

2009

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

INTRODUCTION

ABOUT HORIZON BCBS

- 1 Horizon BCBS Customer Service Team
- 1 BlueCard® Network Providers
- 2 Precious Additions®
- 2 Carewise® — 24/Seven Nurse-Line
- 2 Complex Cases and Other Assistance by Horizon BCBS

MERCK PPO OPTION

- 4 About the Merck PPO Option
- 5 How the Merck PPO Option Works
- 5 Merck PPO Option At a Glance
- 10 Precertification
- 11 In Case of an Emergency
- 12 How to File a Claim

MERCK 80/20 OPTION

- 14 About the Merck 80/20 Option
- 15 How the Merck 80/20 Option Works
- 15 Merck 80/20 Option At a Glance
- 20 Precertification
- 21 Precertification of Behavioral Health Care Services
- 22 In Case of an Emergency
- 23 How to File a Claim

MERCK 80/20 OUT-OF-AREA OPTION

- 25 About the Merck 80/20 Out-of-Area Option
- 26 Merck 80/20 Out-of-Area Option At a Glance
- 30 Precertification
- 31 Precertification of Behavioral Health Care Services
- 32 In Case of an Emergency
- 33 How to File a Claim

RETIREE CATASTROPHIC OPTION

- 35 About the Retiree Catastrophic Option
- 36 How the Retiree Catastrophic Option Works
- 36 Retiree Catastrophic Option At a Glance
- 40 Precertification
- 41 In Case of an Emergency
- 42 How to File a Claim

COVERED SERVICES

- 44 What's Covered Under the Horizon BCBS Medical Options

SERVICES NOT COVERED

- 51 What's Not Covered Under the Horizon BCBS Medical Options

SCHEDULE A

OUT-OF-POCKET MAXIMUM AMOUNTS

- 55 Merck PPO Option
56 Merck 80/20 Option
57 Merck 80/20 Out-of-Area Option

- 58 **CONTACT INFORMATION**

About Horizon BCBS

Horizon BCBS is the Claims Administrator and fiduciary for the Merck PPO, Merck 80/20, Merck 80/20 Out-of-Area and Retiree Catastrophic options. This section describes the tools and resources Horizon BCBS offers to help you manage your health and your health care. As the Claims Administrator and fiduciary, Horizon BCBS, not Merck, makes the final determination regarding claims for coverage under the Merck Medical Plan non-HMO options.

KEY POINT — ABOUT CLAIMS

Horizon BCBS is the Claims Administrator and fiduciary for the non-HMO Merck Medical Plan options. As Claims Administrator and fiduciary, Horizon BCBS determines how individual claims are paid in accordance with the Plan. Merck does not substitute its judgment for Horizon BCBS decisions with respect to claims administration.

Horizon BCBS Customer Service Team

If you have questions about your coverage, need help finding a physician, want to check the status of a claim or request I.D. cards, contact Horizon BCBS at 877-663-7258.

Horizon BCBS website www.horizonblue.com/merck or www.horizonblue.com/merckretirees

Horizon BCBS's website is a secure self-service member website designed specially for Merck Employees and Retirees, available 24 hours a day, seven days a week. You can access benefits and health information, including claims, who's listed as covered, cost tools and a comprehensive health encyclopedia. To register for Horizon's website, simply log on to the appropriate site:

- For active employees: www.horizonblue.com/merck; or.
- For retirees: www.horizonblue.com/merckretirees.

At the website, select "sign up now" and complete the requested information.

BlueCard® Network Providers

The national provider networks are referred to as BlueCard PPO and BlueCard Traditional. The Merck PPO option utilizes the BlueCard PPO network while the Merck 80/20, the Merck 80/20 Out-of-Area and the Retiree Catastrophic options utilize the BlueCard Traditional network.

BlueCard PPO is a national provider network and is the only network in which providers will be considered In-Network under the Merck PPO option. Members enrolled in this option receive the highest level of benefits when they receive treatment from an In-Network provider.

BlueCard Traditional is a national provider network and is the only network in which providers will be considered In-Network under the Merck 80/20 option, Merck 80/20 Out-of-Area option and Retiree Catastrophic option. Members enrolled in one of these options receive the same level of benefits regardless of the network status of the provider they utilize. However, members who receive treatment from a participating BlueCard Traditional provider will receive BlueCard negotiated discounts.

Note that the BlueCard Traditional network is not considered In-Network for the Merck PPO option and the BlueCard PPO network is not considered In-Network for the Merck 80/20 option, Merck 80/20 Out-of-Area option and Retiree Catastrophic option. So, if you are looking for an In-Network provider, be sure to confirm that the provider is in the appropriate network.

Members who utilize In-Network providers through the BlueCard PPO or BlueCard Traditional networks will receive the following advantages:

- No up front billing (other than office visit Copay or Coinsurance);
- BlueCard providers will file all claims on your behalf; and
- BlueCard providers will accept the allowance as payment in full leaving you only responsible for any Deductible, Copay and/or Coinsurance.

You can find an In-Network BlueCard provider by calling the Merck Dedicated Customer Service team at 877-663-7258 or by visiting the appropriate website:

- For active employees: www.horizonblue.com/merck; or
- For retirees: www.horizonblue.com/merckretirees.

Precious Additions[®]

Precious Additions, Horizon BCBS's Pregnancy Management program, is designed to provide support in every aspect of your pregnancy, from the first physician visit through the transition home from the hospital after delivery. You can enroll yourself in the program by calling the Horizon Customer Service team or by logging on to www.horizonblue.com/Merck. For more information, contact Horizon BCBS at 877-663-7258.

Carewise[®] — 24/Seven Nurse-Line

Horizon BCBS's Carewise (888-624-3096) gives you and your family access to registered nurses 24 hours a day, seven days a week. This toll-free line connects members to a team of nurses experienced in providing information on a variety of health topics. Carewise nurses provide information about health issues, medical procedures and treatment options, and help members communicate more effectively with their doctors. Carewise nurses can provide information on more than 5,000 health topics. Keep in mind that only a doctor can diagnose, prescribe or give medical advice. Members should contact their doctors first with any questions or concerns regarding their health care needs.

Please note that Carewise is not a substitute for calling Horizon BCBS or ValueOptions[®] to precertify services. For more information about ValueOptions, please refer to the Managed Behavioral Health Care Program chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD."

Complex Cases and Other Assistance by Horizon BCBS

Horizon BCBS offers a voluntary program to assist those with complex or severe medical situations requiring a lengthy hospital stay, such as:

- Catastrophic accidental medical injuries;
- Cancer;
- High-risk pregnancy or premature infants;
- Lung disorder;
- Cardiac problems or stroke; or
- Multiple sclerosis.

Some other conditions may also qualify you for the program. Call Horizon BCBS to discuss your situation if you would like their assistance. Medical management specialists can work with your physician to develop a plan for your inpatient care, as well as your care after you are discharged. For example, Horizon BCBS can arrange home health care services. Horizon BCBS can also arrange for therapeutic care at a skilled nursing facility (care must be precertified) when it would be better for the patient than recuperating in the hospital. In addition, Horizon BCBS can arrange hospice care if you or a covered family member is terminally ill.

KEY POINT – THE BLUE DISTINCTION CENTER FOR TRANSPLANTATION

If your physician has recently discussed with you the need for transplantation, please contact Horizon BCBS in order to obtain information regarding our participating national transplant facilities. Horizon BCBS presently participates with the Blue Distinction Center for Transplantation, a national, comprehensive network of transplant centers for both solid organ and bone marrow transplants.

The Horizon BCBS case management program is available to assist you throughout the transplantation process. When you need to travel 100 or more miles to use a Blue Distinction facility, you and one companion may be eligible for travel and lodging allowances. Travel and Lodging allowances are available only with precertification. 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. For more information, call Horizon BCBS at **877-663-7258**.

Transplant services, including evaluation, must be precertified by Horizon BCBS.



Merck PPO Option

The Merck PPO option is administered by Horizon BCBS and gives you the flexibility to see any licensed health care provider of your choice.

KEY POINT – ELIGIBILITY

You are eligible to enroll in the Merck PPO option if you are an Eligible Employee or a Retiree and your home address on file with Fidelity Investments is within the BlueCard PPO network area. *Eligible Employees who are residents of Hawaii and Merck Temporary Employees are not eligible for the Merck PPO option.*

About the Merck PPO Option

The Merck PPO option covers you for a range of services, including preventive care, hospitalizations and Emergency care. When you visit a health care provider who participates in the BlueCard PPO network you will pay lower out-of-pocket costs than if you obtained care from an Out-of-Network provider. Under the Merck PPO you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. Horizon BCBS is the Claims Administrator and fiduciary for the Merck PPO option.

Key Features

In general, under the Merck PPO option:

- You may receive care from any licensed provider of your choice.
- Every time you need care, you have the choice to see an In-Network or Out-of-Network provider. However, if you do obtain care from an Out-of-Network provider you will likely pay more for those services.
- Network providers have agreed in advance to accept specific negotiated fees, so you will never have to pay for fees in excess of Reasonable and Customary (R&C) Limits if you use a network provider.
- Generally, you must meet an Individual Deductible or Family Deductible before the Plan pays for In-Network or Out-of-Network coverage.
- You will pay \$15 for an In-Network doctor's office visit and \$25 for an In-Network specialist office visit.
- If you receive care Out-of-Network, your Coinsurance for most covered expenses will generally be paid at 70% after you meet the Deductible, subject to R&C Limits.
- You must precertify certain services, including inpatient hospitalization, certain surgeries and certain maternity care.

Prescription Drug and Behavioral Health Benefits

When you enroll in the Merck PPO option, you automatically receive coverage under Merck's Managed Prescription Drug Program. If your medical coverage is provided through the Flexible Benefits Program, you also receive coverage in the Managed Behavioral Health Care Program. For more information, see the Managed Prescription Drug Program and Managed Behavioral Health

Care Program chapters in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

Note: Retirees are not eligible to participate in the Managed Behavioral Health Care Program. Mental health and substance abuse benefits for Retirees are coordinated through the Merck PPO option and administered by Horizon BCBS.

How the Merck PPO Option Works

Each time you receive care for covered expenses you have a choice of obtaining care In-Network, using one of the BlueCard PPO providers, or Out-of-Network from any other physician of your choice. You pay an Annual Deductible each year for In-Network and Out-of-Network coverage, then the Merck Medical Plan pays a percentage of your covered expenses. If you receive care Out-of-Network, the Merck Medical Plan pays a percentage up to R&C Limits.

In-Network Benefits

You receive the highest level of benefits available under the Merck PPO option when you use an In-Network provider. Every time you visit a health care provider who participates in the BlueCard PPO network, you have the potential to save money – and the Company does too. Since the In-Network provider’s fees are negotiated (and generally lower), you are charged less. Plus, you have to satisfy a lower Deductible before the Plan begins to pay In-Network benefits than you do for Out-of-Network benefits. This means you pay less out of your own pocket for health care. Your In-Network provider files claims for you so you don’t have to do the paperwork, or worry about being billed for costs that exceed the negotiated fees or R&C Limits.

Generally, most physician office visits are covered at 100% after you pay a \$15 Copay, or a \$25 Copay for an office visit to a specialist. After you satisfy the annual In-Network Deductible, other services may require you to pay a Coinsurance amount until you reach the annual Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the Merck Medical Plan pays 100% of covered expenses for the remainder of the calendar year.

Out-of-Network Benefits

Each time you need care, you can choose to see a provider who does not belong to the BlueCard PPO network. The difference is that you likely will pay more for Out-of-Network care. You are also responsible for any expenses above the R&C Limit (even if you have met your Out-of-Pocket Maximum for the year). You will be considered to have chosen to go Out-of-Network if you receive care from a provider who does not participate in the BlueCard PPO network.

KEY POINT – IMPORTANT BENEFIT TERMS

Important benefit terms, such as Annual Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the Glossary located in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

Merck PPO Option At a Glance

The charts on the following pages summarize the coverage levels for services under the Merck PPO option. *For Out-of-Network services, there is no coverage for charges above the Reasonable and Customary (R&C) Limit.* The Coinsurance percentages apply after you have met any applicable Deductibles and assume you have not already reached the Out-of-Pocket Maximum. Except for the preventive services listed on the following pages, there is no coverage for services that Horizon BCBS determines are not Medically Necessary. In addition, not all services that are Medically Necessary are covered. See “What’s Covered Under the Horizon BCBS Medical Options” for a complete list of covered services and any applicable additional limitations under the Merck PPO option.

Merck PPO Option At a Glance

	In-Network Coverage	Out-of-Network Coverage ¹
COSTS		
Annual Deductible ² <i>Individual</i> <i>Family</i>	\$250 \$500	\$500 \$1,000
Coinsurance	Plan pays: 90% You pay: 10%	Plan pays: 70% of R&C Limit You pay: 30% of R&C Limit plus any amounts in excess of R&C Limit
Annual Out-of-Pocket Maximum ² <i>Individual</i> <i>Family</i> <i>See "Schedule A" at the back of this booklet for complete information about your annual Out-of-Pocket Maximum</i>	Minimum \$750; maximum \$3,200 Minimum \$1,500; maximum \$6,400	Minimum \$1,500; maximum \$6,400 Minimum \$3,000; maximum \$12,800
Lifetime Benefit Maximum	None ³	
Reasonable and Customary (R&C) Limit	Not applicable	Applies
PREVENTIVE MEDICAL CARE — EXAMS		
Well-Child Care <i>(up to age 6)</i>	\$15 Physician Copay \$25 Specialist Copay	70% of R&C Limit, no Deductible
Routine Annual Physical Exams <i>One exam per calendar year (over age 6)</i>	\$15 Physician Copay \$25 Specialist Copay	70% of R&C Limit, no Deductible
Routine Immunizations	100%, no Copay and no Deductible	100% of R&C Limit, no Deductible
Routine Immunization-Related Office Visits	\$15 Physician Copay \$25 Specialist Copay	70% of R&C Limit, no Deductible
Routine Preventive OB/GYN Exams <i>One exam per calendar year</i>	\$15 Copay	70% of R&C Limit, no Deductible
Routine Eye Exams <i>One exam every 24 months</i> <i>Eyewear discounts available through Complete Advantage™⁴</i>	\$15 Physician Copay \$25 Specialist Copay	70% of R&C Limit, no Deductible
Routine Hearing Exams <i>One exam every 24 months</i>	\$15 Physician Copay \$25 Specialist Copay	70% of R&C Limit, no Deductible
Routine Preventive Lab/X-Ray ⁵ <i>Services related to routine annual physical exams limited to one per calendar year (over age 6)</i>	100%, no Deductible	70% of R&C Limit, no Deductible

¹ For Out-of-Network charges, you pay the Coinsurance amount plus the full amount of any charges above the Reasonable and Customary (R&C) Limit. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Expenses incurred to satisfy your Deductible and Out-of-Pocket Maximum will be credited to both your In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

³ Certain treatment limits may apply to certain services such as infertility-related services and inpatient substance-abuse treatment.

⁴ For more information about the Complete Advantage Discount Program and participating providers, contact Complete Advantage Customer Service at **877-518-8748**.

⁵ Coverage for routine preventive lab/x-ray is determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force and guidelines established by the American Medical Association (AMA) and provided they are designated by your physician as preventive. Contact Horizon BCBS at **877-663-7258** or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services.



	In-Network Coverage	Out-of-Network Coverage ¹
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY		
Certain Preventive Services that Are Not Part of a Routine Annual Physical/Office Visit ²	100%, no Deductible	70% of R&C Limit, no Deductible
Routine Mammography Screenings <i>Ages 35–39, one baseline; ages 40 and above, one screening per year; additional screenings if prescribed by your physician as Medically Necessary</i>	100%, no Deductible <i>If additional screenings are prescribed by your physician as Medically Necessary, 90% after Deductible</i>	70% of R&C Limit, no Deductible <i>If additional screenings are prescribed by your physician as Medically Necessary, 70% of R&C after Deductible</i>
Routine Preventive Pap Test <i>One per calendar year</i>	100%, after office visit Copay	70% of R&C Limit, no Deductible
OUTPATIENT MEDICAL CARE		
Office Visits	\$15 physician Copay \$25 specialist Copay	70% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a doctor's office</i>	\$15 physician Copay \$25 specialist Copay	70% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a hospital or ambulatory surgical center</i>	90%, after Deductible <i>Includes physician's charges</i>	70% of R&C Limit, after Deductible <i>Includes physician's charges</i>
Allergy Testing	\$15 physician Copay \$25 specialist Copay	70% of R&C Limit, after Deductible
Allergy Treatment <i>Injections, serum</i>	\$15 physician Copay \$25 specialist Copay <i>Copay only applies when office visit is billed</i>	70% of R&C Limit, after Deductible
Infertility Diagnosis and Treatment ³ <i>Artificial insemination, advanced reproductive treatment (ART)</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Chiropractic Care <i>Up to 25 visits per calendar year per person</i> <i>Maintenance therapy not covered</i>	\$25 specialist Copay	70% of R&C Limit, after Deductible
Acupuncture <i>For pain, illness or injury when performed by an M.D., D.O. or state-licensed physician or practitioner and is Medically Necessary</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Second Surgical Opinion	\$15 physician Copay \$25 specialist Copay	70% of R&C Limit, after Deductible

¹ For Out-of-Network charges, you pay the Coinsurance amount plus the full amount of any charges above the Reasonable and Customary (R&C) Limit. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Preventive care services are covered as determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force. Contact Horizon BCBS at **877-663-7258** or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services.

³ For infertility: 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. These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, you do not restart these limits. 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.



	In-Network Coverage	Out-of-Network Coverage ¹
OUTPATIENT MEDICAL CARE continued		
Short-Term Rehabilitation ² <i>Physical therapy, occupational therapy, speech therapy</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Oral Surgery <i>Certain procedures if performed in a hospital or ambulatory surgical facility due to medical necessity³</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Outpatient Hospice Care <i>Includes bereavement counseling for one year</i>	90%, after Deductible	70% of R&C Limit, after Deductible
OUTPATIENT MEDICAL CARE — LABS AND X-RAY		
Diagnostic Labs and X-Rays <i>Performed in a physician's office</i>	100%, after office visit Copay	70% of R&C Limit, after Deductible
Diagnostic Labs and X-Rays <i>Performed in an outpatient hospital or other outpatient facility (including lab processing)</i>	90%, after Deductible	70% of R&C Limit, after Deductible
INPATIENT MEDICAL CARE		
Inpatient Hospital Services <i>Includes inpatient surgery expenses, semi-private room and board, physician expenses, routine nursery care, prescription drugs, all other inpatient care</i>	90%, after Deductible Precertification required ⁴	70% of R&C Limit, after Deductible Precertification required ⁴
Maternity Services <i>Delivery charges in a hospital or approved, licensed birthing center</i>	90%, after Deductible Precertification required ⁴	70% of R&C Limit, after Deductible Precertification required ⁴
Inpatient Hospice Care <i>Up to 60 days per lifetime</i>	90%, after Deductible Precertification required ⁴	70% of R&C Limit, after Deductible Precertification required ⁴
OTHER SERVICES		
Emergency Services <i>Ambulance Emergency Room Urgent Care</i>	90%, after Deductible 90%, after Deductible ⁵ \$15 physician Copay; \$25 specialist Copay	90% of R&C Limit, after Deductible 90% of R&C Limit, after Deductible ² 70% of R&C Limit, after Deductible

¹ For Out-of-Network charges, you pay the Coinsurance amount plus the full amount of any charges above the Reasonable and Customary (R&C) Limit. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Short-term rehabilitation may include physical, occupational and speech therapy for a limited period based on medical necessity. Maintenance therapy is not covered. Contact Horizon BCBS at **877-663-7258** 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.

³ Oral surgery performed in a dental office, whether it be dental or medical in nature, will be considered for payment under dental benefits only. See The Merck Dental Plan SPD for information. Oral surgery that is not performed in a dental office which is dental or medical in nature may be considered for payment under medical benefits, provided the patient has a medical condition where medical necessity requires service outside of a dental office.

⁴ You must precertify all inpatient medical hospitalizations with Horizon BCBS at **877-663-7258**, including surgeries and certain maternity care. Failure to precertify Medically Necessary care will result in a 20% reduction in coverage for both In-Network and Out-of-Network care. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify inpatient care.

⁵ If your emergency room visit is deemed not to be an Emergency, your coverage will be reduced by 20% for both In-Network and Out-of-Network coverage. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency. If you or a Covered Dependent(s) are admitted, you must call Horizon BCBS at **877-663-7258** within 48 hours (even if you are discharged by then) to receive In-Network benefits, if applicable. If you do not call within 48 hours you will receive Out-of-Network benefits, and the 20% reduction for failure to precertify care.

	In-Network Coverage	Out-of-Network Coverage¹
OTHER SERVICES (continued)		
Durable Medical Equipment ² <i>Wheelchairs, walkers, etc.</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Foot Orthotics ³	90%, after Deductible	70%, after Deductible
Prosthetics and Appliances <i>Artificial limbs, etc.</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Skilled Nursing Facility <i>Up to 120 days per calendar year</i>	90%, after Deductible	70% of R&C Limit, after Deductible
Home Health Care	90%, after Deductible	70% of R&C Limit, after Deductible
Custodial Care	Not covered	Not covered
Contraceptive Devices ⁴ <i>Diaphragms, IUDs, implants, injections</i>	90%, after Deductible	70% of R&C Limit, after Deductible
PRESCRIPTION DRUG BENEFITS		
Inpatient	90%, after Deductible Merck-brand drugs covered at 100%	70% of R&C Limit, after Deductible Merck-brand drugs covered at 100%
Outpatient — Drugs Administered in a Doctor's Office or provided by a Doctor for In-Home Administration, unless ordered for the patient through Medco By Mail™	100% coverage, no Deductible after payment of the applicable office visit Copay	70% of R&C Limit, after Deductible Merck-brand drugs covered at 100%
Outpatient — Drugs Administered in an Ambulatory Surgical Facility	90%, after Deductible Merck-brand drugs covered at 100%	70% of R&C Limit, after Deductible Merck-brand drugs covered at 100%
Outpatient — Prescriptions Filled through Retail Pharmacies or Medco By Mail	Provided under the Merck Managed Prescription Drug Program. See that chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD."	

¹ For Out-of-Network charges, you pay the Coinsurance amount plus the full amount of any charges above the Reasonable and Customary (R&C) Limit. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Excludes coverage for items otherwise covered under the Merck Managed Prescription Drug Program (for example, insulin, needles and syringes and other diabetic products, etc.). For details about coverage, visit www.medco.com or call Medco Member Services at **800-RX-MERCK**.

³ Foot Orthotics refer to devices of rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions. Orthotics and orthotic shoes are covered. Examples of items NOT considered as a foot orthotic because they lack rigid construction are: inner soles (foam rubber, leather, flexible, etc.), corn plasters (pads, etc.), foot padding (adhesive moleskin, etc.) Arch supports are covered for children only for pes cavus, pes planus and pes varus because they can affect foot development and cure or reduce the severity of these conditions. In all other cases, charges for arch supports are not covered as supportive devices for the feet. 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.

⁴ Oral contraception is covered under the Merck Managed Prescription Drug Program (Medco By Mail only).

	In-Network Coverage	Out-of-Network Coverage¹
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Coverage for Eligible Employees	Mental health benefits for employees are provided through Merck's Managed Behavioral Health Care Program administered by ValueOptions. See that chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD."	
Coverage for Eligible Retirees² Inpatient Mental Health and Substance Abuse Care ³	90%, after Deductible Precertification required ^{4, 5}	60% of R&C Limit, after Deductible Precertification required ^{4, 5}
	<i>Substance abuse limited to four treatment programs In-Network and Out-of-Network combined, per patient per lifetime⁶</i>	
Outpatient Mental Health and Substance Abuse Care	90% after Deductible Precertification required ⁵	60% of R&C Limit, after Deductible

Precertification

- **Eligible Employees:** If you or your Covered Dependent(s) require inpatient hospitalization (other than for a maternity admission covered by the Newborns' and Mothers' Health Protection Act), including admission to a hospital, treatment facility, skilled nursing facility or hospice, or certain behavioral health care services, you must obtain precertification in order to receive the highest level of benefits available under the Merck PPO option.
- **Retirees:** Retirees age 65 or older and their Covered Dependent(s) age 65 or older are not required to precertify inpatient medical or behavioral health care services. Retirees under age 65 and their Covered Dependent(s) under age 65 must precertify inpatient hospitalization and certain behavioral health care services.

KEY POINT — PRECERTIFICATION OVERVIEW

	Eligible Employees and Their Covered Dependent(s)	Retirees and Their Covered Dependent(s) Under Age 65	Retirees and Their Covered Dependent(s) Age 65 or Older
Inpatient Medical	Horizon BCBS 877-663-7258	Horizon BCBS 877-663-7258	Not required
Behavioral Health	ValueOptions 877-44-MERCK	Horizon BCBS 877-663-7258	Not required

¹ For Out-of-Network charges, you pay the Coinsurance amount plus the full amount of any charges above the Reasonable and Customary (R&C) Limit. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Retirees are not eligible to participate in the Merck Managed Behavioral Health Care Program administered by ValueOptions. Behavioral health benefits for Retirees are administered by Horizon BCBS. In-Network behavioral health care may be available to Retirees through the BlueCard network.

³ Inpatient services apply to Medically Necessary hospital and treatment facility stays and Medically Necessary Emergency treatment.

⁴ You must precertify all inpatient behavioral health care. If you don't precertify Medically Necessary In-Network hospitalizations, benefits will be paid at 70%, after Deductible. If you don't precertify Medically Necessary Out-of-Network hospitalizations, a 20% reduction in coverage will apply (that is, coverage will be paid at 40% of the R&C Limit, after Deductible). If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees under age 65 and their Covered Dependent(s) under age 65 must call Horizon BCBS at **877-663-7258** to precertify inpatient behavioral health care. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify care.

⁵ The following services and procedures also require precertification: psychological testing, neuropsychological testing, outpatient electroconvulsive therapy (ECT), biofeedback, amygdala interview, hypnosis, psychiatric home health care services and outpatient detoxification. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify care.

⁶ These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, your treatment limits do not restart.

How to Precertify Inpatient Medical Services (*not* behavioral health)

To precertify an inpatient admission, or to determine if a particular service requires precertification, contact Horizon BCBS at **877-663-7258**. You must call at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency admissions to a hospital or other facility.

You must follow precertification procedures for both In-Network and Out-of-Network care, even if your physician is a network provider. Failure to precertify will result in a 20% reduction in coverage. Also, where no precertification is obtained and Horizon BCBS determines that the care provided was not Medically Necessary, the services will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

Lengthened Maternity Hospital Stays

If you expect your or your Covered Dependent(s)' maternity hospital stay to exceed 48 hours for a normal delivery or 96 hours for a Caesarian-section, you must precertify the continued hospitalization by calling Horizon BCBS at **877-663-7258**.

How to Precertify Behavioral Health Care Services

Inpatient

Inpatient behavioral health care services require precertification. Failure to precertify In-Network inpatient hospitalizations will result in benefits being paid at Out-of-Network rates. Failure to precertify Out-of-Network inpatient hospitalizations will result in a 20% reduction in coverage. Also, where no precertification is obtained, both In-Network and Out-of-Network, and the Claims Administrator determines that the care provided was not Medically Necessary, the services will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

Outpatient

You must precertify In-Network outpatient behavioral health care. Failure to precertify will result in benefits being paid at Out-of-Network rates. Out-of-Network outpatient care does not require precertification.

Employees – Call ValueOptions

Behavioral health precertification for Employees and their Covered Dependent(s) is handled by ValueOptions, the Merck Managed Behavioral Health Care Program's Claims Administrator. Call the ValueOptions precertification line at **877-44-MERCK (877-446-3725)**. You must call at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency admissions to a hospital or other facility.

Retirees Under Age 65 – Call Horizon BCBS

Behavioral health precertification for Retirees (under age 65) and their Covered Dependent(s) (under age 65) is handled by Horizon BCBS. Call Horizon BCBS at **877-663-7258**. You must call at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency admissions to a hospital or other facility.

In Case of an Emergency

If you or a Covered Dependent(s) have a medical or behavioral health Emergency, you should call 911 or immediately go to the nearest emergency room. Emergency room services are covered at 90%, after you satisfy the Deductible, for both In-Network and Out-of-Network services. If your emergency room visit is deemed not an Emergency as defined by the Merck Medical Plan (see Key Point) then your emergency room coverage will be reduced by 20% for both In-Network and Out-of-Network coverage. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency.

KEY POINT — HOW EMERGENCY IS DEFINED

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention could result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ.

For more details, please refer to the definition of Emergency in the Glossary of “General Information about the Merck Medical Plan — Part 1 of the SPD.”

You Must Contact the Claims Administrator If You Have an Emergency Admission***For Medical Reasons***

If you or a Covered Dependent(s) are admitted to the hospital for medical reasons, you must call Horizon BCBS at **877-663-7258** within 48 hours of the Emergency admission (even if you are discharged by then) to receive the highest level of benefits available under the Merck PPO option.

For Behavioral Health

- **Employees and their Covered Dependent(s).** You must contact ValueOptions, the Merck Managed Behavioral Health Care Program’s Care Manager, at **877-44-MERCK (877-446-3725)** within 48 hours of an Emergency admission to a hospital or other facility (even if you are discharged by then) to receive the highest level of benefits available under the Merck PPO option.
- **Retirees under age 65 and their Covered Dependent(s) under age 65.** You must contact Horizon BCBS at 877-663-7258 within 48 hours of an Emergency admission to a hospital or other facility (even if you are discharged by then) to receive the highest level of benefits available under the Merck PPO option.

Failure to Notify the Claims Administrator

In all cases, if you do not call the applicable Claims Administrator within 48 hours of the Emergency admission, certain penalties will apply. (For specific information about penalties, see the “Precertification” section.) Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

How to File a Claim**In-Network Care**

If you receive care from an In-Network provider, you do not have to file any claims. Your In-Network provider will file all claims for you. Simply show your medical I.D. card and pay the applicable Copay. Your network provider then bills the Merck Medical Plan directly for its share of the cost of your care. Subsequently, your network provider bills you for your remaining share of the cost of your care (e.g., Coinsurance).

However, if you have duplicate coverage, including Medicare, and the Merck Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to Horizon BCBS using the Out-of-Network address listed on the next page — even if you received care from an In-Network provider. For more information when you have other coverage, see “Coordination of Benefits” in the Administrative Information section of “General Information about the Merck Medical Plan — Part 1 of the SPD.”

Out-of-Network Care

When you receive care from an Out-of-Network provider you generally pay for services up front and then file a claim for reimbursement for the share of the cost covered by the Merck Medical Plan. Here's how:

- Complete the "Employee" section of the Horizon BCBS Medical Expense Claim Form, available on:
 - NetBenefits at <http://netbenefits.fidelity.com>;
 - <http://hr.merck.com>; or
 - www.horizonblue.com/merck or www.horizonblue.com/merckretirees.Forms are also available by calling the Merck Benefits Service Center at **800-66-MERCK**.
- Obtain an itemized bill from your provider that includes:
 - Patient's name;
 - Date(s) of service(s);
 - Condition being treated;
 - Relationship to employee;
 - Type of service(s) rendered; and
 - The provider's name and Internal Revenue Service (IRS) tax identification number.
- Attach a copy of your itemized bill to the claim form and submit both to:
 - Merck Dedicated Service Team
 - Horizon BCBS
 - P.O. Box 18
 - Newark, NJ 07101-0018

In all cases, your claim must be submitted within two years of receiving treatment, unless you can show that it was not reasonably possible to file a claim within that time period. Claims submitted more than 24 months after the date of service are considered not valid and will not be paid.

KEY POINT — KEEP COPIES OF CLAIMS FOR YOUR RECORDS

It's a good idea to keep copies of all claim forms and bills that you submit for reimbursement. Because Deductible amounts and other limitations apply separately to each covered person, it's important to keep separate records for each covered person.

Appealing a Claim

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



Merck 80/20 Option

The Merck 80/20 option is a traditional, fee-for-service option administered by Horizon BCBS that gives you the flexibility to see any licensed health care provider of your choice. You also have the option of using the BlueCard Traditional network, where available.

KEY POINT — ELIGIBILITY

You are eligible to enroll in the Merck 80/20 option if you are an Eligible Employee or a Retiree and your home address on file with Fidelity Investments is within the BlueCard network area. *Eligible Employees who are residents of Hawaii are not eligible for the Merck 80/20 option.*

About the Merck 80/20 Option

The Merck 80/20 option covers you for a range of services, including preventive care, hospitalizations and Emergency care. Under the Merck 80/20 option you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. Generally, after you reach the Deductible, your Coinsurance for most covered expenses is 80%. With the Merck 80/20 option you also have the option of using the BlueCard Traditional network. When you obtain services from a health care provider that participates in the BlueCard Traditional network, your Coinsurance amount will still be 80% but it will be calculated using negotiated rates which are generally lower. Horizon BCBS is the Claims Administrator and fiduciary for the Merck 80/20 option.

Key Features

In general, under the Merck 80/20 option:

- You may receive care from any licensed provider of your choice.
- Every time you need care, you have the choice to see an In-Network or Out-of-Network provider. However, if you do obtain care from an Out-of-Network provider you will likely pay more for those services.
- Network providers have agreed in advance to accept specific negotiated fees, so you will never have to pay for fees in excess of Reasonable and Customary (R&C) Limits if you use a network provider.
- Generally, you must meet an Individual Deductible or Family Deductible before the Plan pays benefits.
- If you receive care Out-of-Network, your Coinsurance is subject to R&C Limits.
- You must precertify certain services, including inpatient hospitalization, certain surgeries and certain maternity care.

Prescription Drug and Behavioral Health Benefits

When you enroll in the Merck 80/20 option, you automatically receive coverage under Merck's Managed Prescription Drug Program. If your medical coverage is provided through the Flexible Benefits Program, you also receive coverage in the Managed Behavioral Health Care Program. For more



information, see the Managed Prescription Drug Program and Managed Behavioral Health Care Program chapters in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

Note: Retirees are not eligible to participate in the Managed Behavioral Health Care Program. Mental health and substance abuse benefits for Retirees are coordinated through the Merck 80/20 option and administered by Horizon BCBS.

How the Merck 80/20 Option Works

The Merck 80/20 option provides you with access to a national network of providers – the BlueCard Traditional network. Each time you receive care for covered expenses you have a choice of obtaining care In-Network, using one of BlueCard Traditional providers, or Out-of-Network from any other physician of your choice. While you are not required to use a participating provider there are advantages to using BlueCard Traditional providers. Participating providers will file the claim on your behalf and will accept the plan allowance as payment in full.

Whether you use a network provider or not, you pay an Annual Deductible each year, then the Merck Medical Plan generally pays 80% Coinsurance for your In-Network covered expenses. If you receive care Out-of-Network, the Merck Medical Plan pays 80% Coinsurance up to the R&C Limit. Once you reach the annual Out-of-Pocket Maximum, the Merck Medical Plan pays 100% of your covered expenses up to the R&C Limit for the rest of the year. You are responsible for any expenses above the R&C Limit.

In-Network Benefits

You receive the highest level of benefits available under the Merck 80/20 option when you use an In-Network provider. Every time you visit a health care provider who participates in the BlueCard Traditional network, you have the potential to save money. Since the In-Network provider’s fees are negotiated (and generally lower), you are charged less. This means you pay less out of your own pocket for health care. If you receive services from a provider participating in the BlueCard Traditional network, their services are negotiated; therefore they never exceed the R&C Limit.

Out-of-Network Benefits

Each time you need care, you can choose to see a provider who does not belong to the BlueCard Traditional network. The difference is that you will likely pay more for Out-of-Network care. You are also responsible for any expenses above the R&C Limit. You will be considered to have chosen to go Out-of-Network if you receive care from a provider who does not participate in the BlueCard Traditional network.

KEY POINT – IMPORTANT BENEFIT TERMS

Important benefit terms, such as Annual Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the Glossary located in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

Merck 80/20 Option At a Glance

The following chart summarizes the coverage levels for services under the Merck 80/20 option. *There is no coverage for charges above the Reasonable and Customary (R&C) Limit.* The Coinsurance percentages apply after you have met any applicable Deductibles and assume you have not already reached the Out-of-Pocket Maximum. Except for the preventive services listed on the following pages, there is no coverage for services that Horizon BCBS determines are not Medically Necessary. In addition, not all services that are Medically Necessary are covered. See “What’s Covered Under the Horizon BCBS Medical Options” for a complete list of covered services and any applicable additional limitations under the Merck 80/20 option.

**Merck 80/20 Option At a Glance**

	Coverage
COSTS	
Annual Deductible ¹ <i>Individual</i> <i>Family</i>	\$400 \$800
Coinsurance <i>Plan pays</i> <i>You pay</i>	80% of R&C Limit 20% of R&C Limit plus any amounts in excess of R&C Limit ²
Annual Out-of-Pocket Maximum ¹ <i>Individual</i> <i>Family</i> See "Schedule A" at the back of this booklet for complete information about your annual Out-of-Pocket Maximum	Minimum \$1,250, maximum \$5,000 Minimum \$2,500, maximum \$10,000
Lifetime Benefit Maximum	None ³
Reasonable and Customary (R&C) Limit	Applies, unless services are provided by a provider who participates in the BlueCard Traditional network
PREVENTIVE MEDICAL CARE — EXAMS	
Well-Child Care <i>(up to age 6)</i>	80% of R&C Limit, no Deductible
Routine Annual Physical Exams <i>One exam per calendar year</i> <i>(over age 6)</i>	80% of R&C Limit, no Deductible
Routine Immunizations	100% of R&C Limit, no Deductible
Routine Immunization-Related Office Visits	80% of R&C Limit, no Deductible
Routine Preventive OB/GYN Exams <i>One exam per calendar year</i>	80% of R&C Limit, no Deductible
Routine Eye Exams <i>One exam every 24 months</i> <i>Eyewear discounts available through Complete Advantage™⁴</i>	80% of R&C Limit, no Deductible
Routine Hearing Exams <i>One exam every 24 months</i>	80% of R&C Limit, no Deductible
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY	
Routine Preventive Lab/X-Rays <i>Services related to routine annual physical exams for individuals over age 6; limited to one per calendar year⁵</i>	80% of R&C Limit, no Deductible

¹ Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² If you receive services from a provider who participates in the BlueCard Traditional network, fees are based on negotiated rates; R&C Limits do not apply.

³ Certain treatment limits may apply to certain services such as infertility-related services and inpatient substance-abuse treatment.

⁴ For more information about the Complete Advantage Discount Program and participating providers, contact Complete Advantage Customer Service at **877-518-8748**.

⁵ Coverage for routine preventive lab/x-ray is determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force and guidelines established by the American Medical Association (AMA) and provided they are designated by your physician as preventive. Contact Horizon BCBS at **877-663-7258** or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services.



	Coverage
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY (continued)	
Certain Preventive Services That Are Not Part of a Routine Annual Physical/Office Visit ¹	80% of R&C Limit, no Deductible
Routine Mammography Screenings <i>Ages 35–39, one baseline; ages 40 and above, one screening per year; additional screenings if prescribed by your physician as Medically Necessary</i>	Routine: 100%, no Deductible If additional screenings are prescribed by your physician as Medically Necessary, 80% of R&C Limit after Deductible
Routine Preventive Pap Test <i>One per calendar year</i>	80% of R&C Limit, no Deductible
OUTPATIENT MEDICAL CARE	
Office Visits	80% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a doctor's office</i>	80% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a hospital or ambulatory surgical center</i>	80% of R&C Limit, after Deductible
Allergy Testing	80% of R&C Limit, after Deductible
Allergy Treatment <i>Injections, serum</i>	80% of R&C Limit, after Deductible
Infertility Diagnosis and Treatment ² <i>Artificial insemination, advanced reproductive treatment (ART)</i>	80% of R&C Limit, after Deductible
Chiropractic Care <i>Up to 25 visits per calendar year per person Maintenance therapy not covered</i>	80% of R&C Limit, after Deductible
Acupuncture <i>Medically Necessary for pain, illness or injury, performed by an M.D., D.O. or state-licensed physician or practitioner and is Medically Necessary</i>	80% of R&C Limit, after Deductible
Second Surgical Opinion	80% of R&C Limit, after Deductible
Short-Term Rehabilitation ³ <i>Physical therapy, occupational therapy, speech therapy</i>	80% of R&C Limit, after Deductible

¹ Preventive care services are covered as determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force. Contact Horizon BCBS at **877-663-7258** or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services.

² For infertility: 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. These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, you do not restart these limits. 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.

³ Short-term rehabilitation may include physical, occupational and speech therapy for a limited period based on medical necessity. Maintenance therapy is not covered. Contact Horizon BCBS at **877-663-7258** 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.



	Coverage
OUTPATIENT MEDICAL CARE continued	
Oral Surgery ¹ <i>Certain procedures if performed in a hospital or ambulatory surgical facility due to medical necessity</i>	80% of R&C Limit, after Deductible
Outpatient Hospice Care <i>Includes bereavement counseling for one year</i>	80% of R&C Limit, after Deductible
OUTPATIENT MEDICAL CARE — LABS AND X-RAY	
Diagnostic Labs and X-Rays <i>Performed in a physician's office</i>	80% of R&C Limit, after Deductible
Diagnostic Labs and X-Rays <i>Performed in an outpatient hospital or other outpatient facility (including lab processing)</i>	80% of R&C Limit, after Deductible
INPATIENT MEDICAL CARE	
Inpatient Hospital Services <i>Includes inpatient surgery expenses, semi-private room and board, physician expenses, routine nursery care, prescription drugs, all other patient care</i>	80% of R&C Limit, after Deductible Precertification required ²
Maternity Services <i>Delivery charges in a hospital or approved, licensed birthing center</i>	80% of R&C Limit, after Deductible Precertification required ²
Inpatient Hospice Care <i>Up to 60 days per lifetime</i>	80% of R&C Limit, after Deductible Precertification required ²
OTHER SERVICES	
Emergency Services <i>Ambulance Emergency Room Urgent Care</i>	80% of R&C Limit, after Deductible 80% of R&C Limit, after Deductible ³ 80% of R&C Limit, after Deductible
Durable Medical Equipment ⁴ (<i>Wheelchairs, walkers, etc.</i>)	80% of R&C Limit, after Deductible
Foot Orthotics ⁵	80%, after Deductible

¹ Oral surgery performed in a dental office, whether it be dental or medical in nature, will be considered for payment under dental benefits only. See the Merck Dental Plan SPD for information. Oral surgery that is not performed in a dental office which is dental or medical in nature may be considered for payment under medical benefits, provided the patient has a medical condition where medical necessity requires service outside of a dental office.

² You must precertify all inpatient medical hospitalizations by calling Horizon BCBS at **877-663-7258**, including surgeries and certain maternity care. Failure to precertify Medically Necessary care will result in a 20% reduction in coverage. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify inpatient care.

³ If your emergency room visit is deemed not to be an Emergency, your coverage will be reduced by 20%. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency. If you or a Covered Dependent(s) are admitted, you must call Horizon BCBS at **877-663-7258** within 48 hours (even if you are discharged by then) to receive In-Network benefits, if applicable. If you do not call within 48 hours the 20% reduction for failure to precertify care will apply.

⁴ Excludes coverage for items otherwise covered under the Merck Managed Prescription Drug Program (for example, insulin, needles and syringes and other diabetic products, etc.). For details about coverage, visit www.medco.com or call Medco Member Services at **800-RX-MERCK**.

⁵ Foot Orthotics refer to devices of rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions. Orthotics and orthotic shoes are covered. Examples of items NOT considered as a foot orthotic because they lack rigid construction are: inner soles (foam rubber, leather, flexible, etc.), corn plasters (pads, etc.), foot padding (adhesive moleskin, etc.) Arch supports are covered for children only for pes cavus, pes planus and pes varus because they can affect foot development and cure or reduce the severity of these conditions. In all other cases, charges for arch supports are not covered as supportive devices for the feet. 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.



	Coverage
OTHER SERVICES continued	
Prosthetics and Appliances Artificial limbs, etc.	80% of R&C Limit, after Deductible
Skilled Nursing Facility <i>Up to 120 days per calendar year</i>	80% of R&C Limit, after Deductible
Home Health Care	80% of R&C Limit, after Deductible
Custodial Care	Not covered
Contraceptive Devices ¹ (<i>Diaphragms, IUDs, implants, injections</i>)	80% of R&C Limit, after Deductible
PRESCRIPTION DRUG BENEFITS	
Inpatient	80% of R&C Limit, after Deductible Merck-brand drugs covered at 100%
Outpatient — Drugs administered in a doctor's office or provided by a doctor for on-home administration, unless ordered for the patient through Medco By Mail	80% of R&C Limit, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Drugs administered in an ambulatory surgical facility	80% of R&C Limit, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Prescriptions filled through retail pharmacies or Medco By Mail	Provided under the Merck Managed Prescription Drug Program. See that chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD" for coverage details.
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS	
Coverage for Eligible Employees	Mental Health benefits for employees are provided through Merck's Managed Behavioral Health Care Program administered by ValueOptions. See that chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD" for coverage details.
Coverage for Retirees²	80% of R&C Limit, after Deductible
Inpatient Mental Health and Substance Abuse Care ³ <i>Substance abuse limited to four treatment programs In-Network and Out-of-Network combined⁴</i>	Precertification required ^{5, 6}
Outpatient Mental Health and Substance Abuse Care	80% of R&C Limit, after Deductible ⁶

¹ Oral contraception is covered under the Merck Managed Prescription Drug Program (Medco By Mail only).

² Retirees are not eligible to participate in the Merck Managed Behavioral Health Care Program administered by ValueOptions. In-Network behavioral health care may be available to Retirees through the BlueCard network. Behavioral health utilization and case management for Retirees under age 65 and their Covered Dependent(s) under age 65 is administered by Horizon BCBS.

³ Inpatient services apply to Medically Necessary hospital and treatment facility stays and Medically Necessary Emergency treatment.

⁴ These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, your treatment limits do not restart.

⁵ You must precertify all inpatient behavioral health care. If you don't precertify Medically Necessary hospitalizations, a 20% reduction in coverage will apply (that is, coverage will be paid at 60% of the R&C Limit, after Deductible). If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees under age 65 and their Covered Dependent(s) under age 65 must call Horizon BCBS at **877-663-7258** to precertify inpatient hospitalizations. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify care. You must precertify all inpatient behavioral health care. If you don't precertify Medically Necessary hospitalizations, a 20% reduction in coverage will apply (that is, coverage will be paid at 60% of the R&C Limit, after Deductible). If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees under age 65 and their Covered Dependent(s) under age 65 must call Horizon BCBS at **877-663-7258** to precertify inpatient hospitalizations. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify care.

⁶ The following services and procedures also require precertification: psychological testing, neuropsychological testing, outpatient electroconvulsive therapy (ECT), biofeedback, amygdala interview, hypnosis, psychiatric home health care services and outpatient detoxification. Retirees and their Covered Dependents, who are at least age 65, are not required to precertify care.

Precertification

KEY POINT — PRECERTIFICATION OVERVIEW

	Eligible Employees and Their Covered Dependent(s)	Retirees and Their Covered Dependent(s) Under Age 65	Retirees and Their Covered Dependent(s) Age 65 or Older
Inpatient Medical	Horizon BCBS 877-663-7258	Horizon BCBS 877-663-7258	Not required
Behavioral Health	ValueOptions 877-44-MERCK	Horizon BCBS 877-663-7258	Not required

How to Precertify Inpatient Medical Services (*not* behavioral health)

- **Eligible Employees:** If you or your Covered Dependent(s) require inpatient hospitalization for medical reasons (other than for a maternity admission covered by the Newborns' and Mothers' Health Protection Act), including admission to a hospital, treatment facility, skilled nursing facility or hospice, you must obtain precertification from Horizon BCBS.
- **Retirees:** Retirees age 65 and older and their Covered Dependent(s) age 65 and older are not required to precertify inpatient hospitalizations. Retirees under age 65 and their Covered Dependent(s) under age 65 are required to precertify inpatient hospitalizations.

KEY POINT — ABOUT HORIZON BCBS

Horizon BCBS is the utilization and case management provider for the Merck 80/20 and Merck 80/20 Out-of-Area options. When you call Horizon BCBS, you speak to a medical management specialist who can help you:

- Precertify an inpatient admission;
- Receive important information about a pregnancy, especially for high-risk situations;
- Coordinate a second surgical opinion for certain non-emergency procedures; and
- Coordinate care and provide case management if you have a complex or severe medical situation requiring a lengthy hospital stay.

Call Horizon BCBS at 877-663-7258.

How to Precertify Inpatient Medical Services Through Horizon BCBS

When your doctor recommends a hospital stay, call Horizon BCBS seven to 10 days before the scheduled admission. Horizon BCBS will contact your physician to confirm the need for hospitalization. After approving your hospitalization and the length of stay, Horizon BCBS will send you a letter. If you do not receive the letter within three days before your scheduled hospitalization, call Horizon BCBS at **877-663-7258** to verify that your hospital stay has been authorized, provided you have precertified your hospital stay.

You must follow these precertification procedures for both In-Network and Out-of-Network care, even if your physician is a network provider. If you do not call Horizon BCBS as required, your benefit will be reduced by 20%. For example, the 80% coverage would be reduced to 60%. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the service will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

Emergency Admissions

You must call Horizon BCBS within 48 hours of an Emergency admission to a hospital or other facility, even if you are discharged by then.



Lengthened Maternity Hospital Stays

If you expect your or your Covered Dependent(s)' maternity hospital stay to exceed 48 hours for a normal delivery or 96 hours for a Caesarian-section, you must precertify the continued hospitalization by calling Horizon BCBS at **877-663-7258**.

Outpatient Surgeries

The surgeries listed below are examples of surgeries that should normally be performed on an outpatient basis. If your doctor feels that you need to stay overnight in the hospital, you must call Horizon BCBS for precertification at **877-663-7258**. Please note that the following list is not intended to be all-inclusive:

- D&C (dilation and curettage – scraping of uterus);
- Eye muscle operations;
- Hammertoe repair;
- Hemorrhoidectomy (removal of hemorrhoids);
- Herniorrhaphy (hernia repair);
- Mastoidectomy (removal of mastoid process);
- Nasal submucous resection (partial excision of nasal septum);
- Neuroplasty (surgery of nerves/nerve tissues);
- Skin lesion excision (subcutaneous or soft tissue, either malignant or benign);
- Tendon sheath release/repair (incision/repair of tendons); or
- Varicose vein ligation.

Precertification of Behavioral Health Care Services

Employees

Call ValueOptions to Precertify Behavioral Health Care Services

Behavioral health precertification for Employees and their Covered Dependent(s) is handled by ValueOptions, the Merck Managed Behavioral Health Care Program's Claims Administrator. Call the ValueOptions precertification line at **877-44-MERCK (877-446-3725)**. You must call at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency admissions to a hospital or other facility.

- **Inpatient.** All inpatient behavioral health care services require precertification through ValueOptions. Failure to precertify In-Network inpatient hospitalizations will result in benefits being paid at Out-of-Network rates. Failure to precertify Out-of-Network inpatient hospitalizations will result in a 20% reduction in coverage. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the service will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.
- **Outpatient.** You must precertify In-Network outpatient behavioral health care. Failure to precertify will result in benefits being paid at Out-of-Network rates. Out-of-Network outpatient care does not require precertification.

Retirees Under Age 65

Call Horizon BCBS to Precertify Behavioral Health Care Services

Behavioral health precertification for Retirees (under age 65) and their Covered Dependent(s) (under age 65) is handled through Horizon BCBS. You must call Horizon BCBS at **877-663-7258** at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency



admissions to a hospital or other facility. Please note that Retirees age 65 or older and their Covered Dependent(s) age 65 or older are not required to precertify behavioral health care services.

- **Inpatient.** All inpatient behavioral health care services require precertification. Failure to precertify In-Network or Out-of-Network inpatient hospitalizations will result in a 20% reduction in coverage. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the service will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.
- **Outpatient.** You must precertify In-Network outpatient behavioral health care. Failure to precertify will result in a 20% reduction in coverage.

KEY POINT — RETIREES AND THEIR COVERED DEPENDENT(S) AGE 65 AND OLDER

Retirees age 65 and older and their Covered Dependent(s) age 65 and older are not required to precertify medical or behavioral health care services.

In Case of an Emergency

If you or a Covered Dependent(s) have a medical or behavioral health Emergency, you should call 911 or immediately go to the nearest emergency room. Emergency room services are covered at 80%, after you satisfy the Deductible, for both In-Network and Out-of-Network services.

If your emergency room visit is deemed *not an Emergency* as defined by the Merck Medical Plan (see Key Point below) then your emergency room coverage will be reduced by 20% for both In-Network and Out-of-Network coverage. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency.

KEY POINT — HOW EMERGENCY IS DEFINED

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention could result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ.

For more details, please refer to the definition of Emergency in the Glossary of "General Information about the Merck Medical Plan — Part 1 of the SPD."

You Must Contact the Claims Administrator If You Have an Emergency Admission

For Medical Reasons

If you or a Covered Dependent(s) are admitted to the hospital for medical reasons, you must call Horizon BCBS at **877-663-7258** within 48 hours of the Emergency admission (even if you are discharged by then) to receive the highest level of benefits available under the Merck 80/20 option. Additionally, if you or your Covered Dependent(s) need non-Emergency medical hospitalization or surgery, you may need to call Horizon BCBS for advance approval.



For Behavioral Health

- **Employees and their Covered Dependent(s).** You must contact ValueOptions, the Merck Managed Behavioral Health Care Program's Claims Administrator, at **877-44-MERCK** within 48 hours of an Emergency admission to a hospital or other facility (even if you are discharged by then) to receive the highest level of benefits available under the Merck 80/20 option.
- **Retirees (under age 65) and their Covered Dependent(s) (under age 65).** You must contact Horizon BCBS at **877-663-7258** within 48 hours of an Emergency admission to a hospital or other facility (even if you are discharged by then) to receive the highest level of benefits available under the Merck 80/20 option.

Failure to Notify the Claims Administrator

In all cases, if you do not call the applicable Claims Administrator within 48 hours of the Emergency admission, certain penalties will apply. (For specific information about penalties, see the applicable Precertification sections.) Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

How to File a Claim

When you receive care you generally pay for, or arrange for the payment of, services up front and then file a claim for reimbursement for the share of the cost covered by the Merck Medical Plan. If you have duplicate coverage, including Medicare, and the Merck Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to Horizon BCBS. For more information when you have other coverage, see "Coordination of Benefits" in "General Information about the Merck Medical Plan – Part 1 of the SPD."

To file a claim with the Merck 80/20 option:

- Complete the "Employee" section of the Horizon BCBS Medical Expense Claim Form, available on:
 - NetBenefits at <http://netbenefits.fidelity.com>;
 - <http://hr.merck.com>; or
 - www.horizonblue.com/merck or www.horizonblue.com/merckretirees.Forms are also available by calling the Merck Benefits Service Center at **800-66-MERCK**.
- Obtain an itemized bill from your provider that includes:
 - Patient's name;
 - Date(s) of service(s);
 - Condition being treated;
 - Relationship to employee;
 - Type of service(s) rendered; and
 - The provider's name and Internal Revenue Service (IRS) tax identification number.
- Attach a copy of your itemized bill to the claim form and submit both to:
 - Merck Dedicated Service Team
 - Horizon BCBS
 - P.O. Box 18
 - Newark, NJ 07101-0018

In all cases, your claim must be submitted within two years of receiving treatment, unless you can show that it was not reasonably possible to file a claim within that time period. Claims submitted more than 24 months after the date of service are not considered valid and will not be paid.



KEY POINT — KEEP COPIES OF CLAIMS FOR YOUR RECORDS

It's a good idea to keep copies of all claim forms and bills that you submit for reimbursement. Because Deductible amounts and other limitations apply separately to each covered person, it's important to keep separate records for each covered person.

Appealing a Claim

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



Merck 80/20 Out-of-Area Option

The Merck 80/20 Out-of-Area option is a traditional, fee-for-service option administered by Horizon BCBS that gives you the flexibility to see any licensed health care provider of your choice. It is designed for — and only available to — participants who live outside the BlueCard network.

KEY POINT — ELIGIBILITY

You are eligible to enroll in the Merck 80/20 Out-of-Area option if you are an Eligible Employee or a Retiree whose home address on file with Fidelity Investments is outside the BlueCard network area. *Eligible Employees who are residents of Hawaii are not eligible for the Merck 80/20 Out-of-Area option.*

About the Merck 80/20 Out-of-Area Option

The Merck 80/20 Out-of-Area option covers you for a range of services, including preventive care, hospitalizations and Emergency care. Coverage is generally similar to the Out-of-Network benefits under the Merck 80/20 option, but with lower Deductibles and Out-of-Pocket Maximums.

Under the Merck 80/20 Out-of-Area option you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. Horizon BCBS is the Claims Administrator and fiduciary for the Merck 80/20 Out-of-Area option.

In general, you must arrange for payment at the time you receive health care services. The 80/20 Out-of-Area option will reimburse you for your share of the cost of Medically Necessary covered services after you submit a claim for benefits. Once you've met the Annual Deductible, the Merck Medical Plan generally pays 80% of the Reasonable and Customary (R&C) Limit for most covered services and you pay 20%. Once you reach the annual Out-of-Pocket Maximum, the Merck Medical Plan pays 100% of your covered expenses up to the R&C Limit for the rest of the year. You are responsible for any expenses above the R&C Limit.

Key Features

In general, under the Merck 80/20 Out-of-Area option:

- You may receive care from any licensed provider of your choice.
- You must meet an Individual Deductible or Family Deductible before the Plan pays benefits.
- Your Coinsurance is subject to R&C Limits, except for In-Network behavioral health care.
- You must precertify certain services, including inpatient hospitalization, certain surgeries and certain maternity care.

Prescription Drug and Behavioral Health Benefits

When you enroll in the Merck 80/20 Out-of-Area option, you automatically receive coverage under Merck's Managed Prescription Drug Program. If your



medical coverage is provided through the Flexible Benefits Program, you also receive coverage in the Managed Behavioral Health Care Program. (Retirees are not eligible to participate in the Managed Behavioral Health Care Program. Mental health and substance abuse benefits for Retirees are coordinated through the Merck 80/20 Out-of-Area option.) For more information, see the Managed Prescription Drug Program and Managed Behavioral Health Care Program chapters in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

KEY POINT — IMPORTANT BENEFIT TERMS

Important benefit terms, such as Annual Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the Glossary located in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

Merck 80/20 Out-of-Area Option At a Glance

The following chart summarizes the coverage levels for services under the Merck 80/20 Out-of-Area option. *There is no coverage for charges above the Reasonable and Customary (R&C) Limit.* The Coinsurance percentages apply after you have met the Annual Deductible and assume you have not already reached the Out-of-Pocket Maximum. Except for the preventive services listed below, there is no coverage for services that Horizon BCBS determines are not Medically Necessary. In addition, not all services that are Medically Necessary are covered. See “What’s Covered Under the Horizon BCBS Medical Options” for a complete list of covered services and any applicable additional limitations under the Merck 80/20 Out-of-Area option.

	Coverage
COSTS	
Annual Deductible ¹ <i>Individual</i> <i>Family</i>	\$250 \$500
Coinsurance <i>Plan pays</i> <i>You pay</i>	80% of R&C Limit 20% plus any amounts in excess of R&C Limit
Annual Out-of-Pocket Maximum ¹ <i>Individual</i> <i>Family</i> <i>See “Schedule A” at the back of this booklet for complete information about your annual Out-of-Pocket Maximum</i>	Minimum \$750, Maximum \$3,200 Minimum \$1,500, Maximum \$6,400
Lifetime Benefit Maximum	None ²
Reasonable and Customary (R&C) Limit	Applies
PREVENTIVE MEDICAL CARE — EXAMS	
Well-Child Care <i>(up to age 6)</i>	80% of R&C Limit, no Deductible
Routine Annual Physical Exams <i>One exam per calendar year</i> <i>(over age 6)</i>	80% of R&C Limit, no Deductible
Routine Immunizations	100% of R&C Limit, no Deductible
Routine Immunization-Related Office Visits	80% of R&C Limit, no Deductible
Routine Preventive OB/GYN Exams <i>One exam per calendar year</i>	80% of R&C Limit, no Deductible

¹ Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Certain treatment limits may apply to certain services such as infertility-related services and inpatient substance-abuse treatment.



	Coverage
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY	
Routine Eye Exams <i>One exam every 24 months</i> <i>Eyewear discounts available through Complete Advantage™¹</i>	80% of R&C Limit, no Deductible
Routine Hearing Exams <i>One exam every 24 months</i>	80% of R&C Limit, no Deductible
Routine Preventive Lab/X-Rays <i>Services related to routine annual physical exams for individuals over age 6. Limited to one per calendar year²</i>	80% of R&C Limit, no Deductible
Certain Preventive Services that are not part of a routine annual physical/office visit ³	80% of R&C Limit, no Deductible
Routine Mammography Screenings <i>Ages 35–39, one baseline; ages 40 and above, one screening per year; additional screenings if more are prescribed by your physician as Medically Necessary</i>	100% of R&C Limit, no Deductible If additional screenings are prescribed by your physician as Medically Necessary, 80% of R&C Limit after Deductible
Routine Preventive Pap Test <i>One per calendar year</i>	80% of R&C Limit, no Deductible
OUTPATIENT MEDICAL CARE	
Office Visits	80% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a doctor's office</i>	80% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a hospital or ambulatory surgical center</i>	80% of R&C Limit, after Deductible
Allergy Testing	80% of R&C Limit, after Deductible
Allergy Treatment <i>Injections, serum</i>	80% of R&C Limit, after Deductible
Infertility Diagnosis & Treatment ⁴ (<i>Artificial insemination, Advanced Reproductive Treatment (ART)</i>)	80% of R&C Limit, after Deductible
Chiropractic Care (<i>Up to 25 visits per calendar year per person</i> <i>Maintenance therapy not covered</i>)	80% of R&C Limit, after Deductible

¹ For more information about the Complete Advantage Discount Program and participating providers, contact Complete Advantage Customer Service at **877-518-8748**.

² Coverage for routine preventive lab/x-ray is determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force and guidelines established by the American Medical Association (AMA) and provided they are designated by your physician as preventive. Contact Horizon BCBS at **877-663-7258** or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services.

³ Preventive care services are covered as determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force. Contact Horizon BCBS at **877-663-7258** or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services.

⁴ For infertility: 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. These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, you do not restart these limits. 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.



	Coverage
OUTPATIENT MEDICAL CARE continued	
Acupuncture (<i>Medically Necessary for pain, illness or injury, performed by an M.D., D.O. or state-licensed physician or practitioner and is Medically Necessary</i>)	80% of R&C Limit, after Deductible
Second Surgical Opinion	80% of R&C Limit, after Deductible
Short-Term Rehabilitation ¹ <i>Physical therapy, occupational therapy, speech therapy</i>	80% of R&C Limit, after Deductible
Oral Surgery ² <i>Certain procedures if performed in a hospital or ambulatory surgical facility due to medical necessity</i>	80% of R&C Limit, after Deductible
Outpatient Hospice Care <i>Includes bereavement counseling for one year</i>	80% of R&C Limit, after Deductible
OUTPATIENT MEDICAL CARE — LABS AND X-RAY	
Diagnostic Labs and X-Rays <i>Performed in a physician's office</i>	80% of R&C Limit, after Deductible
Diagnostic Labs and X-Rays <i>Performed in an outpatient hospital or other outpatient facility (including lab processing)</i>	80% of R&C Limit, after Deductible
INPATIENT MEDICAL CARE	
Inpatient Hospital Services <i>Includes inpatient surgery expenses, semi-private room and board, physician expenses, routine nursery care, prescription drugs, all other patient care</i>	80% of R&C Limit, after Deductible Precertification required ³
Maternity Services <i>Delivery charges in a hospital or approved, licensed birthing center</i>	80% of R&C Limit, after Deductible Precertification required ³
Inpatient Hospice Care <i>Up to 60 days per lifetime</i>	80% of R&C Limit, after Deductible Precertification required ³
OTHER SERVICES	
Emergency Services <i>Ambulance Emergency Room Urgent Care</i>	80% of R&C Limit, after Deductible 80% of R&C Limit, after Deductible ⁴ 80% of R&C Limit, after Deductible

¹ Short-term rehabilitation may include physical, occupational and speech therapy for a limited period based on medical necessity. Maintenance therapy is not covered. Contact Horizon BCBS at **877-663-7258** 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.

² Oral surgery performed in a dental office, whether it be dental or medical in nature, will be considered for payment under dental benefits only. See the Merck Dental Plan SPD for information. Oral surgery that is not performed in a dental office which is dental or medical in nature may be considered for payment under medical benefits, provided the patient has a medical condition where medical necessity requires service outside of a dental office.

³ You must precertify all inpatient medical hospitalizations with Horizon BCBS at **877-663-7258**, including surgeries and certain maternity care. Failure to precertify Medically Necessary care will result in a 20% reduction in coverage. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify inpatient care.

⁴ If your emergency room visit is deemed not to be an Emergency, your coverage will be reduced by 20%. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency. If you or a Covered Dependent(s) are admitted, you must call Horizon BCBS at **877-663-7258** within 48 hours (even if you are discharged by then). If you do not call within 48 hours, the 20% reduction for failure to precertify care will apply.



	Coverage
OTHER SERVICES continued	
Durable Medical Equipment ¹ (<i>Wheelchairs, walkers, etc.</i>)	80% of R&C, after Deductible
Foot Orthotics ²	80%, after Deductible
Prosthetics and Appliances (<i>Artificial limbs, etc.</i>)	80% of R&C, after Deductible
Skilled Nursing Facility (<i>Up to 120 days per calendar year</i>)	80% of R&C, after Deductible
Home Health Care	80% of R&C, after Deductible
Custodial Care	Not covered
Contraceptive Devices ³ (<i>Diaphragms, IUDs, implants, injections</i>)	80% of R&C, after Deductible
PRESCRIPTION DRUG BENEFITS	
Inpatient	80% of R&C, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Drugs administered in a doctor's office or ambulatory surgical facility, or drugs provided by a doctor for in-home administration, unless ordered for the patient through Medco By Mail	80% of R&C, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Prescriptions filled through retail pharmacies or Medco By Mail	Provided under the Merck Managed Prescription Drug Program. See "General Information about the Merck Medical Plan — Part 1 of the SPD" for coverage details.
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS	
Coverage for Eligible Employees	Mental Health benefits for employees are provided through Merck's Managed Behavioral Health Care Program. See "General Information about the Merck Medical Plan — Part 1 of the SPD" for coverage details.
Coverage for Retirees⁴	80% of R&C Limit, after Deductible
Inpatient Mental Health and Substance Abuse Care ⁵ <i>Substance abuse limited to four treatment programs In-Network and Out-of-Network combined⁶</i>	Precertification required ^{7, 8}
Outpatient Mental Health and Substance Abuse Care	80% of R&C Limit, after Deductible ⁷

¹ Excludes coverage for items otherwise covered under the Merck Managed Prescription Drug Program (for example, insulin, needles, syringes and other diabetic products, etc.). For details, visit www.medco.com or call **800-RX-MERCK**.

² Foot Orthotics refer to devices of rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions. Orthotics and orthotic shoes are covered. Examples of items NOT considered as a foot orthotic because they lack rigid construction are: inner soles (foam rubber, leather, flexible, etc.), corn plasters (pads, etc.), foot padding (adhesive moleskin, etc.) Arch supports are covered for children only for pes cavus, pes planus and pes varus because they can affect foot development and cure or reduce the severity of these conditions. In all other cases, charges for arch supports are not covered as supportive devices for the feet. 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.

³ Oral contraception is covered under the Merck Managed Prescription Drug Program (Medco By Mail only).

⁴ Retirees are not eligible to participate in the Merck Managed Behavioral Health Care Program. In-Network behavioral health care may be available to Retirees through the BlueCard network. Behavioral health utilization and case management for Retirees under age 65 and their Covered Dependent(s) under age 65 is administered by Horizon BCBS.

⁵ Inpatient services apply to Medically Necessary hospital and treatment facility stays and Medically Necessary Emergency treatment.

⁶ These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, your treatment limits do not restart.

⁷ You must precertify all inpatient behavioral health care. If you don't precertify Medically Necessary hospitalizations, a 20% reduction in coverage will apply (that is, coverage will be paid at 60% of the R&C Limit, after Deductible). If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees must call Horizon BCBS at **877-663-7258** to precertify inpatient hospitalizations. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify care.

⁸ The following services and procedures also require precertification: psychological testing, neuropsychological testing, outpatient electroconvulsive therapy (ECT), biofeedback, amygdala interview, hypnosis, psychiatric home health care services and outpatient detoxification. Retirees and their Covered Dependent(s) who are at least age 65 are not required to precertify care.



Precertification

KEY POINT — PRECERTIFICATION OVERVIEW

	Eligible Employees and Their Covered Dependent(s)	Retirees and Their Covered Dependent(s) Under Age 65	Retirees and Their Covered Dependent(s) Age 65 or Older
Inpatient Medical	Horizon BCBS 877-663-7258	Horizon BCBS 877-663-7258	Not required
Behavioral Health	ValueOptions 877-44-MERCK	Horizon BCBS 877-663-7258	Not required

How to Precertify Inpatient Medical Services (*not* behavioral health)

- **Eligible Employees:** If you or your Covered Dependent(s) require inpatient hospitalization for medical reasons (other than for a maternity admission covered by the Newborns' and Mothers' Health Protection Act), including admission to a hospital, treatment facility, skilled nursing facility or hospice, you must obtain precertification from Horizon BCBS.
- **Retirees:** Retirees age 65 and older and their Covered Dependent(s) age 65 and older are not required to precertify inpatient hospitalizations. Retirees under age 65 and their Covered Dependent(s) under age 65 are required to precertify inpatient hospitalizations.

KEY POINT — ABOUT HORIZON BCBS

Horizon BCBS is the utilization and case management provider for the Merck 80/20 and Merck 80/20 Out-of-Area options. When you call Horizon BCBS, you speak to a medical management specialist who can help you:

- Precertify an inpatient admission;
- Receive important information about a pregnancy, especially for high-risk situations;
- Coordinate a second surgical opinion for certain non-emergency procedures; and
- Coordinate care and provide case management if you have a complex or severe medical situation requiring a lengthy hospital stay.

Call Horizon BCBS at 877-663-7258.

How to Precertify Inpatient Medical Services Through Horizon BCBS

When your doctor recommends a hospital stay, call Horizon BCBS seven to 10 days before the scheduled admission. Horizon BCBS will contact your physician to confirm the need for hospitalization. After approving your hospitalization and the length of stay, Horizon BCBS will send you a letter. If you do not receive the letter within three days before your scheduled hospitalization, call Horizon BCBS at **877-663-7258** to verify that your hospital stay has been authorized, provided you have precertified your hospital stay.

If you do not call Horizon BCBS as required, your benefit will be reduced by 20%. For example, the 80% coverage would be reduced to 60%. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the services will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

Emergency Admissions

You must call Horizon BCBS within 48 hours of an Emergency admission to a hospital or other facility, even if you are discharged by then.



Lengthened Maternity Hospital Stays

If you expect your or your Covered Dependent(s)' maternity hospital stay to exceed 48 hours for a normal delivery or 96 hours for a Caesarian-section, you must precertify the continued hospitalization by calling Horizon BCBS at **877-663-7258**.

Outpatient Surgeries

Listed below are examples of surgeries that should normally be performed on an outpatient basis. If your doctor feels that you need to stay overnight in the hospital, you must call Horizon BCBS for precertification at **877-663-7258**. Please note that the following list is not intended to be all-inclusive.

- D&C (dilation and curettage – scraping of uterus);
- Eye muscle operations;
- Hammertoe repair;
- Hemorrhoidectomy (removal of hemorrhoids);
- Herniorrhaphy (hernia repair);
- Mastoidectomy (removal of mastoid process);
- Nasal submucous resection (partial excision of nasal septum);
- Neuroplasty (surgery of nerves/nerve tissues);
- Skin lesion excision (subcutaneous or soft tissue, either malignant or benign);
- Tendon sheath release/repair (incision/repair of tendons); or
- Varicose vein ligation.

Precertification of Behavioral Health Care Services

Employees

Call ValueOptions to Precertify Behavioral Health Care Services

Behavioral health precertification for Employees and their Covered Dependent(s) is handled by ValueOptions, the Merck Managed Behavioral Health Care Program's Claims Administrator. Call the ValueOptions precertification line at **877-44-MERCK**. You must call at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency admissions to a hospital or other facility.

- **Inpatient.** All inpatient behavioral health care services require precertification through ValueOptions. Failure to precertify In-Network inpatient hospitalizations will result in benefits being paid at Out-of-Network rates. Failure to precertify Out-of-Network inpatient hospitalizations will result in a 20% reduction in coverage. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the services will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.
- **Outpatient.** You must precertify In-Network outpatient behavioral health care. Failure to precertify will result in benefits being paid at Out-of-Network rates.

Retirees Under Age 65

Call Horizon BCBS to Precertify Behavioral Health Care Services

Behavioral health precertification for Retirees and their Covered Dependent(s) is handled through Horizon BCBS. You must call Horizon BCBS at **877-663-7258** at least 48 hours in advance for non-Emergency inpatient admissions and no later than 48 hours after Emergency admissions to a hospital or other facility. Please note that Retirees age 65 or older and their Covered Dependent(s) age 65 or older are not required to precertify behavioral health care services.

- **Inpatient.** All inpatient behavioral health care services require precertification. Failure to precertify In-Network or Out-of-Network inpatient hospitalizations will result in a 20% reduction in coverage. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the services will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.
- **Outpatient.** You must precertify In-Network outpatient behavioral health care. Failure to precertify will result in a 20% reduction in coverage. Out-of-Network outpatient care does not require precertification.

KEY POINT — PRECERTIFICATION FOR RETIREES AGE 65 OR OLDER AND THEIR COVERED DEPENDENT(S) AGE 65 OR OLDER

Retirees and their Covered Dependent(s) ages 65 and older who are on Medicare are not required to precertify medical or behavioral health care services.

In Case of an Emergency

If you or a Covered Dependent(s) have a medical or behavioral health Emergency, you should call 911 or immediately go to the nearest emergency room. Emergency room services are covered at 80%, after you satisfy the Deductible, for both In-Network and Out-of-Network services.

If your emergency room visit is deemed *not an Emergency* as defined by the Merck Medical Plan (see the Key Point below) then your emergency room coverage will be reduced by 20% for both In-Network and Out-of-Network coverage. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency.

KEY POINT — HOW EMERGENCY IS DEFINED

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention could result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ.

For more details, please refer to the definition of Emergency in the Glossary of "General Information about the Merck Medical Plan — Part 1 of the SPD."

You Must Contact the Claims Administrator If You Have an Emergency Admission

For Medical Reasons

If you or a Covered Dependent(s) are admitted to the hospital for medical reasons, you must call Horizon BCBS at **877-663-7258** within 48 hours of the Emergency admission (even if you are discharged by then) to receive the highest level of benefits available under the Merck 80/20 Out-of-Area option.



Additionally, if you or your Covered Dependent(s) need non-Emergency medical hospitalization or surgery, you may need to call Horizon BCBS for advance approval.

For Behavioral Health

- **Employees and their Covered Dependent(s).** You must contact ValueOptions, the Merck Managed Behavioral Health Care Program's Claims Administrator, at **877-44-MERCK (877-446-3725)** within 48 hours of an Emergency admission to a hospital or other facility (even if you are discharged by then) to receive the highest level of benefits available under the Merck 80/20 Out-of-Area option.
- **Retirees (under age 65) and their Covered Dependent(s) (under age 65).** You must contact Horizon BCBS at **877-663-7258** within 48 hours of an Emergency admission to a hospital or other facility (even if you are discharged by then) to receive the highest level of benefits available under the Merck 80/20 Out-of-Area option.

Failure to Notify the Claims Administrator

In all cases, if you do not call the applicable Claims Administrator within 48 hours of the Emergency admission, certain penalties will apply. (For specific information about penalties, see the applicable Precertification sections.) Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

How to File a Claim

When you receive care you generally pay for, or arrange for the payment of, services up front and then file a claim for reimbursement for the share of the cost covered by the Merck Medical Plan. If you have duplicate coverage, including Medicare, and the Merck Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to Horizon BCBS. For more information when you have other coverage, see "Coordination of Benefits" in "General Information about the Merck Medical Plan – Part 1 of the SPD."

How to file a claim with the Merck 80/20 Out-of-Area option:

- Complete the "Employee" section of the Horizon BCBS Medical Expense Claim Form, available on:
 - NetBenefits at <http://netbenefits.fidelity.com>;
 - <http://hr.merck.com>; or
 - www.horizonblue.com/merck or www.horizonblue.com/merckretirees.

Forms are also available by calling the Merck Benefits Service Center at **800-66-MERCK**.

- Obtain an itemized bill from your provider that includes:
 - Patient's name;
 - Date(s) of service(s);
 - Condition being treated;
 - Relationship to employee;
 - Type of service(s) rendered; and
 - The provider's name and Internal Revenue Service (IRS) tax identification number.

- Attach a copy of your itemized bill to the claim form and submit both to:

Merck Dedicated Service Team
Horizon BCBS
P.O. Box 18
Newark, NJ 07101-0018



In all cases, your claim must be submitted within two years of receiving treatment, unless you can show that it was not reasonably possible to file a claim within that time period. Claims submitted more than 24 months after the date of service are not considered valid and will not be paid.

KEY POINT — KEEP COPIES OF CLAIMS FOR YOUR RECORDS

It's a good idea to keep copies of all claim forms and bills that you submit for reimbursement. Because Deductible amounts and other limitations apply separately to each covered person, it's important to keep separate records for each covered person.

Appealing a Claim

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



Retiree Catastrophic Option

The Retiree Catastrophic option is available to Merck Retirees and their Covered Dependent(s). The Retiree Catastrophic option is designed to provide a basic level of financial protection.

About the Retiree Catastrophic Option

The Retiree Catastrophic option provides another coverage option for Retirees and their Covered Dependent(s). If you are enrolled in the Retiree Catastrophic option and you are age 65 or older, you must be enrolled in Medicare Part A and Part B. **For those who are Medicare-eligible, the Retiree Catastrophic option is considered secondary coverage, and Medicare is primary.** For more information, see “Coordinating Benefits with Medicare” in the Administrative Information chapter in “General Information about the Merck Medical Plan – Part 1 of the SPD.”

This option covers you for a range of services, including preventive care, hospitalizations and Emergency care. Coverage is generally similar to the benefits under the Merck 80/20 option, but with significantly higher Deductibles and Out-of-Pocket Maximums. Under the Retiree Catastrophic option you don’t need to select a primary care physician (PCP) and you don’t need a referral to see a specialist. Generally, after you reach the Deductible, your Coinsurance for most covered expenses is 80%. Horizon BCBS is the Claims Administrator and fiduciary for the Retiree Catastrophic option.

In general, you must arrange for payment at the time you receive health care services. The Retiree Catastrophic option will reimburse you for your share of the cost of Medically Necessary covered services after you submit a claim for benefits.

Key Features

In general, under the Retiree Catastrophic option:

- You may receive care from any licensed provider of your choice.
- Every time you need care, you have the choice to see an In-Network or Out-of-Network provider. However, if you do obtain care from an Out-of-Network provider you will likely pay more for those services.
- Network providers have agreed in advance to accept specific negotiated fees, so you will never have to pay for fees in excess of Reasonable and Customary (R&C) Limits if you use a network provider.
- Generally, you must meet an Individual Deductible or Family Deductible before the Plan pays benefits.
- If you receive care Out-of-Network, your Coinsurance is subject to R&C Limits.
- If you are under age 65 and *not* on Medicare, you must precertify certain services, including inpatient hospitalization, certain surgeries and certain maternity care.



Prescription Drug Benefits

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

How the Retiree Catastrophic Option Works

The Retiree Catastrophic option provides you with access to a national network of providers – the BlueCard Traditional network. Each time you receive care for covered expenses you have a choice of obtaining care In-Network, using one of the BlueCard Traditional providers, or Out-of-Network from any other physician of your choice. While you are not required to use a participating provider there are advantages to using BlueCard Traditional providers. Participating providers will file the claim on your behalf and will accept the plan allowance as payment in full.

Whether you use a network provider or not, you pay an Annual Deductible each year, then the Merck Medical Plan generally pays 80% Coinsurance for your In-Network covered expenses. If you receive care Out-of-Network, the Merck Medical Plan pays 80% Coinsurance up to the R&C Limit. Once you reach the annual Out-of-Pocket Maximum, the Merck Medical Plan pays 100% of your covered expenses up to the R&C Limit for the rest of the year. You are responsible for any expenses above the R&C Limit.

In-Network Benefits

You receive the highest level of benefits available under the Retiree Catastrophic option when you use an In-Network provider. Every time you visit a health care provider who participates in the BlueCard Traditional network, you have the potential to save money. Since the In-Network provider's fees are negotiated (and generally lower), you are charged less. This means you pay less out of your own pocket for health care. If you receive services from a provider participating in the BlueCard Traditional network, their services are negotiated; therefore they never exceed the R&C Limit.

Out-of-Network Benefits

Each time you need care, you can choose to see a provider who does not belong to the BlueCard Traditional network. The difference is that you will likely pay more for Out-of-Network care. You are also responsible for any expenses above the R&C Limit. You will be considered to have chosen to go Out-of-Network if you receive care from a provider who does not participate in the BlueCard Traditional network.

KEY POINT – IMPORTANT BENEFIT TERMS

Important benefit terms, such as Annual Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the Glossary located in "General Information about the Merck Medical Plan – Part 1 of the SPD."

Retiree Catastrophic Option At a Glance

The following chart summarizes the coverage levels for services under the Merck Retiree Catastrophic option. *There is no coverage for charges above the Reasonable and Customary (R&C) Limit.* The Coinsurance percentages apply after you have met the Annual Deductible and assume you have not already reached the Out-of-Pocket Maximum. Except for the preventive services listed on the following pages, there is no coverage for services that Horizon BCBS determines are not Medically Necessary. In addition, not all services that are Medically Necessary are covered. See "What's Covered Under the Horizon BCBS Medical Options" for a complete list of covered services and any applicable additional limitations under the Retiree Catastrophic option.



Retiree Catastrophic Option At a Glance

	Coverage
COSTS	
Annual Deductible ¹ <i>Individual</i> <i>Family</i>	\$1,500 \$3,000
Coinsurance <i>Plan pays</i> <i>You pay</i>	80% of R&C Limit 20% of R&C Limit plus any amounts in excess of R&C Limit ²
Annual Out-of-Pocket Maximum ¹ <i>Individual</i> <i>Family</i>	\$5,000 \$10,000
Lifetime Benefit Maximum	None ³
Reasonable and Customary (R&C) Limit	Applies
PREVENTIVE MEDICAL CARE — EXAMS	
Routine Annual Physical Exams <i>One exam per calendar year</i>	80% of R&C Limit, no Deductible
Routine Immunizations	100% of R&C Limit, no Deductible
Routine Immunization-Related Office Visits	80% of R&C Limit, no Deductible
Routine Preventive OB/GYN Exams <i>One exam per calendar year</i>	80% of R&C Limit, no Deductible
Routine Eye Exams <i>One exam every 24 months</i> <i>Eyewear discounts available through Complete Advantage⁴</i>	80% of R&C Limit, no Deductible
Routine Hearing Exams; <i>one exam every 24 months</i>	80% of R&C Limit, no Deductible
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY	
Routine Preventive Lab/X-Ray <i>Services related to routine annual physical exams. Limited to one per calendar year⁵</i>	80% of R&C Limit, no Deductible
Certain Preventive Services that Are Not Part of a Routine Annual Physical/Office Visit ⁶	80% of R&C Limit, no Deductible
Routine Mammography Screenings Ages 35–59, one baseline; ages 40 and above, one screening per year; additional screenings if prescribed by your physician as Medically Necessary	100% of R&C Limit, no Deductible If additional screenings are prescribed by your physician as Medically Necessary, 80% of R&C Limit after Deductible
Routine Preventive Pap Test <i>One per calendar year</i>	80% of R&C Limit, no Deductible

¹ Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² If you receive services from a provider who participates in the BlueCard Traditional network, fees are based on negotiated rates; R&C limits do not apply.

³ Certain treatment limits may apply to certain services such as infertility-related services and inpatient substance-abuse treatment.

⁴ For more information about the Complete Advantage Discount Program and participating providers, contact Complete Advantage Customer Service at **877-518-8748**.

⁵ Coverage for routine preventive lab/x-ray is determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force and guidelines established by the American Medical Association (AMA) and provided they are designated by your physician as preventive. Contact Horizon BCBS for information about specific age and gender guidelines for covered preventive services.

⁶ Preventive care services are covered as determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force. Bone mass density testing designated by your physician as preventive is also covered. Contact Horizon BCBS for information about specific age and gender guidelines for covered preventive services.



	Coverage
OUTPATIENT MEDICAL CARE	
Office Visits	80% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a doctor's office</i>	80% of R&C Limit, after Deductible
Outpatient Surgery <i>Performed in a hospital or ambulatory surgical center</i>	80% of R&C Limit, after Deductible
Allergy Testing	80% of R&C Limit, after Deductible
Allergy Treatment <i>Injections, serum</i>	80% of R&C Limit, after Deductible
Infertility Diagnosis and Treatment ¹ <i>Artificial insemination, advanced reproductive treatment (ART)</i>	80% of R&C Limit, after Deductible
Chiropractic Care <i>Up to 25 visits per calendar year per person; maintenance therapy not covered</i>	80% of R&C Limit, after Deductible
Acupuncture <i>Medically Necessary for pain, illness or injury, performed by an M.D., D.O. or state licensed physician or practitioner and is Medically Necessary</i>	80% of R&C Limit, after Deductible
Second Surgical Opinion	80% of R&C Limit, after Deductible
Short-Term Rehabilitation ² <i>Physical therapy, occupational therapy, speech therapy</i>	80% of R&C Limit, after Deductible
Oral Surgery ³ <i>Certain procedures if performed in a hospital or ambulatory surgical facility due to medical necessity</i>	80% of R&C Limit, after Deductible
Outpatient Hospice Care <i>Includes bereavement counseling for one year</i>	80% of R&C Limit, after Deductible

¹ For infertility: 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. These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, you do not restart these limits. 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.

² Short-term rehabilitation may include physical, occupational and speech therapy for a limited period based on medical necessity. Maintenance therapy is not covered. Contact Horizon BCBS at **877-663-7258** 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.

³ Oral surgery performed in a dental office, whether it be dental or medical in nature, will be considered for payment under dental benefits only. See the Merck Dental Plan SPD for information. Oral surgery that is not performed in a dental office which is dental or medical in nature may be considered for payment under medical benefits, provided the patient has a medical condition where medical necessity requires service outside of a dental office.



	Coverage
OUTPATIENT MEDICAL CARE — LABS AND X-RAY	
Diagnostic Labs and X-Rays <i>Performed in a physician's office</i>	80% of R&C Limit, after Deductible
Diagnostic Labs and X-Rays <i>Performed in an outpatient hospital or other outpatient facility (including lab processing)</i>	80% of R&C Limit, after Deductible
INPATIENT HOSPITAL SERVICES	
Maternity Services <i>Delivery charges in a hospital or approved, licensed birthing center</i>	80% of R&C Limit, after Deductible ¹
Inpatient Hospice Care <i>Up to 60 days per lifetime</i>	80% of R&C Limit, after Deductible
OTHER SERVICES	
Emergency Services <i>Ambulance</i> <i>Emergency Room</i> <i>Urgent Care</i>	80% of R&C Limit, after Deductible 80% of R&C Limit, after Deductible ² 80% of R&C Limit, after Deductible
Durable Medical Equipment ³ <i>Wheelchairs, walkers, etc.</i>	80% of R&C Limit, after Deductible
Foot Orthotics ⁴	80%, after Deductible
Prosthetics and Appliances <i>Artificial limbs, etc.</i>	80% of R&C Limit, after Deductible
Skilled Nursing Facility (<i>Up to 120 days per calendar year</i>)	80% of R&C Limit, after Deductible
Contraceptive Devices ⁵ <i>Diaphragms, IUDs, implants, injections</i>	80% of R&C Limit, after Deductible
OTHER SERVICES	
Home Health Care	80% of R&C Limit, after Deductible
Custodial Care	Not covered

- ¹ If you are under age 65, you must precertify all inpatient medical hospitalizations with Horizon BCBS at **877-663-7258**, including surgeries and certain maternity care. Failure to precertify Medically Necessary care will result in a 20% reduction in coverage. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify inpatient care.
- ² If your emergency room visit is deemed not to be an Emergency, your coverage will be reduced by 20%. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency.
- ³ Excludes coverage for items otherwise covered under the Merck Managed Prescription Drug Program (for example, insulin, needles and syringes and other diabetic products, etc.). For details about coverage, visit www.medco.com or call Medco Member Services at **800-RX-MERCK**.
- ⁴ Foot Orthotics refer to devices of rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions. Orthotics and orthotic shoes are covered. Examples of items NOT considered as a foot orthotic because they lack rigid construction are: inner soles (foam rubber, leather, flexible, etc.), corn plasters (pads, etc.), foot padding (adhesive moleskin, etc.) Arch supports are covered for children only for pes cavus, pes planus and pes varus because they can affect foot development and cure or reduce the severity of these conditions. In all other cases, charges for arch supports are not covered as supportive devices for the feet. 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.
- ⁵ Oral contraception is covered under the Merck Managed Prescription Drug Program (Medco By Mail only).



	Coverage
PRESCRIPTION DRUG BENEFITS	
Inpatient	80% of R&C Limit, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Drugs administered in a doctor's office or provided by a doctor for in-home administration, unless ordered for the patient through Medco By Mail	80% of R&C Limit, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Drugs administered in an ambulatory surgical facility	80% of R&C Limit, after Deductible; Merck-brand drugs covered at 100%
Outpatient — Prescriptions filled through retail pharmacies or through Medco By Mail	Provided under the Merck Managed Prescription Drug Program. See that chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD."
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS¹	
Inpatient Mental Health and Substance Abuse Care ² <i>Substance abuse limited to four treatment programs In-Network and Out-of-Network combined³</i>	80%, after Deductible ^{4,5}
Outpatient Mental Health and Substance Abuse Care	80%, after Deductible

Precertification

KEY POINT — PRECERTIFICATION FOR RETIREES AND THEIR COVERED DEPENDENT(S)

Retirees and their Covered Dependent(s) who are under age 65, must precertify all inpatient medical hospitalizations with Horizon BCBS at **877-663-7258**, including surgeries and certain maternity care. Failure to precertify Medically Necessary care will result in a 20% reduction in coverage. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care.

Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify inpatient care.

How to Precertify Inpatient Medical Services Through Horizon BCBS

When your doctor recommends a hospital stay, call Horizon BCBS seven to 10 days before the scheduled admission. Horizon BCBS will contact your physician to confirm the need for hospitalization. After approving your hospitalization and the length of stay, Horizon BCBS will send you a letter. If you do not receive the letter within three days before your scheduled hospitalization, call Horizon BCBS at **877-663-7258** to verify that your hospital stay has been authorized, provided you have precertified your hospital stay.

You must follow these precertification procedures for both In-Network and Out-of-Network care, even if your physician is a network provider. If you do not call Horizon BCBS as required, your benefit will

¹ Retirees are not eligible to participate in the Merck Managed Behavioral Health Care Program administered by ValueOptions. Behavioral health benefits for Retirees are administered by Horizon BCBS. In-Network behavioral health care may be available to Retirees through the BlueCard network.

² Inpatient services apply to Medically Necessary hospital and treatment facility stays and Medically Necessary Emergency treatment.

³ These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, treatment limits do not restart.

⁴ If you are under age 65, you must precertify all inpatient medical hospitalizations with Horizon BCBS at **877-663-7258**, including mental health care. Failure to precertify Medically Necessary care will result in a 20% reduction in coverage. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify inpatient care.

⁵ The following services and procedures also require precertification: psychological testing, neuropsychological testing, outpatient electroconvulsive therapy (ECT), biofeedback, amytal interview, hypnosis, psychiatric home health care services and outpatient detoxification. Retirees and their Covered Dependent(s), who are at least age 65, are not required to precertify care.



be reduced by 20%. For example, the 80% coverage would be reduced to 60%. Also, where no precertification is obtained and the Claims Administrator determines that the care provided was not Medically Necessary, the service will not be covered at all. Any extra charges you incur for failure to precertify do not count toward your Annual Deductible or Out-of-Pocket Maximum.

KEY POINT — ABOUT HORIZON BCBS

When you call Horizon BCBS, you speak to a medical management specialist who can help you:

- Precertify an inpatient admission;
- Receive important information about a pregnancy, especially for high-risk situations;
- Coordinate a second surgical opinion for certain non-emergency procedures; and
- Coordinate care and provide case management if you have a complex or severe medical situation requiring a lengthy hospital stay.

Call Horizon BCBS at 877-663-7258.

Emergency Admissions

You must call Horizon BCBS within 48 hours of an Emergency admission to a hospital or other facility, even if you are discharged by then.

Lengthened Maternity Hospital Stays

If you expect your or your Covered Dependent(s)' maternity hospital stay to exceed 48 hours for a normal delivery or 96 hours for a Caesarian-section, you must precertify the continued hospitalization by calling Horizon BCBS at **877-663-7258**.

Outpatient Surgeries

The surgeries listed below are examples of surgeries that should normally be performed on an outpatient basis. If your doctor feels that you need to stay overnight in the hospital, you must call Horizon BCBS for precertification at **877-663-7258**. Please note that the following list is not intended to be all-inclusive:

- D&C (dilation and curettage – scraping of uterus);
- Eye muscle operations;
- Hammertoe repair;
- Hemorrhoidectomy (removal of hemorrhoids);
- Herniorrhaphy (hernia repair);
- Mastoidectomy (removal of mastoid process);
- Nasal submucous resection (partial excision of nasal septum);
- Neuroplasty (surgery of nerves/nerve tissues);
- Skin lesion excision (subcutaneous or soft tissue, either malignant or benign);
- Tendon sheath release/repair (incision/repair of tendons); or
- Varicose vein ligation.

In Case of an Emergency

If you or a Covered Dependent(s) have a medical or behavioral health Emergency, you should call 911 or immediately go to the nearest emergency room. Emergency room services are covered at 80%, after you satisfy the Deductible.

If your emergency room visit is deemed *not an Emergency* as defined by the Merck Medical Plan (see the Key Point on the next page) then your emergency room coverage will be reduced by 20% for both



In-Network and Out-of-Network coverage. Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency.

KEY POINT — HOW EMERGENCY IS DEFINED

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention could result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ.

For more details, please refer to the definition of Emergency in the Glossary of “General Information about the Merck Medical Plan — Part 1 of the SPD.”

How to File a Claim

When you receive care you generally pay for, or arrange for the payment of, services up front and then file a claim for reimbursement for the share of the cost covered by the Merck Medical Plan. If you have other coverage (e.g., Medicare), and the Merck Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to Horizon BCBS. For more information when you have other coverage, see “Coordination of Benefits” in “General Information about the Merck Medical Plan — Part 1 of the SPD.”

How to file a claim with the Merck Catastrophic option if you’re not on Medicare:

- Complete the “Employee” section of the Horizon BCBS Medical Expense Claim Form, available on:
 - NetBenefits at <http://netbenefits.fidelity.com>;
 - <http://hr.merck.com>; or
 - www.horizonblue.com/merck or www.horizonblue.com/merckretirees.

Forms are also available by calling the Merck Benefits Service Center at **800-66-MERCK**.

- Obtain an itemized bill from your provider that includes:
 - Patient’s name;
 - Date(s) of service(s);
 - Condition being treated;
 - Relationship to employee;
 - Type of service(s) rendered; and
 - The provider’s name and Internal Revenue Service (IRS) tax identification number.

- Attach a copy of your itemized bill to the claim form and submit both to:

Merck Dedicated Service Team
Horizon BCBS
P.O. Box 18
Newark, NJ 07101-0018

In all cases, your claim must be submitted within two years of receiving treatment, unless you can show that it was not reasonably possible to file a claim within that time period. Claims submitted more than 24 months after the date of service are not considered valid and will not be paid.



KEY POINT — KEEP COPIES OF CLAIMS FOR YOUR RECORDS

It's a good idea to keep copies of all claim forms and bills that you submit for reimbursement. Because Deductible amounts and other limitations apply separately to each covered person, it's important to keep separate records for each covered person.

Appealing a Claim

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

What's Covered Under the Horizon BCBS Medical Options

This section provides an alphabetical list of Medically Necessary covered services and supplies for the Merck PPO, Merck 80/20, Merck 80/20 Out-of-Area and Retiree Catastrophic options, as limited by the Horizon BCBS Medical Policy, which you can access online at www.horizonblue.com/merck or www.horizonblue.com/merckretirees.

Services that are not deemed Medically Necessary, as determined by Horizon BCBS, 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 Horizon BCBS Medical Options" or contact Horizon BCBS for more details. For more information on coverage limits, see the "At-a-Glance Charts". Finally, since additional limits may apply, you should contact Horizon BCBS directly to confirm coverage for a particular service or supply.

KEY POINT — PRECERTIFICATION

Certain inpatient and outpatient medical and behavioral health care services require precertification from the Claims Administrator in order for you to receive the highest level of benefits available. For more information, please refer to the Managed Behavioral Health Care Program chapter in "General Information about the Merck Medical Plan — Part 1 of the SPD" or, if you are enrolled in an HMO, "Your HMO Coverage Information—Part 2 of the SPD."

Acupuncture Treatments when performed by a licensed M.D., D.O. or a state-licensed physician for the treatment of pain, illness or injury.

Allergy Testing and Treatment, including serum and injections. See "Drug Therapy."

Bereavement Counseling. See "Hospice Care."

Charges for Contraceptive Devices, Implants and Injectables (other than oral contraceptives that may be covered under Merck's Managed Prescription Drug Program), including diaphragms, IUDs, implants and injectables.

Chiropractic Services (including the initial exam) performed by a licensed chiropractor, up to a maximum of 25 visits per calendar year. Chiropractic benefits are limited to the diagnosis and treatment only for a misalignment or dislocation of the spine (including any strained muscle or related ligament). Chiropractic maintenance therapy is excluded.

Dental Expenses are primarily covered through the Dental Plan. For more information, see The Merck Dental Plan SPD. Covered dental expenses under the Merck Medical Plan include:

- Any dental surgery or other dental service performed in a hospital (inpatient or outpatient) or an ambulatory surgical facility, provided the covered person has a condition (e.g., diabetes, heart condition, etc.) which makes the provision of those services in that setting Medically Necessary;
- Any restorative or corrective surgery or other dental services in the event of accidental injury to sound natural teeth; and
- Any surgery or other service for the reduction of dislocation or management of temporomandibular joint dysfunction (TMJ). However, the TMJ appliance is not covered under the Merck Medical Plan. The appliance may be covered under the Merck Dental Plan. For more information, see The Merck Dental Plan SPD.

Drug Therapy administered in a doctor's office or in an outpatient surgical facility or provided by the doctor for in-home administration (for example, allergy shots and chemotherapy), unless covered through the Merck Managed Prescription Program. Merck-brand drugs administered in these settings are covered at 100%.

Durable Medical Equipment. Medically necessary durable medical equipment may be considered a covered service. Examples of covered durable medical equipment may include the following:

- Apnea monitors;
- Artificial limbs and eyes;
- Casts and splints;
- Trusses, braces, crutches, walkers and canes;
- Rental of oxygen equipment for its administration;
- Rental of wheelchair or hospital-type bed; anesthesia and mechanical equipment for therapeutic treatment;
- Rental of durable medical and surgical equipment;
- Glucose monitors and infusion pumps; and
- Prescribed medical nutrition for the dietary treatment of a disease where the member has either:
 - A permanent non-function or disease of the structures that normally permit food to reach the small bowel, or
 - Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires enteral or parenteral feedings.

Foot Care, including orthopedic shoes and foot orthotics used in the treatment of a condition affecting the foot. Foot orthotics refer to devices of rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions. Foot orthotics are covered 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 (see also "What's Not Covered Under the Horizon BCBS Medical Options" for additional exclusions). Orthotic shoes are covered, subject to medical necessity, for children under age 12. For Eligible Employees, Retirees and Covered Dependent(s) age 12 or older, up to one pair of orthotic shoes is covered per calendar year.

Home Health Care. As a general rule, the Merck Medical Plan will pay covered medical expenses under home health care to the same extent it would have paid for similar services and supplies if you or a Covered Dependent(s) had been hospitalized. Home health care must be administered by a

certified home health care agency. Please note that home health care must be certified by Horizon BCBS for all Horizon BCBS medical options.

The following services provided by a certified home health care agency are covered:

- Continuous or part-time nursing care by or under the supervision of a registered nurse;
- Continuous or part-time home health aide services;
- Medical social work, as well as physical, occupational, respiratory and speech therapy;
- Medical supplies, drugs prescribed by a physician, nutrition services and lab services;
- Rental of durable medical equipment such as a hospital-type bed, wheelchair, oxygen and suction machines;
- Diagnostic, therapeutic and surgical services performed in a hospital, a doctor's office, any other licensed health care facility or in the home; and
- Expenses associated with respite care that is needed if the patient's family is unable to attend to the patient's needs for a brief interval. Respite care must have been certified by hospice and BCBSNJ and is limited to an aggregate maximum of ten days per calendar year.

Home Health Care – Skilled Nursing Services

- **Visiting Nurse Care** by an R.N. or L.P.N for skilled nursing services that are Medically Necessary. Visiting nursing care means a visit of not more than four hours for the purpose of performing specific skilled (non-custodial) nursing tasks.
- **Private Duty Nursing** by an R. N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. Each period of private duty nursing of up to 8 hours will be considered one private duty nursing shift. Benefits are covered when Medically Necessary and approved by Horizon BCBS for all Horizon BCBS medical options.

Hospice Care expenses are covered if you, or a Covered Dependent(s), are diagnosed by your physician as terminally ill. Hospice care is an alternative to acute care hospitalization with emphasis on relieving pain rather than curing a patient. Its purpose is to help the family cope with the physical, psychological, spiritual and social stress associated with the illness and loss of a family member. Care can take place in the hospice unit of a hospital or other health care facilities, in a free-standing hospice or in the patient's home. The Merck Medical Plan will pay covered expenses under hospice care to the same extent it would have paid for similar services and supplies had you or a Covered Dependent(s) been hospitalized.

The "hospice benefit period" begins on the date the patient is diagnosed as terminally ill and continues for six months (or longer if a physician certifies that additional time is necessary). In addition, the hospice benefit period includes a one-year family bereavement period following the death of a Covered Dependent(s). Covered hospice care expenses must be provided by a medically-supervised team of professionals who must work with an independent hospice administration. The hospice administration must:

- Meet the standards of the National Hospice Organization;
- Satisfy any applicable licensing requirements; and
- Be accredited by the Joint Commission on Accreditation of Hospitals.

The following expenses are covered when they are part of an approved hospice care program:

- Inpatient care in a hospice unit of a health care facility or in a free-standing hospice for up to 60 days of inpatient care (precertification is required). Charges for an inpatient hospice stay solely for palliative (pain relief) care will not be considered a covered hospice care expense unless your physician certifies that the stay is Medically Necessary in place of hospice care provided at home or on an outpatient basis;
- Home health care services;
- Physician's services;
- Emotional support services, including assistance in relieving stress, coping with anticipated losses, and maintaining the patient in the most appropriate environment. Covered hospice care expenses include charges for the professional services of a person having a Master's degree in social work or a Master's or PhD in the mental health counseling field, for up to one visit per week;
- Bereavement services, including supportive services provided in counseling sessions with Covered Dependent(s) following the death of the hospice patient. Covered hospice care expenses include charges for the professional services of a certified pastoral counselor, for up to six counseling sessions during the period of bereavement. Covered hospice expenses do not include charges for services provided by a certified pastoral counselor to a member of his or her congregation; and
- Special incidental services for the patient, including special dietary requirements and transportation by Medically Necessary professional ambulance to and from the nearest inpatient hospice facility.

Hospice care may be provided either at home or through an accredited hospice care agency.

Hospital Services and Supplies. Semi-private room and board expenses in a recognized hospital or approved rehabilitative facility. If you stay in a private room because your doctor establishes that isolation is Medically Necessary, the Merck Medical Plan options cover the private room and board expenses.

Covered hospital expenses include (see also "Surgery"):

- Services of a surgeon;
- Preoperative and postoperative care;
- Administration of anesthesia;
- Ambulance services to the first hospital where you receive treatment and transfers when Medically Necessary;
- X-rays, laboratory and pathology services;
- Maternity services – professional fees for delivery made by either an obstetrician or a midwife; approved, licensed birthing centers (see Key Point: "Newborns' and Mothers' Health Protection Act" below);
- Inpatient prescription drugs;
- Other outpatient services and supplies billed by the hospital; and
- Hospital charges for outpatient services, other than those included as covered hospital expenses.

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).

Hospital Alternatives are alternatives to hospitalization that can provide the same quality care in a way that is often more convenient and suitable to the patient. The following alternative care facilities are covered:

- **Ambulatory Surgical Centers and Other Outpatient Facilities.** Special surgical facilities have been established in many parts of the country to allow patients to have surgery and be released within one day. The facility must be licensed and accredited by the state. The facility must also be operated under the supervision of a physician, staffed with full-time RNs, equipped with diagnostic x-ray and lab facilities (or have a written agreement with a hospital to supply these facilities). The facility must also keep medical records for each patient showing diagnosis, operative notes and a discharge summary. In addition, a written agreement must be in existence between the facility with a hospital to provide postoperative confinement if needed and to handle complications.
- **Birthing Facilities.** These must be licensed by the state.
- **Skilled Nursing Facilities.** A facility operated under the supervision of a physician and staffed with full-time nurses. Benefits are covered for up to 120 days per calendar year when Medically Necessary and certified by Horizon BCBS for all Horizon BCBS medical options.

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. These limits apply across the non-HMO options. If you change non-HMO options under the Merck Medical Plan, you do not restart these limits. 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."

Laboratory Tests/X-Rays

- Charges for laboratory tests and x-ray examinations (other than those for which benefits are payable as covered hospital and alternative care expenses); and
- Diagnostic x-rays and laboratory tests (including pre-admission testing).

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

Preventive Care services are covered as determined by Horizon BCBS in accordance with the recommendations established by the U.S. Preventive Services Task Force and guidelines established by the American Medical Association (AMA), provided they are designated by your physician as preventive. Contact Horizon BCBS at 877-663-7258 or visit www.horizonblue.com/merck or www.horizonblue.com/merckretirees for information about specific age and gender guidelines for covered preventive services. Covered preventive care services include:

- Routine doctor visits and examinations, maximum of one routine physical per calendar year, over age six;
- Well-child care visits up to age six, unlimited visits;
- Routine immunizations and inoculations;
- Hearing exam, one per every 24 months;
- Eye exam, one per every 24 months;
- Bone mass density testing;
- Cholesterol testing;
- Routine fecal occult blood testing;
- Routine sigmoidoscopy and colonoscopy;
- Routine mammograms (see "Women's Health"); and
- Routine prostate specific antigen (PSA) test and digital rectal exam.

Professional Services of a Registered Nurse (R.N.), or a Licensed Practical Nurse (L.P.N.) when an R.N. is unavailable.

Short-Term Rehabilitation Therapy, 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, including inpatient and outpatient hospital and surgical treatment for an illness or injury. The Merck Medical Plan also covers:

- Bariatric surgery subject to the Horizon BCBS Medical Policy; and
- Surgery associated with reconstructive surgery following a mastectomy, 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 (see Key Point: "Women's Health and Cancer Rights Act" on the next page). Normal plan Copays, Deductibles, Coinsurances and Out-of-Pocket Maximums will apply.

Vision Care services covered under the Merck Medical Plan include:

- Eye exams when Medically Necessary due to vision impairment as a side effect of prescribed medication;
- Charges for an eye exam once every 24 months; and
- Discounts on eyeglasses and contact lenses. For more information about Horizon BCBS's Complete Advantage™ Discount Program call 877-518-8748.

Voluntary Sterilization covers tubal ligation and vasectomy; reversals are excluded.

Wigs or hairpieces when prescribed by a physician for hair loss due to injury, disease or treatment of a disease.

KEY POINT — REPLACEMENT OF DURABLE MEDICAL EQUIPMENT, WIGS, ETC.

Coverage for replacement of durable medical equipment, prosthetics, wigs, etc., may be available in accordance with Horizon BCBS's standard repair or replacement guidelines. For more information, call Horizon BCBS at **877-663-7258**.

Women's Health services covered under the Merck Medical Plan include:

- One routine wellness exam, including Pap Smear (one per calendar year);
- Mammography screenings—baseline between ages 35–39; ages 40 and above—one screening every year, unless additional screenings are prescribed by your physician as Medically Necessary;
- 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
- Protheses 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 Horizon BCBS Medical Options

This section provides a list of services and supplies that are not covered by the Merck PPO, Merck 80/20, Merck 80/20 Out-of-Area and Retiree Catastrophic options. Services that are not deemed Medically Necessary, as determined by Horizon BCBS, 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.

To verify coverage of a medical service or device, contact Horizon BCBS at **877-663-7258**.

Medical expenses *not covered* under the Merck Medical Plan include, but are not limited to:

Charges paid under **Auto Insurance Benefits**.

- Expenses where benefits are payable under no-fault automobile insurance policies.
- Expenses payable under your (or your covered Eligible Dependent(s)') automobile insurance policy's personal injury policy, whether or not elected by you or your Eligible Dependent(s).

Claims Submitted More Than Two Years After Charges Were Incurred, unless it is shown that it was not reasonably possible to furnish the claims within the time limit.

Cosmetic Procedure Charges that are not Medically Necessary or are not required because of an accident or disease or are not correcting a child's birth defect that caused a functional disorder.

Any charges incurred in connection with **Custodial or Maintenance Care** (including chiropractic maintenance therapy).

Dental Work Charges, except as listed in "Covered Medical Services." Oral surgery performed in a dental office, whether dental or medical in nature, will not be considered for payment under the medical benefits.

Eye Surgery that is primarily intended to allow you to see better without glasses or contact lenses, including vision-correcting surgery, such as radial and photo refracture surgery, keratotomy and laser surgery are not covered by the Merck Medical Plan.

Charges for care in **Excess of Plan Limits**, whether provided In-Network or Out-of-Network, including:

- Routine physical exams in excess of one exam every 12 months;
- OB/GYN exams in excess of one exam every 12 months;
- Mammography screenings – for those at least age 35, but not yet 40, in excess of one baseline; for those at least age 40, in excess of one visit every year; for those under age 35, no visits are covered, unless additional screenings are prescribed by your physician as Medically Necessary;
- Eye exams in excess of one every 24 months;
- Hearing exams in excess of one every 24 months; and
- Charge for bone mass density (office visit and test), fecal occult blood tests and sigmoidoscopy/ colonoscopy in excess of the guidelines established by the U.S. Preventive Services Task Force.

Charges for procedures, services, drugs and other supplies that are, as determined by the Claims Administrator under its internal procedures, **Experimental or Still Under Clinical Investigation** by health professionals.

Eyeglasses or Contact Lenses, including their purchase or fitting, other than discounts offered through the Complete Advantage Program.

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.

Funeral arrangements and services.

Treatment in a **Government-Operated Facility**. Charges resulting from confinement or treatment in any hospital or other facility owned, operated by or contracted by the United States government, any agency of the government or by a state or political subdivision of a state, unless there is an unconditional requirement to pay the charges.

Hearing Aids, including their purchase or fitting.

Services or supplies not included in the **Home Health Care Plan**.

Certain **Hospice Care Services**

- Services and supplies that are not usual, reasonable and necessary for palliative (pain relief) or supportive care of the patient.
- More than one visit by the hospice or home health care team or any member of the team in any one day (for a description of covered hospice benefits, see “What’s Covered Under the Horizon BCBS Medical Options”).

Services given by a member of the **Immediate Family or a Person Who Lives in Your Home**.

Charges for **infertility treatments** in excess of the lifetime maximum. 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.

Charges as a result of your **Involvement in War**. Any charges incurred in the care or treatment of any sickness or injury incurred after the effective date of your coverage as a result of your active involvement in war (declared or undeclared).

Legal or Financial services or counseling.

Medicare Parts A or B Payable Expenses when Medicare is the primary payer of benefits, or would be the primary payer of benefits had you and/or your covered Eligible Dependent(s) enrolled in Medicare Parts A and B as soon as eligible for Medicare.

Services and supplies for which there would be **No Charge if the Employee Were Not Covered Under the Medical Plan**.

Charges for expenses incurred while covered under the **No Coverage Option**.

Any charges for services and supplies that are **Not Medically Necessary** (other than for certain specified preventive care, see "What's Covered Under the Horizon BCBS Medical Options").

Any charges for care or treatment **Not Recommended and Approved** by a licensed physician.

Services of a **Nurse Who Ordinarily Resides in Your Home** or who is a member of your family or your spouse's immediate family.

Private Hospital Room Charges in excess of the highest daily rate charged by the hospital for a semi-private room, unless your doctor establishes that isolation is Medically Necessary.

Reversal of Sterilization.

Services by Homemakers.

Services by Volunteers or persons who do not usually charge for their services.

Sex-Change Surgery (gender reassignment surgery, transgender surgery) or any treatment of gender-identity disorders.

Charges for **Speech Therapy in Connection with Delayed Speech** or speech impairments as a result of a learning disability. 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.

Expenses covered under **Workers' Compensation**. Medical expenses resulting from an accidental bodily injury or sickness arising from the **treatment of work-related illness or injury**.

Charges for treatment which is considered by the plan to be **educational or provided primarily for research**.

Service, treatment or supplies **not generally accepted in medical practice** for the prevention, diagnosis or treatment of an illness or injury.

Services for the **treatment of weak, strained, flat, unstable or unbalanced feet, matatarsalgia or bunion**, except open cutting operations.

Services for the **treatment of corns, calluses or toenails**, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease.

Out-of-Pocket Maximum Amounts

The Out-of-Pocket Maximum Amount is the most that you and your Covered Dependent(s) are required to pay for covered expenses in a year after your Deductibles have been met. This maximum is determined based on your Medical Plan option, calculated using the following tables and uses your Base Pay as of the November 1st immediately before the beginning of the given calendar year. For a definition of "Out-of-Pocket Maximum," please refer to the Glossary in the "General Information about the Merck Medical Plan — Part 1 of the SPD."

Merck PPO Option

Annual Out-of-Pocket Maximum ²		In-Network		Out-of-Network ¹	
		<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
Varies based on your Base Pay: ³					
\$5,000	\$42,500	\$750	\$1,500	\$1,500	\$3,000
\$42,501	\$45,000	\$766	\$1,531	\$1,531	\$3,063
\$45,001	\$47,500	\$809	\$1,619	\$1,619	\$3,238
\$47,501	\$50,000	\$853	\$1,706	\$1,706	\$3,413
\$50,001	\$52,500	\$897	\$1,794	\$1,794	\$3,588
\$52,501	\$55,000	\$941	\$1,881	\$1,881	\$3,763
\$55,001	\$57,500	\$984	\$1,969	\$1,969	\$3,938
\$57,501	\$60,000	\$1,028	\$2,056	\$2,056	\$4,113
\$60,001	\$65,000	\$1,094	\$2,188	\$2,188	\$4,375
\$65,001	\$70,000	\$1,181	\$2,363	\$2,363	\$4,725
\$70,001	\$75,000	\$1,269	\$2,538	\$2,538	\$5,075
\$75,001	\$80,000	\$1,313	\$2,713	\$2,713	\$5,425
\$80,001	\$85,000	\$1,400	\$2,888	\$2,888	\$5,775
\$85,001	\$90,000	\$1,531	\$3,063	\$3,063	\$6,125
\$90,001	\$95,000	\$1,619	\$3,238	\$3,238	\$6,475
\$95,001	\$100,000	\$1,706	\$3,413	\$3,413	\$6,825
\$100,001	\$110,000	\$1,838	\$3,675	\$3,675	\$7,350
\$110,001	\$120,000	\$2,013	\$4,025	\$4,025	\$8,050
\$120,001	\$130,000	\$2,188	\$4,375	\$4,375	\$8,750
\$130,001	\$140,000	\$2,363	\$4,725	\$4,725	\$9,450
\$140,001	\$150,000	\$2,538	\$5,075	\$5,075	\$10,150
\$150,001	\$160,000	\$2,713	\$5,425	\$5,425	\$10,850
\$160,001	\$170,000	\$2,888	\$5,775	\$5,775	\$11,550
\$170,001	\$180,000	\$3,063	\$6,125	\$6,125	\$12,250
\$180,001	and above	\$3,200	\$6,400	\$6,400	\$12,800

¹ For Out-of-Network charges, you pay the Coinsurance amount plus the full amount of any charges above the Reasonable and Customary (R&C) Limit. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum. Covered Dependent(s) of an Eligible Employee or Retiree enrolled in the Merck PPO option who live permanently outside the BlueCard network area may be eligible for Out-of-Network coverage at 80% (rather than 70%) of the R&C Limit, subject to the Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. To receive the higher level of coverage, you or your dependent(s) must contact Horizon BCBS Customer Service team. Coverage at the higher level becomes effective on the date of notification to Horizon BCBS and is only available in areas where no network providers are available.

² Expenses incurred to satisfy your Deductible and Out-of-Pocket Maximum will be credited to both your In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

³ Base Pay equals Base Pay plus COLA.

Merck 80/20 Option

Annual Out-of-Pocket Maximum¹		Individual	Family
Varies based on your Base Pay: ²			
\$5,000	\$42,500	\$1,250	\$2,500
\$42,501	\$45,000	\$1,250	\$2,500
\$45,001	\$47,500	\$1,250	\$2,500
\$47,501	\$50,000	\$1,341	\$2,681
\$50,001	\$52,500	\$1,409	\$2,819
\$52,501	\$55,000	\$1,478	\$2,956
\$55,001	\$57,500	\$1,547	\$3,094
\$57,501	\$60,000	\$1,616	\$3,231
\$60,001	\$65,000	\$1,719	\$3,438
\$65,001	\$70,000	\$1,856	\$3,713
\$70,001	\$75,000	\$1,994	\$3,988
\$75,001	\$80,000	\$2,131	\$4,263
\$80,001	\$85,000	\$2,269	\$4,538
\$85,001	\$90,000	\$2,406	\$4,813
\$90,001	\$95,000	\$2,544	\$5,088
\$95,001	\$100,000	\$2,681	\$5,363
\$100,001	\$110,000	\$2,888	\$5,775
\$110,001	\$120,000	\$3,163	\$6,325
\$120,001	\$130,000	\$3,438	\$6,875
\$130,001	\$140,000	\$3,713	\$7,425
\$140,001	\$150,000	\$3,988	\$7,975
\$150,001	\$160,000	\$4,263	\$8,525
\$160,001	\$170,000	\$4,538	\$9,075
\$170,001	\$180,000	\$4,813	\$9,625
\$180,001	and above	\$5,000	\$10,000

¹ Expenses incurred to satisfy your Deductible and Out-of-Pocket Maximum will be credited to both your In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Base Pay equals Base Pay plus COLA.

Merck 80/20 Out-of-Area Option

Annual Out-of-Pocket Maximum ¹		Individual	Family
Varies based on your Base Pay: ²			
\$5,000	\$42,500	\$750	\$1,500
\$42,501	\$45,000	\$766	\$1,531
\$45,001	\$47,500	\$809	\$1,619
\$47,501	\$50,000	\$853	\$1,706
\$50,001	\$52,500	\$897	\$1,794
\$52,501	\$55,000	\$941	\$1,881
\$55,001	\$57,500	\$984	\$1,969
\$57,501	\$60,000	\$1,028	\$2,056
\$60,001	\$65,000	\$1,094	\$2,188
\$65,001	\$70,000	\$1,181	\$2,363
\$70,001	\$75,000	\$1,269	\$2,538
\$75,001	\$80,000	\$1,313	\$2,713
\$80,001	\$85,000	\$1,400	\$2,888
\$85,001	\$90,000	\$1,531	\$3,063
\$90,001	\$95,000	\$1,619	\$3,238
\$95,001	\$100,000	\$1,706	\$3,413
\$100,001	\$110,000	\$1,838	\$3,675
\$110,001	\$120,000	\$2,013	\$4,025
\$120,001	\$130,000	\$2,188	\$4,375
\$130,001	\$140,000	\$2,363	\$4,725
\$140,001	\$150,000	\$2,538	\$5,075
\$150,001	\$160,000	\$2,713	\$5,425
\$160,001	\$170,000	\$2,888	\$5,775
\$170,001	\$180,000	\$3,063	\$6,125
\$180,001	and above	\$3,200	\$6,400

¹ Expenses incurred to satisfy your Deductible and Out-of-Pocket Maximum will be credited to both your In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums. Expenses in excess of the R&C Limit do not count toward your Deductible or Out-of-Pocket Maximum.

² Base Pay equals Base Pay plus COLA.

Contact Information

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

	PROVIDER	CONTACT
MERCK BENEFITS		
Merck Benefits <i>New Hire Enrollment, COBRA, Life Events</i>	Merck Benefits Service Center	800-66-MERCK (800-666-3725) http://netbenefits.fidelity.com
Merck Payroll, New Hire, General HR Policies	Merck HR Service Center	866-MRK-HR4U (866-675-4748)
Merck Benefits Information, Forms, Literature	Merck Intranet Merck Website	http://hr.merck.com
HORIZON BCBS MEDICAL PLAN OPTIONS		
<i>Merck PPO</i>	Horizon BCBS	877-663-7258 www.horizonblue.com/merck or www.horizonblue.com/merckretirees
<i>Merck 80/20</i>	Horizon BCBS	877-663-7258 www.horizonblue.com/merck or www.horizonblue.com/merckretirees
<i>Merck 80/20 Out-of-Area</i>	Horizon BCBS	877-663-7258 www.horizonblue.com/merck or www.horizonblue.com/merckretirees
<i>Retiree Catastrophic</i>	Horizon BCBS	877-663-7258 www.horizonblue.com/merck or www.horizonblue.com/merckretirees
OTHER HEALTH BENEFITS		
Carewise	Horizon BCBS 24/Seven Nurse-Line	888-624-3096
Managed Prescription Drug Program	Medco Health Solutions, Inc.	800-RX-MERCK (800-796-3725) www.medco.com
BEHAVIORAL HEALTH CARE		
Managed Behavioral Health Care Program	ValueOptions	877-44-MERCK (877-446-3725) www.achievesolutions.net/merck
PRECERTIFICATION		
Horizon BCBS Options <i>Medical</i>	Horizon BCBS	877-663-7258
<i>Behavioral Health— Employees</i>	ValueOptions	877-44-MERCK (877-446-3725)
<i>Behavioral Health—Retirees</i>	Horizon BCBS	877-663-7258
ELIGIBILITY		
<i>Questions about Eligibility, Add or Drop a Dependent(s)</i>	Merck Benefits Service Center	800-66-MERCK (800-666-3725) http://netbenefits.fidelity.com

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