

2009

# Your HMO Coverage Information

Part 2 of Your Summary  
Plan Description

**Flex/Retiree**

Effective January 1, 2009  
Released October 17, 2008

**The complete Summary Plan Description (SPD)** for the Merck Medical Plan consists of General Information about the Merck Medical Plan – Part 1 of the SPD and Coverage Information – Part 2 of the SPD. Please note that the Coverage Information section of the SPD is divided into two separate documents:

- For information about the Health Maintenance Organization (HMO) options, please refer to this document, “Your HMO Coverage Information.”
- For information about the Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBS) options, please refer to “Your Horizon BCBS Medical Coverage Information.”

Together, Parts 1 and 2 of the SPD merely summarize the benefits and benefit coverage levels provided under the Merck Medical Plan. Details about the employees to whom the SPD applies can be found in “General Information about the Merck Medical Plan – Part 1 of the SPD.” Decisions regarding what treatments are appropriate (e.g., level and duration of care) are always left to the discretion of the patient and his/her attending physician.

This SPD replaces the Medical SPD dated January 2008, as applicable, entitled, “Your Medical Benefits Flex/Retiree” and all summaries of material modifications applicable to it dated before January 1, 2009. This SPD reflects the provisions of the Merck Medical Plan in effect as of January 1, 2009.

Merck reserves the right to amend the Merck Medical Plan in whole or in part or to completely discontinue the Merck Medical Plan at any time.

### **Frequently Used Terms**

Key words that are frequently used in the SPD are capitalized and defined in the Glossary, which is located in the “General Information about the Merck Medical Plan – Part 1 of the SPD.”

## **AETNA HMO OPTION**

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## Aetna HMO Option

The Aetna HMO is a form of managed health care through which you have access to a managed care provider network and a primary care physician (PCP). Your PCP provides routine care and referrals to other providers within the network, when necessary. There is no coverage for care received out-of-network or if you fail to have care coordinated through your PCP — except for emergencies. The Aetna HMO is administered by Aetna.

This section describes the self-insured Aetna HMO option that is available in New Jersey, New York, Pennsylvania, Delaware, Florida and Texas.

### KEY POINT — ELIGIBILITY

You are eligible to enroll in the Aetna HMO option if you are an Eligible Employee or Retiree whose home address on file with the Merck Benefits Service Center is within the New Jersey/New York, Pennsylvania/Delaware, Florida or Texas service areas. *Residents of Hawaii and Merck Temporary Employees are not eligible for the Aetna HMO option.*

Eligibility to participate in an Aetna HMO may be limited if you are a Retiree and you, or your Covered Dependent(s), are eligible for Medicare.

For a list of HMO options that are available in your geographic area, see the Regional HMO Options chapter of this SPD or visit NetBenefits<sup>SM</sup> at <http://netbenefits.fidelity.com>.

### About the Aetna HMO Option

Under the Aetna HMO option, you choose a primary care physician (PCP) who coordinates all of your medical care. Your PCP becomes familiar with your medical history, provides you with basic health care and refers you to specialists when necessary. Whenever you need care, simply contact your PCP. Most medical services are covered at 100% after you pay a \$15 Copay.

#### Key Features

- You generally file no claim forms;
- You pay a Copay for office visits and emergency room visits. Most other care is covered at 100%;
- You pay a fixed Copay per hospital admission;
- Your PCP manages your care;
- You pay the full cost for care outside the HMO (except in Emergencies); and
- You are eligible for the Aetna Behavioral Health Program.

#### Prescription Drug Benefits

When you enroll in the Aetna HMO option, you automatically receive coverage under Merck's Managed Prescription Drug Program. For more information, see the Managed Prescription Drug Program chapter of the "General Information about the Merck Medical Plan — Part 1 of the SPD."

## Behavioral Health Care

Your behavioral health care benefits are provided by the Aetna Behavioral Health Program in accordance with the Aetna HMO (not the Managed Behavioral Health Care Program that is available to the non-HMO options). See the “Aetna HMO At a Glance Chart” for more information. The information provided in the Behavioral Health Care section of the “General Information about the Merck Medical Plan – Part 1 of the SPD” does not apply to you.

## Aetna HMO Option At a Glance

The following chart summarizes the level of coverage under the Aetna HMO (New Jersey/New York, Pennsylvania/Delaware, Texas and Florida) for Medically Necessary covered expenses. There are no out-of-network benefits, except in the case of a medical Emergency. In addition, not all services that are Medically Necessary are covered. For a list of covered services see “What’s Covered Under the Aetna HMO.”

IN-NETWORK COVERAGE	
<b>COSTS</b>	
Annual Deductible	Doesn't apply
Coinsurance	The plan pays 100% (except for Copay)
Annual Out-of-Pocket Maximum	Doesn't apply
Lifetime Benefit Maximum	None (except where noted)
Reasonable and Customary (R&C) Limit	Doesn't apply
<b>PRESCRIPTION DRUGS</b>	
Outpatient prescriptions filled through Retail Pharmacies or Medco By Mail™	Provided under the Merck Managed Prescription Drug Program — see the “General Information about the Merck Medical Plan — Part 1 of the SPD” for coverage details
<b>PREVENTIVE MEDICAL CARE</b>	
Routine Annual Physical Exams (over age 6) <i>One exam every 12 months</i>	\$15 Copay
Well-Child Care (up to age 6)	\$15 Copay
Travel Immunizations	Covered at 100%; no Copay
Routine Immunizations	Covered at 100%
Routine Immunizations-Related Office Visits	\$15 Copay
Routine OB/GYN Exams <i>One exam per calendar year</i>	\$15 Copay
Annual Pap Test	Covered as part of OB/GYN exam
Mammography Screenings <i>One screening per year</i>	\$15 Copay Baseline between ages 35-39; ages 40 and above — one screening per year, unless additional screenings are prescribed by your physician as Medically Necessary
Routine Eye Exams <sup>1</sup> <i>One exam every 24 months</i>	\$15 Copay Eyewear discounts available through the Aetna Vision Discount Program
Routine Hearing Exams	\$15 Copay ( <i>One exam every 24 months</i> )
Allergy Testing	\$15 Copay
Allergy Treatment <i>Injections, serum</i>	\$15 Copay <i>No Copay when members are only picking up serum — office Copay applies when provider bills for allergy injection</i>

<sup>1</sup> See the schedule of covered routine vision exams in “What’s Covered Under the Aetna HMO.”

IN-NETWORK COVERAGE	
<b>OUTPATIENT MEDICAL CARE</b>	
Office Visits	\$15 Copay; \$15 Copay for after-hour visit or home visit
Prenatal Office Visits	\$15 Copay first OB visit; no Copay thereafter
Infertility Diagnosis and Treatment <sup>1</sup>	\$15 Copay per office visit
Infertility-Related Prescription Drugs	All drugs indicated for use in infertility treatment require prior authorization. You, your doctor or pharmacist must call Medco at <b>800-RX-MERCK</b> to obtain authorization before your prescription is filled in order to receive coverage under the Merck Managed Prescription Drug Program.
Lab/X-Ray	\$15 Copay
Chiropractic Care	\$15 Copay with PCP referral (up to 20 visits per calendar year)
Outpatient Surgery, same day procedure	Covered at 100%; no Copay
Short-Term Rehabilitation <sup>2</sup> <i>Speech, Occupational and Physical Therapy</i>	\$15 Copay, with PCP referral — unlimited visits during a 60 consecutive-day period per illness or injury beginning with the first day of treatment
<b>INPATIENT MEDICAL CARE</b>	
Hospital	Covered at 100% after \$250 Copay per inpatient admission
Surgical	Covered at 100% after \$250 Copay per inpatient admission
Maternity	Covered at 100% after \$250 Copay per inpatient admission
Short-Term Rehabilitation <sup>2</sup> <i>Speech, Occupational and Physical Therapy</i>	Covered at 100% with no Copay if authorized by Aetna's Patient Management/ Precertification teams
<b>OTHER MEDICAL CARE</b>	
Emergency Services	\$50 Copay, waived if admitted <i>Out-of-network emergency room visits are covered for serious or life-threatening Emergency care treated in an emergency room</i>
Durable Medical Equipment <i>Wheelchairs, walkers, etc.</i>	Covered at 100% with no Copay if certified by PCP and/or as precertified by Aetna as required
Prosthetics and Appliances <i>Artificial limbs, etc.</i>	Covered at 100% with no Copay if certified by PCP and/or as precertified by Aetna as required
Contraceptive Devices <i>Diaphragms, IUDs, implants, injections</i>	Not Covered <i>Oral contraceptives are covered under the Managed Prescription Drug Program through Medco By Mail Only. See "Managed Prescription Drug Program" in Part 1 of the SPD</i>
Skilled Nursing Facility	Covered at 100% with no Copay if certified by PCP <i>Up to 120 days per 365-day period</i>
Home Health Care	Covered at 100% with no Copay if authorized by Aetna's Patient Management/Precertification teams, unlimited as long as pre-approved
Hospice Care	Covered at 100% with no Copay if authorized by Aetna's Patient Management/Precertification teams, unlimited outpatient visits; inpatient limited to 60 days per lifetime

<sup>1</sup> For infertility diagnosis and treatment, including Artificial Insemination and Advanced Reproductive Technology (ART): Six attempt cycles per patient per lifetime for artificial insemination; three attempted transfers for ART per patient per lifetime under the Merck Medical Plan. A transfer constitutes the actual placing of the embryo (e.g., FET, GIFT, ET, TET, ZIFT) into the embryo recipient (i.e., female patient requesting pregnancy/or "donor"). If at a later date, the embryos are transferred, it is considered a new cycle and counted as another attempt toward the lifetime maximum. Each ART procedure counts as one attempt. Embryos can be frozen and transferred to the recipient to use at a later date, however, cryopreservation and related costs are not covered. All drugs indicated for use in infertility treatment require prior authorization through the Merck Managed Prescription Drug Program. You, your doctor or pharmacist must call Medco at **800-RX-MERCK** to obtain authorization before your prescription is filled to receive coverage under the Merck Managed Prescription Drug Program.

<sup>2</sup> Short-term rehabilitation may include physical, occupational and speech therapy for a limited period based on medical necessity. Maintenance therapy is not covered. Contact Aetna HMO for coverage details. Charges for physical, occupational and speech therapy in connection with developmental delays including delayed speech or speech impairments as a result of a learning disability are not covered. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function as a result of disease or injury.

OUT-OF-AREA SERVICES FOR NON-URGENT CARE	
Traveling Outside the Network Area	In-network benefits with PCP referral
MENTAL HEALTH AND SUBSTANCE ABUSE CARE	
Mental Health	
<i>Inpatient Treatment<sup>1</sup></i>	Covered at 100% after \$250 Copay per inpatient admission
<i>Outpatient Treatment</i>	\$15 Copay per visit, up to 20 visits per 365-day period
Substance Abuse	
<i>Inpatient Detoxification<sup>1</sup></i>	Covered at 100% after \$250 Copay per inpatient admission
<i>Inpatient Rehabilitation<sup>1</sup></i>	Covered at 100% after \$250 Copay per inpatient admission, up to 30 days per 365-day period
<i>Outpatient Rehabilitation</i>	\$15 Copay per visit, up to 60 visits per 365-day period

## Choosing a PCP Under the Aetna HMO

When you enroll in the Aetna HMO option, you must select a primary care physician (PCP) for yourself and any Covered Dependent(s) by contacting Aetna HMO. PCPs may be family practitioners, internists or pediatricians. Although OB/GYN specialists are primary care physicians, a woman may see a network OB/GYN for an annual check-up without a referral from her PCP.

PCPs for your area are listed in Aetna's HMO provider directory, which is available on Aetna's website at [www.aetna.com](http://www.aetna.com) or by calling Aetna HMO Member Services at **888-287-4296**. Since provider directories can become out-of-date, it's a good idea to call the office of the PCP to confirm that he/she is still a member of the Aetna network for the Aetna HMO option and intends to remain a member.

If your PCP drops out of the network after you enroll in the HMO option, you will be able to choose a new PCP, but you will not be able to change your medical option until the next annual enrollment period. In this case, such a change will become effective the next January 1<sup>st</sup>, unless you experience a Life Event that otherwise allows you to make a Permitted Plan Change or you are a Retiree.

### How to Select or Change Your PCP

When you enroll in the Aetna HMO, you must select your PCP on Aetna's website at [www.aetna.com](http://www.aetna.com) or by calling Aetna HMO Member Services at **888-287-4296**.

If you elect family coverage, you can select a different PCP for each Covered Dependent(s). For example, children may have a pediatrician as their PCP. Similarly, your PCP could be located near your workplace while your spouse's PCP could be near your home.

If your covered child lives outside your zip code, you may choose a PCP in your area for your child or you may choose a PCP in the area closest to where your child lives. Call Aetna HMO Member Services at **888-287-4296** for the appropriate provider directories.

**Note:** If you choose the HMO option, but do not select a PCP, you will receive an I.D. card indicating "no PCP" selection. To receive the in-network level of coverage, care must be coordinated by your PCP. Remember, until you notify Aetna that you have selected a PCP, claims submitted for services rendered are not eligible for payment.

<sup>1</sup> You must precertify all inpatient behavioral health and substance abuse hospitalizations and certain outpatient services by calling the precertification phone number on your I.D. card. If you don't have an I.D. card, call **800-424-1580** to precertify. See "Precertification of Behavioral Health Care Services" in Part 1 of the SPD for more information.

**KEY POINT — MERCK-CUSTOMIZED DOCFIND**

The Merck-customized DocFind feature through Aetna Navigator™ can help you quickly and easily locate doctors and providers who participate in the Aetna HMO network.

To register for Aetna Navigator, log on to [www.aetna.com](http://www.aetna.com) > select "Navigator Log In" from the "Secure Sites" drop-down menu > click on "Register Now" > complete the requested information.

**Your Aetna HMO I.D. Cards**

Several weeks after you enroll or change your PCP, Aetna will send you an identification card that lists your name and the names of all your Covered Dependent(s) enrolled in the Aetna HMO. Your I.D. card also lists the telephone number of the HMO PCP you have chosen. If you change any of your PCPs, you will automatically receive a new card displaying the changes. Always carry your I.D. card with you. It identifies you as an Aetna HMO participant when you receive services from participating providers or when you receive Emergency services at non-participating facilities. If your card is lost or stolen, call Aetna HMO Member Services at **888-287-4296**. Additionally, you will also receive a separate I.D. card for the Managed Prescription Drug Program from Medco, the prescription drug Claims Administrator.

**KEY POINT — SPECIALIST AS PRINCIPAL PHYSICIAN DIRECT ACCESS PROGRAM — AETNA HMO**

If you have a serious or complex medical condition, you may need ongoing specialty care. A "serious or complex medical condition" is generally a life-threatening, degenerative or disabling condition or disease such as AIDS, cancer, emphysema, an organ failure that may require a transplant or diabetes with target organ involvement. The Specialist as Principal Physician Direct Access Program is a voluntary program. Eligibility is based upon the nature of your medical condition, your need for continuing specialty care and a specialist's willingness to serve as your principal physician for treatment of the condition. Enrollment in the program must be approved by Aetna.

Once you are enrolled, a case manager will be available to answer questions about the features of the program, to assist with any necessary authorizations or precertifications and to facilitate communications between your PCP and the specialist treating your condition.

If you are interested in enrolling in the Specialist as Principal Physician Direct Access Program, contact Aetna HMO Member Services at **888-287-4296** and ask to be transferred to a disease management representative.

**Precertification of Behavioral Health Care and Substance Abuse Services**

All inpatient behavioral health and substance abuse hospitalizations require precertification through Aetna Behavioral Health. Most outpatient behavioral health care and substance abuse care services do not require precertification. However, you must precertify the following outpatient services:

- Intensive outpatient programs (IOP);
- Partial hospitalization programs;
- Psychological testing;
- Neuropsych testing;
- Outpatient ECT;
- Biofeedback; and
- Amytal interview and hypnosis (that are reimbursed at the outpatient level).

Please note that Retirees age 65 and older and their Covered Dependent(s) age 65 and older are not required to precertify behavioral health care and substance abuse care. Retirees under age 65 and their Covered Dependent(s) under age 65 are required to precertify the behavioral health care and substance abuse services described above.

To precertify behavioral health care and substance abuse services, call Aetna Behavioral Health's phone number on your I.D. card. If you haven't received your card yet, call Aetna Behavioral Health at 800-424-1580.

## In Case of an Emergency

If you or a Covered Dependent(s) have a medical or behavioral health Emergency, you should call 911 or seek assistance from the nearest emergency room or urgent care facility. You may obtain Emergency or urgent care from:

- A private practice physician;
- A walk-in clinic;
- An urgent care center; or
- Emergency facility.

## Emergency Room Care

If you are treated in an emergency room, the \$50 emergency room Copay is waived if you are admitted to the facility. Out-of-network emergency room visits are covered for serious or life-threatening Emergency care that is treated in an emergency room. Aetna determines whether use of an emergency room meets the prudent layperson standard of Emergency.

### KEY POINT — HOW EMERGENCY IS DEFINED

Emergency means a sudden, serious and unexpected illness, injury or condition that could place your life or health in immediate jeopardy including: Serious breathing difficulties; uncontrollable bleeding; major burns; caustic substance in eyes; sudden onset of severe chest pain; seizures/convulsions; unconsciousness; spinal injuries; shock and fractures. A behavioral health Emergency is defined using the prudent layperson standard. Any thoughts of hurting yourself or others constitutes an Emergency.

## Notify Your PCP Immediately

If you receive Emergency or urgent care, the treating physician or urgent care center should try to contact your PCP to allow your physician to contribute to the treatment. If your PCP is not contacted by the Emergency caregiver, you or a family member should notify your PCP of the treatment received as soon as possible. If you are admitted to an inpatient facility, you or a family member must notify the PCP and Aetna as soon as possible after admission. If you are not admitted to an inpatient facility, you must notify your PCP as soon as possible after the treatment received. Failure to promptly notify Aetna as required may result in the denial of coverage. **Note:** Follow-up care must be coordinated through your PCP.

## How to File a Claim

If you visit an Aetna HMO provider, you do not have to submit a claim form. You simply pay your Copay at the time of service. If you have a medical Emergency and visit a non-participating provider, you or your family member must notify your PCP as soon as possible after the treatment was received.

## Appealing a Claim

If you believe you are entitled to a benefit, or to a greater amount of benefits under the Aetna HMO option than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator. For more information, see "Claims and Appeals" in the Administrative Information section of the "General Information about the Merck Medical Plan — Part 1 of the SPD."

## What's Covered Under the Aetna HMO Option

This section provides an alphabetical list of Medically Necessary covered services and supplies for the Aetna HMO option, as limited by the Aetna Clinical Policy Bulletins, which you can access on Aetna Navigator at [www.aetna.com](http://www.aetna.com). Services that are not deemed Medically Necessary, as determined by Aetna, are not covered expenses (these include, but are not limited to, services that are deemed maintenance or custodial).

In addition, certain services that may be deemed Medically Necessary may not be covered expenses. See "What's Not Covered Under the HMO Option" or contact Aetna for more details. For more information on coverage limits, see the "Aetna HMO At a Glance Chart." Finally, since additional limits may apply, you should contact the Aetna HMO directly to confirm coverage for a particular service or supply.

**Chiropractic Services** are covered for up to 20 visits per calendar year.

**Durable Medical Equipment**, including but not limited to:

- Prosthetic devices;
- Orthotic devices, if they are used to control a change in the shape of the foot during growth or to relieve pressure on an injured or inflamed part of the foot (additional orthotics purchased only for your convenience are not covered); and
- Glucose monitors.

**Foot Orthotics used Only for Comfort or Support** or for the treatment of flat feet, pronation, corns, calluses and hammertoes. Examples of items *not* considered as a foot orthotic because they lack rigid construction are:

- Inner soles (foam rubber, leather, flexible, etc.); and
- Corn plasters (pads, etc.), foot padding (adhesive moleskin, etc.).

Arch supports are not covered for anyone other than for treatment of children with pes cavus, pes planus and pes varus. Orthotic shoes are covered, subject to medical necessity, for children under age 12. For anyone age 12 or older, up to one pair of orthotic shoes is covered per calendar year.

### Hospital Services and Supplies

- Semi-private room and board expenses;
- Medical and surgical specialist care;
- Administration of anesthesia;
- Ambulance services to the nearest hospital during a medical Emergency;
- Maternity services (see the Key Point on the next page for information about inpatient maternity hospitalizations);
- Diagnostic testing;
- Inpatient prescription drugs (while a hospital inpatient); and
- Chemotherapy.

### Hospital Alternatives

- Home health care, if authorized by Aetna;
- Private duty or special nursing, if authorized by Aetna; and
- Inpatient hospice, if authorized by Aetna.

**KEY POINT — NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Infertility Treatment**

- Artificial insemination, up to six attempt cycles per patient per lifetime (treatment received before January 1, 2002 does not count toward the Lifetime Benefit Maximum for infertility treatment).
- Advanced reproductive treatment (ART), up to three attempt cycles per patient per lifetime (treatment received before January 1, 2002 does not count toward the Lifetime Benefit Maximum for infertility treatment). A transfer constitutes the actual placing of the embryo (e.g., FET, GIFT, ET, TET, ZIFT) into the embryo recipient (i.e., female patient requesting pregnancy/or "donor"). If at a later date, the embryos are transferred, it is considered a new cycle and counted as another attempt toward the lifetime maximum. Each ART procedure counts as one attempt. This includes in vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intra fallopian transfer (GIFT), cryopreserved embryo transfers (excluding storage costs), intracytoplasmic sperm injection (ICSI) or ovum microsurgery. All drugs indicated for use in infertility treatment require prior authorization through the Merck Managed Prescription Drug Program. You, your doctor or pharmacist must call Medco at **800-RX-MERCK** to obtain authorization before your prescription is filled to receive coverage under the Merck Managed Prescription Drug Program.
- Infertility-related prescriptions are covered through the Managed Prescription Drug Program. Prior authorization is required. See the Managed Prescription Drug Program chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD."

Charges for infertility treatments in excess of the above maximums *do not qualify* as covered expenses. In addition, the following specific advanced reproductive treatment (ART) and/or artificial insemination (AI) services are not covered, including but not limited to:

- The purchase of donor sperm and any charge for storage of sperm and any charges incurred by the donor;
- Any charge associated with care of the donor required for donor egg retrievals or transfer;
- Charges associated with Cryopreservation or storage of cryopreserved embryos (e.g., charges for office, hospital, ultrasounds, laboratory tests, etc.); and
- Any compensation fees paid to the donor.

**Laboratory Tests/X-rays**, including diagnostic outpatient lab/x-ray testing (at Aetna-contracted facility or specialist's office).

**Medical Services** performed as an inpatient or outpatient in a hospital or an ambulatory surgical facility, provided the covered person has a condition (e.g., diabetes, heart condition, etc.) that makes the provisions of those services in that setting Medically Necessary.

**Physician Services**, including care or treatment by a licensed physician.

### Preventive Care

- Routine hearing exams (one exam every 24 months);
- Routine physicals (see also "Vision" for frequency of eye exam coverage);
- Routine child and well-baby care (up to age 6);
- Immunizations;
- Routine gynecological care;
- Routine mammography (one mammogram per year for women age 40 and over);
- Fecal occult blood tests;
- Allergy testing/treatment; and
- Diagnostic outpatient lab/x-ray testing.

**Reconstructive Surgery** following a mastectomy, including expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses and the costs for treatment of physical complications at any stage of the mastectomy including lymphedemas, as required by federal law. Normal Plan Copays will apply.

**Rehabilitation Therapy.** Short-term outpatient therapy is covered with PCP referral. Treatment is covered over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment and may include physical, speech and occupational therapy for a limited time if required to restore a function that was lost due to illness or injury.

**Surgery.** Inpatient and outpatient hospital and surgical treatment for an illness or injury.

#### KEY POINT — NATIONAL MEDICAL EXCELLENCE PROGRAM®

The National Medical Excellence Program from Aetna can help you receive access to appropriate care in an appropriate setting. For more information, call Aetna HMO Member Services at **888-247-4296**.

##### The National Transplantation Program

The Institutes of Excellence network provides access to facilities that have exhibited successful clinical outcomes and have been credentialed using quality criteria. When significant travel is required to use an Institutes of Excellence facility, you and one companion may be eligible for travel and lodging allowances. Travel and Lodging allowances are available only with pre-certification by Aetna. Travel and lodging is limited to \$50 per day per person, up to a maximum of \$100 per day and a total of \$10,000 per occurrence. Transplant services, including evaluation, must be preauthorized by Aetna. Refer to Aetna DocFind at [www.aetna.com/docfind/custom/merck](http://www.aetna.com/docfind/custom/merck) for a listing of Institutes of Excellence network facilities.

##### The National Special Case Program

If faced with a rare or complex condition requiring specialized treatment, the National Medical Excellence Program collaborates with you and your health care team in evaluating treatment options.

**Vision.** Most vision care is available through the Vision Plan. See "Your Vision Benefits SPD." The Aetna HMO option covers one exam every 24 months. Discounts on eyeglasses and contact lenses are available. For more information about the Aetna Vision Discount Program call **800-793-8616**.

### Women's Health

- One routine wellness exam, including Pap Smear, once per calendar year;
- Mammography screenings;
- Follow-up gynecological care;
- Obstetrical care;
- Prenatal care; and
- Gynecological-related problems.

#### KEY POINT — WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits with respect to mastectomy must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to Annual Deductibles and Coinsurance provisions applicable to other such medical and surgical benefits provided under the Plan.

For more information contact the Merck Benefits Service Center at **800-66-MERCK**.

### What's Not Covered Under the Aetna HMO Option

There are some expenses that are not covered by the Aetna HMO option. For confirmation of covered medical expenses, contact Aetna HMO Member Services at **888-287-4296**.

## Regional HMO Options

In addition to the Aetna HMO option, Merck also offers a number of regional HMO options to Eligible Employees (except Merck Temporary Employees) and Retirees. This section provides a brief overview of the Regional HMO options. For more information about a specific HMO, including participating providers, contact the HMO directly.

### KEY POINT – ELIGIBILITY

You are eligible to enroll in an HMO option if you are an Eligible Employee or Retiree who lives in an HMO service area. To find out which HMO(s) are available in your area, see your Enrollment Worksheet on NetBenefits at <http://netbenefits.fidelity.com>. Please note that a Retiree's ability to enroll in an HMO may be limited by the Medicare status of the Retiree and their Covered Dependent(s). Retirees who are Medicare eligible may enroll in a Medicare Advantage HMO, if one is available. Contact the Merck Benefits Service Center at **800-66-MERCK** for more information about the HMOs that may be available to you.

### About the HMO Options

An HMO is a highly-managed form of coverage. When you enroll in an HMO, you may be required to choose a physician as your primary care physician (PCP) who handles or arranges for all of your care. With most HMOs, you must receive medical treatment or services from participating providers. Any services received outside the HMO network are generally not covered, except in the case of a medical Emergency. You may locate participating HMO providers through NetBenefits at <http://netbenefits.fidelity.com>, the HMO's website or by calling the HMO directly.

Merck currently offers the following HMO options.

HMO	MEDICARE ADVANTAGE HMO
Aetna HMO – NJ/NY, PA/DE, FL, TX	Aetna HMO – NJ/NY/PA
BlueOptions – NC, Exclusive Provider Network (EPO)	Geisinger Health Plan Gold PA
CIGNA HealthCare – NC	Kaiser Permanente – Southern CA
Geisinger Health Plan – PA	Keystone Health Plan Central – PA
Health Plan Hawaii Plus – HI	Keystone Health Plan East – PA
Kaiser Permanente – CA	PacifiCare of CA
Keystone Blue – PA	
Keystone Health Plan Central – PA	
Keystone Health Plan East – PA	
Network New England Blue – MA	
Oxford Health Plans – NJ	
PacifiCare SignatureValue <sup>SM</sup> – CA	
Southern Health – VA	

## For More Information

All benefits, limitations and exclusions for the HMO options are listed in their respective member brochures and contracts. The HMO will supply you with the written materials concerning:

- The nature of services provided to members;
- Conditions pertaining to eligibility to receive services (other than general conditions pertaining to eligibility for participation in the Merck Medical Plan) and circumstances under which services may be denied; and
- The procedures to be followed in obtaining such services.

For more information about an HMO, including covered services, contact the HMO directly. See “Contact Information” at the end of this SPD for telephone numbers and website addresses.

This Merck Benefits Book together with the written information describing coverage under an HMO option (other than the Aetna HMO of NY/NJ, PA/DE, FL and TX) provided to you by the HMO (e.g., brochures, contracts, booklets, certificate of insurance, etc.) constitute the Summary Plan Description for that HMO option under the Merck Medical Plan.

### KEY POINT — DEPENDENT ELIGIBILITY RULES IN CERTAIN STATES

Some state laws mandate eligibility for individuals that are not considered Eligible Dependent(s) under the Merck Plan (e.g., older than age 19 or 25, if a full-time student). If you are covered under an insured HMO option in a state where this is applicable, you should contact the HMO for more information. Keep in mind that premiums for this coverage must be fully paid for by the covered individual directly to the HMO.

## How to File a Claim

If you visit a Regional HMO provider, you do not have to submit a claim form. You simply pay your Copay at the time of service. If you have a medical Emergency and visit a non-participating provider, you or your family member must notify your PCP as soon as possible after the treatment was received.

## Appealing a Claim

If you believe you are entitled to a benefit, or to a greater amount of benefits under the Regional HMO option than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator. For more information, see “Claims and Appeals” in the Administrative Information section of the “General Information about the Merck Medical Plan – Part 1 of the SPD.”

## Contact Information

When you have a question or need information about your HMO benefits, there are many resources that can help.

If you are enrolled in the Aetna HMO, you can reach Aetna HMO Member Services at 888-287-4296.

### Aetna Navigator™ at [www.aetna.com](http://www.aetna.com)

Aetna Navigator™ is Aetna’s secure self-service member website, available 24 hours a day, 7 days a week. You can access benefits and health information, who’s listed as a covered dependent, cost tools and a comprehensive health encyclopedia. In addition to obtaining health information, you can also conduct transactions such as ordering a member I.D. card and changing your primary care physician. This site also contains the Aetna Clinical Policy Bulletins, which you can review to understand the medical criteria that Aetna uses to determine which services are Medically Necessary. To register for Aetna Navigator, simply log on to [www.aetna.com](http://www.aetna.com), select Aetna Navigator from the “Quick Tools” drop-down box, click on the “Register” link and complete the requested information.

### Merck-Customized DocFind at [www.aetna.com/docfind/custom/merck](http://www.aetna.com/docfind/custom/merck)

If you are covered under the Aetna HMO, you can access a Merck-specific DocFind page through Aetna Navigator. This Merck-specific DocFind page will help you locate doctors and providers.

### Additional Resources Are Also Available

	PROVIDER	CONTACT
<b>MERCK BENEFITS</b>		
<b>Merck Benefits</b> <i>New Hire Enrollment, COBRA, Life Events</i>	Merck Benefits Service Center	800-66-MERCK (800-666-3725) <a href="http://netbenefits.fidelity.com">http://netbenefits.fidelity.com</a>
<b>Merck Payroll, New Hire, General HR Policies</b>	Merck HR Service Center	866-MRK-HR4U (866-675-4748)
<b>Merck Benefits Information, Forms, Literature</b>	Merck Intranet/Website	<a href="http://hr.merck.com">http://hr.merck.com</a>
	Merck Benefits Service Center	800-66-MERCK (800-666-3725) <a href="http://netbenefits.fidelity.com">http://netbenefits.fidelity.com</a>
<b>OTHER HEALTH BENEFITS</b>		
<b>Aetna Vision Discount Program</b>	Aetna	800-793-8616 <a href="http://www.aetna.com">www.aetna.com</a>
<b>Managed Prescription Drug Program</b>	Medco Health Solutions, Inc.	800-RX-MERCK (800-796-3725) <a href="http://www.medco.com">www.medco.com</a>
<b>ELIGIBILITY</b>		
<i>Questions about Eligibility, Add or Drop a Dependent(s)</i>	Merck Benefits Service Center	800-66-MERCK (800-666-3725) <a href="http://netbenefits.fidelity.com">http://netbenefits.fidelity.com</a>

	PHONE	WEB
<b>AETNA HMO OPTIONS</b>		
Aetna HMO – NJ/NY, PA/DE and FL/TX	888-287-4296	www.aetna.com
<b>REGIONAL HMO OPTIONS</b>		
BlueOptions – NC, Exclusive Provider Network (EPO)	877-258-3334	www.bcbsnc.com
CIGNA HealthCare – NC	800-849-9300	www.cigna.com
Geisinger Health Plan – PA	800-447-4000	www.thehealthplan.com
Health Plan Hawaii Plus – HI	808-948-6372	www.hmsa.com
Kaiser Permanente – CA	800-464-4000	www.kaiserpermanente.org/ california
Keystone Blue – PA	800-547-9378	www.highmarkbcbs.com
Keystone Health Plan Central – PA	800-669-7061	www.capbluecross.com
Keystone Health Plan East – PA	800-227-3114	www.ibx.com
Network New England Blue – MA	800-358-2227	www.bluecrossma.com
Oxford Health Plans – NJ	800-760-4566	www.oxfordhealth.com
PacifiCare SignatureValue <sup>SM</sup> – CA	800-624-8822	www.pacificare.com
Southern Health – VA	800-627-4872	www.southernhealth.com
<b>MEDICARE ADVANTAGE HMO OPTIONS</b>		
Aetna HMO – NJ/NY/PA	888-287-4296	www.aetna.com
Geisinger Health Plan Gold PA	800-498-9731	www.thehealthplan.com
Kaiser Permanente – Southern CA	800-464-4000	www.kaiserpermanente.org/ california
Keystone Health Plan Central – PA	800-779-6962	www.capbluecross.com
Keystone Health Plan East – PA	800-645-3965	www.ibx.com
PacifiCare of CA	800-624-8822	www.pacificare.com

*The information contained herein has been provided by Merck and is solely the responsibility of Merck.*