

The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the monthly amount you need to pay to participate in this [plan](#) (called the contribution) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit <http://netbenefits.com/merck> or call 1-800-666-3725. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <http://netbenefits.com/merck> or call 1-800-666-3725 to request a copy. If there is a conflict, the [plan](#) document determines the benefits.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">In-network</a> : \$500 individual / \$1,000 family; <a href="#">Out-of-network</a> : \$1,000 individual / \$2,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">prescription drugs</a> and <a href="#">preventive</a> services	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">In-network</a> medical; by salary band (per member/per family): Under \$60,000      \$1,500/\$3,000 \$60,001-\$100,000      \$2,500/\$5,000 \$100,001-\$150,000      \$3,500/\$7,000 Over \$150,000      \$4,500/\$9,000 <a href="#">Out-of-network</a> medical twice these amounts. <a href="#">Prescription drug</a> : \$1,500 per member / \$3,000 per family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.

<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, amounts over reasonable and customary limits, and uncovered charges.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.horizonblue.com/merck">www.horizonblue.com/merck</a> or call <a href="tel:877-663-7258">877-663-7258</a> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. If services are obtained from an [out-of-network provider](#) the [coinsurance](#) will apply to the [allowed amount](#), or what the [plan](#) calls reasonable and customary (R&C) limits. If you use an [out-of-network provider](#) you will also be responsible for any amounts in excess of R&C.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	<a href="#">Primary care</a> visit to treat an injury or illness	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a> of R&C <a href="#">Deductible</a> does not apply	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <http://netbenefits.com/merck>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a>	Generic drugs	Retail: \$10 <a href="#">copay</a> (\$0 diabetic drugs and supplies); Mail Order: \$20 <a href="#">copay</a> (\$0 <a href="#">copay</a> diabetic drugs and supplies)	Reimbursement based on <a href="#">network</a> -negotiated price of medication, minus applicable <a href="#">copayment</a> .	Retail: Up to 30-day supply; Mail Order: Up to 90-day supply \$1,500 per member/\$3,000 per family <a href="#">out-of-pocket limit</a> for participating <a href="#">providers</a>  <a href="#">Deductible</a> does not apply.
	Merck/Organon brand drugs where no generic equivalent is available (Preferred brand drugs)	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	Merck/Organon & non-Merck/non-Organon Brand Drugs where a generic equivalent is available: Retail: 40% <a href="#">coinsurance</a> up to \$100 maximum (per prescription); Mail order: 40% <a href="#">coinsurance</a> up to \$200 maximum (per prescription). \$1,500 per member/\$3,000 per family <a href="#">out-of-pocket limit</a> for participating <a href="#">providers</a> .  <a href="#">Deductible</a> does not apply.
	Non-Merck/non-Organon brand drugs and Merck/Organon brand drugs where a generic equivalent is available (Non-preferred brand drugs)	Non-Merck/non-Organon Brand Drugs when a generic equivalent is not available: Retail: 20% up to \$50 maximum (\$10 diabetic drugs and supplies); Mail Order: 20% up to \$100 maximum (\$20 diabetic drugs and supplies)	Reimbursement based on <a href="#">network</a> -negotiated price of medication, minus applicable <a href="#">copay</a> and/or <a href="#">coinsurance</a> . Any costs in excess of <a href="#">network</a> -negotiated fees do not count toward the prescription drug out-of-pocket maximum limit.	
	<a href="#">Specialty drugs</a>	Same as above for generic and brand.	Same as above for generic and brand.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	<a href="#">Preauthorization</a> is required. Also responsible for amounts over R&C.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	The carrier determines if the use of the <a href="#">emergency room</a> meets the prudent layperson standard. Carrier must be contacted within 48 hours for in- <a href="#">network</a> benefits.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	<a href="#">Preauthorization</a> is required. Failure to <a href="#">preauthorize</a> could result in no coverage if care is deemed not <a href="#">medically necessary</a> . Also
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <http://netbenefits.com/merck>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				responsible for amounts over R&C.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	<a href="#">Preauthorization</a> is required. Also responsible for amounts over R&C.
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	<a href="#">Preauthorization</a> is required. Also responsible for amounts over R&C. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Only applied behavioral analysis (ABA) therapy will be covered with diagnosis of autism spectrum disorder. <a href="#">Preauthorization</a> and medical necessity required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Up to 120 days per calendar year. Also responsible for amounts over R&C.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	Also responsible for amounts over R&C
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> of R&C	<a href="#">Preauthorization</a> is required for inpatient. Also responsible for amounts over R&C.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	30% <a href="#">coinsurance</a> of R&C <a href="#">Deductible</a> does not apply	One exam every 24 months.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <http://netbenefits.com/merck>.

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery charges that are not medically necessary or not required because of accident or disease or not correcting a child's birth defect that caused a functional disorder
- Dental care (Adult and Child) except for limited exceptions for [medical necessity](#), accidental injury to sound natural teeth and surgery related to TMJ
- [Habilitation services](#) – with limited exception for ABA therapy for children with autism
- Long-term care
- Routine eye care (Adult and child, except for annual exam / screening)
- Weight loss program

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture - performed by licensed M.D., D.O. or state-licensed physician for treatment of pain, illness or injury
- Bariatric surgery, only if performed at an Horizon Blue Distinction Center
- Chiropractic care – up to 25 visits per calendar year; maintenance therapy not covered
- Hearing aids, up to a maximum of \$3,000 every 36 months
- Infertility treatment – diagnosis and treatment of infertility, limited to \$25,000 lifetime maximum for medical and \$10,000 lifetime maximum for non-Organon [prescription drugs](#)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing service provided by R.N. or L.P.N. if person's condition requires [skilled nursing care](#) and visiting nursing care is inadequate
- Routine foot care - limited to [medically necessary](#) foot [orthotics](#) or one pair of [medically necessary orthotic](#) shoes per calendar year

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. You can also contact the Merck Benefits Service Center at Fidelity at 800-666-3725.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Merck Benefits Service Center at Fidelity at 800-666-3725. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

This document is not an official [plan](#) document or SPD. If any information included in this document or any website or any verbal representation conflicts in any way with the official [plan](#) document(s), including any contract(s) of insurance purchased, pursuant to the [plan](#) document(s), the provisions of the [plan](#) document(s), as amended, will govern.

Merck (and its subsidiaries) reserves the right to amend the health care benefits described in the SBC (and the [plans](#), policies and programs under which they are provided) in whole or in part or completely discontinue them at any time.

### Does this plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Healthcare Help:

Personalized assistance for you and your family to help understand your benefits, find doctors, hospitals and other providers, secure doctors' appointments, assist with claims, billing questions and transferring medical records and manage acute or chronic conditions is available from your Horizon Health Guide at 800-544-1112.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-666-3725.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-666-3725.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-666-3725.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-666-3725.

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage. The maternity example is for an employee in the \$60,001 to \$100,000 salary band. The other two examples apply to all salary bands.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,560</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,010</b>