

Covered Expenses include charges for medical services which are covered under the POS Program, provided by licensed medical practitioners, and determined by the Claims Administrator to be Medically Necessary for treatment of a covered illness or injury and prescription drugs which are covered under the Prescription Drug Program. The Claims Administrator, in its discretion and as applicable, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural Terminology; or

- The methodologies as reported by generally recognized professionals or publications.

A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

Ineligible expenses include charges for Non-Network services which are in excess of the amount the Claims Administrator determines as the reasonable charge for the service provided.

Each Covered Person must satisfy certain Co-payments and/or Deductibles before any payment is made for certain Covered Services and Supplies. The POS Program and/or the Prescription Drug Program pay the percentage of Covered Expenses shown in the **Schedule of Benefits**.

There is a Lifetime Maximum shown in the **Schedule of Benefits**.

Claims Administrators

The claims administrators for the POS Program and Prescription Drug Program described in this SPD are:

Point of Service Program
CIGNA HealthCare
P.O. Box 5200
Scranton, PA 18505-5200

Prescription Drug Program
Caremark
P.O. Box 686005
San Antonio, TX 78268-6005

CIGNA HealthCare is the named fiduciary for purposes of claims and appeals under the POS Program. Caremark is the named fiduciary for purposes of claims and appeals regarding outpatient prescription drug benefits. The Claims Administrators are responsible for decisions regarding the certification of health care services, claim payment, interpretation of the applicable POS Program or Prescription Drug Program provisions, benefit determinations, and eligibility for benefits.

Filing Claims

Network Medical Charges

When you use Network services, the Network Providers are responsible for filing claims with CIGNA HealthCare. If you receive any bill for Network services which requires payment of more than your normal Co-payment or coinsurance amount, contact CIGNA HealthCare Customer Service at 1-800-244-6224 (1-800-CIGNA-24). You may also write to CIGNA HealthCare at the above address.

Charges for Non-Network Medical Services and Prescription Drugs

Medical claims should be submitted to CIGNA HealthCare on a CIGNA HealthCare claim form. If you do not use your Caremark card when you are having a prescription filled, you should send your claim to Caremark using a Caremark direct reimbursement claim form.

All claims must be accompanied by an itemized statement of charges from the provider of services. You must submit claims as soon as possible, but no later than 12 months after the date of the service. No benefits will be paid if you do not file within this time.

Claim forms are available from the Claims Administrator or McKNet, McKesson's Intranet.

In cases of questionable claims, the Claims Administrator may request an independent medical examination.

Claims for Medical and Prescription Drug Services
If you have a claim for medical or prescription drug benefits, you or your authorized representative should contact the applicable Claims Administrator immediately to obtain the necessary forms on which to submit your claim. An "authorized representative" is a person you have authorized, in writing, to act on your behalf. An individual will also be recognized as your authorized representative if a court order gives such individual authority to submit claims on your behalf. In the case of Urgent Care Claims, a health care professional with knowledge of your condition may always act as your authorized representative. (Hereinafter, all references to "you" in this section **Claims Information** include "authorized representative".)

Claims for medical and prescription drug benefits will be classified in one of the following four categories:

- Pre-Service Claim;
- Urgent Care Claim;
- Post-Service Claim; or
- Concurrent Care Claim.

Pre-Service Claim: A Pre-Service Claim is any claim for a POS Program or Prescription Drug Program benefit with respect to which the terms of the POS Program or Prescription Drug Program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care, service, treatment, supply or prescription drug. Consequently, any benefit which requires prior authorization or approval from your PCP, the Utilization Review Manager or Caremark is a Pre-Service Claim.

Urgent Care Claim: An Urgent Care Claim is any claim for a benefit for medical care or treatment with respect to which the applications of the time periods for making non-urgent care determinations either:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Post-Service Claim: A Post-Service Claim is any claim for a benefit that is neither a Pre-Service nor an Urgent Care Claim.

Concurrent Care Claim: A Concurrent Care Claim is any claim for a benefit regarding an on-going course of treatment that was previously approved by the POS Program or Prescription Drug Program for a specific period of time or number of treatments.

Time Limits for Processing Claims

The Claims Administrators will follow the time limits described in the following table in providing notices of their decisions, notices of extensions and notices of the need for additional information to you. The time limits which you are required to follow regarding the provision of additional information to complete your claim or to correct your claim are also described in the following table.

Type of Notice or Claim Event	Types of Claims		
	Urgent Care Claims	**Pre-Service Claims**	**Post-Service Claims**
Notice of failure to follow the proper procedure for filing a claim	**Not later than 24 hours** after receiving the improper claim.	**Not later than 5 days** after receiving the improper claim.	**Not later than 30 days** after receiving the improper claim.
Your deadline to provide additional information required by the Plan to decide your claim	**48 hours** after receiving notice that additional information is required.	**45 days** after receiving notice that additional information is required.	**45 days** after receiving notice that additional information is required.
Notice of initial claim decision	1. **Not later than 72 hours** after receipt of the initial claim if the claim was proper and complete. 2. Not later than 48 hours after receipt of the requested information or, within 48 hours after the expiration of the 48-hour claimant deadline, whichever is earlier if additional information is needed to decide your claim.	1. **Not later than 15 days** after receipt of the initial claim, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the POS Program or Prescription Drug Program. You will be notified within the initial 15 days if an extension is needed by the Claims Administrator. The notice shall state the reason for the extension and the date by which the Claims Administrator expects to render its decision. 2. Not later than 15 days after receipt of the additional information or, within 15 days after the expiration of the 45-day claimant deadline, whichever is earlier if additional information is needed to decide your claim. Notice of the need for additional information will be provided during the initial 15-day period.	1. **Not later than 30 days** after receipt of the initial claim, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the POS Program or Prescription Drug Program. You will be notified within the initial 15 days if an extension is needed by the Claims Administrator. The notice shall state the reason for the extension and the date by which the Claims Administrator expects to render its decision. 2. Not later than 15 days after receipt of the additional information or, within 15 days after the expiration of the 45-day claimant deadline, whichever is earlier if additional information is needed to decide your claim. Notice of the need for additional information will be provided during the initial 30-day period.

If you have a Concurrent Care Claim that is also an Urgent Care Claim to extend a previously approved ongoing course of treatment provided over a period of time or number of treatments, the Claims Administrator will make a determination as soon as possible, taking into account the medical exigencies, and notify you of the determination within twenty-four (24) hours after receipt of the claim, provided that the claim was made to the Claims Administrator at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your request for extended treatment is not made at least twenty-four (24) hours prior to the end of the prescribed period of time or number of treatments, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the claimant requests to extend treatment in a non-urgent circumstance, the claimant's request will be considered a new claim and decided according to the Post-Service Claim or Pre-Service Claim time limits, whichever applies.

If your Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by Plan amendment or termination) before the end of the period of time or number of treatments, you will be notified by the Claims Administrator sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit.

Notice and Payment of Claims
The Claims Administrators makes claim determinations on behalf of the Plan in accordance with the Plan. If the Claims Administrator approves your claim in whole or in part, your claim will be paid to you accordingly unless your claim has been properly assigned to your health care provider. If your claim is denied, the Claims Administrator will provide you with written notice of its decision and the procedure for filing an appeal.

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

- The reason(s) for the denial, including references to specific POS Program or Prescription Drug Program provision(s), as applicable, upon which the denial was based;

- The additional materials or information needed to support your claim and why such information or materials are necessary if the claim was denied because you did not furnish complete information or documentation;

- The appeals procedures and the time limits that apply to them; and

- Your right to bring a civil action under Section 502(a) of ERISA after completion of all levels of appeal required by the POS Program or Prescription Drug Program, as applicable.

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

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

If the notice of denial involves an Urgent Care Claim, the notice may be provided orally (a written or electronic confirmation will follow within three days).

Filing a First Appeal

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

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

Time Limits for Processing First Level Appeals

The time limits shown in the following table describe the time by which you are required to submit first level appeals to the applicable Claims Administrator and the time by which the Claims Administrators are required to provide you with notice of their determinations of first level appeals.

	Types of Claims		
Time Limits	**Urgent Care Claims**	**Pre-Service Claims**	**Post-Service Claims**
Your deadline to file a first appeal	**180 days** after receiving claim denial notice.	**180 days** after receiving claim denial notice.	**180 days** after receiving claim denial notice.
Plan notice of first appeal decision	**Not later than 72 hours** after receiving a first level appeal.	**Not later than 15 days** after receipt of a first level appeal	**Not later than 30 days** after receipt of a first level appeal

Procedure on Appeal
The review of your appeal will take into account all comments, documents, records, and other information submitted by you that relate to your claim. In addition, the decision maker on appeal will be different from the decision maker at the initial claim level, as will any health care professional who is consulted at the appeal level.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who was consulted in connection with any denial of the claim that is the subject of the appeal (nor the subordinate of such individual).

Upon request, the Claims Administrator will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the POS Program or Prescription Drug Program, as applicable, in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

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

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

- The reason(s) for the denial, including references to specific POS Program or Prescription Drug Program provisions, as applicable, upon which the denial was based;

- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits;

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

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

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

If the claim is denied based on a Medical Necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the POS Program or Prescription Drug Program, as applicable, to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

Filing a Second Level Appeal

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

You may submit written comments, documents, records, and other information relating to your claim that you did not submit with your previous appeal. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to your claim for benefits.

You are not entitled to a second appeal of an Urgent Care Claim under the Prescription Drug Program.

Time Limits for Processing Second Level Appeals

The time limits shown in the following table describe the time by which you are required to submit second level appeals to the applicable Claims Administrator and the time by which the Claims Administrators are required to provide you with notice of their determinations of second level appeals.

	Types of Claims		
Time Limits	**Urgent Care Claims**	**Pre-Service Claims**	**Post-Service Claims**
Your deadline to file a second appeal	**60 days** after receiving notice of denial on review	**60 days** after receiving notice of denial on review	**60 days** after receiving notice of denial on review
Notice of second appeal decision	**Not later than 36-72 hours** after receiving a second appeal	**Not later than 15 days** after receiving a second appeal	**Not later than 30 days** after receiving a second appeal

Procedure on a Second Appeal

The procedural steps that are applicable to first level appeals also apply to second level appeals. See the section **Procedure on Appeal**.

Notice of Determination on a Second Level Appeal

Within the time prescribed in the table above regarding second level appeals, the Claims Administrator will provide you with written notice of its decision. If the Claims Administrator determines that benefits should be paid, the Claims Administrator will take whatever action is necessary to pay them as soon as possible.

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

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

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

COORDINATION OF BENEFITS

Non-Duplication of Benefits
This provision applies when you or a Dependent is covered by another group medical or dental plan, or Medicare, in addition to a McKesson program. One plan pays first, and the other pays second.

In general, the following rules determine which plan pays first – the primary plan – and which pays second – the second plan. When the POS Program and/or Prescription Drug Program are secondary, benefits are coordinated so that the total benefits from all the plans are no more than the maximum allowed by the POS Program and Prescription Drug Program.

Order of Coverage—Employee and Spouse or Domestic Partner
- If one of the plans does not have a coordination of benefits provision, that plan will pay first.
- If you (or your Spouse or Domestic Partner) 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 or Domestic Partner 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 or Domestic Partner 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 and the plan of the non-custodial parent will be second.

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

  — The plan of the custodial parent will be primary.

  — The plan of the stepparent will be second.

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

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

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 POS Program and Prescription Drug Program will remain your primary plan and Medicare will be secondary. If you are a disabled Employee eligible for Medicare, Medicare will generally pay first.

Amount of Payment
When a McKesson program is the second plan, it will reimburse you only for the difference between what it would have paid if it were the primary payer and what the other plan actually paid.

When a McKesson program is the second payer, no benefit is paid unless the amount paid by the primary plan for total charges is less than the benefit that would have been payable by the McKesson program.

Right to Exchange Information
In order to coordinate benefit payments, the Claims Administrator needs certain information. It may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this.

A Covered Person must give the Claims Administrator the information it asks for about other plans. If the Covered Person cannot furnish all the information the Claims Administrator needs, the Claims Administrator has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Claims Administrator has the right to give that organization or person such information. Information can be given or obtained without the consent of any person.

FACILITY OF PAYMENT

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

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 POS Program or Prescription Drug Program provides a benefit for you or a covered Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested; or

- Reduce a future benefit payment for your or your Dependent by the amount of the overpayment.

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

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

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

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

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

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

- 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 point above.

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

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

GLOSSARY

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

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

Acupuncture
Treatment by a Physician for anesthesia, injury or disease, or to alleviate chronic pain, as Medically Necessary.

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

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

- It meets all of the following requirements:

  — It is operated and equipped in accordance with any applicable state law.

  — It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.

  — It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.

  — It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.).

— It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.

— It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.

— It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of this Plan.

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

Claims Administrator
CIGNA HealthCare for the POS Program and Caremark for the outpatient Prescription Drug Program.

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

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

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility; or

- It meets all of the following tests:

  — It provides at least the following comprehensive outpatient rehabilitation services:

    – Services of Physicians who are available at the facility on a full or part- time basis.

    – Physical therapy.

    – Social or psychological services.

  — It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time Physician.

  — It has a requirement that every patient must be under the care of a Physician.

— It is established and operated in accordance with the applicable licensing and other laws.

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

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

- Services related to watching or protecting a person;

- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and

- Services not required to be performed by trained or skilled medical or paramedical personnel.

Designated Transplant Facility
A facility designated by the Claims Administrator to render Medically Necessary Covered Services and Supplies for Qualified Procedures under this Plan.

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

Emergency Care
Treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy;

- Serious impairment to bodily function;

- Serious dysfunction of a body part or organ; or

- In the case of a pregnant woman, serious jeopardy to the health of the fetus

In addition, Emergency Care includes immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

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

- Is scheduled to work not less than 30 hours per week on a regular and continuous basis; provided, however, that this requirement will not apply to a group of Grandfathered MIS Employees who were working 20 hours but less than 30 hours per week and who were eligible for and enrolled in health care coverage under any other health plan sponsored by the Company as in effect on December 31, 1999;

- 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; and

- 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 or she is:

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

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

- Designated by the Company, its subsidiaries or 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.

Experimental, Investigational or Unproven Services
Contact CIGNA HealthCare directly for its definition of "Experimental or Investigational Services".

Home Health Care Agency
An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare;

- It is established and operated in accordance with the applicable licensing and other laws; or

- It meets all of the following tests:

  — It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.

  — It has a full-time administrator.

— It maintains written records of services provided to the patient.

— Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.

— Its employees are bonded and it maintains malpractice insurance.

Hospice
An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice;

- It is licensed in accordance with any applicable state laws; or

- It meets the following criteria:

  — It provides 24 hour-a-day, 7 day-a-week service.

  — It is under the direct supervision of a duly qualified Physician.

  — It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.

  — The main purpose of the agency is to provide Hospice services.

  — It has a full-time administrator.

  — It maintains written records of services given to the patient.

  — It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of this Plan.

Hospital
An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient’s expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;

- It is approved by Medicare as a Hospital; or

- It meets all of the following tests:

— It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.

— It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.

— It is operated continuously with organized facilities for operative surgery on the premises.

Medically Necessary or Medical Necessity
Medically Necessary Covered Services and Supplies are those determined by the medical director to be:

- Required to diagnose or treat an illness, injury, disease or its symptoms;
- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, Physician or other health care provider; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the medical director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

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

Mental Disorder Treatment
Mental Disorder Treatment is treatment for either of the following:

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

All inpatient services, including Room and Board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Network Provider
A provider which participates in the network.

Non-Network Hospital
A Hospital (as defined) which does not participate in the network.

Non-Network Pharmacy
A pharmacy other than a network pharmacy.

Non-Network Provider
A provider which does not participate in the network.

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

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

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

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

Occupational Disease or Injury
Occupational disease or injury that arises out of (or in the course of) any work for pay or profit.

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

Payroll
The system used by an entity to pay those individuals it regards as its common law Employees for their services and to withhold employment taxes from the compensation it pays such common law Employees. Payroll does not include any system an entity uses to pay individuals whom it does not regard as its common law Employees and for whom it does not actually withhold

employment taxes (including, but not limited to, individuals it regards as independent contractors) for their services.

Physician
A licensed practitioner of the healing arts who is acting within the scope of his/her license and is licensed to prescribe and administer drugs or to perform surgery.

Primary Care Physician (PCP)
A Physician in general practice or who specializes in pediatrics, family practice or internal medicine who has agreed with the Claims Administrator to act as the entry point to the health care delivery system and as the coordinator of member care. The Primary Care Physician is not an agent or employee of the Claims Administrator.

Psychologist
A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist; or

- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge
As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service;

- The range of services provided;

- The provider's usual charge for furnishing the service; and

- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

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

Room and Board
Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of

accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Sickness
Physical or mental illness, disease or pregnancy. The term "Sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled Nursing Facility
If the facility is approved by Medicare as a Skilled Nursing Facility, then it is covered by the POS Program.

If not approved by Medicare, the facility may be covered if it meets all of the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision;
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed Physician;
- It is authorized to administer medication to patients on the order of a licensed Physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of the POS Program.

Substance Abuse Services
Covered Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded from the Plan. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service under the POS Program.

Treatment Center
A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a Physician and the Claims Administrator;
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services:
  - — Room and Board (if this Plan provides inpatient benefits at a Treatment Center).
  - — Evaluation and diagnosis.
  - — Counseling.
  - — Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Utilization Review
A review and determination as to the Medical Necessity of services and supplies.

Utilization Review Manager
A program which performs a Utilization Review for the Claims Administrator. A Review Organization performs Utilization Review under the CIGNA HealthCare POS Medical Program.

YOUR RIGHTS AS A PLAN MEMBER

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

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

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

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the 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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest

office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADDITIONAL PLAN INFORMATION

Name of Plan
McKesson Corporation Health Plan

Type of Plan
The Plan is a group health plan which provides medical, dental, and vision benefits.

Plan Number
501

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

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

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

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

Claims Administrators

POS Program
CIGNA HealthCare
P.O. Box 5200
Scranton, PA 18505-5200
1-800-244-6224 (1-800-CIGNA-24)

Prescription Drug Program
Caremark
P.O. Box 686005
San Antonio, TX 78268-6005
1-800-378-0822

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 Sponsor has contracted with contract administrators to administer its component programs. CIGNA HealthCare provides administrative services with respect to the Medical Benefits furnished under the CIGNA HealthCare Point of Service Medical Program component of the POS Program pursuant to an administrative services only agreement. Caremark provides administrative services with respect to the prescription drug benefits furnished under the Prescription Drug Program pursuant to an administrative services only agreement.

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

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

Source of Contributions
The Plan is funded by Employee and Company contributions, which are deposited into a trust fund 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.

Service of Legal Process
Service of legal process should be directed to the Vice President, Compensation and Benefits of McKesson Corporation at One Post Street, San Francisco, CA 94104-5296.

Service of legal process may also be made to the Plan Trustee or Plan Administrator at the addresses above.

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

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