Employee Assistance Program (Resources for Living)

Summary Plan Description
Effective June 1, 2018
Introduction

The Employee Assistance Program (EAP) provides confidential counseling and worklife services to help employees manage everyday challenges, such as getting in control of finances, dealing with the loss of a loved one or coping with a rebellious teenager. This Summary Plan Description (SPD) summarizes benefits under the EAP, administered and insured by Resources for Living®.

We hope that the information provided in this SPD answers most of the questions you have regarding your benefits. When you need assistance or have specific questions, contact Resources for Living at 888.425.6174 or visit www.resourcesforliving.com (username: mckesson, password: eap).

Provisions of the EAP are summarized in this SPD. This description doesn’t state all plan terms and conditions. The information provided here doesn’t cover every situation and isn’t intended to replace the plan documents — or to change their meaning. In all cases, the plan documents — and not this summary — govern benefits paid under the plan.

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

The benefits described in this SPD apply to coverage in effect as of June 1, 2018.

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

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

McKesson intends that this EAP be exempt from health care reform requirements as an excepted benefit and that it not be considered a health plan for purposes of eligibility to contribute to a health savings account under Section 223 of the Internal Revenue Code. In that regard, the EAP shall not provide significant benefits in the nature of medical care. In addition, EAP benefits shall not be coordinated with benefits under any other McKesson group health plan as follows:

- A participant in a McKesson group health plan shall not be required to use and exhaust EAP benefits before he or she is eligible for benefits under the group health plan.
- Participant eligibility for benefits under the EAP is not dependent on participation in another McKesson group health plan.
- No employee premiums or contributions are required as a condition of participation in the EAP.
- There is no cost sharing under the EAP.

Any provision or benefit described in this SPD that conflicts with the foregoing requirements shall be deemed void and of no effect.
Although this summary plan description summarizes your coverage under the plan, the information provided doesn’t cover all of the plan’s terms and conditions. In all cases, the plan documents and applicable insurance contracts — and not this summary — govern benefits paid under the plan.
EAP Coverage

McKesson has contracted with Resources for Living to provide Employee Assistance Program (EAP) benefits. EAP benefits are available 24 hours a day, 7 days a week and may be accessed by calling Resources for Living at 888.425.6174 or visiting www.resourcesforliving.com (username: mckesson, password: eap). An EAP Specialist can help you identify the nature of your concerns and refer you to the right resources to address them. All services are confidential and are provided in accordance with federal and state law.

EAP benefits provide short-term, professional and confidential counseling services that are designed to help address the personal concerns and life issues you’re facing. The EAP provides you, your household members and your eligible dependents with access to services such as:

- Consultations with licensed behavioral health professionals
- 10 counseling sessions per issue, per calendar year at no charge
- Interactive web resources
- Worklife services in connection with child care, caregiver support, adoption and more
- Legal consultation with a licensed attorney and discounted legal services
- Financial services
- Identity theft services
- Educational kits for different topics
- Senior Care Manager services to assist with elder care
- Discounts on brand-name products and services

When you access free EAP services that have been approved in advance by Resources for Living, you don’t have to file any claims. Services that aren’t approved in advance or services that are given by an out-of-network provider aren’t covered.

Telephone Support Services

Unlimited telephone support services are available 24 hours a day, seven days a week. An EAP Specialist can address your concerns and may refer you to local resources in your community or other counselors that can help you deal with a variety of personal issues, such as the loss of a loved one or marital and family conflicts. Examples include:

- Depression, stress and anxiety
- Relationship difficulties
- Financial and legal advice
- Parenting and family problems
- Elder care services and support
- Domestic violence
- Substance abuse and recovery concerns
- Eating disorders

During your initial telephone call, the EAP Specialist makes an assessment of your needs — and may recommend short-term professional counseling.

In-Network Professional Counseling Services

Under the EAP, up to 10 free counseling sessions per issue, per calendar year are available to you, your household members and your eligible dependents. (For purposes of the EAP, an eligible dependent is any member of your household including dependent children up to age 26, whether or not they live at home.) These sessions with licensed counselors are available face to face, by phone or televideo. Resources for Living providers include licensed psychologists, social workers and marital family therapists who are trained to deal with a wide variety of personal and emotional concerns. Resources for Living referrals are treated with the highest degree of confidentiality consistent with applicable laws.

If a Resources for Living provider determines that a problem requires either more than 10 counseling sessions or another type of treatment, such as inpatient mental health treatment, you’re referred to an appropriate resource for treatment, such as your McKesson-sponsored medical plan or a community resource. Your Resources for Living provider will work with you to assist in the transition of care.

Call Resources for Living at 888.425.6174 whenever you need assistance. Let knowledgeable professionals help you with life’s challenges.

Visit www.resourcesforliving.com (username: mckesson, password: eap) for information on a variety of topics such as options for disabled dependents, adoption counseling, child care and summer camps, private school alternatives and more.

You’re responsible for any cost incurred for additional services that are beyond those available through the EAP.
**Worklife Balance Services**
- Consultation, information and assistance with locating resources such as:
  - Child care, parenting and adoption
  - Summer programs for kids
  - School and financial aid research
  - Elder care
  - Caregiver support
  - Special needs
  - Pet care
  - Home repair and improvement
  - Household services
- Care kits related to prenatal, child or adult care
- Senior Care Manager services (up to three free hours each calendar year) to help with evaluating and making decisions about your aging or disabled family member’s care. Senior Care Manager services also include in-home assessments, facility reviews, post-hospitalization assessments and ongoing care coordination.

**Financial Services**
Financial services include a half hour consultation on an unlimited number of new financial counseling topics each plan year. Topics include:
- Budgeting and planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax preparation*

Services must be for financial matters related to the employee and eligible household members.

* A 25% discount is available for tax preparation services.

**Legal Services**
Legal services include a half hour free consultation with a selected plan attorney for an unlimited number of new legal topics (each plan year). Topics include:
- General, family and criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

Legal counseling referral services aren’t available for third party consultations, medical malpractice or health insurance issue advice or assistance with employment law-related questions. Legal services aren’t available for disputes related to your/your dependent’s employment.

**Mediation Services**
Mediation services provide access to an in-network mediator to help resolve a dispute when it’s determined that mediation would be a good alternative to litigation. The initial office or telephone consultation (up to 30 minutes) is available at no charge for each separate dispute. Topics include:
- Child custody
- Child support
- Property disputes
- Landlord or tenant issues

Services must be related to the employee and eligible household members; employment law is excluded.
EAP Benefits

Elder Care Services
Resources for Living provides consultation and assistance with locating resources for elderly family members. In addition, Resources for Living offers enhanced elder care services.

Enhanced Elder Care/Senior Care Manager Services
Up to three (3) hours of in-person services per calendar year from highly qualified Senior Care Managers (SCM) who can provide personalized care plans for:

• **In-home assessments** — an SCM provides a thorough assessment of the care recipient’s home and activities of daily living and delivers a detailed care plan with recommended providers and resources.

• **Facility reviews** — an SCM visits and tours selected care facilities to evaluate and report on environment, care, staffing and overall level of quality.

• **Post-hospitalization assessments** — an SCM visits and helps evaluate the condition/needs of an adult who is returning home or to a facility after a hospital stay and recommends appropriate care.

Employees can also choose to use their three (3) hour benefit for ongoing care coordination by an SCM:

• **Ongoing care coordination** — an SCM provides a variety of services including coordinating medical services, paying bills, making appointments and setting up community services.

Online Services
Go to www.resourcesforliving.com, a customized website which offers a full range of interactive tools and resources on behavioral health and worklife balance topics. Most sections of the website are available in Spanish. Website links include:

• Articles and self-assessments

• Access to worklife service providers

• Stress Resource Center

• Live webinars and on-demand library

• Mobile app

• myStrength – a “health club” for your mind

• Discount Center with discounts on brand-name products and services, including computers and electronics, theme parks, movie tickets, local attractions, travel, gifts, apparel, flowers, jewelry and fitness centers

Any member of your household, including eligible dependents living away from home, may use the online services.

Other Services

**Identity theft services**

• One-hour phone consultation for fraud resolution

• Coaching for identity theft prevention and restoring credit

• Free identity theft emergency response kit if your identity is stolen
How to Access EAP Services

To access EAP services, call 888.425.6174 or visit www.resourcesforliving.com (username: mckesson, password: eap). The EAP is available 24 hours a day, seven days a week.

If the EAP Specialist who initially assesses your concern determines that counseling services are required, he/she refers you to a licensed practitioner in your area who’s experienced with helping people with concerns similar to yours. Preauthorization from the EAP Specialist is required to receive EAP benefits. Once you, your household member or your eligible dependent receives authorization, all services must be provided by a Resources for Living provider. The EAP Specialist can provide you with a list of Resources for Living providers or make an appointment for you.

The EAP Specialist accommodates your needs and preferences for a day or evening appointment, a male or female practitioner or a practitioner who speaks your language. If your situation is life-threatening, you should go to an emergency room or call 911.

If you’re referred to a practitioner and have difficulty scheduling an appointment with that person for any reason, call the EAP back. The EAP Specialist who answers your call will assist you in making an appointment.

If counseling beyond the authorized number is needed, Resources for Living will facilitate additional counseling sessions through your medical plan, when available.

• If you, your household member or eligible dependent are covered under a McKesson medical plan, additional care may be covered under that plan. Contact your medical plan carrier to find out if the Resources for Living in-network counselor also participates in your medical plan’s network.

• If you, your household member or your eligible dependent aren’t covered under a McKesson medical plan, counseling may be continued privately with the Resources for Living in-network provider on a fee-for-service basis. You’re responsible for paying the provider’s fees.

• You, your household member or your eligible dependent may be referred to other appropriate community resources. You’re responsible for paying any fees for their services.

In-Network Providers

Resources for Living has a nationwide provider network for your counseling sessions that is subject to the same credentialing standards applied to all participating Resources for Living network providers and includes psychologists, social workers and marriage and family therapists.

You can search for a provider listing via www.aetna.com. You can also call the EAP customer service toll-free number and request a listing of participating providers in your geographical area.

Services received from out-of-network providers aren’t covered under the EAP.
General Exclusions and Limitations

Exclusions and Limitations

The following services are outside the scope of the EAP:

- Counseling services beyond the allowed number of sessions covered by the EAP benefit
- Court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody or visitation evaluations, or paid for by Workers’ Compensation
- Formal psychological evaluations which normally involve psychological testing and result in a written report
- Diagnostic testing and/or treatment
- Psychiatrist visits, including medication management
- Prescription medications
- Services for remedial education
- Inpatient, residential treatment, partial hospitalizations, intensive outpatient
- Ongoing counseling for a chronic diagnosis that requires long-term care
- Biofeedback
- Hypnotherapy
- Aversion therapy
- Examination and diagnostic services required to meet employment, licensing, insurance coverage and travel needs
- Services with a non-contracted EAP provider
- Fitness for duty evaluations
- Legal representation in court, preparation of legal documents or advice in the areas of taxes, patents or immigration, except otherwise described in this document
- Investment advice (nor does the plan loan money or pay bills)
Claims Administrator

Resources for Living is the claims administrator and the named fiduciary for purposes of claims and appeals under the plan. The claims administrator is responsible for decisions regarding the certification of services, claim payment, interpretation of applicable plan provisions, benefit determination and eligibility for benefits.

Filing Claims

When you receive care from a Resources for Living in-network EAP provider, you will not have any claims to file. In-network providers are responsible for filing claims with Resources for Living. If you receive a bill for precertified in-network services that requires payment, contact Resources for Living immediately.

EAP services are available on an in-network basis only. Expenses for services received from out-of-network providers are not covered under the EAP.

Types of Claims

When a claim is received from your in-network provider, it is classified in one of the following four categories:

- **Pre-Service Claims** — any claim for a benefit for which the plan requires you to obtain approval in advance of receiving services or supplies. Therefore, any benefit that requires advance approval from the claims administrator is a pre-service claim.

- **Urgent Care Claims** — any claim for a benefit for care or treatment for which the application of the time periods for making non-urgent care determinations could, as determined by a physician with knowledge of your medical condition, either:
  - Seriously jeopardize your life or health or your ability to regain maximum function.
  - Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Post-Service Claims** — any claim for a benefit that is neither a pre-service nor an urgent care claim.

- **Concurrent Care Claims** — any claim for a benefit regarding an on-going course of treatment that was previously approved under the plan for a specific period of time or number of treatments.

Right to Appeal

You have the right to appeal any decision or action taken to deny, reduce, or terminate the provision of or payment for healthcare services covered by the plan or to retroactively terminate (“rescind”) your coverage. The plan provides an internal appeal process as summarized below. The claims administrator is the fiduciary with respect to claims and appeals determinations and has the full discretion and authority to determine entitlement to and the payment of plan benefits, including the right to construe and interpret the terms of the plan and the SPD, which may include other incorporated documents that govern the provision of benefits.

The claims administrator takes steps to avoid conflicts of interest in the appeals process and ensure independence and impartiality of the individuals making claims decisions.
Filing an Appeal

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

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

Time Limits for Appeal Processing
The following table summarizes time limits by which:

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

### Internal Appeal Time Limits

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Type of claim</th>
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<tbody>
<tr>
<td></td>
<td>Urgent Care</td>
</tr>
<tr>
<td>Your deadline for filing a first level appeal.</td>
<td>180 days after receipt of claim denial notice.</td>
</tr>
<tr>
<td>Claim administrator’s deadline for providing notice of first level appeal decision.</td>
<td>72 hours after receipt of appeal.</td>
</tr>
</tbody>
</table>

### Appeals Procedure
The review of your appeal will:

- Take into account all comments, documents, records, and other information submitted by you that relate to your claim.
- Be decided by a decision maker who is different from the decision maker at the initial claim level. This also applies to any healthcare professional who is consulted at the appeal level. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the claims administrator will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The healthcare professional consulted will not be the individual who was consulted in connection with any denial of the claim that is the subject of the appeal (nor his/her subordinate).

Upon request, the claims administrator will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, whether or not the advice was relied upon in making the benefit determination.

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

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

- The reasons for the denial, including references to any specific plan provisions on 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.
- Your right to bring an action under Section 502(a) of ERISA following an adverse benefit determination.
If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will:

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

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

**Right to File a Legal Action**

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

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

**Your Grievance and Appeals Rights**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice or assistance, call 888.425.6174 or the EAP at:

Employee Assistance Program 151 Farmington Ave, Appeals 1250 Hartford, CT 06156 Mail Code: RSAA.

**For California Members:** The California Department of Managed Health Care (the "Department") is responsible for regulating healthcare service plans such as the EAP. If you're a California member and have a grievance against the EAP, you should first call the EAP at (800.342.8111) and use EAP's grievance process (or locate the EAP's grievance form at www.resourcesforliving.com) before contacting the Department. Utilizing this grievance procedure doesn’t prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the EAP or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process provides an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (888.HMO.2219) and a TDD line (877.688.9891) for the hearing and speech impaired.

The Department’s internet website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions. The EAP’s grievance process and the Department’s complaint review process are in addition to any other dispute resolution procedures that may be available to you (including the claims procedure described on pp. 9-11) and your failure to use these processes doesn’t preclude your use of any other remedy provided by law.
Appendix A
Eligibility, Enrollment and Cost

Eligibility

Eligible Employees
You’re eligible for coverage under the EAP if you’re an employee on McKesson’s U.S. payroll.

<table>
<thead>
<tr>
<th>When You Become Eligible</th>
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</thead>
<tbody>
<tr>
<td>All U.S. McKesson employees</td>
</tr>
</tbody>
</table>

Eligible Dependents
Your eligible dependents include:

- Your spouse unless legally separated or divorced (including a common-law spouse if recognized in your state of residence) or your qualified domestic partner.

- Your child or your qualified domestic partner’s child from birth through age 26 (regardless of whether that child qualifies as your “dependent” for tax purposes).

- Any child age 26 or older, if the child is mentally or physically disabled and dependent on you for maintenance and support. The child’s disabling sickness or injury must have begun prior to age 26.

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

You may be required to provide periodic proof of relationship for eligible dependents and, for those children age 26 or older, you may also be required to provide periodic proof of disability and support.

Eligible Dependents Do Not Include
A spouse, domestic partner or child on active duty in any military, naval or air force of any country isn’t eligible.

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

Enrollment and Effective Date of Coverage
You were automatically enrolled for EAP benefits on the date you first became eligible. For purposes of dependent coverage under the plan:

- Initial dependents are those family members who are eligible dependents on the date you first became eligible for employee coverage. These dependents were automatically covered on the date you first became eligible.

- Subsequent dependents are any family members who become eligible dependents after the date you first became eligible under the plan. These dependents are automatically covered on the dates they become eligible.

Cost and Cost-Sharing
McKesson currently pays the full cost of benefits under the EAP. Employee contributions aren’t required and there’s no cost-sharing under the EAP.
Employees

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

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

Dependents

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

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

Coverage for an individual dependent ends on the earlier of:

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

Coverage for Incapacitated Children

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

• The child is incapacitated.
• The child isn’t capable of self-support.
• The child depends mainly on you for support.

You must provide Resources for Living with proof that the child meets these conditions when requested.

Coverage Continuation (COBRA)

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

Coverage may continue during a period in which you’re away from work on a Company-approved leave of absence.

When you need to take a leave of absence for any reason, contact the HR Support Center at 855.GO.MCKHR (855.466.2547). Press 2 for leave of absence questions. Benefit experts are available 7 a.m. - 6 p.m. Central time, M-F.

Coverage During Family Medical Leave Act (FMLA) Leaves

Coverage may be continued while you’re on an approved FMLA leave of absence to the extent required by applicable law.

Coverage During Non-Family Medical Leave Act (Non-FMLA) Leaves

Coverage may be continued for up to a maximum of six months, provided that you:

- Remain on an approved leave under the Company’s Non-FMLA Medical Leave Policy or another similar Company policy and
- Are receiving benefits under the McKesson Short Term Disability Plan or are in the process of receiving those benefits.

In addition, the Company may, in its discretion, extend continued coverage to employees whose coverage would otherwise end as a result of a leave of absence.

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

Coverage During Military Leaves

If you voluntarily or involuntarily serve in the uniformed services for a period of five years or less while covered under the plan, you, your household members and your covered dependents may elect to continue coverage for 24 months or for the period ending on the day after the date you fail to apply for or return to employment with the Company as determined under §4312(e) of the Uniformed Services Employment and Reemployment Rights Act (USERRA), whichever is earlier. The period of coverage will run concurrently with COBRA continuation coverage. Any election of COBRA continuation coverage will be treated as an election to continue coverage under USERRA. The payment procedures and deadlines that apply to COBRA continuation coverage also apply to USERRA continuation coverage. This provision applies if you’re:

- On active duty.
- On active duty for training.
- 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.
- Absent for the purpose of determining your fitness for duty in the uniformed services.

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

A covered person whose coverage would otherwise end under the plan may be entitled to elect continuation coverage in accordance with federal law under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

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

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

Eligibility

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Individuals Eligible for Continuation Coverage</th>
<th>Coverage Period from Date of Initial Qualifying Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment ends</td>
<td>Employee, spouse/domestic partner, children</td>
<td>18 months</td>
</tr>
<tr>
<td>Your hours of employment are reduced</td>
<td>Employee, spouse/domestic partner, children</td>
<td>18 months</td>
</tr>
<tr>
<td>You divorce or legally separate</td>
<td>Spouse, children</td>
<td>36 months</td>
</tr>
<tr>
<td>You terminate a domestic partnership</td>
<td>Domestic partner, children</td>
<td>36 months</td>
</tr>
<tr>
<td>Your child is no longer an eligible</td>
<td>Child losing coverage</td>
<td>36 months</td>
</tr>
<tr>
<td>dependent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You die</td>
<td>Spouse/domestic partner, children</td>
<td>36 months</td>
</tr>
</tbody>
</table>

Extension of Continuation Coverage

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

- **Disability.** If the qualifying event is the covered employee’s termination of employment or reduction of hours, qualified beneficiaries may obtain up to an 11-month extension of continuation coverage for a total continuation coverage period of up to 29 months if a qualified beneficiary has been determined by the Social Security Administration to have been disabled at any time during the first 60 days of continuation coverage. All other covered family members who are qualified beneficiaries as a result of the same qualifying event and who elect continuation coverage will also be entitled to the 11-month extension.

- **Extension of Continuation Coverage for Spouse/Domestic Partner and Dependent Children.** In certain circumstances, an 18- or 29-month continuation coverage period may be extended up to 36 months. These include:
  - Second Qualifying Event (employee’s death, divorce, legal separation, termination of domestic partnership or a covered child’s loss of eligible dependent status). If any of these events occur during the 18- or 29-month continuation coverage period, the period of continuation coverage for the spouse/domestic partner and dependent children may be extended for up to a total of 36 months measured from the date of the original qualifying event. A termination of employment following a reduction in hours of employment isn’t a second qualifying event.
  - Medicare Entitlement of Employee. If the employee became entitled to and enrolled in Medicare (under Part A, Part B or both) within 18 months prior to the employee’s termination of employment or reduction in hours of employment, the period of continuation coverage for the employee’s spouse/domestic partner and dependent children is 36 months from the date of the employee’s Medicare enrollment. For example, if the employee became enrolled in Medicare eight months prior to the qualifying event, the employee’s spouse/domestic partner and dependent children would be eligible for 28 months of continuation coverage (36 – 8 = 28).
Notification Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

McKesson Benefits Center
4 Overlook Point
PO BOX 1530
Lincolnshire, IL 60069-1530
Appendix C
Continuation Coverage (COBRA)

Notification Requirements, continued

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

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

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

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

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

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

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

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

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

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

Carefully Consider Your Election of Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law.

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

Keep the Plan Informed of Address Changes

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

For More Information

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

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

Send written correspondence to:

McKesson Benefits Center
4 Overlook Point
PO BOX 1530
Lincolnshire, IL 60069-1530

For more information about your rights under ERISA, including continuation coverage under COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 866.444.3272.
Plan Name
The McKesson Corporation Health and Welfare Wrap Plan and Employee Assistance Program Plan.

Plan Type
The plan is a group welfare plan that provides employee assistance benefits.

Plan Number
501

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

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

Plan
Copies of the plan document can be requested for a nominal fee by contacting:
McKesson Corporation
c/o Sr. Vice President, Compensation and Benefits
One Post Street
San Francisco, CA 94104-5296

There is a copying charge of $0.10 per page.

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

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

Employer Identification Number (EIN)
Plan Sponsor and Plan Administrator: 94-3207296

Insurance Company
This benefit is provided by Resources for Living.

Resources for Living
www.resourcesforliving.com
Username: mckesson
Password: eap

Benefits Administrator
McKesson Benefits Center
4 Overlook Point
PO BOX 1530
Lincolnshire, IL 60069-1530
855.GO.MCKHR (855.466.2547)
Press 1 for Health, Vitality and Pension questions.

Type of Administration
The Employee Assistance Program is fully insured. The plan sponsor has entered into an agreement with Resources for Living to provide Employee Assistance Program benefits under the plan. Claims for benefits are sent directly to Resources for Living, which is financially responsible for paying claims.

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 premiums paid by McKesson from McKesson’s general assets to Resources for Living.

Participating Employers
A participating employer is any corporation that is a subsidiary of or affiliated with McKesson Corporation, whose employees are authorized by McKesson 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 the EAP may be obtained on written request to the plan administrator.
Your Rights Under ERISA

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

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

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

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

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

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

**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, don’t receive them within 30 days and you have exhausted the plan’s claim and appeal procedures, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after you have exhausted the plan’s claim and appeal procedures. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money or if you’re 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’re successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
Appendix E
Your Rights Under the Plan

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

No Employment Contract
Nothing in the plan or this summary plan description gives any rights of continued employment to any employee or in any way prohibits changes in the terms and conditions of or the termination of, employment of any employee covered by the plan.

No Retroactive Termination of Coverage
Generally, coverage under the plan may not be terminated retroactively. However, coverage will be retroactively canceled or terminated (“rescinded”) if an enrollee acts fraudulently or intentionally makes any material misrepresentation of fact. Each enrollee is responsible for providing accurate and true information to the claims administrators and McKesson representatives. This includes, but isn’t limited to, providing accurate information about family status, place of residence, age, relationships and other information that is required to enroll in the plan and to receive benefits under the plan.

It’s each enrollee’s responsibility to notify the claims administrators and McKesson representatives immediately if any previously furnished information isn’t longer correct (e.g., if a spouse ceases to be eligible because of divorce or legal separation or if a child ceases to qualify as a dependent). Failure to do so will result in retroactive cancellation of coverage of the enrollee and his/her covered dependents. The enrollee will also be required to make the plan whole for any losses incurred on account of the fraud, misrepresentation or material omission. Coverage is also retroactively cancelled upon an enrollee’s failure to pay any required contributions, regardless of the reason for non-payment.

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

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

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

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

The plan’s privacy practices may be changed at any time at the plan administrator’s sole discretion. If any material revision is made to the plan’s Notice of Privacy Practices, the revised notice will be distributed in accordance with applicable law.
The following words and phrases when used in this summary plan description will have the meanings as set forth below.

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

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

**Claims Administrator**
An outside firm with which the Company contracts to administer benefits under the plan and generally accepted insurance practices. The claims administrator for the EAP is Resources for Living.

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

**Covered Family Members or Covered Person**
The employee, employee’s spouse/domestic partner and eligible dependent children who are enrolled in this plan.

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

• Is performing in the customary manner all of the regular duties of his/her occupation either at one of the Company’s business establishments or at some location to which Company business requires the employee to travel, or is not performing his/her regular duties due to illness, provided that he/she has already commenced performing his/her regular duties of employment prior to his/her illness, and
• Is not in one of the excluded categories described in the “Excluded Categories” below.

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/she is:

• Covered by a health plan established pursuant to collective bargaining (other than this plan).
• Covered by another health plan to which the Company contributes.
• Designated by the Company, its subsidiaries, or its affiliates as a seasonal or temporary employee.
• Compensated for services by a person other than the Company, its subsidiaries, or its affiliates and for any reason is deemed to be an employee.
• Not on the U.S. payroll of the Company, its subsidiaries, or its affiliates and for any reason is deemed to be an employee.

• A leased employee within the meaning of Section 414(n) of the Internal Revenue Code, or would be a leased employee but for the period-of-service requirement of Code Section 414(n)(2)(B), and who is providing services to the Company, its subsidiaries, or its affiliates.
• Subject to a written agreement that provides that such individual shall not be eligible to participate in the plan.

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

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

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

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

**ERISA**

**HR Support Center/McKesson Benefits Center**
A resource for plan members to obtain benefits information and gateway to a Personal Health Advocate. Call 855.GO.MCKHR (855.466.2547) and press 1 for the McKesson Benefits Center for Health, Vitality and Pension questions. Benefit experts are available 7 a.m. - 6 p.m. Central time, M-F. Written correspondence should be sent to the McKesson Benefits Center at 4 Overlook Point, PO BOX 1530, Lincolnshire, IL 60069-1530.

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

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

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

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

**Plan**
The Employee Assistance Program (EAP) plan, which is part of the McKesson Corporation Health Plan for active employees.

**Plan Administrator**
McKesson Corporation.

**Plan Sponsor**
McKesson Corporation.

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

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

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

**UPoint**
http://resources.hewitt.com/mckesson
The website where employees go to review and manage their Total Rewards.
This document provides only a summary of coverage. The official plan document — and not this summary — governs benefits paid under the plan.

**Contact the EAP 24/7**
**Resources for Living**
888.425.6174
www.resourcesforliving.com
Username: mckesson
Password: eap

**HR Support Center**
855.GO.MCKHR (855.466.2547)
Press 1 for the McKesson Benefits Center for Health, Vitality and Pension questions. Benefit experts are available 7 a.m. - 6 p.m. Central time, M-F.
**Oprime 1 para recibir asistencia en español a través del McKesson Benefits Center.**

**Upoint**
http://resources.hewitt.com/mckesson
Enroll in, review and manage your Total Rewards.