Plan Eligibility

**HSA plan**
This plan is available to benefit-eligible employees scheduled to work at least 20 hours a week.

**HSA Plus plan**
This plan is available to benefit-eligible employees scheduled to work at least 30 hours a week.

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**Two Plans, One Guide**

Use this guide to make the most of your HSA or HSA Plus plan. Inside, you’ll find information about:

- **When to Expect Your ID Cards**
- **Plan Features**
- **5 Reasons to Love Your Health Savings Account**
- **Health Savings Account Tips**
- **Your Non-Emergency Care Options**
- **Prescription Drug Coverage**
- **Healthcare Tools and Services**
- **Your Medical Plan in Action**
- **Contacts**
When to Expect Your ID Cards

If you switched to a new medical plan or your carrier changed, you can expect your new medical ID card to arrive in the mail:

By January 1, if you enrolled during Annual Enrollment. or

Three to four weeks after your enrollment period.

You’ll also get a CVS Caremark prescription drug ID card if you don’t already have one. Take your medical and prescription drug ID cards with you whenever you visit the doctor or pharmacy.

How to Print a Temporary ID Card

If you lose your medical or prescription drug ID card, or if you’re waiting for both ID cards to come in the mail, you can print temporary ones. You need to register on your plan carrier’s website before you can print your card.

**Aetna**
Go to [www.aetnanavigator.com](http://www.aetnanavigator.com) and select **View/Print an ID Card** in the I want to... menu on the main page.

**Anthem**
Log on to [www.anthem.com/ca](http://www.anthem.com/ca) and select **Customer Support**, then click **Request an ID Card** or **Print a temporary ID card**. Electronic copies of ID cards are available using the Anthem Anywhere app.

**Cigna**
Log on to [www.myCigna.com](http://www.myCigna.com) and select **ID Card** in the upper right corner of the page. Then, select **Print or Request an ID Card**.

**CVS Caremark**
Go to [www.caremark.com](http://www.caremark.com), select **Plan and Benefits** and choose **Print Member ID Card**.

Qualified Status Change

The coverage you chose during your enrollment period is for all of 2019 unless you have a qualified status change, such as marriage, the birth of a child, going from part-time to full-time work or your spouse/domestic partner losing or gaining medical coverage. If you have a qualified status change, you can update certain enrollment choices within 31 days of the change at [UPoint > Life Changes](#).

Visit UPoint to learn about Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Rights that let you enroll in coverage outside of Annual Enrollment.
Taking care of your health is a lot easier when you know how your medical plan works. This guide can help you be ready to use your plan’s comprehensive medical and prescription drug coverage when you need it. Let’s start with the basics.

**Prevention Is Key**

Your plan covers in-network preventive services at 100%, without you having to meet the annual deductible. Preventive care services covered at 100% include:

- Physical exams
- Health screenings
- Certain immunizations and prescription medications on the HSA Preventive Therapy Drug List.

Visit your medical plan carrier’s website and the CVS Caremark website to see all the preventive services that are covered at 100%.

**Looking for a new doctor?**

You can find in-network doctors on your carrier’s website. See p. 17.

**In-Network vs. Out-of-Network**

When possible, use in-network providers to keep your healthcare and prescription drug costs down.

When you use out-of-network providers:

- Generally, your costs are higher than for in-network providers (see chart on next page).
- You pay more in coinsurance (40% vs. 20%).
- Out-of-network providers may charge more than the plan’s Reasonable & Customary (R&C) charge. The R&C charge is based on a fee schedule similar to Medicare’s. You’re responsible for any amounts billed over the R&C charge.
- Prescription medications aren’t covered because only in-network providers accept your coverage.

**Coverage That’s Got Your Back**

You’re covered for a variety of health services, such as chiropractic care, acupuncture, addiction treatment, infertility treatment, speech therapy, physical therapy and applied behavior analysis (ABA) therapy. See what else is covered in the Summary of Benefits and Coverage (SBC) at Total Rewards Library > Plan Documents.
### HSA Plan

<table>
<thead>
<tr>
<th></th>
<th>Deductible</th>
<th>Coinsurance out-of-pocket maximum</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td><strong>EE</strong>*</td>
<td>$3,500</td>
<td>$2,750</td>
<td>$5,500</td>
</tr>
<tr>
<td><strong>EE + SP/DP</strong>*  or Child(ren)</td>
<td>$5,250</td>
<td>$4,125</td>
<td>$8,250</td>
</tr>
<tr>
<td><strong>EE + Family</strong></td>
<td>$7,000</td>
<td>$5,500</td>
<td>$11,000</td>
</tr>
</tbody>
</table>

HSA Plus Plan (Available only to eligible employees scheduled to work 30 or more hours a week.)

<table>
<thead>
<tr>
<th></th>
<th>Deductible</th>
<th>Coinsurance out-of-pocket maximum</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>EE + SP/DP</strong>*  or Child(ren)</td>
<td>$3,175</td>
<td>$3,750</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>EE + Family</strong></td>
<td>$4,250</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

* EE = employee. SP/DP = spouse/domestic partner.
** There’s an embedded individual out-of-pocket maximum of $6,850. Once an individual meets the individual out-of-pocket maximum of $6,850, the plan pays 100% of all eligible expenses for that person, even if the family out-of-pocket maximum hasn’t been met.

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### What’s the “Plus” in HSA Plus?

The HSA Plus plan comes with a McKesson contribution to your health savings account. The contribution puts the “plus” in the plan’s name. In this case, the “plus” doesn’t mean “better plan” or “first class,” it simply means that McKesson chips in between $750-$1,500 to your health savings account depending on who you cover. See p. 6 for contribution details.

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### Annual Deductible + Coinsurance = Out-of-Pocket Maximum

- **Annual Deductible**: Your annual deductible is the amount you pay for office visits, prescription drugs and other covered services before your plan begins sharing the cost.
- **Coinsurance**: Coinsurance kicks in after you meet your annual deductible. It’s the percentage you and your plan each pay when you’re sharing costs.
- **Out-of-Pocket Maximum**: The most you pay in a year for covered services is called the out-of-pocket maximum. After you reach the out-of-pocket maximum, the plan pays 100% of covered services for the remainder of the plan year.
The health savings account is a powerful financial tool that can help you save money for healthcare expenses.

1. You call the shots when it comes to spending, investing or saving the money in your health savings account.

2. You keep the money in your account whether you change medical plans, leave McKesson or retire.

3. You get three tax breaks.

   **First break**
   You may pay less taxes by lowering your taxable income with before-tax or tax-deductible contributions to your account.*

   **Second break**
   You aren’t taxed on withdrawals you make to pay eligible healthcare expenses.

   **Third break**
   Your account’s earnings and interest aren’t taxed, unless you live in one of the few states that taxes them.**

4. If you’re an HSA Plus plan member, McKesson contributes to your health savings account each year. How much McKesson contributes depends on your coverage:

   **Employee Only**
   $750

   **Employee + Spouse/Domestic Partner or Child(ren)**
   $1,100

   **Employee + Family**
   $1,500

5. You can invest the money in your account to help meet long-term financial goals and build a nest egg for healthcare expenses in retirement. Fidelity offers a variety of investment options, such as mutual funds and bonds. Always talk to your financial advisor before investing.

** TIP **
McKesson’s contribution counts toward the IRS annual contribution limit. Avoid taxes and penalties by making sure your contribution plus McKesson’s doesn’t go over the IRS limit. See p. 7 for IRS limits.

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* As of 2019, California and New Jersey tax the money you and McKesson put in a health savings account. If you live in one of these states, you may need to pay state income tax on the money you and McKesson contribute to your health savings account.

** As of 2019, only California, New Hampshire, New Jersey and Tennessee tax health savings account interest and earnings. If you live in one of these states, talk to your tax advisor or contact Fidelity for more guidance.
Activate Your Account

If you haven't yet, activate your health savings account at [www.netbenefits.com](http://www.netbenefits.com) within 90 days of your effective date of coverage. The contribution amount you set on UPoint during your enrollment period can’t be deducted from your paychecks and deposited into your health savings account until you activate your account on Fidelity’s website. You also need to activate your account to get McKesson’s contribution if you enrolled in the HSA Plus plan.

IRS Contribution Limits

Whether you’re enrolled in the HSA or HSA Plus plan, the IRS limits how much you can put into your health savings account in 2019.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Contribution Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$3,500/year</td>
</tr>
<tr>
<td></td>
<td>$291.66/month</td>
</tr>
<tr>
<td>Family</td>
<td>$7,000/year</td>
</tr>
<tr>
<td></td>
<td>$583.33/month</td>
</tr>
</tbody>
</table>

If you’re 55 or older in 2019, you can contribute up to an additional $1,000.

If you’re eligible for a health savings account for only part of the year, be sure to stay at or under the monthly IRS limit to avoid taxes and penalties. You can learn more in the Health Savings Account FAQs at [www.mckesson.com/totalrewardslibrary](http://www.mckesson.com/totalrewardslibrary) > Health Savings Account.

Paying With Your Health Savings Account

Once you activate your health savings account, Fidelity mails you a health savings account debit card, which you can swipe at your provider’s office.

- If you pay out of pocket for an eligible expense, you can reimburse yourself later from your health savings account at [www.netbenefits.com](http://www.netbenefits.com) or through the Fidelity mobile app.
- The expenses are eligible under IRS rules, so you’re not taxed on your withdrawal.
- Be sure to keep all your receipts in case you’re ever audited by the IRS.

What can I pay for with my health savings account?

Technically, you can withdraw money from your health savings account for any reason. If you use it to pay for an eligible healthcare expense, such as a doctor’s visit or a lab test, your withdrawal is tax-free. If you withdraw money for an ineligible expense, you'll pay a 20% penalty tax on top of normal income tax.

If you’re 65 or older, the 20% penalty tax doesn’t apply, but you’ll still need to pay income taxes on ineligible expenses.

See a complete list of eligible expenses at [www.mckesson.com/totalrewardslibrary](http://www.mckesson.com/totalrewardslibrary) > Health Savings Account.

**TIP** Have an HSA-compatible healthcare flexible spending account (FSA) too? It might be best for you to use your FSA — not your health savings account — to pay for eligible dental and vision expenses. Once you’ve spent your FSA funds, you can then use your health savings account to pay for any additional dental and vision expenses.

* McKesson flexible spending accounts, including the HSA-compatible FSA, are only available to employees scheduled to work 30 or more hours a week.
Your Non-Emergency Care Options

Nurse Advice Line
Call the free nurse advice line when you:

- Have a headache, sprain or other non-emergency symptom.
- Need help deciding whether to visit a doctor, urgent care clinic or emergency room.

Find your nurse advice line’s phone number on your medical ID card.

Retail Clinics
Visit a retail clinic when:

- Your doctor’s office is closed.
- You need help with a sinus infection, non-severe burn, or another common symptom or a minor injury.

Retail clinics are available at many local pharmacies, not just CVS. Find an in-network clinic through your medical plan carrier’s website or by calling the phone number on your medical ID card.

Urgent Care Clinics
Visit an urgent care clinic when you need attention right away for symptoms or injuries that are serious but not life-threatening.

Visit your medical plan carrier’s website to find an in-network urgent care clinic near you.

Telemedicine
Feeling too sick to get out of bed, have questions about medication side effects or don’t want to wait for an appointment with your doctor? Use your plan’s telemedicine service.* Telemedicine allows you to talk to a doctor about non-urgent health concerns through video streaming on your laptop, tablet or mobile device. This means that you can make an appointment, speak to a doctor and get a treatment plan without leaving your bed.

*Aetna
Teladoc
teladoc.com
800.835.2362
App: Teladoc**

*Anthem
LiveHealth Online
livehealthonline.com
888.548.3432
App: LiveHealth Online Mobile**

*Cigna
• MDLIVE
MDLIVEforCigna.com
888.726.3171
App: MDLIVE**
• Amwell
AmwellforCigna.com
855.667.9722
App: Amwell**

* State laws regarding telemedicine vary.
** Available on the App Store®, Google Play™ and Windows Store. Teladoc is available on the App Store and Google Play only.
What to Do in an Emergency

If you have an emergency, get medical help right away.* You pay for emergency care like any other eligible expense. If coinsurance applies, the plan pays 80% of the cost whether you get care from an in-network or out-of-network provider. However, you may have higher out-of-pocket costs if you use an out-of-network provider.

*An emergency is a severe medical condition (including severe pain and/or unexpected symptoms during an illness or after a serious accident) that would cause a reasonable person to expect that the absence of immediate medical attention will result in placing the health or survival of the individual in serious jeopardy, seriously impair bodily functions or cause serious dysfunction to a bodily organ or part.
You have a prescription benefits administrator. That’s CVS Caremark if you enroll in the HSA or HSA Plus plan.

You need to use pharmacies that accept your coverage.
- Only pharmacies within the CVS Caremark network accept your coverage. The CVS Caremark network includes hundreds of retail pharmacies, such as Health Mart® and Walmart®. Use the pharmacy locator at www.caremark.com to search for in-network pharmacies near you.
- Out-of-network pharmacies aren’t covered by the plan. You pay the full cost of your prescription medicines when you use out-of-network pharmacies.

Prescription medicines count toward the annual deductible.
You pay the bill for prescription medicines until you meet your medical plan’s annual deductible. When you meet the deductible, coinsurance kicks in and you and the plan start sharing costs.

### Prescription Coverage

<table>
<thead>
<tr>
<th>Before Meeting the Deductible</th>
<th>After Meeting the Deductible</th>
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<tbody>
<tr>
<td>• You pay the cost for prescription medicines until you meet your medical plan’s annual deductible.</td>
<td>You and the plan start sharing the cost for prescription medicines.</td>
</tr>
<tr>
<td>• When your prescription medicine is on the HSA Preventive Therapy Drug List (p. 11), the plan shares the cost with you even if you haven’t met your deductible.</td>
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</tr>
</tbody>
</table>

#### Prescription Medications on the HSA Preventive Therapy Drug List (p. 11)

- **Generic medications** — Plan pays 100%.
- **Preferred brand name medications** — You pay half the normal coinsurance without having to meet your deductible.

#### Prescription Medications not on the HSA Preventive Therapy Drug List (p. 11)

- **Generic medications** — You pay 100%.
- **Preferred brand name medications** — You pay 100%.
- **Non-preferred brand name medications** — You pay 100%.
- **Generic medications** — You pay 20%, plan pays 80%.
- **Preferred brand name medications** — You pay 20%, plan pays 80%.
- **Non-preferred brand name medications** — You pay 40%, plan pays 60%.

Any health savings account money you use to pay for prescription medicines counts toward your deductible.
HSA Preventive Therapy Drug List

If you’re an HSA or HSA Plus plan member, certain preventive generic medications on the HSA Preventive Therapy Drug List may be covered 100% without having to meet a deductible. That means certain generic prescriptions may be available to you at no cost. These preventive generic medications include those prescribed for you:

- In response to risk factors for a disease.*
- To prevent the recurrence of a disease from which you have recovered.
- As part of procedures providing preventive care services, such as smoking-cessation and weight-loss programs.

* In some cases, if risk factors are high enough, you may be given a preventive prescription although you haven’t been diagnosed with the disease or show symptoms of the disease.

In addition to the HSA Preventive Therapy Drug List, there’s the Comprehensive Specialty Pharmacy Drug List and Performance Drug List to help you receive the most effective medications at a lower cost. You can find all three lists at Total Rewards Library > Healthcare Benefits > Costs, Pharmacies and Medication Lists. You can also find the lists on the CVS Caremark website (www.caremark.com) after registering.
Coverage with You in Mind

Medicines that are effective and priced right? Yes, please! In the HSA and HSA Plus plans, your prescription drug coverage helps you get medicine through a process called step therapy. Step therapy requires you to use generic alternatives before brand names within the same class of drugs. You have coverage for more expensive prescription medicines, but only if your doctor and CVS Caremark agree that there’s a medical reason a lower-priced medicine isn’t effective for your condition. You and your doctor make the final decisions about which medications are right for you.

Following step therapy rules and the Center for Disease Control’s best practice guidelines for opioid care help ensure you get the most appropriate and cost-effective treatment.

How Step Therapy Works at the Pharmacy

The pharmacist enters your prescription in the CVS Caremark computer system.

For certain conditions, step therapy requires you to try preferred prescription medications before other medicines to treat the same condition.

If your prescription doesn’t require you to try a preferred medication first, the pharmacist fills your prescription.

If your prescription requires you to try a preferred medication first and your prescription is for another medication, you’re required to try the medication preferred by step therapy first.

Other medications may be considered second or third step medicines in the step therapy process. If your prescription is for a second or third step therapy medication and you haven’t used the first step therapy medication, you’re required to try the first step therapy (cost-effective) medication — see below.

If you’re required to try a preferred medication, you have the following options:

You or your pharmacist can call your doctor to:

Change your prescription to a medication preferred by step therapy.

Or

Ask your doctor to request a medical necessity exception from CVS Caremark. There may be a wait depending on how quickly CVS Caremark can determine whether to grant the exception.

If your exception isn’t approved by your doctor and CVS Caremark, you can pay the full price for your second or third choice medication.*

If you submit a prescription to CVS Caremark’s mail order pharmacy that doesn’t meet step therapy requirements, the pharmacy won’t fill your prescription. You’ll be notified by mail.

* If you purchase a brand name medicine that is part of the step therapy program and a first or second step therapy medication is available, you pay the full cost of that brand name medicine. The brand name medicine is covered only when your doctor and CVS Caremark agree that there’s a medical reason a lower-priced medicine isn’t appropriate for your condition.

If you purchase a brand name medicine that isn’t part of the step therapy program and a generic equivalent is available, you pay the difference in cost between the generic and the brand name medicine. For example, if you choose to purchase a preferred brand name medicine that costs $65 and the generic medicine cost is $20, you pay $45 out of pocket before the plan coverage applies to the purchase. In this example, you would pay the $45 difference in price plus 20% coinsurance ($4) on the remaining $20 for a total out-of-pocket cost of $49.

If you purchase a brand name medicine that isn’t part of step therapy and a generic equivalent is unavailable, coinsurance applies after meeting your annual deductible. For example, if you purchase a preferred brand name medicine that costs $65, you pay the full $65 cost for the medicine. Once you meet your annual deductible, you pay $13 in coinsurance (20%).
Register on the CVS Caremark Website

Go to www.caremark.com > Register now to sign up and:

• Estimate prescription medication costs.
• Order a refill.
• Get details about the mail order and specialty pharmacies.
• Use the pharmacy locater to find in-network pharmacies near you.
• Access the HSA Preventive Therapy Drug List, Performance Drug List and Comprehensive Specialty Pharmacy Drug List.

Family members 19 years old or older enrolled in your plan can have their own secure accounts on the CVS Caremark website.

Download the CVS Caremark App

Download it at www.caremark.com to access your prescription medication benefits on the go. The app is free, but standard mobile phone carrier and data usage charges apply.

Mail Order Program

You can fill your prescriptions — up to a 90-day supply — at CVS Caremark’s mail order pharmacy or at any retail pharmacy in CVS Caremark’s network. Visit www.caremark.com to order your prescriptions online.
**Healthcare Tools and Services**

### Need Help Managing a Chronic Condition?

Contact your plan's condition support manager when you need help managing chronic conditions, such as diabetes, high blood pressure and high cholesterol. This service is available at no additional cost to you and your covered family members.

**Aetna**
Aetna In Touch Care
877.286.3900

**Anthem**
Condition Care
866.820.0763

**Cigna**
Personal Health Team
800.244.6224

### Get an Expert Second Opinion from Best Doctors

When you have concerns about a treatment plan or serious diagnosis, such as cancer or other medical condition, Best Doctors has a network of more than 50,000 physicians in more than 450 medical specialties ready to provide an expert second opinion and answers to your questions. Learn more at [www.mckesson.com/totalrewardslibrary](http://www.mckesson.com/totalrewardslibrary) > Healthcare Benefits.

### Get a New Hip or Knee Without Paying an Arm and a Leg

You (or a covered family member) may be eligible to get a hip or knee replacement at little or no cost to you through the Centers of Excellence (COE) program. The program gives you access to world-class hospitals and surgeons so you can get the best care and lower your risk of complications. Find out more at [www.mckesson.com/totalrewardslibrary](http://www.mckesson.com/totalrewardslibrary) > Healthcare Benefits > Hip or Knee Replacement Program.
Let’s take a closer look at how the HSA and HSA Plus plans work with in-network and out-of-network providers. You may need to tell your doctor’s office about the plan’s claim process. Your medical ID card has contact information for your providers to use if they have questions.

Meet Luke


TIP
Always use in-network providers when possible. Out-of-network providers can charge you for the difference between their charges and what your plan covers.

In-Network Claims

Let’s see how the claim process works for Luke’s visit with an in-network doctor.

1. Luke shows his medical ID card at his doctor’s office.
4. Because Luke hasn’t met his deductible, he’ll have to pay the full cost of his doctor’s visit. Luke can use money from his health savings account to pay down his deductible.

If Luke had already met his deductible, the plan would’ve paid 80% of his bill for covered services. Luke would be responsible for paying the other 20%.

5. Luke’s medical plan carrier sends him an Explanation of Benefits (EOB) listing the total cost of each service, amounts paid by the plan, and the amount Luke is responsible for paying.

6. Luke’s doctor sends him a bill for the full amount of his visit. Luke checks his bill against the EOB and contacts his medical plan carrier if he has questions. He can then pay the balance out of pocket or use money from his health savings account. Either way, the payment counts toward his deductible and out-of-pocket maximum.

If Luke’s bill is for a small amount, he can pay out of pocket and keep more money in his health savings account to save for future expenses.

Out-of-Network Claims

Let’s see how Luke’s claim process works when he visits an out-of-network doctor.

1. Luke shows his medical ID card at the doctor’s office.
3. If Luke’s doctor doesn’t submit a claim for him and he pays out of pocket or with his health savings account, Luke has to download a claim form from his medical plan carrier’s website, complete the form and submit it to his carrier.

4. Since Luke hasn’t met his deductible, he’ll have to pay the full cost of his doctor’s visit. Luke can use money from his health savings account to pay down his deductible.

If Luke had already met his deductible, the plan would’ve paid 60% of his bill for covered services. Luke would be responsible for paying the other 40%.

5. Luke’s medical plan carrier processes his claim, pays his doctor, if his expenses are eligible, and sends Luke an EOB listing the total cost of each service, amounts paid by the plan, and the amount Luke is responsible for paying.


If Luke doesn’t have enough money in his health savings account at the time to cover the expense, he can pay out of pocket and reimburse himself once the money is in his account.
Explanation of Benefits

Your medical plan carrier processes your claims and sends you an EOB that shows how much the plan paid, how much you paid and what you may still need to pay out of pocket. An EOB isn’t a bill, it’s simply a summary of your claims.

Review your EOB carefully before paying your provider and call your medical plan carrier if you have questions. If you want to review your claims activity or need additional information, visit your medical plan carrier’s website.
Medical Plan Carrier Information

If you still have questions about how your plan works, contact your carrier. Be sure to register on your medical plan carrier’s website and the CVS Caremark website to search for in-network doctors in your area, access online tools and learn how you can use your medical and prescription medication budget more effectively. Check out the map to see the McKesson medical plan carrier for your state.

Aetna
www.aetna.com
877.286.3900
8 a.m. - 6 p.m. your local time, M-F

Anthem
www.anthem.com/ca
866.820.0763
6 a.m. - 9 p.m. Mountain time

Cigna
www.myCigna.com
800.244.6224
Available 24/7

CVS Caremark
www.caremark.com
800.378.0822
Available 24/7

Tap into Advocacy Services
If there's something your medical plan carrier can’t help you with, contact an Alight Health Pro™. A Health Pro can help you understand your benefits, resolve billing errors, transfer medical records or schedule appointments at no cost to you. Click the Advocacy Services tile on UPoint to get in touch with an Alight Health Pro. You can also call the HR Support Center at 855.GO.MCKHR (855.466.2547) and press 1.
Review and manage your Total Rewards.

Find information 24/7 about health and wellness programs from any device connected to the internet.

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

The Employee Assistance Program (EAP) offers free, confidential support 24/7 for everything from child care referrals to addiction counseling. No problem is too big or too small.

Join the MCK Health FYI group on Yammer to share health tips, memes and words of encouragement with your coworkers. Connect to Yammer through Office 365.

This document summarizes highlights of some of our benefit plans. This document also serves as a “summary of material modifications” to our benefit plans in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Please keep this document with your copy of the Summary Plan Description.