Health Incentive
Health Reimbursement Account (HRA)

1. Employer Information	Employer Name **McKesson Corporation**		HRA Control Number **620225**
2. Employee Information	Social Security Number	Name	Daytime Telephone Number ( )
	Address (include ZIP code) ☐ Check if address is new		Evening Telephone Number ( )
3. Expense Information	Name ______		Relationship to Employee ☐ Self ☐ Spouse ☐ Child
	Date(s) of Service (MM/DD/YYYY) From ______ Thru ______		**Total Amount Submitted** $ ______
	Name ______		Relationship to Employee ☐ Self ☐ Spouse ☐ Child
	Date(s) of Service (MM/DD/YYYY) From ______ Thru ______		**Total Amount Submitted** $ ______
	Name ______		Relationship to Employee ☐ Self ☐ Spouse ☐ Child
	Date(s) of Service (MM/DD/YYYY) From ______ Thru ______		**Total Amount Submitted** $ ______
4. Employee Certification	I certify that all expenses for which reimbursement is claimed from my Health Incentive HRA have been incurred and have not been reimbursed by any other health plan coverage. I understand that I am required to submit, in addition to this claim form, an invoice or other statement from a health care provider (such as a physician or pharmacy) or other independent third party stating that the medical expenses have been incurred and the amount of such expense. I represent that any individual (other than myself or my spouse) for whom a claim is filed hereunder qualifies as my dependent for federal income tax purposes and that all individuals (including myself or my spouse) are covered under a McKesson-sponsored medical plan. I further declare that I have not and will not deduct these expenses on my federal, state or local income tax returns. **Employee Signature** ______ **Date** ______ Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information may be guilty of a crime		

PREPARING YOUR CLAIM FORM

- Attach appropriate documentation, which may include:
  - **Explanation Of Benefits (EOB)** – for expenses partially covered by a medical/prescription drug plan. If coverage is available, you must submit your EOB with your completed claim form.
  - **Copay receipt** from the provider.
  - **Itemized bill or statement** from the provider when expenses are not covered by a medical/prescription drug plan, which includes:
    - Name & address of the provider
    - Dates of service
    - Dollar amount charged
    - Patient's name
    - Type of service
- ***Canceled check or credit card receipts are not adequate documentation.***

NOTE: Covered expenses are listed on the back page.

SUBMITTING YOUR CLAIM

- Retain copies for your files. Claim information cannot be returned.
- Send this completed claim form and documentation to:

  Aetna
  P.O. Box 4000
  Richmond, KY 40476-4000
  Fax to: 1-888-AET-FLEX (1-888-238-3539)
- If you have questions about your Health Incentive HRA claim, call **1-877-286-3900, and for the hearing impaired 1-877-703-5572 TDD/TTY.**

Covered Expenses – Out-of-pocket expenses for the following items are included as Covered Expenses under your Health Incentive HRA. Note that only medical and prescription drug expenses are covered; dental and vision expenses are not covered. For information on whether or not a specific expense is covered, call 1-877-286-3900.

- amounts over Reasonable and Customary
- amounts in excess of any Health Coverage Program limits
- contraception devices such as IUDs, Depo Provera, Norplant and Norplant-like inserts (including contraceptive services associated with insertion of IUDs, Norplant, Norplant-like inserts, and Depo-Provera injections)
- the difference in cost between brand name prescription drugs and generics prescription drugs
- allergy injections, testing and serum
- alternative care settings (such as skilled nursing facilities, hospice or home care
- ambulance service to and from the nearest facility where you can receive needed medical care services (air ambulance will be covered when it is the only acceptable means of transporting the patient)
- anesthesia
- blood and blood plasma transfusions and blood not donated or replaced
- chemical dependency treatment
- chemotherapy
- chiropractic care
- cochlear implants
- circumcision
- dialysis
- diabetic supplies and insulin
- emergency room and urgent care center
- home infusion therapy when ordered by a physician, including solutions and pharmaceutical additives; pharmacy compounding and dispensing services; ancillary medical supplies; nursing services to train you or your caregiver or to monitor the home infusion therapy, provide emergency care, collection, analysis and reporting of lab test to monitor response to home infusion therapy, enteral feedings, or other eligible home health supplies and services provided during home infusion therapy
- hospital services such as nursing care, drugs and medicines, x-rays and laboratory test
- inhalation therapy (provided by a registered or licensed therapist) when needed to correct a functional disorder due to an illness or injury
- inpatient physician care
- inpatient rehabilitation
- mammography
- maternity care (including services and supplies provided by a birthing center or midwife)
- mental healthcare
- nutritionists, when required to treat a medical condition
- occupational therapy (by a licensed therapist)
- orthotics
- outpatient (ambulatory) surgery
- outpatient cardiac rehabilitation services
- outpatient x-ray and laboratory charges
- oxygen and other gases
- physical therapy (provided by a licensed physical therapist)
- physicians' visits
- pre-admission testing
- prosthetic appliances
- pulmonary rehabilitation
- rental (not more than the purchase price) or, if less costly, purchase, of durable equipment and related supplies
- semi-private room and board for hospital stays and alternative care settings (private rooms are covered only if Medical Necessary)
- speech therapy to restore speech lost due to a congenital condition for which corrective surgery cannot be performed, or due to injury or illness
- sterilization and reversal of sterilization
- surgical care
- surgery for morbid obesity. To qualify for this benefit a participant must:
  - weigh more than 100 pounds over standard weight for height, sex and age; or
  - weigh more than two times the standard weight for participant's height, sex and age
- TMJ (temporomandibular joint syndrome) surgical treatment by a dentist or physician (excludes orthodontic treatment)
- x-rays, radium, radio, isotope treatments