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

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

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Specialist visit	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Preventive care/screening/ immunization	No charge	30% coinsurance of R&C Deductible does not apply	Also responsible for amounts over R&C. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com	Generic drugs	Retail: $10 copay ($0 diabetic drugs and supplies); Mail Order: $20 copay ($0 copay diabetic drugs and supplies)	Reimbursement based on network-negotiated price of medication, minus applicable copayment.	Retail: Up to 30-day supply; Mail Order: Up to 90-day supply $1,500 per member/$3,000 per family out-of-pocket limit for participating providers Deductible does not apply.
	Merck brand drugs, including those that transferred to Organon, provided there is no generic equivalent (Preferred brand drugs)	$0 copay	$0 copay	Organon brand drugs have $0 copay through the end of 2023, provided there is no generic equivalent
	Non-Merck/non-Organon brand drugs and Merck/Organon brand drugs that have a generic equivalent (Non-preferred brand drugs)	Non-Merck/non-Organon Brand Drugs when there is no generic equivalent: 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 network-negotiated price of medication, minus applicable copay and/or coinsurance. Any costs in excess of network-negotiated fees do not count toward the prescription drug out-of-pocket maximum limit.	Merck/Organon & non-Merck/non-Organon Brand Drugs where there is a generic: Retail: 40% coinsurance up to $100 maximum (per prescription); Mail order: 40% coinsurance up to $200 maximum (per prescription). $1,500 per member/$3,000 per family out-of-pocket limit for participating providers. Deductible does not apply.
	Specialty drugs	Same as above for generic and brand.	Same as above for generic and brand.	Certain specialty medications are only available through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Physician/surgeon fees	20% coinsurance	30% coinsurance of R&C	Preauthorization may be required. Also responsible for amounts over R&C.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	The carrier determines if the use of the emergency room meets the prudent layperson standard. Carrier must be contacted within 48 hours for in-network benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	30% coinsurance of R&C	None

If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance of R&C	Preauthorization is required. Failure to preauthorize could result in no coverage if care is deemed not medically necessary. Also responsible for amounts over R&C.
	Physician/surgeon fees	20% coinsurance	30% coinsurance of R&C	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Inpatient services	20% coinsurance	30% coinsurance of R&C	Preauthorization is required. Also responsible for amounts over R&C.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance of R&C	Preauthorization is required. Also responsible for amounts over R&C. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance of R&C	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance of R&C	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Rehabilitation services	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C.
	Habilitation services	20% coinsurance	30% coinsurance of R&C	Only applied behavioral analysis (ABA) therapy will be covered with diagnosis of autism spectrum disorder. Preauthorization and medical necessity required.
	Skilled nursing care	20% coinsurance	30% coinsurance of R&C	Up to 120 days per calendar year. Also responsible for amounts over R&C.
	Durable medical equipment	20% coinsurance	30% coinsurance of R&C	Also responsible for amounts over R&C
	Hospice services	20% coinsurance	30% coinsurance of R&C	Preauthorization is required for inpatient. Also responsible for amounts over R&C.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance of R&C Deductible 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

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. 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 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.

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.

* For more information about limitations and exceptions, see the plan or policy document at http://netbenefits.com/merck.

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, □□□□□□□ 800-666-3725.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at http://netbenefits.com/merck.

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 plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,010**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.